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Comprehensive responses to gender-based violence in low-resource settings: Lessons learned from implementation

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Acronyms

CBD	Community-Based Distributor
CEFOREP	Centre de Formulation et de Recherche en Santé de la Reproduction
CMIC	Copperbelt Model of Comprehensive Care
DHS	Demographic Heath Survey
EBD	Employer-based contraceptive distributor
EC	Emergency contraception
ECP	Emergency contraception pill
ECSA-HC	East, Central and Southern African Health Community
ESOG	Ethiopian Society of Obstetricians and Gynaecologists
FGD	Focus group discussion
FHD	Ethiopian Ministry of Health, Family Health Department
FIGO	International Federation of Obstetricians and Gynecologists
GRIP	Greater Nelspruit Rape Initiative Project
ICRH	International Center for Reproductive Health
IPV	Intimate partner violence
KAP	Knowledge, attitudes and practices
KII	Key Informant Interview
LVCT	Liverpool VCT, Care and Treatment
MOH	Ministry of Health
MRC	Medical Research Council (South Africa)
MSM	Men who have sex with men
NGO	Non-governmental organization
OIC	Officers in-Charge (police)
PEP	Post-exposure prophylaxis
RADAR	Rural AIDS and Development Action Research Programme
SADC	South African Development Community
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SV	Sexual violence
SVRI	Sexual Violence Research Initiative
TLAC	Tshwaranang Legal Advocacy Centre
TVEP	Thohoyandou Victim Empowerment Program
VA	Victim advocate
VCT	Voluntary counseling and testing
VSU	Victim Support Units

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Executive Summary

From 2006-2009, the Population Council undertook a program of technical assistance and research to strengthen the evidence base on gender-based violence (SGBV) programming in sub-Saharan Africa. This project created an active network of implementers and researchers across sub-Saharan Africa, all of whom were charged with developing, implementing and evaluating core elements of a comprehensive, multisectoral model for strengthening responses for survivors of SGBV, especially survivors of sexual violence. The comprehensive model includes health, criminal justice, and psychosocial services required by survivors, and works to strengthen the linkages between these sectors.

Seven organizations in six countries (Zambia, South Africa, Kenya, Malawi, Zimbabwe, Ethiopia and Senegal) partnered with the Population Council to implement the comprehensive model in part or in whole, and an additional thirteen organizations actively participated in the South-South technical assistance network.

Based on the experiences of these partners, this document reviews the findings, lessons learned, and promising practices in the provision of comprehensive SGBV services in sub-Saharan Africa. It draws on the data generated by the network partners to identify core issues in the provision of quality, comprehensive care for survivors of SGBV. These findings are intended to serve as a resource for programmers and policymakers throughout the region, and contribute to the emerging evidence-base on such program strategies. Key findings include:

Client characteristics

- Children constitute a significant proportion of survivors seeking services.
- Girls and women represent the bulk of survivors, but boys and men also seek care.

Guidelines are necessary, but not sufficient for providing comprehensive care.

- The process of developing national guidelines can spur multisectoral collaboration.
- Development and implementation of guidelines is often reliant upon a champion.
- Recognition of the need for guidelines and services specifically for child survivors is increasing.

Health services

- Several models of comprehensive, integrated care have proven feasible.
- Integrated services can improve quality and timeliness of health care.
- Ensuring and enabling HIV PEP adherence requires particular attention.
- Simple interventions can dramatically increase access to emergency contraception in a healthcare setting.
- Provider capacity remains an important barrier to quality, comprehensive care.
- Requirements that doctors collect forensic evidence undermine a survivor's access to justice and healthcare.
- Children are underserved by adult-oriented programs.

Police and Legal responses

- Police are often the first and only point of contact for survivors.
- Police provision of emergency contraception can strengthen multisectoral collaboration and response.
- Cross-sectoral training can improve linkages between police and health sectors.

- Greater access to legal services does not necessarily entail greater utilization.
- Police officers require more training on handling child survivors.

Psychosocial support

- Interpersonal skills at the first point of contact are a critical, but often overlooked, component of quality care.
- Safe houses and temporary shelters are costly to maintain.
- More evidence is needed on effective models for providing long-term psychosocial care.

The document also offers a framework of validated indicators for monitoring and evaluating comprehensive SGBV programs, and provides reflections on successes in facilitating south-south technical assistance among network partners.

Introduction

Worldwide, an estimated 1 in every 3 women will experience some form of gender-based violence (SGBV) in their lifetime.[1] Defined broadly, SGBV includes all forms of physical, psychological and sexual violence that are related to the survivor's gender or gender role in a society or culture.[2]

The link between sexual and gender based violence (SGBV) and HIV, as well as other sexually transmitted infections (STIs) is increasingly well-documented. Research indicates that the risk of HIV sero-conversion following forced sex is likely to be higher than following consensual sex, especially among children.[3] The increased violence associated with forced intercourse, and the lack of lubrication, can result in both microscopic and mucosal tears. Forced anal penetration is thought to carry a commensurably higher risk of HIV/STI transmission.[4] The increased risk of infection is especially pronounced in the high HIV-prevalence settings of sub-Saharan Africa.[5] DHS data have shown that women who have suffered violence are twice as likely to have an STI than women who have not. [6] Moreover, learning and communicating her HIV status with a partner, particularly in a discordant relationship, increases the likelihood of intimate partner violence (IPV) [7].

The link between SGBV and sexual and reproductive health (SRH) is also increasingly acknowledged. Studies from such diverse settings as China, Peru, the USA, and Uganda, have found that girls and/or young women who previously experienced sexual coercion are significantly less likely to use condoms, and more likely to experience genital tract infection symptoms, unintended pregnancy and unsafe abortion.[8] Women who experience IPV are more likely to use contraception secretly, be stopped from using family planning, and are more likely to become pregnant as adolescents.[9] Women abused during pregnancy are more likely to suffer depression, bleeding, and poor maternal weight gain.[10] Studies in Nicaragua show that children born to abused women have a lower birth weight and a higher risk of death before reaching age five. [11, 12]

Available data, while limited, demonstrate the impact of the 'dual epidemics' of SGBV and HIV in sub-Saharan Africa. As highlighted in Table 1, in many countries, physical and sexual violence are reported to be more prevalent than HIV, and intimate partners (such as husbands) are most frequently identified as the perpetrators of physical violence. Other data indicate that coerced sexual initiation is common among girls in the region, and is often viewed as a routine part of relationships.[13]

Table 1: SGBV and HIV prevalence in selected African countries

Country	Data Source	*Ever experienced physical violence**	*Husband/ Partner was the perpetrator of physical violence**	*Ever experienced sexual violence **	*HIV Prevalence†*		
					Female	*Male*	*Total*
Kenya	DHS 2003	40	57.8	16	8.7	4.6	6.7
Kenya	DHS 2008	39	51.8	21	8.0	4.3	6.3
Ethiopia	DHS 2005	--	--	--	1.9	0.9	1.4
	WHO 2005	49	--	59	--	--	--
Zambia	DHS 2007	46.8	59.6	15	16.1	12.3	14.3
Malawi	DHS 2004	28	43.2	--	13.3	10.2	11.8
South Africa	DHS 1998	6	--	7	--	--	--
	National HIV/ STI Strategic Plan 2007-11	--	--	--	21.2	15.4	18.3

* Question asked of women only
†Adults 15-49

Over the past decade, many African countries have begun to recognize the importance of both preventing SGBV and responding to the needs of SGBV survivors at a national level. South Africa and Kenya have led the continent with the development and implementation of national guidelines on the clinical management of sexual assault, and several non-governmental organizations (NGOs) have undertaken smaller-scale efforts to address SGBV in a range of settings.[14,15] However, in the absence of a strong, regionally-relevant evidence base, these national programs have tended to adopt strategies that have proven successful in the high resource settings of Europe and North America. The utility and sustainability of such approaches is not well-established in countries where access to even the most basic care is undermined by national and personal resource constraints.

Towards an evidence base on SGBV Programming

From 2006-2009, the Population Council undertook a program of technical assistance and research to strengthen the evidence base on SGBV programming in sub-Saharan Africa, so as to inform national and regional efforts. This program created an active network of implementers from across sub-Saharan Africa, all of whom were charged with developing, implementing and evaluating core elements of a comprehensive, multisectoral response model.

To inform the development and implementation of partner projects, the first Council undertook an extensive review of all existing formal and 'grey' literature on SGBV in Africa.[16] This review was published in February 2008, and includes a comprehensive overview of region-specific best policies, programmatic experiences and best practices related to the management of SGBV from a medical and criminal-justice perspective, as well as the reduction of violence at the community level. The analysis is structured around seven components collectively designed to meet the medical, psychological and justice needs of survivors of sexual violence. In addition to producing a full literature, the Council also published a booklet summarizing the key points in the literature review.[17] These two documents are important resources for developing a comprehensive model of care, support and prevention that can be adapted as a whole or in part. They have been distributed

widely, and the booklet has proven to be exceptionally popular with program implementers and policymakers and is now in its second re-print.

Drawing on these findings, the Council developed a model for a comprehensive response that serves as the conceptual framework for the entire initiative. This model, summarized in Table 2, identifies the key components of a comprehensive SGBV response, and highlights the overlapping and complementary responsibilities of the three core sectors (health, justice and social support).

Table 2: Key components of a multisectoral response to SGBV

Sector	Key components of response
Health	Pregnancy testing and emergency contraception
	HIV diagnostic testing and counseling and post-exposure prophylaxis (PEP)
	Prophylaxis for sexually transmitted infections
	Evaluation and treatment of injuries, forensic examination and documentation
	Trauma counseling
	Referrals to/from police and social support sectors
Police/ Justice	Statement-taking and documentation
	Investigation of crime scenes
	Collection of forensic evidence and maintaining the chain of evidence
	Ensuring the safety of the survivor
	Prosecution of the perpetrator
	Referrals to/from health and social support sectors
Social Support	Provision of safe housing, relocation services, if required
	Long-term psychosocial counseling and rehabilitation
	Referrals to/from police and health sectors
	Community awareness-raising and stigma reduction

The Population Council's SGBV network

Seven partners in six countries were recruited to implement the comprehensive model in part or in whole. As identified in Table 3, four "large scale" partners undertook projects that tested models and approaches for linking the sectors to provide comprehensive care. An additional three partners received "seed funding" to implement smaller, strategic activities intended to promote multisectoral collaboration on SGBV prevention and response. Throughout the course of implementation, an additional set of technical assistance partners joined the network to support partners through information provision, training and exchange visits. Each of the partner projects is summarized in Appendix 1, and detailed reports are available on each individual project.

Table 3: The Population Council SGBV Network

Country	Project Title	Implementing partners
Large-scale project partners		
Zambia	Copperbelt Model of Comprehensive Care (CMIC)	Zambia Ministry of Health, Zambia Police Service, Population Council
South Africa	Refentse Phase II[1]	Tshwaranang Legal Advocacy Centre (TLAC)
	Sustainable implementation of a multi-sectoral prevention and support strategy	Thohoyandou Victim Empowerment Program (TVEP)
Kenya	Improving 'custody-of-evidence' chain for post-rape care services in Kenya	Liverpool VCT, Care and Treatment (LVCT)
Seed grantees		
Malawi	Towards a multisectoral approach on sexual and gender-based violence in Malawi	Malawi Police Service, Ministry of Health, Human Rights Resource Centre
Zimbabwe	Musasa Project	Zimbabwe National Family Planning Association
Ethiopia	Nationalization of Guidelines on Comprehensive Management of SGBV	Ethiopian Society of Obstetricians and Gynaecologists (ESOG)
Senegal	**will begin implementing in phase II of the SGBV network*	Centre de Formulation et de Recherche en Santé de la Reproduction (CEFOREP)
PEPFAR partners		
Rwanda	PEPFAR Special Initiative on Gender-Based Violence	IntraHealth
		Drew Cares International and the Rwanda Defense Force
		The International Centre for AIDS Care and Treatment Programs/ Columbia Univ.
		Catholic Relief Services, AIDS Relief
Uganda	PEPFAR Special Initiative on Gender-Based Violence	Makerere University Joint AIDS Program
		Northern Uganda Malaria, Tuberculosis and HIV/AIDS Program
		Uganda People's Defense Force
South-South TA network partners		
Kenya	International Center for Reproductive Health (ICRH)	Supports gender-based violence recovery center at Coast General Hospital
Uganda	Raising Voices	Regional network on community- based approaches to SGBV prevention
South Africa	Sexual Violence Research Initiative (SVRI)	International network that promotes research and training on SGBV
	Sonke Gender Justice Network	Regional network that promotes male involvement in SGBV prevention efforts
	Medical Research Council (MRC)	Hosts a regional program on training and guideline development for clinical management of SGBV
	Greater Nelspruit Rape Initiative Project (GRIP)	Community-based victim empowerment project, which supports survivors of sexual and IPV

[1] This project is a continuation of the Refentse project, which was implemented by the Rural AIDS and Development Action Research Programme (RADAR), School of Public Health, University of the Witwatersrand with support from the Population Council and PEPFAR. For more information on Refentse phase I, see the program's final report (reference 24).

Technical exchanges

One of the most notable successes of this program has been the creation of a lively, functional network of implementing partners. Partners have actively shared their achievements, challenges and lessons learned throughout the period of project implementation. On a yearly basis the partners met to review project progress, exchange experiences, and identify technical assistance needs (see Table 4 for a summary of the meetings.) Partners were also given the opportunity to conduct South-South technical exchange visits within the network in order to encourage cross-learning and capacity building (see table 5 for a summary of these exchanges).

Table 4: The Population Council's SGBV network meetings

	Date and Location	Outcomes
Network launch [18]	October 2006 (Zambia)	• Agreement on the structure and functioning of the project's regional network. • Procedures for regular exchanges of information and updating progress. • Draft 18-month work plans and budgets for each of the implementing partners. • A uniform analytical framework for describing and documenting the process of expanding each program.
Mid-term review meeting [19]	March 2008 (South Africa)	• Identification of best practices from existing programs and initial discussion of evidence needs for new programming • Development of mechanisms for South-South technical assistance.
End of implementation review meeting [20]	October 2008 (Kenya)	• Identification of validated strategies for monitoring SGBV interventions, and the need for further development of data-capturing tools. • Information-sharing on specific strategies for providing SGBV services for children and men. • Discussion on the need to scale up projects to national and regional levels. • Recognition of the important role played by the network in sharing information and resources, and for consolidating the gains of partner efforts in the region as a team. • To provide the greatest benefit to participants, the final review meeting was convened in conjunction with the international conference, "Strengthening linkages between sexual and reproductive health and HIV/AIDS services: the sexual violence nexus."[2]
Annual review meeting [21]	July 2009 (South Africa)	• Active information-sharing and identification of best practices among partners and other experts. • Planning initiated for new partner projects. • Partners exposed in emerging global debates, resources and research on GBV through engagement with regional and international experts.

[2] For more information, see the conference website: http://www.svconference2008.org/

Table 5: South-South technical assistance exchanges

	Date and Location	Description
LVCT and CMIC visit TVEP	May 2008	• The objectives of the visit were to learn more about the comprehensive clinic-to-community model implemented by TVEP. • Lessons learned included innovative strategies for engaging traditional leaders in prevention activities and for overcoming barriers associated with transportation.
Zambian and Malawi police participate in LVCT workshop "Medico-legal Responses to SGBV" [22]	June 2008	• Police and forensic medical specialists from across the region were selected to participate in a4-day workshop, where participants deliberated on issues pertaining to SV. • Presentations reviewed best practices (including CMIC) which could be adapted by other countries within the region.
TVEP, TLAC, CMIC, Malawi, Musasa, ESOG, CEFOREP visit LVCT site [20]	October 2008	• In conjunction with the network meeting, participants conducted a site visit to the post-rape care centre in Gatundu District Hospital, which is managed by LVCT in conjunction with the Kenyan Ministry of Health (MOH). • Participants noted that this was an exceptionally valuable aspect of the meeting because it allowed them the opportunity to see how comprehensive services can be integrated into a lower-level health facility.
Malawi and ICRH visit to CMIC	December 2008	• The visiting team comprised three officials from Malawi Ministry of Health and Police Service, a representative from ICRH and staff from the Population Council's South Africa Office. The Malawi team included an official from the MOH Reproductive Health Unit and two officers from the Malawi Police Service. • Following this visit, both Malawi and ICRH have begun work on efforts to replicate this approach in their own programs.
CMIC, Malawi, Rwandan and Ugandan PEPFAR partners participate in South Africa MRC training on clinical management of SGBV[23]	February 2009	• Network partners from Zambia, Malawi, Rwanda and Uganda participated in a regional, multisectoral training on the management of SGBV. • The training was organized by the South African Medical Research Council, with support from the Population Council, PEPFAR and other partners. • The overall goal of the training was to improve medical, legal and psychosocial responses to sexual violence, both immediately after sexual assault and in the longer term.
CMIC technical assistance visit to Malawi	June 2009	• Following the December 2008 exchange visit to Zambia by a team from Malawi and ICRH, the Malawi Ministry of Health and the Malawi Police Service invited the CMIC team to participate in a national stakeholder meeting in Malawi. • Representatives from the Zambian police and the CMIC project team travelled to Lilongwe to participate in a one-day meeting on sexual assault management • The meeting successfully raised the visibility of SGBV among key government stakeholders, and participants agreed that it was feasible and necessary to replicate the CMIC study in Malawi, and that a multisectoral GBV steering committee be established to coordinate all GBV efforts in the country. • Following this meeting, Council staff provided further technical assistance in developing the terms of reference for the steering committee.

	Date and Location	Description
GRIP visits Malawi	August 2009	• The Academy for Educational Development (AED), through its Umbrella Grants Management Program, sponsored an exchange visit between the Malawi partners and GRIP, leveraging support from outside the network. • The objectives of the visit were to learn about the GBV response being implemented in that country and to share ideas and experiences on response strategies and approaches. • The visiting team was particularly impressed with the Men-to-Men campaigns aimed at increasing men's awareness of GBV that were being conducted throughout the peri-urban and rural areas of the country and expressed interest in replicating a similar approach. • The Community Policing initiatives were also noted as highly visible, well organized and closely linked with the activities of the Community Action Groups.
Sexual Violence Research Initiative Forum [24]	July 2009	• Following the July 2009 network meeting, partners were given the opportunity to attend the 2009 SVRI Forum, themed "Coordinated Evidence-Based Responses to End Sexual Violence." • The international conference took place from 6-9 July in South Africa and brought together almost 200 participants from over 28 countries. • The Council delivered a plenary presentation that reviewed lessons learned from partners' programs, and partners from Zambia (Ministry of Health), South Africa (TVEP), and Kenya (LVCT) participated in a panel on comprehensive response models.
CMIC technical assistance visits to Uganda	July, September 2009	• Leveraging support from the PEPFAR Special Initiative on GBV, the Zambian team provided technical assistance to the Ugandan PEPFAR partners throughout 2009. • In July, the Zambian program manager traveled to Uganda to co-facilitate a workshop on developing and implementing national SGBV guidelines, based on similar processes currently underway in Zambia. • In September, program staff returned to Uganda to support further support the implementation of the guidelines in government facilities, including the national referral hospital. Technical assistance was provided on updating the national SGBV reporting form, integrating service provision and on collecting forensic evidence.
Multisectoral training in Rwanda	February 2010	• In early 2010, the Rwandan Ministry of Health requested that the Council provide training on SGBV management to support the implementation of their new national guidelines. • The Council collaborated with South Africa's Medical Research Council and experts from Zambia and Rwanda to provide South-South technical assistance during the training. • A total of 35 participants attended the 10-day training, which was widely regarded as a success.

Contributions to Policy Dialogues

Throughout program implementation, the Council has widely disseminated the emerging lessons from this program, and has collaborated with partners to contribute to national, regional and international policy dialogues. As discussed in more detail below, information generated from this program has influenced national policy development activities in Ethiopia and Zambia and Kenya. On the regional level, the network has partnered with the South African Development Community (SADC) and the East, Central and Southern African Health Community (ECSA-HC) in increasing Health Minister's and AIDS authorities' awareness of SGBV, reviewing a regional SGBV implementation framework, and guiding the preparation of a literature review on child sexual abuse in the region. The Council has also participated in international expert review meetings convened by the World Health Organization and PEPFAR's Gender Technical Working Group. Project staff have extensively presenting project findings to conferences and workshops at the national, regional and international levels. See Appendix 2 for a detailed listing of all the information-sharing activities conducted under the project.

To increase the visibility and utility of our findings, the project also established a website has to archive partner tools and share program findings with the wider GBV community. The website, www.svri.org/popcouncil.htm, is hosted by the international Sexual Violence Research Initiative, a leading resource on SGBV.

Lessons learned on SGBV programming in Africa

The remainder of this document reviews the findings, lessons learned, and promising practices in the provision of comprehensive SGBV services in sub-Saharan Africa. As noted above, it draws on the experiences of the network partners to identify core issues in the provision of quality, comprehensive care for survivors of SGBV. These findings are intended to serve as a resource for programmers and policymakers throughout the region, and contribute to the emerging evidence-base on such program strategies.

While the comprehensive care framework was developed to address the broad range of SGBV services, in practice this program focused almost exclusively on services targeted to sexual violence (SV). This is largely a function of partner programs, which like many other organizations in the field have much more highly developed SV response services. As a result, the bulk of the data, programmatic experiences and lessons learned reviewed below apply primarily to the provision of comprehensive services for survivors of SV. Nonetheless, SGBV and SV services are naturally complementary, so the evidence generated on the SV services from this project can also be used to inform efforts to address SGBV more broadly.

Program data were collected by each implementing partner under the guidance of the Population Council. Each partner reported data on a common set of indicators that included client characteristics and services provided, as well as a series of project-specific indicators identified by the partners. Each of the large-scale partners published a final project report that details the results of their specific activities and outlines the lessons learned regarding comprehensive service provision. Appendix 1 summarizes the interventions undertaken by each partner, and outlines the data that were used to evaluate its effectiveness. The project

final reports constitute the primary data source for this document, and are complemented by the experiences of program staff in supporting implementation throughout the three-year initiative.

It is important to note that these data reflect programmatic data and experiences, but were not designed to be representative at a national level. The majority of the data was collected, analyzed and self-reported by the partners, and in many cases, was not subjected to independent quality controls. As a result, the data may contain bias or inaccuracies, although Population Council staff have carefully reviewed program data and records when possible.

Client characteristics

Comparative analysis of partner data demonstrated clear trends in the age and gender of survivors who presented for SV services: most survivors who report are young and female, although some boys and men experiencing violence also report for services. For those who do not seek care, barriers are reported to include a preference for settlements within the family or community, fear of shame and stigma, lack of awareness of services, bureaucracy and corruption. These findings have important implications for the types of services offered within a facility, how providers are trained, and how community-level awareness activities are targeted and conducted.

Children constitute a significant proportion of survivors seeking services

Sexual violence survivors who sought care in partner sites were disproportionately young. While survivor age ranged from 3 months to 89 years, children and minors constituted a significant proportion of those who presented for services.

Table 6 summarizes the age data collected by partners. Because of differences in data collection methodologies across countries, which was often related to the legal definition of minors, direct comparisons for all ages is not possible. Nonetheless, it is clear that young children comprise an important sub-set of survivors who seek services in all countries.

As table 6 indicates, the proportion of young survivors varied by country. In South Africa, partner organizations reported smaller proportions of children presenting at their facilities than in other countries, ranging from one-third under the age of 16 at the TVEP Trauma Centers and slightly less than half under age 17 at Tintswalo hospital.

Ethiopia, Zambia and Kenya, however, reported a much higher proportion of children and younger adolescents. In Ethiopia, approximately 80% of all clients who reported to the One Stop Centre (OSC) in Gandhi Memorial Hospital were under 18 years old, and 37% of those were under age 11. In Zambia's Copperbelt Province, 85% of those who presented to the police were under the age of 19, and nearly half (49%) were under 14. Similarly, in Kenya's Coast General Hospital SGBV Recovery Center, 77% of survivors were under 19, the bulk of whom (67%) were below the age of 14.

Table 6: Proportion of child survivors presenting to study sites, both genders

Age range	Country	Partner	%
Children and younger adolescents			
Under 11	Ethiopia	ESOG	37
Under 14	Kenya	ICRH	67
	Zambia	CMIC	49
	South Africa	Refentse	31
Under 16	South Africa	TVEP	34
Older adolescents			
Under 17	South Africa	Refentse	44
Under 18	Ethiopia	ESOG	80
Under 19	Zambia	CMIC	85
	Kenya	ICRH	77

It is important to note that these data reflect only those who seek care from either health or police services, and does not reflect prevalence in the general population. In countries such as Ethiopia, Zambia and Kenya, the disproportionate number of cases involving children and adolescents is likely to reflect higher reporting rates for such cases. Stigma against sexual violence survivors is strong in these highly traditional societies, and may serve as a deterrent to reporting among older adolescents and young women. This bias is voiced by a female nurse in Kampala, Uganda, who places the blame on the survivor: "*you find a young girl moving at night at 2am alone in the night that is one; and two, even how some people are dressed these days.*" Beliefs such as this, held by both providers and the community, are likely to discourage reporting among women and girls.

While these data do not establish trends over time, it is widely believed that sexual violence is on the increase across Africa. As one nurse in Uganda noted, "*we can't give you the percentage because there is no full analyzed research on SGBV [in our hospital], but through observation we think it's on a rise.*" Much of the rise is attributed to an increase in child sexual violence. A doctor in Rwanda recounted this concern, noting that "*it is in these last days that I heard a man raping a one-year-old child, so that we find that this is worrying because formerly maybe only mature girls would be raped.*" These attitudes are common across the region, and are often attributed to either increased vulnerability of children, including growing numbers of orphans, and to the belief that sex with children can cure HIV/AIDS.

Girls and women represent the bulk of survivors, but boys and men also seek care

In most partner sites, girls and women constituted all or nearly all of the survivors who presented for care. In Zambia and Malawi, for example, 100% of those who sought care from the police were women and girls. In Tintswalo hospital, just 4.2% of cases were men or boys. At two sites, however, men and boys represented a greater proportion of the survivors: TVEP in South Africa (14%) and ICRH in Mombasa, Kenya (20%). In both cases, the partners have conducted specific outreach activities to target these special populations of men.

Of the 209 males who sought services from the TVEP Trauma Centers, 74% (154) were prisoners referred through TVEP's prison outreach services. TVEP has entered into a memorandum of understanding with the prisons service that ensures that men who report sexual violence are transported to their Trauma Centers for services. These men are then provided the same level of care as other TVEP clients, including 'home visits' to the prisons.

Of this population, 57% experienced one-on-one rape or attempted rape, while another 33% suffered gang rape. Outside of the prison population, boys and young men under 16 accounted for one-quarter (26%) of those who sought care from the Trauma Centers, reporting either rape (49%) or sexual assault without penetration (45%).

On the Kenyan coast, the bulk of male survivors who seek services for sexual violence are boys under 19. All of the boys who presented at Coast General Hospital (100%) claimed that the perpetrators were men, typically a community figure such as a teacher or a priest. This is likely to be associated with an overall higher proportion of men who have sex with men (MSM) in the region. Although no definitive data are available, it is believed that MSM are more prevalent on the Kenyan coast due to the dual influences of Swahili culture and sex tourism. Research has indicated that this population is vulnerable to sexual violence; one study conducted by the Population Council and ICRH found that 70% of MSMs on the Kenyan coast reported recent experience with sexual abuse or rape.[25] To reach this population, ICRH has created a network of four drop-in centers throughout the Mombasa area that maintain referral links with the SGBV Recovery Center in Coast General Hospital.

Barriers to seeking SV services

While reliable estimates of SV prevalence are not available, it is widely believed that only a small proportion of those who experience violence seek any type of institutional care. In order to identify the barriers to seeking such services, qualitative research was conducted in Uganda and Rwanda as part of the PEPFAR Special Initiative on Sexual Violence, implemented by the Population Council. Focus groups were conducted among doctors and nurses is 15 participating sites in Rwanda and Uganda, as part of the baseline for the initiative.[26] Table 7 summarizes the barriers to seeking care, primarily identified by respondents as either police services or health care.

Table 7: Barriers to accessing SV services, Rwanda and Uganda

Barriers	Rwanda	Uganda
Preference for community level settlement	X	X
Fear of stigma	X	X
Lack of awareness of services		X
Poverty & distances		X
Overcrowded facilities		X
Threats by perpetrator		X
Bureaucracy & corruption	X	X

The most common barrier cited was the preference of survivors and their families for resolving the issue at home. This was attributed either to deference to traditional culture, fear of stigma or the desire for remuneration. Some were encouraged to do so by local leaders, or by family members who prefer to seek compensation directly from the perpetrator, particularly if he is well off and the family is poor.

A typical situation, according to one Rwandan nurse, is one in which "*the parents do not want the events to be known, for example, if the events took place in families or were perpetrated by grandfather, cousin or uncle and the parents would not want that awkwardness to be known.*"

Stigma was another frequently mentioned barrier to care-seeking. As one doctor in Uganda observed, "*Another issue is stigma related to being raped. People fear being associated with that name 'that so and so was raped by so and so' and keep quiet. Sometimes they don't report to their own parents/guardians because they fear the stigma attached to it.*"

In Uganda, it was commonly observed that survivors do not seek medical services because they are not aware of the health risks associated with SV, the appropriate procedures to follow and where to seek care. According to one doctor, "*in the communities, they are ignorant of services that are provided in the health facilities. They actually don't know that it is very important to access medical services immediately.*"

The lengthy bureaucratic procedures and need for reporting to different offices which may be far apart before reaching the health facility also discourages survivors from seeking medical care. Corruption also hampers efforts to provide services as survivors may be faced with demands for payments at several steps which they can ill afford. A nurse in Uganda observed that "t*here is demand of money from those who are carrying out these activities like the police. When they want these forms, I hear those people always request for money and the person who is filling the form also.*" Justice is also hindered by corruption, as characterized by a nurse in Rwanda "*If the man who has abused the child is a rich person while the child is a poor one, the man can go and see the authorities to silence them.*"

Guidelines are necessary, but not sufficient for providing comprehensive care

In all countries, partners identified national guidelines as an essential element in providing comprehensive SGBV care to all populations. One of the most critical elements in the development and implementation of such guidelines is the recognition of the multisectoral nature of an SGBV response, and the active engagement of a wide range of actors. Although such collaboration is rife with challenges, as discussed below, it is indispensible in creating the framework needed to implement a comprehensive approach to care.

The process of developing guidelines can spur multisectoral collaboration

Partners in both Zambia and Ethiopia developed national guidelines under this program, although the content of these documents, and process of developing them, differed significantly. The development of Ethiopia's guidelines took place solely within the health sector and only involved other actors at the dissemination and implementation stage. Conversely, Zambia took a multisectoral approach from the start, but the process of drafting and approving the guidelines has been lengthy due to the numerous actors and issues involved. Both models demonstrate the importance of a multisectoral, participatory process for ensuring stakeholder buy-in, but also indicate that such a process can be time-consuming and costly. They also highlight how the process of guideline development and dissemination can establish the relationships needed to enable multisectoral collaboration in the course of implementation.

***Ethiopia: National Guideline for the Management of Sexual Assault Survivors*[27]**

In Ethiopia, ESOG worked primarily with officials in the Federal Ministry of Health's Family Health Department (FHD) to draft the *National Guideline for the Management of Sexual Assault Survivors*, which was published in late 2009. The process began in 2008, when ESOG recognized the need to expand upon and nationalize the 2004 guidelines that were drafted in association with the International Federation of Obstetricians and Gynecologists (FIGO).[28] ESOG saw the need to protect its membership from increased scrutiny on the part of the police and courts, which had begun to imprison doctors whose testimony was contradictory, unsubstantiated by proper documentation or reflected improper treatment procedures. Without the presence of a single standard of care, and forms for documenting the collection of medico-legal evidence, health professionals remained at risk of wrongful arrest. It was also noted that while police and judicial systems of responding to sexual violence were more developed, the health sector lagged behind.

The guidelines were developed in slightly over one year, and were the product of two national-level consultations. The first stakeholder consultation took place in late 2008, where a small group of medical professionals reviewed and revised the draft guidelines. A second review meeting took place approximately six months later, which drew participants from the judiciary and police as well as medical professionals and representatives from the FHD. Representatives from the legal sectors were invited to provide input on the legal obligations faced by the health care providers.

The resultant document reflects a primarily clinical perspective on SV care. It is targeted toward medical professionals, namely doctors and nurses, who provide post-rape care services in public health facilities. It includes chapters on: clinical evaluation, medical management, administration of HIV and pregnancy prophylaxis, follow-up evaluations, and legal obligations for the provider. The document also introduces a new sexual assault medical evaluation form, which is intended to protect providers by presenting a standardized methodology for collecting and documenting medical examinations and forensic evidence collection.

Once the new guidelines were published, however, ESOG realized that it had missed an opportunity to incorporate a broader, multisectoral perspective into the document. This was prompted through discussions with the Council's SGBV network members at a meeting in July 2009, at which ESOG presented the process of guideline development.[29] Through interaction with the group, the ESOG representatives noted that the guidelines would benefit from more meaningful engagement from other sectors, including guidance on referrals, developing proper documentation and preparing for court. While the initial process was cost-effective, they noted, the final product would have been stronger if it had taken a multisectoral perspective.

To address this issue, ESOG organized a series of national dissemination meetings intended to create a national and regional-level dialogue on comprehensive SGBV services that incorporated all relevant sectors. In a series of two-day meetings held in three of the country's main urban centers, SGBV service providers were brought together for discussion and training under the new national guidelines. Overall, these discussions were rich and productive, providing a forum for exchange between the sectors that had previously not existed. The following excerpt from ESOG's report on one meeting highlights the type of discussion that characterized these meetings.

It was emphasized [by lawyers] that health care providers are not sensitive, they are not well trained and the reports they produce have poor assistance for the jury decisions. Some of the certificates produced from Hawassa referral hospital were presented and there was wonderful discussion between the lawyer, physicians and other participants.

As a result of these meetings, ESOG reports that communications between the sectors in these regions has improved. With support from UNICEF, ESOG has undertaken efforts to strengthen medical services in the three areas where the guidelines were disseminated and has continued to promote dialogue between the sectors.

Zambia: Guidelines for the Multidisciplinary Management of Survivors of Sexual and Gender-based Violence[30]

The process of developing national guidelines in Zambia was dramatically different from that in Ethiopia. From the outset, the process was multisectoral and participatory; but it was also protracted and costly. Zambian stakeholders believe, however, that this extensive process has created the preconditions necessary for successful implementation of a cross-sectoral response to SGBV.

As early as 2001, Zambia demonstrated high-level commitment to addressing SGBV. Increased media coverage of SGBV, especially defilement, spurred several early initiatives from the President's Office, including the creation of special Victim Support Units (VSUs) within the Police Service. This was supported by increased donor funding for programs to address SGBV in the police, health and justice sectors. These activities, however, were uncoordinated and implemented by NGOs that were often working outside of the government structures. To address this, in 2006, the Government of Zambia requested that all stakeholders harmonize their efforts by developing uniform tools and guidelines for SGBV service delivery.

In response to this call, in 2007 a technical committee was formed to guide this process that comprised the key actors working in the field: the Ministries of Health, Home Affairs (Police Service), Community Development and Social Services, Population Council, Care International, Zambia Society for the Prevention of Child Abuse and Neglect (ZASPCAN), Women in Law and Development in Africa (WILDAF), Women in Law in Southern Africa (WILSA), UNICEF and UNFPA. This committee was charged with harmonizing existing materials to develop national guidelines on SV services. At the outset, it was agreed the process should be overseen by the Gender-in-Development Division (GIDD) which was the Cabinet Office unit charged with coordinating gender issues across government departments. It was also agreed that the guidelines would comprise a single volume, containing guidelines for clinical management, police and legal response and psychosocial care. This implied that all sectors must work closely together, but also introduced challenges of coordination that have significantly delayed the process.

The document has been subject to intensive, multisectoral review at the national, provincial and facility level. While such reviews are believed to increase the ownership and acceptability of the document, they have also considerably lengthened the process. At least nine consultations have been held on the document, including one large-scale national-level consultation and a field-based validation exercise with health care providers, police and counselors.[31] In March 2010, the document was finally submitted to the Permanent Secretaries within the Ministries of Health, Home Affairs and Community Development and Social Services for ratification.

The document, termed the *Guidelines for Multidisciplinary Management of Survivors of Sexual and Gender-Based Violence*, is exceptionally comprehensive. It consists of three chapters that address clinical management, police and legal responses and psychosocial care. The first two chapters are evidence-based, and draw heavily on existing international guidance, while the third is based on current practice in Zambia in the absence of a robust evidence base on delivering psychosocial services in low-resource settings. As noted in the introductory chapter, the guideline presents a highly unified vision of SGBV response in the country:

> *As a whole, this document outlines the procedures for an integrated, multidisciplinary response to SGBV in Zambia. Individually, each chapter contains specific guidance for the key sectors charged with responding to the needs of SGBV survivors. Service providers are expected to adhere to the guidelines established for their profession, and familiarize themselves with the other sector's roles and responsibilities in order to ensure that survivors receive all necessary services.*[29]

Thus, this document, and the collaboration that has emerged from the participatory and consultative development process, is expected to serve as the foundation for integrated SGBV service provision across the country. Because these guidelines have yet to be implemented, the ultimate impact of this strategy is not yet apparent. It has, however, spurred a richer debate on SGBV services in the country, with the other sectors recognizing the importance of other sectors in providing care.

Implementation of guidelines is often reliant upon a champion

Just as the process of developing national guidelines requires a core set of champions, implementation is often reliant on advocates both within and outside the government. Under this project, partners in both Uganda and Malawi provided the impetus to more widely implement national guidelines. Their experiences clearly demonstrate that, while the development of national guidelines is an important element in providing comprehensive SGBV services, it is not sufficient and requires continued follow-up and advocacy to ensure proper implementation. It also highlights the shortcomings of guidelines that are "owned" by only one Ministry or sector, which may not have the capacity to promote their use more widely across sectors.

In Malawi, the Police Service and Ministry of Health collaborated to promote implementation of the 2005 national guidelines on SGBV. Stakeholder coordination meetings undertaken at the outset of the project reveled that, despite dissemination to the district health management, the majority of clinicians and nurses were unaware of the existence or content of the national guidelines. To address this, providers in the project area (Lilongwe) were trained on the procedures outlined in the guidelines and on completing proper documentation for survivors of sexual assault. While this training strengthened services in the intervention sites, it did not address the gaps in services nationwide. In recognition of this need, a multisectoral task force was formed in mid-2009 to guide the revision and implementation of the national guidelines. Technical assistance was requested from network partners including South Africa's Medical Research Council and the Population Council. This process is to be followed by a national training exercise for providers, undertaken jointly by the Ministry of Health and Police Services.[32]

Providers in Uganda were similarly unaware of the existence of national guidelines, published by the Ministry of Health in 2007.[33] This national document, intended to guide

health service provision and documentation in Uganda, was largely unused and unrecognized at the outset of program activities. Few government officials, and even fewer civil society partners, were aware of the existence of the document. As part of initial program planning activities, partners in the PEPFAR Special Initiative on Gender-Based Violence identified the guidelines after extensive searches, and obtained limited copies for use in partner facilities. Without such impetus on the part of non-governmental partners, it is likely that the guidelines would not have been implemented as widely as they currently are.

At the 2009 SGBV network meeting, partners discussed these experiences and agreed that the implementation of existing service provision guidelines remains a core challenge of providing quality SGBV services at a national level. Even in countries such as South Africa, which boasts a relatively strong policy and programmatic framework, service quality remains limited by adherence to existing guidelines. As such, participants suggested that successful implementation of existing guidelines requires ownership by a variety of actors, provider training and capacity-building, and sensitization of the communities regarding the services they can expect from all types of service providers.[34]

Recognition of the need for guidelines and services specifically for child survivors is increasing

As providers, partners, and governments have become more aware of the disproportionate number of child survivors seeking SV services, special provisions for children are growing more common. Notably, the 2010 revisions of guidelines in Kenya[35] and Zambia[30] include extensive provisions for the management of child survivors, and South Africa[36] has included such provisions since 2005. All three guidelines explicitly address the clinical care of children, and provide guidance on important issues such as the drug regimens for infants and children and special techniques for examination. All three also address issues associated with the proper documentation and collection of evidence for children, and South Africa has even developed a special *Pediatric Sexual Evidence Collection Kit* for children aged 12 and under. The Kenyan and Zambian guidelines are notable in that they address the psychosocial needs of children, both in the short and long-term.

Other guidelines, including those in Ethiopia[27] and Uganda[33], are much weaker on children's issues. Although all do recognize that some survivors are children, there is limited discussion of their unique status and needs. As sexual assault services develop in these countries, it is likely that the next iteration of these guidelines will more comprehensively address issues related to children. The challenge for all countries, however, lies in ensuring that such guidance is properly and consistently implemented in all health facilitates.

Health services

Health sector response is a core element of comprehensive SGBV care. Many African governments, donors and NGOs have devoted significant resources to developing strategies for ensuring that survivors of SGBV, most especially rape survivors, have access to critical health services such as post-exposure prophylaxis (PEP) for HIV and other STIs and emergency contraception, and that forensic evidence is collected and documented correctly. Little evidence exists, however, on the effectiveness of such interventions and their suitability in low-resource settings. To contribute to the evidence base, many of the partners focused on improving health services for survivors, and on using these interventions to strengthen linkages with services outside of the health facility.

Several models of comprehensive, integrated care have proven feasible

An important finding is that there are various models of comprehensive care that can be implemented within a healthcare setting. Table 8 summarizes the different approaches that were successfully implemented by partners. They range from TVEP's dedicated centers that provide all elements of comprehensive care on-site in South Africa, to the Zambian police who provide one element of care, emergency contraception (EC), and make referrals for further care. All of these models serve both urban and rural communities, although services are primarily provided within district or national-level referral hospitals. The plurality of these models demonstrates that care can be effectively organized in a variety of ways, depending on the context and capacity of existing services.

These models are all organized by the dual principles of minimizing points of contact and ensuring effective linkages with other sectors. In Malawi and Uganda, this was done by centralizing medico-legal services within one unit of the hospital and actively referring to other outside services. In South Africa's Tintswalo hospital, services were streamlined within the hospital through the development of sexual assault protocols and survivor management in a designated and unmarked room, although HIV care was still provided at a different location within the hospital. In Zambia, police officers provided EC as an element of immediate response and then accompanied survivors to the hospital for further care.

Important differences exist in the resources required to implement the models. Although no costing data were collected, partner experiences demonstrate that some approaches were more cost-effective and sustainable. The Zambia, Malawi and Refentse models built on the existing infrastructure and required only minimal inputs in terms of training and protocol development. Early research on the Refentse model found that, once the systems were established, the per-case cost of providing comprehensive medical services was $58, which was deemed to be cost-effective within the South African context.[37] In both Zambia and Malawi, services are still being provided in the intervention sites, even though project funding effectively ended in 2008. This suggests that these models can be self-sustaining if appropriately integrated into the existing infrastructure.

Table 8: Models of Comprehensive Care

	Key elements of model
TVEP, South Africa	Care provided at dedicated trauma centers adjoining district hospitals, independently operated by TVEP • Medical services (PEP, EC) • Forensic evidence collection and documentation • Safe house on-site • Victim advocates support survivor • 24-hour services • Serves rural communities
Tintswalo Hospital, South Africa	Care integrated within facility through development of management protocols • Nurse-driven model, forensic nurses conduct medico-legal exams • Referrals to criminal justice services • Lay counseling services established • Serves rural communities
Kamuzu Central Hospital, Malawi	SV services centralized in one hospital unit • All medical services provided in STI clinic during business hours (in obstetrics and gynecology ward during nights and weekends) • Trauma counseling provided by HIV counselors • Referrals to shelter • Referrals to and from 24-hour Victim Support Unit (VSU) at Lilongwe Police Station • Located in urban Lilongwe • VSU officers conduct community awareness activities
Mulago Hospital, Uganda	SV services centralized in one hospital unit • All medical services provided in "Ward 5A Annex" located within obstetrics and gynecology ward • Referrals to in-hospital police services, psychosocial care services • 24-hour services • Located in urban Kampala
CMIC, Zambia	Police officers provide emergency contraception, referrals for further health care • Specialized officers (VSU) trained to provide emergency contraception to eligible survivors • Referred to partner hospitals, often given police escort • 24-hour services, on-call • Serve urban and peri-urban Ndola communities • VSU officers conduct community awareness activities

The TVEP model, which is co-located within a district hospital, is more costly to maintain. These centers provide dedicated rooms for clinicians, police and counseling and dedicated staff including the unique Victim Advocates who provide on-going survivor support. They have the advantage of being exceptionally client-centered, and offering the full range of high-quality services, but are also highly dependent on external resources to maintain the level of care.

Integrated services can improve quality of health care

Evidence also demonstrates that the overall quality of care improved in intervention sites following the introduction of a comprehensive model of care. Pre- and post intervention data from Kamuzu and Tintswalo hospitals both indicate significant improvements in core indicators of care, including the proportion of survivors who received PEP, EC and STI

prophylaxis. In both programs, core activities included provider training and the identification of facility-specific procedures for care, which are associated with improvements in care. In Malawi, high rates of PEP provision are attributed to the fact that PEP was provided at the examination area, whereas survivors seeking care in Tintswalo hospital were referred to the pharmacy for PEP drugs (Table 9).

Table 9: Improvements in quality of care, pre- and post- intervention: Kamuzu and Tintswalo Hospitals

	Kamuzu Hospital, Malawi[38]		Tintswalo Hospital, South Africa[39]	
Indicator	Pre-intervention (Oct 2006-Sept 2007) N=78	Intervention Period (Oct 2007- Oct 2008) N=134	Pre-intervention (2003) N=161**	Post-intervention (2008) N=284
VCT/ HIV test on 1st visit	18%	63%	41%	73%
Received 28 days of PEP*	43%	95%	15%	68%
Received EC*	43%	59%	65%	81%
Received STI prophylaxis	76%	100%	n/a	n/a
Reported within 72 hours	38%	62%	n/a	80%
Referred from police	n/a	92%	n/a	52%

* Of all eligible clients
**Based on chart review

Referrals from the police were much higher in Malawi, reflecting the fact that police stations are the first point of contact for many survivors for most countries other than South Africa. In both countries, referrals from the police attest to the effectiveness of project efforts to create functional linkages between the two sectors. The proportion of those who reported within 72 hours of the assault also increased which, in Malawi, is attributed to community awareness-raising activities conducted primarily by police (VSU) officers.

Ensuring and enabling HIV PEP adherence requires particular attention

Partner experiences demonstrate that one of the central challenges in providing quality clinical services is ensuring adherence with the full 28-day course of PEP drugs. While notable increases have been made in increasing access to PEP, efforts to ensure compliance with the full regimen have been more limited. The two South African partners, TVEP and TLAC, have explicitly addressed this issue in their programs, with some degree of success. As Table 10 indicates, both programs have demonstrated successful strategies for promoting and measuring PEP adherence, although more work needs to be done in this area.

Table 10: PEP provision and adherence, TVEP and Refentse models

		Received 28 days of PEP	Completed course
TVEP Trauma Centers[41]	2007-2009 (n=1278)	82%	55-92%
Tintswalo Hospital, [37,39]	2004 baseline (n=35)*	39%	20%
	2006 endline (n=74)*	58%	58%
	2006-2008 (n=284)	68%	n/a

*As reported by the patient during in-depth interviews

Across all sites, limited follow-up, on the part of the patient and provider, was consistently noted as undermining attempts to encourage and monitor PEP adherence. This situation

was described by a nurse in Rwanda as one in which, "w*e are not able to assure them because there is no follow-up; when they get out of here, everything is like we are finished with them, and they do not come any more*".[26] In low-resource settings, the cost and availability of transportation was identified as a primary barrier to seeking follow-up care. As a nurse in Zambia noted, "*the biggest hurdle we are facing is the lack of transport because….in most cases it is the victim who pays for all transport costs.*"[40] Given the stigma and trauma associated with sexual violence, and the additional burden posed by limited transportation, partners reported that many survivors did not return to seek any type of follow-up care from the health facility. Limitations in record-keeping within many public facilities also make it difficult to accurately assess follow-up rates, although client follow-up is widely recognized as limited in most partner facilities.

The TVEP model addresses these issues through intensive counseling and household-level follow-up. This model is structured around the *Victim Advocates*, who act as a liaison between the clients and the examining doctor/medical professionals, legal team, and investigating police officer. Clients who present at the TVEP Trauma Centers within 72 hours and agree to take PEP are given pills for all 28 days at the initial visit, and receive initial counseling from the victim advocate. These clients then are visited by the victim advocate at home on Days 3 and 28 to provide continued social, medical, and legal support. A core objective of the home visits is to increase the likelihood that clients complete the full PEP course, but advocates also follow up on other issues, including food security and continued violence. During the home visit, the victim advocates count the remaining PEP pills in order to verify compliance, and provide counseling on management of side-effects.

Through this approach, TVEP has recorded an overall PEP adherence rate of at least 55% for the 765 clients who were given PEP between 2007 and 2009 (55% adherence rate for women, 57% for men).[41] It is likely that the adherence rate is higher than the 55%, because the analysis is limited by the fact that approximately 40% of all case records do not include data on PEP completion. When only those records that provide data on PEP completion are analyzed, the adherence rate is as high as 92% (511 clients completed PEP, 43 did not). This underscores the difficulties of collecting follow-up data on clients, even in a model that includes household-level outreach. Even at the lowest adherence rates, TVEP's performance compares favorably to other studies conducted in South Africa, which recorded 35% adherence rate in Durban's Gandhi Memorial Hospital Crisis Center[42] and 20% at baseline in Tintswalo Hospital.[37]

In Tintswalo hospital, two strategies were undertaken to increase PEP adherence. First, the program encouraged provision of all 28 days of PEP during the first visit, rather than the 3-day "starter pack" that is recommended under the national guidelines. This was based on initial research, which indicated that only 14% of those given starter packs returned for the remaining medication; this was attributed to transportation and other access issues. As indicated in Table 9, this improved access to the full course of PEP throughout the course of the intervention, with as many as 81% of clients receiving all 28 days by the conclusion of phase I in 2008.[39] To ensure that those who received PEP complied with the full course, nurses were given intensive training in adherence counseling, although their ability to follow up cases remained limited. Adherence rates in this model, measured at the conclusion of phase I in 2006, were recorded at 58%.[37]

While both models demonstrated relatively high adherence rates in comparison to other data, at 55% and 58%, these rates are still sub-optimal. Survivors must take the entire 28 day course to ensure protection against HIV transmission. These experiences have demonstrated

that PEP adherence remains a core challenge for SV programs, and that new and innovative program strategies are needed to overcome the barriers to follow-up and adherence.

Simple interventions can dramatically increase access to EC in a healthcare setting

While EC is a basic element of post-rape care, it is often not routinely available in many public health systems. Access is often hampered by absence of a dedicated product, limited provider awareness of the method, provider biases, or availability only in family planning clinics. In Rwanda, a 2009 pre-intervention facility inventory found that none of the eight health facilities surveyed had EC available in the sexual assault examining area.[26] Because the efficacy of EC is greatest when taken as soon as possible after unprotected sex (and no later than 120 hours), immediate to EC access is a critical element of quality post-rape care.

All partners were encouraged to ensure that EC was readily accessible to sexual violence survivors. In the healthcare setting, Tintswalo[39], Kamuzu[38] and Mulago[43] hospitals were able to ensure high rates of EC provision through a set of simple interventions. These included training providers, ensuring that EC was included in care protocols, and that it was in-stock in the units where sexual violence services were provided. Another study in Kenya demonstrated that, within two hours, healthcare providers can be adequately trained to provide EC.[35] Through these interventions, the hospitals were able to provide EC to 81%, 59% and 87% of survivors, respectively. As indicated in Table 9, EC provision rates in Tintswalo and Kamuzu increased substantially from baseline.

In only one of these facilities, Kamuzu Hospital, did providers have access to a dedicated EC pill (ECP). Dedicated ECPs are slightly more efficacious, have fewer side effects and have a lower pill burden than the Yuzpe method that is composed of higher doses of regular oral contraceptive pills. In Malawi, the dedicated product Postinor-2 was donated to the Malawi Ministry of Health by the Population Council under a related project, and availed to Kamuzu hospital for post-rape services. In South Africa and Uganda, the government does not routinely stock dedicated ECPs, and both Tintswalo and Mulago hospitals relied on the Yuzpe method of EC. Despite the fact that the Yuzpe method requires slightly more knowledge and involvement than with dedicated products, both hospitals had high EC provision rates, suggesting that the absence of a dedicated product is not a significant barrier to providing EC services.

Provider capacity remains an important barrier to quality, comprehensive care

Baseline research conducted in Rwanda and Uganda demonstrated that provider knowledge and attitudes serve as important barriers to quality, comprehensive care. While these providers, and those of the other network partners, were trained as part of the interventions in their sites, these initial findings highlight capacity constraints that are common across the continent.[7]

A key issue identified by all partners was the lack of trained medical staff available to provide services. In many public facilities across the continent, there is an acute shortage of staff, creating long waiting times and full waiting areas, particularly in emergency departments. These conditions are extremely daunting for an SV survivor and mean that providers are unable to provide the level of care they would like to, or that the SV trained personnel are not available at all. This is particularly acute given the regulations which require a gynecologist to perform most of the procedures. In both Rwanda and Uganda,

nurses advocated for a greater devolution of responsibly to nurses, noting that "*the doctors in the country are few. They [should] get trained in SGBV and train the nurses because these ones are many. So that when the one who has been raped comes, the nurse would receive her in case the doctor is busy with emergency cases because then she has all the skills*." (Rwandan nurse)[7] The nurse-driven approach successfully piloted in Tintswalo Hospital was designed to address such constraints, and is clearly relevant to many settings.

Quality of care is also undermined by negative attitudes toward survivors of sexual violence. Providers in Uganda frequently demonstrated biases against survivors, with healthcare providers commonly observing that a survivor's behavior can be responsible for an attack. Respondents described several instances in which they perceived the survivor's behavior to be inciting SV, such as women dressed in short skirts and low tops, drinking and accepting alcoholic drinks from men, taking drugs, walking and talking provocatively, and attending discos late into the night. According to one Ugandan doctor "*some of them, it is especially those young girls like 14, 15 and 16 years, they also expose themselves to situations that encourage somebody to rape them. Like when we have dancing and the way they behave, sometimes their behaviors itself, the way they walk.*"[26]

Service providers have begun to express a growing reluctance to provide emergency prophylaxis, such as EC and PEP, for fear that it is being abused. Nurses in Kampala, Uganda specifically identified this as a problem, and have reported increased numbers of clients who engage in consensual unprotected sex but claim they were raped in order to access PEP. As described by a nurse "o*ther times people who come in most frequent like he might come in January and tell you that he was raped, then he comes in after 3 month and says the condom has burst. So people are making a habit since there is PEP. Even boys have unprotected sex with girls and he comes and tells you, 'You know I was with a girl I didn't protect myself and not sure of her so I've come for PEP', something like that. People have started playing around with the drug.*" Anecdotal evidence also suggests that such perceptions are becoming more common in Kenya and Zambia, and are poised to emerge as an important barrier to quality care. More research is urgently needed to identify the extent of such 'abuse' and strategies for ensuring equitable access to such emergency services.

Requirements that doctors collect forensic evidence undermine a survivor's access to justice and healthcare

Forensic evidence collection serves as an important link between the health and criminal justice sectors. Through proper documentation, collection and processing of samples, medical evidence can form the basis for successful prosecution. However, nearly all partners identified forensic evidence collection as one of the most challenging aspects of providing sexual violence services. Even in South Africa, where relatively strong procedures have been instituted, one study found that only 67% of cases in Gauteng had completed evidence collection kits and only 51% of those were sent to the forensic laboratory.[48]

Nonetheless, in many countries, medico-legal evidence serves as the standard for prosecution. Prior to the implementation of LVCT's intervention, police in Kenya noted that they almost exclusively relied on medical evidence for constructing their case.[45] The disjuncture between the over-reliance on medico-legal evidence and the limited ability of medical systems to collect such evidence has been identified by partners as a key barrier to quality services. Specifically, in many countries only doctors have the authority to collect and document such evidence for use in legal proceedings. Because the number of doctors is

exceptionally limited in many countries, this requirement effectively undermines survivors' access to both justice and health care services.

On the most basic level, proper evidence collection is hindered by the lack of necessary supplies and equipment, and by limited provider capacity to do so. As table 11 indicates, only a small proportion of facilities surveyed in Rwanda and Uganda were equipped to conduct forensic examinations in the room where sexual violence services are provided. Similar circumstances were found in Kenya, where LVCT's baseline found that the two district hospitals surveyed did not have proper provisions for evidence storage, including lockable cupboards and refrigerators for storing samples prior to analysis.[45]

Table 11: Supplies and equipment available in SV examination rooms, Uganda and Rwanda[7]

Facility	Exam couch	Speculum	Swabs	Blood tubes	Working angle lamp	Lockable supply/ evidence cupboard
Uganda % yes (n=9 facilities)	78%	78%	78%	67%	22%	22%
Rwanda % yes (n=8 facilities)	100%	50%	38%	38%	50%	25%

Even more important than the physical infrastructure however, are the human resources required to conduct the specialized examination. One of the most commonly identified barriers to medical evidence collection and documentation are legal requirements that limit the cadres of health care providers who can provide forensic services. In Zambia, Kenya, Rwanda and Uganda, the law specifies that only doctors can collect medical evidence from survivors, sign the official medical report, and testify in court as "expert witnesses." In practice, this creates significant delays in receiving emergency medical services, such as PEP and EC, because survivors who report to lower-level health facilities are often referred to hospitals with doctors on duty. At higher-level facilities, this continues to be a barrier as doctors have many other duties, are over-worked, or may not be available when needed. As noted by one nurse in Uganda, "*the major challenge we have been facing is that clients should be first examined by a gynecologist when you don't have a gynecologist around, it becomes a problem.*" The requirement that police supply and doctors sign medical report forms has also contributed to corruption in the police and health sectors, with some police charging for the forms and some doctors charging "signing fees" for the service which should be free. According to one Ugandan nurse, "w*hen they want these forms, I hear [the police] always request for money and the person who is filling the form also.*"[26] Similarly, in Zambia where all sexual violence services are free under Ministry of Health policy, a community member noted that "*unfortunately, most people don't go to the hospital because they cannot afford the hospital charges.*"[40]

Several efforts have been made to address these barriers to care. In South Africa, where the role of forensic nurses is more widely recognized under law, the nurse-driven model implemented in Tintswalo hospital was extended to forensic examination and documentation. Despite receiving three weeks of training, nurses continued to lack confidence in their ability to undertake the lengthy forensic examination and were intimidated at the prospect of testifying in court. At the conclusion of phase one, 95% of forensic examinations were still conducted by a doctor.[37]

In Kenya, LVCT undertook a study in two district hospitals to increase the quantity and quality of forensic evidence collection for sexual violence. Their baseline assessment found

that, despite legal requirements that only doctors collect forensic evidence, all cadres of healthcare workers—clinical officers, nurses and doctors—collected such evidence. Because only doctors could sign the forms, however, the documentation on these cases was often incomplete. To address this, LVCT developed an algorithm to guide the collection, storage and documentation of such evidence, and trained all cadres within two district hospitals on the procedures. The intervention successfully increased the quality of evidence collected in the facilities, which was attributed to an increased awareness at all levels of the required procedures and documentation. This suggests that lower-level providers can positively contribute to the collection of evidence even in countries where the final certification of such reports remains relegated to doctors.[45]

Children are underserved by adult-oriented programs

Despite the fact that children constitute the majority of survivors seeking care in many countries, and a growing recognition of this issue among the partners, none of the partners included child-specific interventions in their programs. Only one, TVEP, collected data specifically on the services provided to children. That data, however, demonstrates that children are typically underserved in adult-oriented programs. Within the TVEP program, as indicated in Table 12, both boys and girls under the age of 16 were 19% and 23% less likely to receive PEP than their adult counterparts. Similarly, forensic evidence collection for boys and girls was significantly less likely to include use of a rape kit used during the forensic examination, despite the existence of specialized pediatric rape kits and collection procedures in South Africa. These findings indicate clearly that adult-oriented programs cannot adequately address the needs of children and young adults, and that specific interventions are necessary for this population.

Table 12: TVEP data on differences in services provided to adults and children[41]

	<16 Years Females (n=452)	< 16 Years Males (n=55)	≥ 16 Years Females (n=816)	≥ 16 Years Males (154)	p-value
Received PEP	69%	64%	88%	87%	<.001
Completed PEP course	93%	90%	92%	93%	.960
Rape kit used	66%	56%	80%	86%	<.001

In Rwanda and Uganda, the baseline facility inventory found that none of the 17 hospitals or health centers included in the review had special aids for examining children. Providers in Kenya, who also lacked special aids for such examinations, identified specific difficulties with collecting forensic evidence from children including their own inexperience and lack of training in collecting samples from young survivors. As one clinical officer noted, "*you see they are not used to such kind of examinations, so they tend to...they are shy, so like some you end up getting the wrong specimen, instead of getting the high vaginal swab, you end up getting the outer swabs.*"

Police and legal responses

Criminal justice and health issues are intimately linked in the provision of comprehensive SGBV services. Survivors not only need health care and forensic evidence collection, but also require appropriate police and legal services if they wish to prosecute the perpetrator or protect themselves from further harm. In many settings, the health and justice sectors have operated independently, and sometimes in opposition, despite their overlapping mandates. Under this initiative, partners implemented several successful strategies to improve the linkages between these two sectors.

Police are often the first, and only point of contact for survivors

Partners from across the continent consistently observed that police were the first, and often, only point of contact for survivors.[46] In South Africa, a record review conducted by TLAC demonstrated that 45% of all cases of domestic violence were initially reported to the police, and very few sought further health and legal services.[47] In Zambia, a pre-intervention record review found that 91% of survivors reported to the police. Records also demonstrated that while 2,203 survivors reported to the police, only 1,077 cases were recorded at the health facilities.[40] Although limited data exists on reporting preferences, the Zambian experience is believed to be characteristic of other low-resource settings across the continent, including Kenya, Uganda, Rwanda and Malawi.

Several reasons are cited for such reporting patterns. First, many healthcare providers, police and survivors believe that the crime must first be reported to the police in order to receive medical care. As recounted by a community member in rural Zambia, "*people usually report to the police first…sometimes a person will go to the hospital first and the doctor will refer them back to the police*" before care is provided.[40] In most countries, this is an incorrect interpretation of existing laws, and in all cases it undermines quality of care by increasing delays in seeking health services. As a result, SV is often viewed as a criminal or legal issue, while the health risks are largely unknown. According to one nurse in Rwanda, "*as far as [the survivors] are concerned, they would like the wrongdoer to be punished straightaway…or be fined, as they do not care about the future [health] consequences.*" Similarly, a doctor in Uganda noted "*people go to police and they will only learn of the hospital when the police require them to come for the medical examinations and by the time they come, they don't even come to seek for medical treatment and management of injuries, but for the form.*" [26]

Thus, a central challenge in ensuring comprehensive services rests with creating functional linkages between police and health services, especially in terms of creating and maintaining strong referral networks.

Police provision of EC can strengthen multisectoral collaboration and response

To strengthen SV services within police stations, the Zambian police piloted efforts to provide EC and strengthen referrals of survivors to health facilities. This intervention was grounded in the recognition that police provision of EC could help survivors prevent pregnancy by reducing the time-to-dose for EC, thereby increasing its effectiveness, and ensuring that those who do not reach the health facility had access to the drug. It also worked to create a functional framework for collaboration between the health and justice sectors as a means of strengthening the entire SV response system.

Under the intervention, Victim Support Unit (VSU) officers were trained to deliver EC to eligible survivors of sexual violence and to refer survivors to health facilities for further clinical management and forensic evidence collection. To ensure the quality and safety of such services, VSU officers were trained under the Ministry of Health's Community-Based/ Employer-Based Family Planning Distributor curriculum, and oversight was provided by a health provider. The study was implemented in five police stations in the Copperbelt's Ndola district and guided by a multisectoral steering committee.

The intervention demonstrated that police can effectively and safely provide EC, and that by doing so, the collaboration between the health and police sectors improved. Over the life of the intervention, VSU officers provided a total of 357 doses of EC to survivors of sexual violence. Health sector staff were pleased with the intervention, noting that "*we haven't faced any challenges regarding these EC being administered by police officers. If any, it has made our job easy because by the time survivors come to the hospital, they already have received some help so we just pick up from where our friends ended.*"

Reporting of sexual violence cases increased by 48% in participating police stations from 2006 to 2007, and community members noted that "*now we quickly report to the police because we know we will find assistance like EC.*" Trained VSU officers consistently referred survivors for other health services, including PEP for HIV, with three of the five intervention sites reporting referral rates of 95 percent or higher.

The program was perceived by provincial health and police management as successful, sustainable and cost-effective. According to a one health official, "*this program is resource cheap in the sense that it doesn't need a lot of funds to be sustained; keeping in mind that the most expensive part of sustainability of such programs is manpower which we partly have in an already existing system*." Based on these findings, national scale-up of this program was widely endorsed by stakeholders and the Council is currently working on a scale-up strategy to be implemented under phase II. [40]

Cross-sectoral training can improve linkages between police and health sectors

In addition to the project in Zambia, police in Malawi also undertook specific interventions to strengthen linkages between police stations and health facilities. As indicated in Table 13, post-intervention evaluation data found that police in both Zambia and Malawi referred the vast majority of survivors (over 90%) to health facilities. This was widely recognized to be a substantial increase from the pre-intervention period, and is notably higher than in Tintswalo Hospital, which did not have direct involvement with the police. In all facilities, however, measurement difficulties across sectors frustrated partners' abilities to track the actual uptake of such services once referred.

Table 13: Post-intervention referral rates between health and police sectors

	Referred to health facility from police	Referred to police from health facility
CMIC, Zambia [34]	93%	n/a
Kamuzu Hospital, Malawi[43]	92%	8%
Tintswalo Hospital, TLAC[37]	52%	n/a

An important element in both the Zambia and Malawi interventions were multisectoral trainings that emphasized both the health and criminal aspects of police response. In Malawi, officers from the Victim Support Units (VSU), Criminal investigations Division (CID) and prosecution wing participated in a two-day training course, conducted in conjunction with clinical officers, nurses and magistrates. The aim of this training was to improve coordination among the service providers through an enhanced understanding of each partner's roles and responsibilities. A second, more specific 2-day "customer care" training was conducted among police officers, which highlighted the linkages within the police system with regard to prosecuting SV cases. Officers were oriented on administration of PEP and EC, including the time limits for such services, in order to encourage prompt referrals to the health facilities. Protocols were also established within the police station, ensuring officers manning the main enquiries desk immediately referred SV cases to the Community Policing Wing of the VSU.

In Zambia, as noted above, VSU officers were trained to provide EC in addition to existing police services for SV cases. Selected VSU officers attended an intensive six-day training program, which integrated an emphasis on EC and SV into the Ministry of Health's existing employer-based contraceptive distributor (EBD) training curriculum. Because most VSU officers had no previous formal exposure to reproductive health or family planning issues, the training ranged from the basics of anatomy and physiology to the specific health needs of SV survivors. The goals of the training were to provide VSU officers with knowledge and skills needed to deliver high-quality EC services to survivors of rape and defilement, and to train them as EC EBDs in compliance with MOH standards. The training also benefitted from the multi-disciplinary facilitation team, which included both health workers and police officers. Because of the regimented nature of police procedures, the presence of a high-ranking police officer throughout the entire course was necessary to demonstrate police commitment to the study and to resolve any questions about how the intervention accorded with institutional policy. The presence of experienced health professionals helped dispel misconceptions held by police officers relating to hospital policy, SV examination procedures, PEP for HIV and STIs, and answered basic questions on reproductive and sexual health.

While police training efforts in Zambia were more intensive than in Malawi, data indicate that both programs were equally effective in ensuring high referral rates to health facilities. A key element of this success, according to participants, was the multisectoral nature of the training and instruction on the health issues associated with sexual violence. Effective supervision from within the police service also ensured that the linkages between the sectors remained functional. In both contexts, the intervention was believed to be cost-effective and sustainable.

Greater access to legal services does not necessarily entail greater utilization

Little reliable data exist on prosecution rates for sexual violence cases within sub-Saharan Africa, but partners unanimously agree that most SV cases do not reach court. Even in South Africa, where the legal framework for sexual assault cases is most highly developed, a study found that that only 17% of rape cases reported to the Gauteng police in 2003 were taken to court. Of those, only 6.2% resulted in prosecution.[48]

To increase access to formal justice services, TLAC worked to strengthen linkages between the health and legal sectors. In conjunction with their ongoing work at Tintswalo hospital, TLAC established a legal service center in the grounds of Acornhoek Police Station, which is

the nearest referral point for the hospital (1.5 kilometers away.) To encourage referrals, TLAC developed a referral letter for hospital staff to provide to all sexual violence survivors, and trained nurses to refer survivors to the TLAC center. From 2007-2008, 49% (112) of the 228 adult rape survivors presenting to the hospital were referred to the TLAC center.

Only 37% (41) of those women, however, ultimately sought legal services from TLAC. Because these women were lost to follow-up, it is impossible to determine why they did not seek further support. Reasons are believed to include that they did not choose to pursue the case in court, were not contacted by police to do so, or experienced other barriers to accessing services such as limited funds for transportation.[39]

These findings demonstrate that the decision to seek legal support is much more complex than initially believed, and that greater access to such services does not necessarily entail greater utilization. More research is needed to establish the reasons why women pursue legal redress for sexual violence, and just as importantly, why they do not. It is also necessary to determine what survivors believe constitutes 'justice', especially in contexts where remuneration is the preferred means of resolution and lengthy jail sentences for family "breadwinners" can severely affect the economic survival of poor families.

Police officers require more training on handling child survivors

As with the health sector, police and legal personnel have expressed frustration with their inability to respond to the special needs of child survivors. While increased efforts have been made across the region to improve legal services for children, including specialized training on child-friendly courts, much less has been done to equip police officers to adequately respond to the needs of child survivors. As one police officer in Zambia noted, *"we need a lot of training on how to deal with children, because the court requires that we present a statement from the victim but in case of a kid it's very difficult to extract information especially those who are five years and below."*[40]

Psychosocial support

One of the least developed components of comprehensive SGBV care is social support services, which include interventions such as short and long-term counseling, provision of safe houses and community outreach to reduce stigma. This is by far the weakest element of the model in all partner countries, and the program has demonstrated that there is still much to learn about providing cost-effective social support services.

This issue received much attention during the 2008 partners' meeting, where partners identified the need for a more robust evidence base on cost-effective and culturally appropriate models for psychosocial care in the African context. As outlined in the meeting report "w*hile much progress has been made in the areas of medical management and legal responses, very little is known about addressing the short and long-term psychosocial needs of survivors. Participants consistently identified this as an area for improvement in their own programs, noting the constraints posed by a limited evidence and experience base."*[51] In the second phase of this project, the Council will devote more attention to identifying promising practices in this area.

Interpersonal skills at the first point of contact are a critical, but often overlooked, component of quality care

A common challenge to providing quality care identified by both healthcare workers and police is the traumatized state of the survivor and family. Such trauma makes it difficult to take the necessary history and statements from the survivor, conduct a physical examination, or collect forensic evidence. As one nurse in Rwanda recounted, "*when rape has occurred, the family of the victim would come with such commotion that the counseling aimed at helping them becomes a problem.*" Another Rwandan nurse recalled the "*case of a child who was 9 years old and refused to enter the consultation room and was all in tears.*"[26] Despite the recognition that such issues frustrate providers' work, limited efforts have been made to improve provider capacity to provide immediate crisis counseling.

Two of the partner projects undertook successful efforts to improve providers' interpersonal communication skills. In South Africa, nurses at Tintswalo hospital were trained on basic counseling and trauma debriefing skills. Following the intervention, the proportion of survivors who agreed that the "counseling was helpful" increased from 62% at baseline to 99% at endline.[37] In Zambia, one of the most challenging topics covered in the police officer training course was interpersonal communication. As police officers, the participants demonstrated an initial tendency to interrogate SV survivors as they would suspects. To address this, facilitators conducted extensive role plays, which were very useful in encouraging the VSU officers to develop empathy with survivors and to conduct initial interviews in a less intimidating manner. In the course evaluation, participants affirmed the value of these role plays and suggested that future trainings include more of such sessions.[40]

National guidelines in Kenya (2010), Uganda (2007) and Zambia (2010 draft) all include guidance on improving provider-level interpersonal communication and crisis counseling. As these documents become more widely disseminated and employed, it is possible that the quality of such communication will improve within first points of contact.

Safe houses and temporary shelters are costly to maintain

Safe houses, temporary shelters and relocation services are critical for ensuring that a survivor is not returned to a potentially dangerous situation. Nonetheless, these services are nearly non-existent in many low-resource settings.

Two partners, TVEP and the Malawi Police Service, maintain temporary shelters for women and children. TVEP trauma centers contain 8-10 bed temporary shelters, where a survivor can stay for up to seven days. In Malawi, both the Lilongwe and Kanengo Model Police stations maintain small on-site shelters where a survivor can stay for a maximum of four days. Both shelters rely heavily on donations from multiple sources in order to provide for the needs of dislocated survivors, including supplies such as beds, mattresses, clothing, hygiene items, food and kitchen goods.[38] Such high maintenance costs, and the need to ensure 24-hour security for the survivors, may serve as barriers to the long-term sustainability of safe houses.

More evidence is needed on effective models for providing long-term psychosocial care

Ongoing psychosocial support is widely recognized as an important component of long-term recovery, improving the survivor's ability to overcome the negative health and behavioral outcomes associated with 'rape trauma syndrome.'[4] Survivors also recognize the

value of such services; according to TVEP monitoring data, over half of all survivors requested to join a support group, with a greater proportion of men (43%) expressing interest than women (33%).[41]

TVEP was the only partner to implement long-term psychosocial care activities in its model of care. A professional counselor was contracted to conduct on-site individual and group counseling sessions. Survivors would either return to the center for the sessions using the bus vouchers provided by TVEP, or would attend during their stay in the safe house. Unfortunately, these services were discontinued in early 2008 due to funding constraints and no evaluation data are available. Nonetheless, TVEP reported that survivors were pleased with the services they received, and most attended at least two group counseling sessions. In the absence of these counselors, TVEP's victim advocates now take a more active role in providing psychosocial support through their follow-up home visits or phone calls. These services, however, are primarily limited to those survivors who are receiving PEP and tend to diminish in frequency following the end of the 28-day course.

Thus, while the need for long-term psychosocial care services is great, evidence on effective programmatic strategies for providing such care in a cost-effective manner is limited. In the resource-poor settings that characterize SGBV services in much of sub-Saharan Africa, such care is frequently seen to be beyond the capacity of current programs. As a result, more research is needed to identify strategies for providing long-term psychosocial care in a cost-effective and culturally relevant manner.

Measurement framework

Throughout program implementation, the Council worked closely with partners to develop and refine a common measurement framework for comprehensive SV service provision. Table 14 contains a set of validated indicators that have been used to monitor and assess the partner projects discussed above. These indicators are intended to inform future efforts to measure comprehensive SV and SGBV services.

Table 14: Validated indicators for measuring comprehensive SV service programs

Sector	Indicator	Data Source
Client characteristics	Number and percent of survivors presenting to site by month	Health facility records
	Number and percent of survivors by age, gender and month	Health facility records
	Number and percentage of: • Adult rape cases (male and female) • Child rape cases • Intimate partner violence cases (IPV)	Health facility records
	Percent of survivors reporting to: • police station first • health center/ hospital first	Health facility records
	Mean and median time elapsed (in hours) from assault to: • care seeking at health center • reporting to police station	Health facility records

Sector	Indicator	Data Source
Health services	Percent of facilities that have dedicated room available for examining SV survivors	Facility inventory
	Mean and median number of health providers seen by clients during the first visit	health facility records
	Percent of survivors given trauma counseling	health facility records
	Percent of eligible survivors receiving core services at health facility (eligibility defined by national guidelines), including: • Percent of eligible clients given emergency contraception (at health facility) • Percent of eligible clients given STI prophylaxis • Number of eligible clients given tetanus prophylaxis	health facility records
	Percent of survivors receiving core HIV services • Percentage of eligible clients who receive HIV test results during first visit • Percent of eligible clients given first or "stat" dose of HIV PEP • Number of ARV/ PEP pills given to survivor during first visit • Percent of PEP recipients referred for adherence counseling • Percent of PEP recipients presenting for follow up care at 1 week; 6 weeks	health facility records
	Mean and median number of weeks survivors presented for their first follow-up visit	health facility records
	Referrals	
	Percent of survivors who reported first to health facility referred to police	health facility records
	Percent of survivors referred to: • Social services/ counseling/ psychosocial support • Legal services • HIV+ survivors referred to HIV/AIDS care and treatment services	health facility records
	Provider capacity	
	Number and percentage of health care providers specifically trained on SV services	Provider survey
	Percentage of health care providers who identify the core elements of clinical SV management (as defined by national guidelines)	Provider survey
	Percent of health care providers who know that PEP can prevent transmission of HIV; percentage who correctly identify 72 hour timeframe for providing PEP	Provider survey
	Percent of providers who know that EC can prevent pregnancy following unprotected sex; percentage who correctly identify 120 hour timeframe for providing EC	Provider survey
	Percentage of health care providers who indicate that a survivor has "other needs" beyond clinical care (police, legal and psychosocial support)	Provider survey
	Percentage of health care providers who can identify at least one referral point for survivors (police, legal and psychosocial support)	Provider survey
	Percentage of health care providers who consider sexual violence a medical emergency	Provider survey
	Percentage of health care providers who believe that a survivor's behavior causes sexual violence	Provider survey
	Guidelines and forensic evidence collection	
	Number and percentage of health care facilities following written guidelines for providing SV services	Facility inventory

Sector	Indicator	Data Source
Health services (continued)	Percent of facilities that have special procedures for dealing with child survivors	Facility inventory
	Mean and median number of staff per facility who only provide SV care	Facility inventory
	Percent of survivors with required medico-legal documentation on file	Medico-legal forms
	Percent of survivors with required medico-legal documentation signed in accordance with national guidelines	Medico -legal forms
	Percent of cases in which at least one piece of medical forensic evidence collected (as indicated by medico-legal documentation)	Medico-legal forms
	Percent of child sexual assault cases where at least one piece of medical forensic evidence collected (as indicated by medico-legal documentation)	Medico-legal forms
Police/legal services	Percent of survivors who report to police station within 120 hours after assault	Police records
	Percent of survivors eligible for emergency contraception • denominator= total number of survivors presenting at facility of reproductive age • numerator= total number of survivors presenting within 120 hours	Police records
	Percent of eligible survivors receiving emergency contraception from police station	EC program records
	Percent of survivors referred to: • Health facility • Social services/ counseling/ psychosocial support • Legal services	Police records
	Provider capacity	
	Number and percentage of police facilities following written guidelines for responding to SV services	Provider survey
	Number and percentage of police officers specifically trained on SV services	Provider survey
	Percent of police officers who know that PEP can prevent transmission of HIV; percentage who correctly identify 72 hour timeframe for providing PEP	Provider survey
	Percent of providers who know that EC can prevent pregnancy following unprotected sex; percentage who correctly identify 120 hour timeframe for providing EC	Provider survey
	Percentage of police who consider sexual violence a medical emergency	Provider survey
	Percentage of police who believe that a survivor's behavior causes sexual violence	Provider survey
	Legal outcomes	
	Percent of cases were a suspect was identified	Police records
	Percent of cases with charges filed	Court records
	Percent of cases with a conviction	Court records
	Mean and median number of years sentenced	Court records
Psychosocial support services	Number of sites offering psychosocial care in catchment area	Community mapping
	Number of survivors seeking psychosocial support, disaggregated by type	Service records
	Mean and median number of psychosocial support sessions/meetings attended by each survivor	Service records

Measurement challenges

One of the major measurement challenges faced by partners was tracking referrals across sectors. While program activities successfully strengthened the linkages between the sectors, they were less successful in developing strategies for monitoring the uptake of those referrals. LVCT, TLAC, TVEP, and police in Malawi and Zambia all experienced difficulties in charting a survivor's progression across various points of contact. This is associated with weak record-keeping procedures in many public facilities, differing record keeping procedures across the sectors, and the ethical and logistical challenges of tracking individual survivors. Much more work remains to be done in developing a system for monitoring and tracking cross-sectoral referrals in low-resource settings.

As in all program monitoring, another challenge partners faced was ensuring accurate and complete reporting. This was especially pronounced in the programs that worked with public sector staff, such as health care workers and police, and complex medico-legal documentation was the most frequently neglected. LVCT's study in Kenya found that at baseline only 20% of cases had the appropriate documentation.[45] Similarly, on-going efforts to introduce medico-legal forms into PEPFAR-supported facilities in Rwanda and Uganda have suffered from widespread provider refusal to complete the level of detail required for adequate medico-legal documentation. Such barriers to complete reporting not only undermine efforts to measure program efficacy, but ultimately limit a survivor's access to justice.

South-South Technical Assistance

The Council facilitated a wide range of South-South technical exchange and assistance activities in the course of the Initiative. These included training programs, provision of on-site technical assistance, site visits and participation in international conferences. As partners' capacities have improved throughout the course of this program, they have been able to offer more targeted assistance to their colleagues in other countries. This approach has also allowed partners to serve as a resource-base for other similar initiatives in the region.

Through the annual network meetings, members have been exposed to the models being explored in each other's projects. As a result, Malawi expressed an interest in adopting the model being developed in Zambia in the CMIC project. The Initiative then supported an exchange visit to Zambia for Malawian officials and a multisectoral stakeholder meeting where the Zambian experience was presented. The meeting successfully raised the visibility of SV issues among key government stakeholders, and participants agreed that it was feasible and necessary to replicate the CMIC study in Malawi. To guide this process, a multisectoral SGBV steering committee was established to coordinate all SGBV efforts in the country. Following this meeting, Zambian partners provided further technical assistance in developing the terms of reference for the steering committee.

To learn from the strengths of Malawi's own project, a partner from outside the network, the South Africa NGO, the Greater Nelspruit Rape Initiative Project (GRIP), undertook a study-tour to Lilongwe. The visiting team was particularly impressed with the community-based interventions undertaken by the police and "Men-to-Men" campaigns aimed at increasing men's awareness of SGBV that were being conducted throughout the peri-urban and rural

areas of the country. Upon their return to South Africa, GRIP instituted similar activities through their community-outreach activities.

The experiences of the Zambian program have been drawn upon extensively by PEPFAR partners in Uganda and Rwanda. This has involved technical support visits to guide the implementation of the national SGBV guidelines in government facilities, including the national referral hospital. Technical assistance was provided on updating the national SV reporting form, integrating service provision and the collection of forensic evidence. The Initiative also facilitated the involvement of the Ugandan NGO, Raising Voices, to promote the health sector's engagement with the community in both countries.

Through their participation in the annual network meetings, ESOG became aware of the gaps in their national guidelines, which were focused exclusively on the clinical management of SV. Based on input from partners, ESOG undertook a series of multisectoral dissemination meetings, which began a national dialogue on providing integrated SV services in Ethiopia.

Conclusion

This project has significantly increased the evidence base on program responses to SV in sub-Saharan Africa. It has demonstrated a range of successful approaches for improving comprehensive services within the health, police, legal and social service sectors, but it has also underscored that there is still much to be done in ensuring that these services are adequately and equitably provided across the region. Most notably, more work is needed to identify successful strategies for improving PEP adherence rates, addressing the special needs of children, and providing immediate and long-term psychosocial support in low-resource settings.

These results also suggest the need to explore other dimensions of SGBV services. As indicated in Table 1, more women experience intimate partner violence than sexual violence, although most response services have focused on addressing the acute needs of sexual violence survivors. More research is needed on appropriate strategies for ethically identifying and meeting the needs of this large, and often silent, population. Just as importantly, much more work is needed on documenting successful strategies for preventing all forms of SGBV before it occurs.

Appendix 1: Overview of partner projects and data sources

Large-scale partner projects

Copperbelt Model of Comprehensive Care (CMIC), Zambia[40]

From 2005-2008, the Zambian Ministry of Home Affairs (Police Service), Ministry of Health and Population Council collaborated on an operations research study designed to improve services for survivors of SV. Specifically, the study tested the feasibility of police provision of EC, a contraceptive method which prevents unwanted pregnancy within 120 hours of unprotected sex. It also tested whether the intervention could strengthen SV services at both police and health facilities through an increased emphasis on multisectoral collaboration.

Under the intervention, specialized Victim Support Unit (VSU) officers were trained to deliver EC to eligible survivors of SV (rape and defilement), and to refer survivors to health facilities for further clinical management and forensic evidence collection. To ensure the quality and safety of such services, VSU officers were trained under the Ministry of Health's Community-Based/ Employer-Based Family Planning Distributor curriculum, and oversight was provided by a health provider. The study was implemented in five police stations in the Copperbelt's Ndola district and guided by a multisectoral steering committee.

The study was evaluated through routine service statistics, a provider knowledge, attitudes and practices (KAP) survey and focus group discussions (FGDs). Service statistics were collected for a total of 612 SV survivors who reported to the police between January 2006 and December 2008; data were collected using a monthly reporting form. A total 210 police officers from 15 stations across the district participated in a KAP survey. At these sites, 100 percent of the police officers who regularly come into contact with SV survivors were surveyed, including VSU officers, Officers in-Charge (OICs), shift supervisors, and inquiry desk officers. This survey was conducted in September 2007, a year before the final evaluation took place. In November 2008, qualitative data on the program's impact were gathered through a series of FGDs and Key Informant Interviews. The objective was to assess successes and challenges in the five intervention sites and compare them with the experiences reported in one comparison site. Respondents included all cadres of police and members of the communities associated with the stations.

Refentse Phase II, South Africa

The Refentse project is based at Tintswalo Hospital and the Acornhoek South African Police Service in the Bushbuckridge municipality of Mpumalanga Province. First instituted in March 2003 by the Rural AIDS and Development Action Research Programme (RADAR) of the University of the Witwatersrand's School of Public Health in collaboration with the Population Council, it is intended to ensure rape survivors' access to justice and health care.

Phase I of the project, funded by USAID, was implemented between 2003 and 2006and demonstrated the feasibility of implementing a nurse-driven, integrated post-rape care program within a rural public sector hospital. A five-part intervention model was introduced, including: a sexual violence advisory committee; hospital rape management policy; training workshop for service providers; designated examining room; and community awareness campaigns. To evaluate the impact of the intervention, 334 hospital charts were reviewed to assess the quality of clinical care provided to patients, and interviews were conducted with 16 service providers and 109 patients. Results

demonstrated that, following the intervention, there were significant improvements in the quality of clinical history and examination, and the provision of pregnancy testing, emergency contraception, STI treatment; HIV counseling and testing, PEP, trauma counseling, and referrals.[37] The study also found that survivors had limited access to, and a lack of confidence in, the criminal justice system.

Based on findings from Phase I, 2006 the Tshwaranang Legal Advocacy Center (TLAC) launched an intervention to link a justice component to the existing health services model. It also explored ways of better addressing the psychological needs of women following sexual assault and domestic violence, and investigated whether the current legislation met the needs of women in rural areas. The main component of the intervention was strengthening the TLAC paralegal office, located within the Acornhoek Police Station, where sexual assault cases from Tintswalo Hospital are referred. The objective of the paralegal office is to ensure the appropriate legal and medico-legal services are provided to the survivor. Both police and health care workers were actively encouraged to refer survivors to the paralegals. TLAC also supported a forensic nurse at Tintswalo Hospital to ensure that forensic medical examinations were properly conducted and documented.

Phase II was evaluated using data collected through reviewed of "clinical care assessment sheets" collected by the TLAC forensic nurse. Between October 2006 and August 2008, data were collected from 284 rape survivors who presented for care at Tintswalo hospital. Data were also collected from those who accessed services from the TLAC paralegal office, which included 77 rape survivors who presented between March 2007 and August 2008. They ranged from age from 5 to 61 years of age and included three male survivors. The mean age was 20.3 years and the median was 18 years.[39]

Thohoyandou Victim Empowerment Program (TVEP), South Africa[41]

The Council partnered with TVEP, a community-based organization established in 1997, to document their innovative "one-stop center" model for post-rape care. TVEP employs a multisectoral, comprehensive model to reduce and address SGBV in the Vhembe District of Limpopo Province.

Using Trauma Centers, TVEP provides medical, legal, and social services and support to survivors of SGBV. While other non-profit organizations in the area address domestic violence cases, TVEP manages the only trauma centers in Thohoyandou and is therefore one of the few places survivors of sexual assault can turn to for services. The trauma centers are staffed by a manager, a professional trauma counselor, a victim advocate (VA), and a general assistant volunteer. Once a survivor arrives at a trauma centre, s/he is debriefed and counseled by the VA. The survivor is informed of her/his medical, social, and legal options, as well as the advantages and disadvantages of each. The VA then calls a doctor to examine the survivor, and if he/she arrived without a police officer, the VA calls the police. The survivor is offered voluntary counseling and testing (VCT) services (including pre-test and post-test counseling), pregnancy testing, PEP, medication for sexually transmitted infections (STIs), EC, and the option to join a support group for survivors of domestic violence, survivors of sexual assault, and/or one of two support groups for HIV positive persons. In addition to these services, each survivor is given a care package, including a comfort plush toy (for children and adults), one month's supply of nutritional supplements, bus tickets for follow-up care (including HIV re-testing and trauma counseling), and an information booklet. Depending on the survivor's situation, s/he may also stay at the on-site safe house, and—when indicated—be referred to professional counseling.

TVEP's VAs play a very important role in providing support to survivors, acting as liaison between the clients and examining the doctor/medical professionals, legal team, and investigating officer. In total TVEP employs 10 VAs who sit at the trauma centers, and at any time there are four VAs on duty (two at each center). Each VA has a 12-hour shift.

PEP provision at TVEP trauma centers was started in 2002. As part of support services, VAs assist HIV negative clients who start PEP to complete the full 28-day course of the prophylaxis. Clients who present at TVEP within 72 hours and agree to take PEP are given all 28 days of pills at the initial visit. If clients agree, VAs conduct home visits at Day 3 and Day 28 to provide continued social, medical, and legal support. One objective of the home visits is to increase the likelihood that clients complete the full PEP course. Home visits are also conducted to follow up on other issues, including food security and concurrent or continued violence. Clients who present after 72 hours, or those who decline PEP or home visits, are not visited at the home by VAs. VAs do, however, continue to support clients through phone calls, and clients can also call VAs.

In addition to providing health and medical support to survivors, VAs also provide psychosocial and legal support. They prepare survivors for court and keep them updated on their cases, as well as attend court hearings when possible. The VAs are also responsible for documenting information on the survivor, the home visits, and other support provided to survivors. VAs document health and legal information at the first trauma center visit, during or immediately after each phone call, and during or immediately after each home visit.

To assess program outcomes, in late 2009 a consultant was contracted to review a total of 5,204 client records collected over the 20 month period between January 2007 and October 2009. Data quality emerged as an important constraint in analyzing the data, and consequently, some service delivery questions could not be answered with the available information.

Liverpool VCT, Kenya[45]

In 2007, Liverpool VCT, Care & Treatment carried out an operations research study, the objectives of which were: (1) to describe the current practices and gaps in the collection, storage, analysis, documentation and transportation of evidence collected from survivors at the hospitals and police stations in the context of sexual violence; (2)to design and test an evidence chain model applicable to the Kenyan system for obtaining and transporting samples from the primary health facilities to the government chemist; and (3) to evaluate the model developed for functional custody of evidence chain suited for the Kenyan context.

The study used an exploratory design with data being collected from two hospitals and two police stations in Nyanza and Eastern provinces. These sites were selected because the health facilities had been involved in the provision of Post Rape Care services since 2004 and the police had been sensitized to the delivery of services to SV survivors who present at the police stations. A total of 29 respondents were interviewed at baseline and 24 at end line. Purposive sampling was utilized in selecting the respondents.

Results show that proper documentation is the most effective way of capturing details on survivors of SV as well as maintaining the custody of evidence chain. This can be achieved through the review of existing protocols and/or development of protocols that clearly stipulate the minimum evidence that should be collected from survivors of SV; what is the

first point of presentation of survivors of SV; who should collect evidence; and what should be used in documenting evidence obtained from survivors. There is also need to review the existing medico-legal documentation, namely, the national PRC1 forms to ensure the maintenance of a proper paper trail of evidence collected from survivors.

Seed grantees

Malawi Police Service, Ministry of Health and Malawi Human Rights Resource Centre[38]

During 2007-2008 the Malawi Ministry of Health, Malawi Police Service and Malawi Human Rights Resource Centre implemented the pilot project, "Towards a multisectoral approach to SGBV" in urban and rural centers of Lilongwe district. The project sought to eradicate SGBV through sensitization of communities and building the capacities of key stakeholder institutions in the handling and management of sexual and gender-based violence cases. The project had two primary objectives: 1) to create a functional and effective network of key stakeholders, including the community, on SGBV; and 2) to build the capacity of service providers in the health, police and judiciary to effectively respond to SGBV survivors. Activities included multisectoral stakeholder coordination meetings, community sensitization activities, and trainings for police, health sector and judiciary.

A key project outcome was the provision of a full package of clinical care under the one-stop model at Kamuzu Central Hospital in the Sexually Transmitted Infections (STI) Department with linkages to the Obstetrics and Gynecology Department. The Police Service at Lilongwe Police station also began operating on a 24-hour basis as a result of the improved coordination among the service providers. There was remarkable improvement in the quality of care provided and an increase in the number of survivors presenting at the two institutions. As a result of orientation that was provided to the key players, there was a reported improvement in coordination of cases that were presented to the court. Clinicians had improved the quality of documentation and they felt more confident to testify in court on cases that they had handled.

Evaluation data is based on a review of records of all SV survivors who presented to the Kamuzu Central Hospital STI unit between October 2006 and October 2008. A total of 68 survivors presented during the pre-intervention period (October 2006- September 2007), and 134 presented during the intervention period (October 2007-October 2008).

Musasa Project, Zimbabwe

The Musasa Project, in partnership with the Zimbabwe National Family Planning Council, undertook a project which sought to strengthen and improve ZNFPC's Community-Based Distributor's (CBD) capacity to deal with issues of SGBV in the Midlands Province. The project was implemented from April 2007 to March 2008.

The main objective of the project was to build the capacity of the CBDs to improve their response to SGBV within the communities where they work. CBDs are a large and important part of the ZNPC's grassroots service delivery network, which provides sexual and reproductive health services at the community level. The project improved the CBD's skills through efforts to mainstream gender and issues related to SGBV in reproductive health services. During its implementation period, Musasa trained 35 CBDs to identify and refer SGBV survivors to appropriate services, and conducted supportive supervisory visits

to participating districts. Project reports indicate that initial efforts were successful: fifteen clients were referred for legal services; two were referred to the Police's Victim-Friendly Units and five to the Musasa Project.

Unfortunately, the political situation prevailing in Zimbabwe at the time adversely affected implementation of activities. Pre-election campaigns and the violence that occurred made it difficult to mobilize people for activities. The suspension of private voluntary organizations (PVOs)/NGOS field operations in June 2008 was a major drawback to the project. This was worsened by restrictions imposed by the Reserve Bank on the withdrawal of foreign currency, as the limits were too low for project requirements. As a result, this project was unable to reach its full potential, although it did begin to realize some important results. No evaluation data for this project is included in this report.

Ethiopian Society of Obstetricians and Gynecologists (ESOG), Ethiopia

In 2004, with support from the International Federation of Obstetricians and Gynaecologists (FIGO), ESOG drafted a guideline for its membership on the management of sexual assault in Ethiopia.[49] This guideline, however, had not been widely disseminated or endorsed by the MOH. In recognition of the need to develop national standards of care that account for the multisectoral nature of SGBV services, this project supported the revision and refinement of the 2004 guidelines to become national guidelines. In May 2009, this document was adopted by the Ministry of Health's Family Health Department (FHD).[27]

To promote the implementation of these guidelines, ESOG, in collaboration with the FHD, organized a series of national and regional dissemination meetings.[50] The national level meeting was held in Addis Ababa on November 30 and December 1, 2009, and regional disseminations took place in Nazareth on December 25 and in Hawassa on December 26, 2009. The broad objective of these dissemination meetings was to create awareness on the importance of multisectoral collaboration in the comprehensive management of survivors of sexual assault, introduce the new national guidelines, and discuss the role of each sector and referral mechanisms in the response to sexual violence. Professionals from the health, legal, police and psychosocial support sectors were brought together for an orientation on the guidelines and to discuss issues associated with multisectoral collaboration. The media was also present during these meetings and the event was covered on national TV, radio and in major newspapers. Copies of the approved guidelines were also distributed on December 3, 2009 at a meeting organized by USAID.

While the participants acknowledged that the approval of the guidelines was critical in improving service delivery, they identified a number of gaps at policy level that needed to be addressed. Some of the issues include whether sexual assault survivors should be exempted from paying hospital fees and whether health care providers would be expected to report to the police if they come across a case of sexual assault. These issues have since been brought to the attention of the Federal Ministry of Health.

Other partners

PEPFAR Special Initiative on Gender-Based Violence, Rwanda & Uganda[26]

The PEPFAR Special Initiative on Sexual and Gender-Based Violence aims to strengthen care for survivors of sexual violence (SV) in 18 pilot sites in Uganda and Rwanda. Within these public facilities, implementing partners will support providers to undertake three sets of core interventions: 1) strengthening health services; 2) strengthening referrals from the health facility to other support services; 3) strengthening linkages between clinical services and other stakeholder groups to facilitate access to health services.

The Initiative is expected to provide an evidence base for scaling up such efforts in the future and will be rigorously evaluated. To provide the evidence base for future policy and programming, the evaluation consists of a pre-post intervention design, complemented by the routine collection of service statistics to document trends over the life of the intervention period. Due to budgetary constraints, no comparison sites are included; rather, changes at each intervention site during the life of the project will be relied upon to gauge Initiative outcomes. Evaluation findings will be reported at the levels of intervention site, implementing partner, country, and initiative as a whole. Equivalent data will be collected at the intervention sites by the implementing partners and the Population Council, as described below.

Key components of data collection and reporting include the following:

- At baseline, quantitative data was collected on facility readiness to provide SV services, using a Facility Inventory form. Qualitative data on service providers' knowledge and attitudes was collected through a series of Focus Group Discussions (FGDs) with doctors and nurses in intervention sites.
- Throughout the intervention, quantitative data is being collected through the use of a SV Client Assessment Form on a routine basis at each intervention site by the implementing partners.
- At endline, the baseline data collection will be replicated. Additional data on program acceptability and impact will be collected through Key Informant Interviews (KIIs) with Program Managers and Stakeholders.

This report contains results of the baseline assessment conducted between September and November 2009 in eight facilities in Rwanda and nine facilities in Uganda. It includes data from two sources: quantitative data from a Facility Inventory completed in 17 of the 18 intervention sites (data could not be collected from a military hospital for security reasons), and qualitative data from a series of focus group discussions (FGDs) conducted with health care providers from 13 of the intervention sites. Facility Inventories were conducted by the data collector who was accompanied by staff from the facility; 53 percent of inventories were led by the facility in-charge. Data collectors were instructed to visually verify the presence of all equipment, supplies and guidelines indicated on the form. Due to the limited number of staff at most sites, all health care providers (defined as doctors, nurses and clinical officers) who treat SV clients were eligible to participate in the FGDs. The size of the FGDs ranged from 5–10 participants.

All data was sent to the Council's office in Nairobi for storage and analysis. The following data analysis procedures were undertaken:

- Quantitative data from the Facility Inventories were entered using EPIDATA and analyzed using SPSS version 13. Descriptive statistics were calculated for all evaluation questions and indicators listed in Appendix 2, by facility and implementing partner to provide data relevant for programming.
- Qualitative data from the FGDs were analyzed by country, partner and cadre of providers to help inform program implementation. All data were analyzed manually by the individual analysis themes and by a 3-point Likert scale for each evaluation question to classify provider responses as "positive," "neutral" or "negative."

International Centre for Reproductive Health (ICRH), Kenya

The International Centre for Reproductive Health, Kenya (ICRH) is an African NGO founded in 2000 by the Faculty of Medicine and Health Services at Ghent University in Belgium, with offices in Mombasa and Nairobi. Project activities in Mombasa include support to the Coast Provincial General Hospital's (CPGH) Gender-Based Violence and Recovery Centre (GBVRC). The centre is the first private, gender-based clinic functioning in collaboration with a public hospital in Kenya. This unique public/private service model offers comprehensive clinical, social and legal care for Mombasa's most vulnerable populations while serving as a demonstration project for Kenya's Ministry of Health, through dedicated services addressing violence and its root causes. ICRH also conducts operations research around SGBV including a project studying violence experience by commercial sex workers in Mombasa which at the same time is training the CSW on human rights and how to collect evidence on violations. ICRH has previously collaborated with the Council on studies exploring the population of men having sex with men (MSM), their involvement in sex work and consequent HIV risk.

Building on this work, ICRH actively participated in the network as a technical assistance partner. Staff from ICRH collaborated with the Council to produce the SV research agenda for Kenya[52], and conducted two joint policy workshops in Kenya. ICRH actively participated in an exchange visit to Zambia and the 2009 network meeting held in South Africa.

Appendix 2: Presentations and policy advocacy activities undertaken by the Program

Level of engagement	Activity
National-level activities	Delivered an invited presentation on CMIC model. USAID/Zambia brown bag on SGBV. 1 June 2009. Lusaka, Zambia.
	Active participation in development and revision of the *Zambia National Guidelines on Multidisciplinary Management of SGBV*.[18]
	Conducted high-level dissemination of CMIC study results in Ndola and Lusaka, Zambia. November-December 2009.
	Contributed to the formulation and publication of "*Sexual Violence: Setting the Research Agenda for Kenya."*[52]
	Sponsored First Annual Coast Policy Conference on Sexual and Gender-based Violence December 10, 2009[53]
	LVCT conducted high-level study dissemination meetings at the national and provincial levels. December 2009.[54]
	Developed an disseminated Ethiopia's *National Guideline for the Management of Sexual Assault Survivors*[29]
Regional-level activities	Presentation: "Lessons Learned on Sexual and Gender-based Violence in Africa: Medico-Legal Linkages." Convening on Medico-Legal Linkages in Sexual Violence Responses; Expert consultation hosted by LVCT and SVRI. Nairobi, Kenya: June 2008.
	Presentation: "Lessons Learned on Sexual and Gender-based Violence in Africa: A Regional Perspective." Strengthening linkages between sexual and reproductive health and HIV/AIDS services: the sexual violence nexus. International Conference. Nairobi, Kenya: 1-3 October 2008.
	Presentation: "Providing PEP for SGBV in Africa." Fifth Forum Meeting of the Directors of Southern African Development Community (SADC) National AIDS Authorities; Pretoria, South Africa. 14-16 October 2008.
	Participant: Expert Meeting to Develop Sub-Regional Framework on Gender-Based Violence. Hosted by the East, Central and Southern African Health Community (ESCA-HC). Arusha, Tanzania: 10-11 November 2008.
	Donor Forum on Current Strategies, Prevention and Response to GBV during the upcoming 16 Days of Activism Against Gender Violence: Human Rights for Women—Human Rights for All, Nairobi, Kenya: 4 December, 2008.
	Presentation""Gender-based Violence and Health" 48th ECSA Health Ministers' Conference. Ezulwini, Swaziland: 16 -20 March 2009.
	Participant: Planning meeting for the development of a GBV model policy for the ECSA Region. Expert consultation hosted by ESCA-HC. Nairobi, Kenya: 25-26 June 2009.
	Presentation: "One-stop Centers for Post-Rape Care" MenEngage Symposium. Johannesburg, South Africa: 5-9 October 2009.
	Participant: Expert planning meeting of the Technical Working Group on Child Sexual Abuse hosted by ECSA-HC. Arusha, Tanzania: February 2-3, 2010.
International-level policy activities	Conference Satellite Session: "PEP for Survivors of Sexual Violence" at the 15th annual International Conference on Aids and STDs in Africa (ICASA). December 2008. Presenters included: Nduku Kilonzo, LVCT; Fiona Nicholson, TVEP; Lufuno Muvhango, Refentse project; Claudia Garcia-Moreno, World Health Organization.

Level of engagement	Activity
	Presentation: "Toward a Comprehensive Response to SGBV in sub-Saharan Africa: Lessons Learned from Implementation." "Gender-based Violence and Sexual and Reproductive Health; Mumbai, India: 15-18 February 2009.
	Presentation: "Toward a Comprehensive Response to SGBV: Lessons Learned from Africa." World Health Organization Meeting on Health Sector in Response to Violence Against Women. A Review Of Promising Practices; Geneva, Switzerland. 17-19 March 2009.
	Presentation: Gender-based Task Force of The Interagency Gender Working Group: Technical Working Group on Sexual Violence against Minors: Paving the Way Forward. Washington, DC: 20 October, 2009
	Presentation: Strengthening Gender Programming in PEPFAR: Technical Exchange of Best Practices, Program Models and Resources. Technical meeting hosted by the US Government Interagency Working Group on Gender. Johannesburg, South Africa: 28-30 October 2009.
	Presentation: "One-stop Centers for Post-Rape Care" Violence against women and HIV/AIDS: What works? Expert consultation hosted by WHO. Geneva, Switzerland: 26-29 October 2009.
	Presentation: "The Copperbelt Model of Integrated Care" Global Health Conference. Washington, DC: 16 June, 2010.
	Poster Presentation: "Gender-based Violence in Rwanda and Uganda" AIDS 2010, Vienna, Austria: 20 July, 2010.

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