Full Report

The Health Sector's Response and Contribution to Addressing Gender-based Violence and Violence Against Women and Girls in the Commonwealth

Evidence Based Solutions

For the Commonwealth Secretariat
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1. Abbreviations and Acronyms

CAPI	Computer-assisted Personal Interviewing
CCR	Coordinated community response
CEDAW	The Convention on the Elimination of all Forms of Discrimination Against Women
CHC	Community Health Centre
EBS	Evidence Based Solutions
GBV	Gender-based violence
GDP	Gross Domestic Product
GII	Gender Inequality Index
GPS	Global Positioning System
HDI	Human Development Index
IPV	Inter-personal violence
MoH	Ministry of Health
MOS	Measure of Size
NGOs	Non-governmental organisations
NPA	National Prosecuting Authority
PrEP	Pre-exposure prophylaxis
PSU	Primary Sample Unit
SDGs	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
SQL	Structured Query Language
UHC	Universal health care
UN	United Nations
UNFPA	United Nations Population Fund
VAWG	Violence against women and girls
WHO	World Health Organisation

2. Introduction and Background

2.1. Introduction

Gender-based violence (GBV) is a global problem with one in three women worldwide experiencing physical or sexual abuse in their lifetime (UNFPA, 2017). Women and girls are victims at home and outside of the household. The violence may take the form of physical, emotional and sexual nature causing which harm to the physical, social and emotional health of the victims. The problem persists despite many declarations, conventions and plans at national, regional and international levels (UN Women, 2020) to protect and support women and girls. The protracted and intensified conflicts as well as humanitarian crises have made women and girls more vulnerable than ever (UN Women, 2020i). The Commonwealth consists of a diverse group of nations of almost two billion people, representing nearly one-third of the world's population. GBV is also present in the Commonwealth Member States, although to varying degrees.

Sustainable Development Goal #5 is the United Nations position on ending sexual violence that leads to increased risk of HIV in adolescent girls and young women. This is one of multiple critical international policies adopted to encourage countries to commit to ending gender-based violence. In this study, the term gender-based violence includes all forms of violence against women and girls. It is important to include all forms of violence GBV because they violate the rights of the victims.

This project serves as a critical step forward towards understanding how the health sector in the Commonwealth Member States is currently responding to gender-based violence . in the light of such policies as the latter.

At the meeting of the Commonwealth Health Ministers held in Geneva on the 20th of May 2018, the Ministers took note of the policy proposals related to the health facility-based coordinated response to gender-based violence. These included:

- Harmonisation of the multi-sector programmes led by the health sector to end GBV;
- Establishment of health sector initiatives of one-stop centres to implement GBV programmes within the Universal Health Coverage (UHC) framework;
- Setting objectives, targets, milestones and time frames to end GBV by implementing evidence-based interventions;
- Taking a multi-dimensional approach to addressing GBV, noting the link between alcohol and drug abuse as key drivers of GBV; and
- Options to improve the capacity by establishing one-stop centres for GBV (Commonwealth, 2018).

The Ministers encouraged member countries to develop and implement relevant tools and toolkits. These include a "health sector toolkit to serve as a guide to prevent and respond to gender-based violence events; a scorecard to promote accountability by monitoring response and prevention, and a database to monitor gender-based violence programmes". Research is required to support countries in their efforts to develop these tools and toolkits.

2.2. The challenge

Despite policies, laws, national strategies, institutional mechanisms and interventions, the rate of GBV is still high. Health sector responses are not adequate in many countries, which results in part

from the failure to implement effective evidence-based interventions. These challenges are compounded by the lack of capacity of many health systems to coordinate a multi-sectoral response. The Commonwealth Secretariat is well-positioned to support the development of coordinated health-sector responses. This coordination, which involves sharing of successful interventions, can improve the response to gender-based violence.

In keeping with the Commonwealth's commitment to the right to health, the Secretariat commissioned a study in 2017 to broadly investigate the extent to which the Commonwealth Member States have coordinated health facility GBV programmes. This study also looked at the GBV programmes' natures, effectiveness and possible models or approaches that can be recommended for implementation or adaptation. These broad global principles should inform the GBV programmes:

- The right to available, accessible and acceptable quality health services provided through universal health coverage (UHC) systems.
- The desire to meet the commitment to attain Sustainable Development Goal target #5.2 (to eliminate all forms of violence against all women and girls in public and private spheres).

Graphic 1: Geneva Switzerland, World Health Organization / The World Health Organization (WHO/OMS) headquarters

2.3. Objective of the Project

The objective of this project was to collect data and review evidence on the effectiveness of healthcare facility-based coordinated (one-stop) centres providing services for gender-based violence/violence against women and girls (VAWG) in the Commonwealth countries to develop a road map to establish evidence- and rights-based health sector response to this scourge.

2.4. Understanding

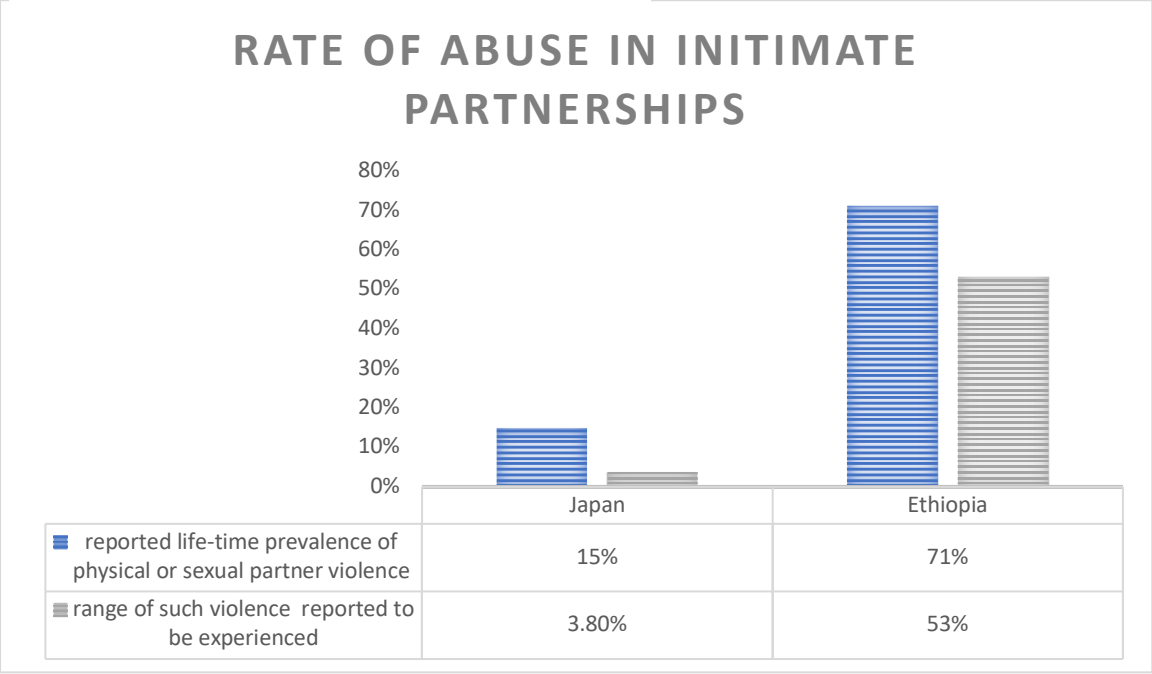
GBV hampers the health status of the victim. According to the Alma-Ata Declaration (WHO, 1978), every person has the right to health, which includes psychosocial, mental, physical and emotional well-being. The recognition that violence obstructs sustainable development and threatens human rights is underscored in the Sustainable Development Goals (SDGs) and related targets, as well as in the UN Declaration on preventing violence against women, girls and children. Additionally, the imperative to end GBV/VAWG is rooted in 'the right to life', freedom from torture and inhumane and degrading treatment, the right to health and reproductive autonomy, as well as freedom from all forms of discrimination against women.

2.4.1. The Magnitude of the Problem

According to a global study of the World Health Organization, the London School of Hygiene and Tropical Medicine and the South African Medical Research Council, worldwide, almost one third (30%) of all women who have been in a relationship, have experienced physical and or sexual violence by their intimate partner (WHO, 2013). A WHO multi-country study found the reported life-time prevalence of physical or sexual partner violence or both is highly prevalent globally and it ranged between 15% and 71% in Japan and Ethiopia, respectively. Furthermore, within the past year, the range of such violence was reported to be experienced by 3.8% in Japan and 53% in

Ethiopia (Garcia-Moreno, et al, 2006). Controlling men were overwhelmingly more likely to be violent towards their sexual partners. Of concern was the finding that women were at far greater risk of intimate partner violence than from other types of people. Later data show that the problem has not abated. In 2017 of the 87,000 women who were intentionally killed worldwide, 58% were killed by an intimate partner or previous partner (UN Women, 2020ii).

Figure 1: Rate of Abuse in Intimate Partnerships



Women who have been physically or sexually abused by their partners reported higher rates of several significant health problems such as depression, alcohol use disorders, and anxiety. There is inadequate data available on the health effects of non-partner sexual violence. However, existing evidence reveals that women who have experienced non-partner violence are 2.3 times more likely

to have alcohol use disorders and 2.6 times more likely to experience depression or anxiety (WHO, 2013). VAWG has an impact on women's sexual and reproductive health, their mental health, their overall health and the health and well-being of their children (WHO, 2013).

Alcohol consumption has been identified as a contributor to intimate partner violence (Graaff and Heinecken, 2017). This assertion is building on evidence generated from multi-country studies. The World Health Organization cited several studies that show that alcohol perpetrators had recently consumed alcohol before perpetrating intimate partner violence. In England and Wales, the study reported 32% of victims believed their partners had been drinking prior to physical assault. In Australia an estimated 36% of perpetrators of intimate partners who committed homicide were under the influence of alcohol at the time of committing this crime. In South Africa, alcohol was reported to be involved in 65% of cases of spousal abuse in the previous 12 months. The strong links between alcohol and intimate partner violence were found in India, Zimbabwe, Uganda (WHO Facts on Intimate Partner violence and Alcohol).

It is accepted that the most common forms of violence experienced by women globally are inter-personal violence (IPV) and sexual violence. However, the level of violence varies significantly between and even within countries. For example, data on men's perpetration from the Asia-Pacific region shows a dramatic range between 26% (Indonesia rural site) and 80% of men who ever had a partner, aged 18-49, reporting perpetrating physical and or sexual violence against an intimate partner in their lifetime (Fulu & Heise, 2015). In a worldwide study of non-partner sexual violence, researchers found a prevalence of 7.2% of women, aged 15 years and older, who have reported non-partner violence during their lifetime (Abrahams et al., 2014). Considerable variation in prevalence was seen across regions, ranging from 3.3% in Southern Asia and 21.0% in central sub-Saharan Africa. It appears that GBV is common worldwide, with endemic levels seen in some areas (Abrahams et al., 2014).

In addition to the classification of GBV/VAWG as a breach of human rights, IPV is specifically associated with severe public health consequences that should be addressed in national and global health policies and programmes (Ellsberg et al., 2008).

VAWG is recognised globally as a fundamental human rights violation. It is widely prevalent across high-, middle-, and low-income countries (Ashe et al., 2013). GBV is also a serious public health problem that has economic and fiscal consequences. The enormous cost can be crippling to societies and economies (Day et al., 2005). GBV is not only devastating to survivors and their families but comes at a social and financial cost as well. In some countries, GBV is estimated to cost up to 3.7% of their GDP (World Bank, 2019).

In a study conducted in 80 countries, it was found that 1 in 3 women have experienced physical and or sexual violence by an intimate partner or non-partner sexual violence (WHO et al. 2013). The data showed that men were more likely to disclose being perpetrators than women revealing of being victims (Abrahams and Jewkes, 2005) because of the shame, stigma, and danger that comes with disclosing the experience of violence. Women who do not tell their experience of GBV perpetrated by an intimate partner cite these reasons:

- fear of losing access to their children;
- stigmatisation in the community;
- fear of more intense violence if the perpetrator discovers that the victim has disclosed IPV to somebody; and
- financial dependence on the perpetrator (Abramsky et al., 2011).

Beyond this, many victims of GBV face the fear of not being believed once they disclose. Even if they are believed, the long process of using the judicial system often takes years and seldom brings justice to the victim. Police officers often treat a victim with suspicion or dismiss their report. Such attitudes discourage women from seeking help. Therefore, the available global statistics of GBV incidence are likely to be underestimated because of the stigma and mitigating circumstances that create barriers to reporting violations (WHO, 2013; Fulu & Heise, 2015).

Female victims of GBV also face a different form of violence known as 'structural violence' (Khan, Kapoor and Cooraswamy, 2000) which incorporates living in poverty, lack of access to adequate health care and in some countries, unequal access to education at all by being born female.

There is also a widespread presence of victim-blaming in healthcare facilities by law enforcement officers and society. It is particularly evident when sexual violence occurs in spaces that are deemed morally compromising, such as nightclubs, or if the victim is dressed in a manner considered as 'inappropriate' within a culture. In victim-blaming, the victim's behaviour is often subject to the moral judgement, which takes the focus away from the perpetrator. It shifts ownership of the violation from the perpetrator to the victim, thereby discouraging further disclosure from the victim.

2.4.2. Inadequacy of Data

The absence of documented instances of GBV in Southern Africa region shows that the epidemic is not a priority. Data collected is not adequate to support effective institutional mechanisms. Those mechanisms, combined with current laws, do not support the fight against GBV effectively. In a review on interventions to reduce violence against women and girls (2014), the World Bank found that the global evidence base is greatly skewed towards the global north.

Graphic 2: The lack of data in this region is indicative of the extent to which countries do not take gender-based violence seriously

Evidence Based Solutions (EBS) extracted data on 'SDG-UHC indicator 3.8.1: Service coverage index, 2015' for Commonwealth member countries (Enabling Environment for Prevention and Response to the Burden of GBV). The data was collected from the Tracking Universal Health Coverage: 2017 Global Monitoring Report, which showed that though there are varying levels of service coverage globally, there are some critical disparities when looking at them regionally. When using the UHC service coverage index, coverage of essential services is highest in the SDG regions of Eastern Asia (77) and Northern America and Europe (77), whereas sub-Saharan Africa has the lowest index value (42), followed by Southern Asia (53). The index is correlated with under-five mortality rates, life expectancy and the Human Development Index (WHO 2017, p.2).

2.4.3. Current Health Sector Response

Although one-stop centres for care and support of GBV victims are the ideal setup, the magnitude of the problem requires a more systematic approach. Women and children experiencing violence are more likely to use health services as the first option. All women are likely to seek health services at some point in their lives. The WHO's Global Plan of Action implores governments to use health systems to respond to, prevent and lead efforts to address GBV (WHO, 2016). Studies suggest that GBV hampers women's uptake of HIV testing and treatment (Leddy et al. 2019). The GBV barriers to

HIV epidemic control permeates all actions including prevention, testing, care and adherence to treatment (Leddy et al. 2019).

Across the Commonwealth member states, there are examples of facility-based one-stop crisis centres. These centres are multi-sectoral support structures where victims of GBV can access services such as medical care, psychosocial support and legal services. These centres are referred to using different terms such as sexual assault referral centre, one-stop centre, and one-stop-shop. Several countries have already established one-stop centres in the Commonwealth which focus on rape prevention, supporting victims of GBV, police assistance and attempting to reduce the high prevalence of maternal mortality, which is partly due to GBV. Some one-stop centres offer integrated services, including 'police assistance, legal aid, and medical and counselling services' (Human Rights Watch, 2017) to victims of GBV.

2.4.3.1. One-stop Centres

Some of the One-Stop Centres have gaps such as inadequate staffing, non-availability of government shelters for the safety of survivors, limited availability of legal support, lack of confidentiality at the Police Victim Support Units, delayed response and lack of follow up and little awareness of One Stop Centres in the community (Chomba et al., 2010).

The proposed EU GBV strategy (European Commission, 2015) and Gender Action Plan for Zambia for 2016 to 2020 outlines gaps in GBV programmes. Most GBV cases are civil cases and not criminal, and therefore 80-90% start at traditional court, but referral systems are weak. Cases are likely to be withdrawn because of victims living far from the courts and having no transport. There is limited understanding of GBV among service providers and community members. Collection and use of medical evidence are weak, and only doctor statements are accepted in court. GBV survivors and witnesses are not correctly, adequately and respectfully interviewed, and generally, there exists a silo approach to the provision of GBV services among various actors. For example, there is no National One-Stop Centre guidelines/policy and there is a lack of clarity about roles, responsibilities and mandates in Zambia.

2.4.3.2. Lack of an Evaluation of Coordinated Responses

The Knowledge Module on Coordinated Responses to address Violence against Women and Girls developed by the London Metropolitan University through the Child and Woman Abuse Studies Unit (2012) has been used to formally evaluate programmes that have not been evaluated for some time. The lack of evaluation may be due to inadequate resources, the difficulty of obtaining reliable information or because it is hard to isolate which indicators can and should be tracked to measure the changes that greater coordination may bring. For example, should more women begin to report abuse, it may be hard to identify precisely how one can measure with greater 'consistency' in approach. It may also be difficult to identify precisely increased understanding and respect for victim-survivors through routine practices vis-a-vis a general decline in the tolerance of violence and stigma by society at large.

According to the Knowledge Module, the coordinated community response (CCR) model for intimate partner violence is the most widely evaluated. Several studies of this model have shown reductions in re-victimisation. An evaluation (Klevens & Cox, 2008) of ten CCRs in the US concluded that:

- CCRs that emphasise coordination between the judicial sphere and probation are more effective when perpetrators have an extensive criminal history;

- in areas where a CCR has been established for at least six years there are significantly lower levels of re-victimisation;
- the availability of particular services for victim-survivors (e.g. safety planning, housing and advocacy) increased their contact with VAWG services.

2.4.3.3. Lessons for Coordinated Responses

The Knowledge module identifies the following as lessons for coordinated responses:

- Whilst a multi-sectoral, participatory process is essential, it can be costly and time-consuming (Keesbury & Askew, 2010).
- The assignment of staff should be strategic and based on expertise and level of influence.
- Funding for the coordination and resourcing for agencies to implement is essential.
- Involving victim-survivors or those working directly with them in decision-making is vital, although not always achieved.
- Clear lines of accountability are needed to ensure the implementation and enforcement of protocols.
- Monitoring and evaluation should be built in from the outset, not after the programme has started.
- High turnover of participating staff can undermine continuity.
- It may be challenging to engage senior-level staff (e.g. judges, doctors, police chiefs) in training and other capacity-building initiatives, and in some contexts, it is helpful to be sensitive to hierarchy and provide separate training for higher and lower-level staff.
- It is vital to demonstrate the benefits of engaging in a coordinated response so that service providers who are often overloaded with responsibility, and face burn out, have the incentive to participate.

2.4.3.4. Barriers to Developing Coordinated Responses

The Knowledge module identifies the following as the barriers to developing coordinated responses:

- Persistence of traditional, patriarchal beliefs about women and violence;
- Failure to translate CEDAW into national law;
- Lack of funded national laws/plans of action on the elimination and prevention of VAWG;
- Lack of political will to address the issue of VAWG;
- Differences in national/federal and local/provincial relations and responsibilities;
- No history of collaboration between state and civil society groups; and
- Government mistrust of women's NGOs
- Lack of thematic networking between organisations.

Whilst these are barriers to be overcome, it is useful to remember that this was the case in other countries before governments developed coordinated responses. These improvements in coordinate responses can change with the election of a new government.

3. Preliminary Findings of the Literature and Desk Reviews

3.1. Literature Review

In 2018, EBS conducted a literature review that focused on GBV globally and in Commonwealth Countries to clarify the concept of GBV; assess the global burden of GBV; identify the risk factors of GBV; identify the international instruments to end GBV; and identify effective GBV interventions. The literature review also identified effective types of interventions. These are:

- Group-based relationship level interventions that include both men and boys
- Group-education interventions that operate at the community level focusing on men and boys
- Interventions that change social norms and create awareness of the dangers of GBV
- Protection orders, but which are rendered ineffective because victims may not have an alternative accommodation
- Theory-based interventions such as parenting and school programmes that involve non-violent conflict resolution approaches.

3.2. Desktop Study

EBS also conducted a Desktop Study that provided a situational analysis of GBV services in Commonwealth countries. The study collated and reviewed data and information on GBV in the Commonwealth, focusing on institutional mechanisms; policy; laws – both national and international; the burden of GBV; child marriage; gender equality index; reports on GBV; and prevention of GBV.

The results suggest that one-stop crisis centres are effective in countries where women may not have financial autonomy or the ability to travel to different facilities. Women typically visit multiple facilities to get medical, legal and psychosocial support after falling victim to GBV.

Because of their comprehensive nature, one-stop crisis centres ensure that women access all the services they need with minimal stigma. The centres enhance confidentiality and anonymity. This reduces anxiety associated with community members identifying the person as a victim of GBV.

The Commonwealth has identified six countries where the study will take place. EBS identified in each country the following GBV indicators as shown in Table 1: prevalence of lifetime physical and or sexual intimate violence, the prevalence of physical and or sexual intimate partner violence in the last 12 months, categorisation of the prevalence of physical and or sexual intimate partner violence during the previous 12 months and presence of a One-Stop Centre in each country (UN Women, 2019, Machisa et al. 2011).

Table 1: Prevalence of Gender-based Violence in Six Countries, 2018

Country	Prevalence of Lifetime Physical and or Sexual Intimate Partner Violence	Prevalence of Physical and or Sexual Intimate Partner Violence in the last 12 months	Categorisation of Prevalence of Physical and or Sexual Intimate Partner Violence in the previous 12 months *
Lesotho	86%	62.0%	Extremely High
Malawi	26%	24.0%	High
Namibia	25%	20.0%	High
Rwanda	34%	21.0%	High
South Africa	25%	56.0%	Extremely high
Zambia	43%	27.0%	High

Source: World Health Organisation, United Nations Women, United Nations Children's Fund, United Nations Population Fund

**Low-0-10; Medium: 11-19 and high 20-30 and very high >31-40; Extremely high: >50*

To further contextualise the magnitude of the problem and the lack of information on gender-based violence in the six countries, EBS also investigated available GBV numbers and services (Table 2). The number of abused women is so large that the one-stop centres that are available (even if they work well) are not adequate to handle all cases. Data on the number of cases that one-stop centres seen per year is either non-existent or fragmented; the same for the number of sexual offences/rape cases reported to the police. In South Africa, where there is relatively good statistics on GBV, the 55 one-stop centres have seen 34,558 cases (NPA, 2019) in 2018/19 compared to an estimated 16 million women who have been abused.

Table 2: Number of cases of intimate partner violence and one-stop centres

	Lesotho	Malawi	Namibia	Rwanda	South Africa	Zambia
Estimated Population	2.1 m	18.6 m	2.5 m	12.8 m	58.8 m	18.1 m
Estimated number of women	1.025 m	9.5 m	1.3 m	6.5 m	30.1 m	9.2
Number of IPV past 12 months	635,500	2,280,000	260,000	2,560,000	16,856,000	4,887,000
Number of sexual offences reported	N/A	N/A	N/A	N/A	52,420	±27,000
Number of One-stop Centres	1	28	17	44	55	16
Number of cases reported at One-stop Centres per year	N/A	N/A	N/A	±16,334	34,558	N/A

Sources: World Population Review, Stats SA, UNWOMEN, UNDOC, Zambia Police Service, USAID, National Director of Public Prosecutions SA, UN Rwanda.

One of the objectives of the study was to analyse the effectiveness of the health facility-based coordinated responses to GBV, within the national, cultural and socio-economic contexts across the Commonwealth. Appropriate socio-economic measures are Human Development Index (HDI), Gender Inequality Index, and unemployment rates. The Human Development Index includes three components: life expectancy at birth, mean years of schooling and expected years of schooling, and gross national income per capita. Based on the 2018 UNDP Human Development Statistical Report, South Africa was ranked in the High Human Development category, Namibia and Zambia in the Medium Human Development category and finally Rwanda, Lesotho and Malawi in the category of Low Human Development.

There appears to be a relationship between Human Development Index and performance of the health system. Alin and Marieta (2011) found that the health system effects, efforts and HDI are related. Effect was defined as output, in this case efficiency. Input was defined as total health spending financed from both public and private sources. Data at the European Union level show that there is a strong correlation between HDI and health systems effects (0.74) implying that the level of human development is "directly proportional to the results of the health system." (Alin and Marieta, 2011).

In the African countries studied, there appear to be no correlation between HDI and health system input and outcome. Health expenditure as a percentage of GDP (input) in the six countries varied substantially. Malawi has the lowest HDI of the six countries, but has the largest % of GDP spent on health and yet the life expectancy is no different from South Africa, which has a high HDI, lower spend on health. Zambia has a medium HDI, the lowest spend on health, but has the same life expectancy as South Africa and Malawi which has the lowest HDI. Rwanda is in the same category as Malawi in terms of HDI ranking, that is low, and spend less than Malawi or South Africa, yet it has the highest life expectancy.

Gender Inequality Index (GII) was also included in the measure of socio-economic status, which highlights women's empowerment. The higher the GII value, the more disparities exist between females and males. The result is a loss to human development. It is expected that Malawi which has the highest gender disparity will also have the lowest ranking in HDI, which is the case. Among the six countries, South Africa, has the high GII, second to Rwanda, has a corresponding high HDI. On the other hand, Rwanda has the highest GII among the six countries, but has a low HDI. Unfortunately the sample size is too small to relate the socio-economic status of the country with the HDI and GII.

Table 3: Socio-Economic Status of the Selected Countries

Country	Human Development Rank!	Gender Inequality^	Life Expectancy (years) +	Current Health Expenditure as % of GDP (2017)#
South Africa	113 (HHD)	97	64	8.11
Namibia	130 (MHD)	108	63	8.55
Zambia	143 (MHD)	131	64	4.47
Rwanda	157 (LHD)	95	69	6.57
Lesotho	164 (LHD)	135	54	8,76
Malawi	172 (LHD)	149	64	9.65

Source: ! http://hdr.undp.org/sites/default/files/2018_human_development_statistical_update.pdf

^ http://hdr.undp.org/en/composite/GII (accessed 25 September 2020)

 # https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS (accessed 25 September 2020)

+ https://data.worldbank.org/indicator/SP.DYN.LE00.IN (accessed 25 September 2020)

4. Technical Approach and Methodology

4.1. Technical Approach

The EBS technical approach is informed by theories of change. We theorise that certain conditions must be met to reduce the burden of GBV. The first theory spells out these conditions and the expected outcomes. The second theory posits the impact of service provision on the participant's ability to seek care actively.

Theory 1: If the health care systems have the appropriate capacity, skill and sensitivity to respond to GBV and communities expand coverage of evidence-based GBV prevention and norms change interventions, strengthen linkages along the entire GBV continuum and improve awareness and availability of high-impact GBV interventions and appropriate health and legal services, then communities will

- reduce their tolerance for GBV,

- expand coverage and quality of violence prevention and mitigation services and decrease the burden of GBV on individuals, families and communities and safety for children, adolescents and young women will improve.

Theory 2: If women and children have accessible, affordable and comprehensive health services, then they

- will be more likely to identify abuse,
- have a reduced tolerance for GBV,
- seek and find appropriate support, including psychosocial care, HIV prevention and treatment, and other related health and support services.

The objectives of the study were:

1. Collate and review data and information on the prevalence and diversity of health facility-based coordinated responses to GBV in the Commonwealth.

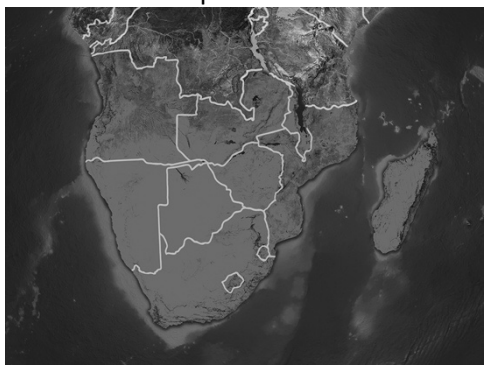
2. Analyse the effectiveness of the health facility-based coordinated responses to GBV, within the national, cultural and socio-economic contexts across the Commonwealth.

3. Identify health facility-based coordinated responses to GBV models and approaches which are effective within different southern Africa contexts and the rationale for their effectiveness, lessons learned across these Commonwealth countries, and challenges in implementing such responses.

4. Recommend innovative, practical and effective health facility-based coordinated responses to GBV models, approaches and strategies, or other alternatives, for different contexts in the Commonwealth, including the rationale for their effectiveness.

4.2. Study Settings

Planning for the study started in October 2019. Data collection was undertaken from January to July 2020 in multiple health care facilities providing post-violence care across five Member States identified by the Commonwealth. EBS used the following GBV indicators for the selection of countries to include in the study: prevalence of lifetime physical and or sexual intimate violence, the prevalence of physical and or sexual intimate partner violence in the last 12 months, categorisation of the prevalence of physical and or sexual intimate partner violence in the previous 12 months and presence of One-Stop Centres. The counties selected were Lesotho, Namibia, Rwanda, South Africa, and Zambia. Initially, Malawi was a study site, but due to a policy on payment for researching a facility, it became unaffordable. Therefore, EBS excluded Malawi due to cost consideration.



Graphic 3: Southern Africa

EBS engaged with Ministries of Health to get lists of hospitals, clinics and other one-stop centres that provide GBV services. The Co-Principal Investigators (Co-PI) were appointed in each country to engage with the local Ministries responsible for gender. EBS used the list of health care facilities and one-stop centres as a sampling frame from which they selected for inclusion ten facilities per country. EBS selected a cluster sample of approximately 50 health facilities representative of the most populous cities/towns in the selected Commonwealth countries with the

assistance of a consultant statistician. The target population consisted of two separate sampling frames:

- A list of public and private Community Health Centres (CHC) providing GBV services in each Commonwealth country's (excluding clinics, mobile, satellite, part-time or specialised clinics) most populous city/town
- A list of all public and private hospitals providing GBV services in each Commonwealth country's most populous city/town including centres such as Thuthuzela Care Centres in South Africa that offer support for victims of GBV.

The lists of health facilities that provide GBV services were reviewed and geolocated on a map. Geolocation in research is often referred to as the application or tool that indicates the location of the unit on a map to be investigated. The position on a map is called a GPS (global positioning system) location and is reflected as coordinates (a combination of latitude and longitude). The primary sampling unit (PSU) was defined by identifying the list of CHCs and Hospitals that are eligible to

Abbreviations:

CHC – Community Health Centre
PSU - Primary Sampling Unit
SSU – Secondary Sampling Unit
MOS - Measure of Size

Figure 2 Abbreviations

es they provided. The names of facilities were verified by checking published databases to ensure accuracy. The corresponding names of CHCs were checked as there are different names for facilities in the target countries. The reporting domain was defined as the country, and statistics were reported by this domain. The secondary sampling unit (SSU), which comprised of two participants that were selected within the sampled CHCs and Hospitals, was defined. A measure of size (MOS) of CHCs was defined as follows:

- CHCs: The logic behind using the MOS was to prevent the imbalance between large and small cities or towns:
    - If the number of CHCs are <=5 then PSU_MOS=1
    - If the number of CHCs are between 6 and 10 then PSU_MOS=2
    - If the number of CHCs are >10 then PSU_MOS=3 Sixth,
- Hospitals: To prevent a high concentration of direct service providers to a few large hospitals, different sizes of hospitals were sampled:
    - If the number of hospital beds is <50, the Hosp_MOS=1
    - If the number of hospital beds is between 51-99, the Hosp_MOS=2
    - If the number of hospital beds is between 100-150, the Hosp_MOS=3
    - If the number of hospital beds is between 150-200, the Hosp_MOS=4
    - If the number of hospital beds is>200, the Hosp_MOS=5 Seventh,

The CHC and Hospitals were allocated to either urban or rural as a stratum 8 or 9, statistician specified the MOS and drew the sample of health facilities and separated CHCs and Hospitals.

4.3. Study Design

EBS used a cross-sectional study method to collect information on infrastructure, medico-legal/forensic investigations, equipment, medication, tests, and the understanding of successes and challenges in the coordination and provision of GBV services.

Data were collected from the managers and direct service providers in the sample list of health facilities to get more information about the GBV services they offered. The fieldwork researchers

conducted qualitative and quantitative interviews with Health Facility Managers and GBV service providers.

A health facility questionnaire was used to collect information on infrastructure, medico-legal/forensic investigations, equipment, medication and tests. It also included the clinical quality of care. The interviews covered the following:

- General questions related to the operation of the facility
- The location where the facility is based
- The processes involved when a victim comes into the facility
- GBV interventions implemented
- Post-violence services provided at the facility and timing of the provision of the services to the victims
- The order of service provision from the time a victim comes in until the time a victim leaves after post-violence care services
- Description of their consent process
- Description of the state of the facility and equipment
- Description of staff competence, attitudes and knowledge
- An understanding of the staff responsibilities and level of skills
- The extent of the level of involvement of the police, legal support and NGOs

The qualitative component of the study gave a better understanding of successes and challenges in the coordination and provision of GBV services in each country. Narrative analysis has been applied to understand the Managers and Superintendents' experiences of running and managing the system in their health facilities. The interviews covered the following: management within different contexts: health care demographic variables-including gender and socio-economic status of patients served at aggregate levels, service providers, protocol, clinical management guide, training received, knowledge and attitudes, and experiences in court. Additional information that was sought related to social and cultural practices that may be related to GBV.

A pilot was conducted to pre-test the data collection instruments. The research team discussed and resolved any issues arising before the roll-out of the questionnaires.

The data was collected on tablets and uploaded to a SQL database. Data collected from the interviews was immediately entered on to online forms or directly on tablets where internet access is unavailable. EBS ensured data integrity through the following steps:

- A custom data collection portal has been developed to house the information from the data collection.
- The portal was secured by passwords for each user account as well as SSL encryption.
- The information entered has been saved directly into the data collection database.
- The Co-PI received a copy of data as it was saved to allow for direct real-time supervision of data collection.
- A secondary copy has been stored on a Google drive (both within a restricted Google Sheet and PDF versions of the entries in a restricted Google Drive).
- The information has been formatted and exported for use within SPSS and NVivo as required.

4.4. Study Participants

The selected sample size was ten healthcare facilities in each of the six countries. In each facility, two people were interviewed. These two people consisted of a facility manager and a direct health services provider, yielding a sample of 20 participants per country. Where there were several staff members providing services to the victims, a random sample has been selected. Where there was only one person providing the services, that person was selected into the sample and interviewed.

Qualitative interviews were conducted with the health care providers, and quantitative interviews with the Health Facility Managers. The choice to collect data from both facility managers/Superintendents and health care providers was to ensure that the research team could conduct data triangulation between the quantitative and qualitative data.

The study is both descriptive and analytic. It is augmented with a sample of case descriptions of how GBV services were coordinated.

Co-PIs and fieldwork researchers were trained during both group and one-on-one training sessions on how to use the data collection system. The overall manager ensured that the 12 fieldworkers were trained on quantitative and qualitative interview techniques to ensure that the data produced are of high quality.

The training included the development of print guides that the data collectors were able to access. These training guides have been available online for an easy referral to the materials. Web-based conference trainings were conducted that covered how to access the system, provide guidance on how to administer the questions, and how to submit information.

4.5. Quantitative Data Management and Statistical Analyses

Data were collected and captured through an electronic system during data collection by data collectors. Each data collector was given a login with direct access to their entries in the system. When a data collector enters information, a notification was sent to the EBS team as well as the relevant Co-PI. This was done to support the ability of the Co-PIs to review the quality of data in real time. Data in the system were converted into excel for ease of distribution. In preparation for statistical analysis data we converted into Statistical Package for Social Sciences (SPSS) version 26. Extensive data cleaning was implemented in SPSS. Data cleaning included converting some string variables into numeric variables of ease of analysis. Data analysis was conducted on Statistical Analysis Software (SAS) version 9.4. Frequency distributions were produced. Frequencies and associated percentages were computed and reported. In some cases, analysis of variables was conducted by country.

4.6. Qualitative Data Analysis

Narrative analysis was done with a focus on the content of the data gathered in the interviews (Riessman, 2008). The narrative analysis allowed for a deeper dive into the intricacies that lay within the raw data and helped the team to unpack and construct a larger narrative on facility-based coordinated responses to GBV models in the Commonwealth.

The researchers conducted a narrative analysis, which allowed for the broader description of the services provided at a model facility. It also allowed the facility managers to narrate along the lines of the questions asked without limiting them by close-ended questionnaire items. It enabled them to disclose how they felt.

Through the data gathered in the qualitative interviews, a broader picture of the effectiveness of the health facility-based coordinated responses to gender-based violence models have been illustrated. Services provided in model facilities have been shown through case studies presented per region in the Commonwealth.

4.7. Ethical Issues

EBS submitted the proposal to the Foundation for Professional Development, a private institution of Higher learning, registered with the South African National Health Research Council for initial ethics approval. EBS secured further ethical approvals for the study from different institutions in the countries where the research was to be undertaken. They are:

- The Research Ethics Committee of the Ministry of Health of Lesotho;
- The National Health Sciences Research Committee of the Ministry of Health of Malawi;
- The Research Management Committee of the Ministry of Health and Social Services of Namibia;
- The National Health Research Committee of the Ministry of Health of Rwanda;
- The Gauteng Health Research Committee, the Tshwane Research Committee and the KwaZulu-Natal Research Ethics Committee of the Department of Health in South Africa. EBS also registered the research protocol at the South African National Health Research Database; and
- The National Health Research Ethics Committee, Ministry of Health of Zambia.

Researchers presented the copies of approval of the countries' ethical committees at each facility where the study took place. Data collectors handed a study leaflet explaining the process of the research, and they also sought informed consent from potential respondents.

The researchers did not collect data from individual recipients of GBV services.

5. Findings

Data were collected from 43 facilities across five countries: Lesotho, Namibia, Rwanda, South Africa and Zambia. There were 26 hospitals, 3 health care centres, 10 GBV Protection Units and 6 One-stop centres in the sample. The services provided at hospitals, health care centres and one-stop centres included health care, counselling, and support services. The GBV Protection Units provide counselling and police services with referral services to health care. The initial plan was to collect data from 60 facilities, but the researchers were unable to conduct research in Malawi due to demand for payment to each facility providing data in the country. The researchers were able to collect data from only three facilities in South Africa due to an arduous and cumbersome ethics process that included five levels, including the original ethics clearance from a registered body. Even after ethical clearance was obtained, some of the facilities were not available to participate in the research due to the advent of Covid-19.

5.1. Facilities Included in the Data Collection

Data were collected from 43 facilities across five countries: Lesotho, Namibia, Rwanda, South Africa and Zambia. There were 26 hospitals, 3 health care centres, 10 GBV Protection Units and 3 One-stop centres. Each of the countries investigated has a different model of providing post-violence care:

Lesotho has a one-stop model (only one at the time of the study) that provides health care services as well as psychosocial support with referral to legal support, police services, victim support and social services. With the exception of the one-stop centre, the rest of the post-violence services are handled by the hospitals. In those settings any of the professional nurses on duty or doctor on call in the Outpatient Department or Accident and Emergency attend to the victims. The country has excellent laboratory support services.

Namibia's Gender-based Violence Protection Units (GBVPU) first known as Women and Child Protection Units were established and managed by the police. The GBVPU model is described as a multi-disciplinary team to respond to sexual and/or gender-based violence in a timely and coordinated manner. The GBVPU offers police services, legal support, psychosocial support and counselling. All medical services are referred to the closest hospital.

Rwanda is implementing health-system based one-stop assistance centres for victims of GBV. The one-stop centres provide survivors access to medical care, psychosocial support, social services, police and legal support as well as facilitation in collection of evidence. The provided medical care includes medical forensic examinations, various medical tests, medication and prophylaxis.

South Africa has a one-stop centre model with a multisectoral response which include a medico-legal examination; prophylaxis and treatment for pregnancy and sexually transmitted infections, including HIV; and immediate and longer-term psychosocial support. The aims of the one-stop centre model are to prevent secondary victimization, improving conviction rates and reducing the time taken to finalise cases.

Zambia's one-stop centre model uses an integrated approach. The centres are integrated into regular Ministry of Health operations and oversight. The one stop centres coordinate the responses of health, police, social workers and legal personnel in cases of gender-based violence. The centres provide health care services, psychosocial, legal support, police services, victim support and social services. Zambia has eight sites; two stand-alone and six hospital-based centres. Victims in areas without a one-stop centre are sent to the nearest hospital where they receive health care and psychosocial services, with referral to the police, legal and victim services. The list of facilities are shown in Table 4.

Table 4: Facilities included in the data collection

Facility name	Facility type	Country
Quthing Hospital	Hospital	Lesotho
Ntsekhe Hospital	Hospital	Lesotho
St. Joseph's Hospital	Hospital	Lesotho
Scott Hospital	Hospital	Lesotho
Mafeteng Hospital	Hospital	Lesotho
Motebang Hospital	Hospital	Lesotho
Mamohau Mission Hospital	Hospital	Lesotho
Seboche Hospital	Hospital	Lesotho
Botha-Bothe Hospital	Hospital	Lesotho
Berea District Hospital	Hospital	Lesotho
Walvis Bay	GBV Protection Unit	Namibia
Windhoek	GBV Protection Unit	Namibia
Gobabis	GBV Protection Unit	Namibia

Facility name	Facility type	Country
Oshakati	GBV Protection Unit	Namibia
Otjiwarongo	GBV Protection Unit	Namibia
Omuthiya	GBV Protection Unit	Namibia
Grootfontein	GBV Protection Unit	Namibia
Luderitz	GBV Protection Unit	Namibia
Keetmanshoop	GBV Protection Unit	Namibia
Rehoboth	GBV Protection Unit	Namibia
Kinihira Hospital	Hospital	Rwanda
Byumba Hospital	Hospital	Rwanda
Butaro Hospital	Hospital	Rwanda
Kibirizi Hospital	Hospital	Rwanda
Nemba Hospital	Hospital	Rwanda
Nyanza Hospital	Hospital	Rwanda
Ngarama Hospital	Hospital	Rwanda
Kizuguro Hospital	Hospital	Rwanda
Gahini Hospital	Hospital	Rwanda
Rwamagana Hospital	Hospital	Rwanda
Port Shepstone Thuthuzela Care Centre	One-stop Centre	South Africa
RK Khan Thuthuzela Care Centre	One-stop Centre	South Africa
Umlazi Thuthuzela Care Centre	One-stop Centre	South Africa
Thelle Mogoerane Thuthuzela Care Centre	One-stop Centre	South Africa
Kopanong Thuthuzela Care Centre	One-stop Centre	South Africa
Kabwe General Hospital	Hospital	Zambia
University Teaching Hospital	Hospital	Zambia
Mumbwa District Hospital	Hospital	Zambia
Chawama First Level Hospital	Hospital	Zambia
Chongwe District Hospital	Hospital	Zambia
Kapiri Urban Health Centre	Health Care Centre	Zambia
Mazabuka General Hospital	Hospital	Zambia
Kafue OSC	One-stop Centre	Zambia
Ngombe Health Centre	Health Care Centre	Zambia
Mtendere Health Centre	Health Care Centre	Zambia

Table 5: Facilities where data were not collected

Facility name	Country	Reason
Madadeni Thuthuzela Care Centre	South Africa	Facility did not want to participate.
Phoenix Thuthuzela Care Centre	South Africa	Unable to obtain permission from manager.
Stanger Thuthuzela Care Centre	South Africa	A COVID-19 hospital. No access allowed.
Laudium Thuthuzela Care Centre	South Africa	The facility was closed due to COVID-19.
Mamelodi Thuthuzela Care Centre	South Africa	Facility did not want to participate.

Overall, the study has a 90% response rate. The ethics clearance process in South Africa created many delays, and data collection ran into the COVID-19 pandemic, which created problems with access.

5.2. General Information

5.2.1. Hours of Service and Waiting Time

Of the 43 facilities that responded, the overwhelming majority (90,7%) reported that they delivered services 24 hours a day as shown in Table 6.

Table 6: 24 Hours of service per day

	Yes	No	Total
Lesotho	10	0	10
Namibia	10	0	10
Rwanda	9	1	10
South Africa	3	0	3
Zambia	7	3	10
Total	39	4	43

5.2.2. Location of Facilities

Slightly more than half of the facilities (53,5%) reported that they were located in a separate area inside the facility. In South Africa (100%) and Rwanda (80%), most of them were located within facilities, while Lesotho and Namibia were not located in a separate facility (Table 7).

Table 7: Service located in a separate area inside the health care facility

	Yes	No	Total
Lesotho	2	8	10
Namibia	8	2	10
Rwanda	8	2	10
South Africa	3		3
Zambia	8	2	10
Total	29	14	43

A little more than 37% of facilities reported that they were located in a park home (temporary structure, usually a shipping container); the rest were located in permanent structures.

5.2.3. Facilities Linked to Sexual Offences Courts

The majority of these facilities (61,2%) were reported to be linked with a sexual offences court, meaning that they are likely to access the criminal justice system. Rwanda and Zambia were more likely than the rest to be linked with sexual offences courts, 100% and 90%, respectively (Table 8).

Table 8: Facilities linked to sexual offences courts

	Yes	No	Total
Lesotho	1	9	10
Namibia	4	5	9
Rwanda	10	0	10
South Africa	2	1	3
Zambia	9	1	10

Total	26	16	42

5.2.4. Waiting Time

In all facilities, the respondents reported that all the survivors were attended by a first responder or a medical professional within 45 minutes to an hour of their arrival. Although the facilities do not have waiting times for victims when they present at facilities, the referral services often create delays. Slow laboratory services, shortage of forensic tests, power cuts, lack of transport, and movement between different departments are cited as delaying the provision of services to victims.

> "Sometimes there is waiting time delays because the victim is still in negotiations with the perpetrator, they want the perpetrator to pay them for damage caused, but once the perpetrator is not agreeable, that's when the victim decides to report the case, and by then the evidence would have already been erased."
> **Facility in Zambia**

5.3. Services Provided at the Facilities

Most of the facilities (97.8%) concur that they work according to a protocol that is entrenched in law to care for victims of GBV. Written protocols are available at facilities and implemented in various ways, from checklists to diagrams to guide the service providers.

The facilities provide the following post-violence services: counselling, clinical examination and management, post-exposure prophylaxis (PEP) for HIV, HIV testing, prophylaxis and treatment of STIs, pregnancy testing, emergency contraceptives, legal support, follow-up services by social workers, Hepatitis B and C antigen tests, and referrals to additional services.

- **Reception of the survivor:** In all the facilities, they reported that the sequence of service provision starts with the reception of the survivor, followed by information explaining the procedure and evidence collection. All facilities affirmed that the progression of a victim through the facility is dependent on the state of the victim. If a victim needs medical care, she/he will be treated for injuries before any other services are offered. Although not all facilities (22,2%) provide clinical care on-site, they consider themselves as providing all services through referrals to hospitals.
- **Medical forensic examination:** Overall, 62,8% of the facilities reported that they provided a medical forensic examination to clients. In Lesotho, Rwanda and South Africa, it was reported that most or all the facilities surveyed provided a medical forensic examination to all victims and survivors.

Graphic 4: Example of DNA sampling

- **Bath/shower facilities and comfort packs:** The majority of facilities (72,1%) reported that they provided a bath or shower. Rwanda, Lesotho and South Africa facility managers reported that they mostly had facilities with a bath or shower. Facilities were reported to be less likely (39,5%) to provide comfort packs and clean

clothes for survivors. In Rwanda and South Africa, all the facilities surveyed provided these services.

- **Taking of Statement:** Except for Lesotho, all the countries surveyed indicated that statements were taken by an investigating officer.
- **Psychological First Aid/Psychological Support:** Most facilities (81,4%) reported that they provided psychological First Aid/psychological support when clients present at facilities, only Namibia's facilities did not offer these services as they refer victims and survivors to health care facilities.
- **Post-violence counselling:** The majority of facilities (89%) offer post violence counselling to victims of GBV. The following counselling services were offered:
    - Psychosocial support
    - Trauma counselling
    - Family Counselling
    - Group counselling
    - Couples counselling
    - Conflict resolution
    - Role-playing therapy
    - HIV counselling
    - Trauma Focussed Cognitive Behaviour Therapy

  When multiple counselling sessions are not available at facilities, victims are referred to partner organisations (NGOs), social workers, and psychiatry department at hospitals for counselling services.

- **Testing for HIV, STIs and pregnancy:** Most of the facilities, except in Namibia, reported that they offered tests for HIV, STIs and pregnancy for survivors. Namibia uses referral hospitals for all medical procedures as their protection units offer psychosocial, police and legal services.
- **Provision of prophylaxis for HIV, STIs and pregnancy:** Four of the countries reported that they provided prophylaxis for HIV, STIs and pregnancy to the clients. In Namibia, only one facility offered such services.
- **Referral to HIV care and treatment for HIV positive clients:** Almost all the facilities reported that they provided a referral to HIV care and treatment for HIV positive clients.
- **Referral to long term counselling and support:** Nearly all facilities reported that they provide a referral to long term counselling and support.
- **Assistance with case reporting and court preparation:** Most of the facilities (83,7%) reported assisting with case reporting and court preparation to survivors of gender-based violence.
- **Cleaning Service:** The bulk of facilities reported providing cleaning service (contracted out or staff employed by the hospital).
- **Security Services:** Security Services (contracted out or employed by the hospital) were reported to be provided in the majority of facilities (86%). Only in Namibia these services were not provided as the police is staff at the facilities for 24 hours per day. The respondents mentioned that security services are essential to ensure the safety and confidentiality of survivors.

Graphic 5: Court House Cape Town, South Africa

- **Other services provided to sexual assault survivors:** The facilities offer the following support services to victims of GBV:
    - Counselling services
    - Follow-up services
    - Home visits
    - Provision of places of safety/shelters
    - Legal support services
    - Referrals to social workers
    - Psychosocial and psychiatric support.
    - Transport of victims
    - Food and snacks
    - Spiritual care

Victims are made aware of specific services that are available when they enter the facility. All services are communicated and explained to them. Most of the facilities provide comprehensive post-violence services with referral to additional services. Where facilities operate on limited hours, victims are taken to the closest hospital for treatment. Police services are also open 24 hours per day for victims.

5.4. Flow of Services

All the respondents reported that the flow of services provided to clients is according to a written protocol that all staff of the facility must follow. However, the medical forensic examination is provided only in 62,8% facilities. The following sequence of services is followed by most of the facilities:

- Reception of the survivor, followed by information explaining the procedure and evidence collection
- Registration for intake/admission and consent
- Psychological First Aid/Psychological Support
- Medical Forensic Examination
- Bath or Shower facilities
- Provision of comfort pack and clean clothes
- Testing for HIV, STIs and pregnancy
- Provision of prophylaxis for HIV, STIs and pregnancy
- Referral to HIV care and treatment for HIV positive clients
- Referral to long term counselling and support
- Statement taken by Investigating Officer
- Assistance with case reporting and court preparation
- The survivor is offered transportation home or to a place of safety if necessary

5.5. Consent

All the facilities maintain that they have a vigorous consent regime for victims entering the facility. If a victim presents to the police first, they give her a written consent form to open a case. If the police are located in the facility, they will ask for consent when the medical staff refer the victim to them. The victim's consent is requested at each step of the examination process, including medical examination, taking of forensic evidence, testing, treatment and counselling. The staff explain to victims the process that is being followed at the facility and the reason informed consent is important. If a victim cannot sign a consent form, a thumbprint is used. If the victim is a child, the parent or guardian must sign the consent forms, but the service providers at the facilities will explain the process to the child.

Graphic 6: Example of the acceptance section of a consent form

5.6. Facilities and Equipment

5.6.1. Facilities

Existence and well-functioning facilities enable the provision of gender-based violence services. Researchers verified whether the facilities existed and whether they were in working order. Table 9 presents the list of verified and functional amenities.

Table 9: Amenities available

	Yes(%)	Working
Private ablution facilities (with shower and toilet)	39,5	43,2
Ablution facilities are disabled friendly	19,0	32,5
Private Room for calming and soothing clients	46,5	64,5
Private room suitable for children to play/wait in	51,2	69,0
Consultation room/s	57,2	46,2
Waiting room (with seating)	53,5	57,4
Counselling Office	53,5	52,4
Room for a police officer for statement taking	67,4	90,6
Room for Victim Assistance Officer (safety planning)	46,5	71,4
HIV Counselling	38,1	44,7
Examination Room	51,2	47,5
NGO room	11,6	21,7
A wheelchair ramp	37,2	42,9

The first observation is that the facilities that provide GBV services are not well equipped. The most well-equipped offices in facilities were the rooms where the police take statements, followed by consultation rooms. The ablution facilities were very few for disabled persons, followed by private ablution facilities (toilets and showers). Surprisingly, there were very few HIV counselling rooms, meaning that many were counselled in non-ideal settings. But even when available, the facilities were not functional. The police office for taking statements was the most functional. The rest had functionality of between 32,5% and 71,4%. What this suggests is that the system for providing services for gender-based violence victims are less than optimal.

5.6.2. Equipment

Most of the examination rooms (81,1%), had the necessary equipment for examining survivors of gender-based violence, except drop sheets for a survivor to stand on while undressing, and slightly less for syringes and needles. A lower percentage of equipment was non-functional. In 50% of the examination rooms, there were no colposcopes that were functional, despite the report that 81,1% were available. A few more types of equipment were non-functional despite their availability. These are speculums, gynae couches, Lithotomy tables, lights to perform examinations, clean bed linen, blood pressure monitors, sterilising equipment, crime/rape kits, and paper bags for evidence collection kits. The percentages of non-working equipment in the examination room, as shown in Table 10, range between 50% and 81,1%.

Table 10: Equipment available in examination rooms

Equipment in the examination room	Available%	In working order %
Colposcope	81,1	50,0
Speculum	81,1	69,8
Gynae couch	81,1	66,0
Lithotomy Table	81,1	60,0
Lighting sufficient to perform examination	81,1	73,6
Crime/Rape Evidence Kits	81,1	58,5
Pregnancy Testing Kits	81,1	81,1
STI collection kits	81,1	81,1
Clean bed linen and gown	81,1	73,6
Hand washing facility with soap and running water	81,1	81,1
Lockable doors	81,1	81,1
Paper bags for evidence collection	81,1	67,9
Drop sheet for a patient to stand on while undressing	79,1	75,5
Blood Pressure Monitor	79,2	77,4
Syringes and needles	79,2	81,1
Blood Tubes	81,1	79,2
Sterilising equipment	81,1	75,5

Graphic 7: Example of sterilizing equipment - autoclave sterilizer

5.7. Staff

The facilities reported that the resources available to deliver a high-quality service to victims of GBV are well trained and highly skilled staff, adequate medical equipment, good referral networks, a facility that provides confidentially through the availability of consulting rooms and the support of NGOs.

The designated first responder at facilities differs from facility to facility. Most of the first responders are professional nurses, doctors, social workers and trained counsellors. The respondents agree that the tasks of the first responder include receiving the victim, assess the victim to ensure medical care is prioritised, ensure the safety and comfort of the victim, register the victim, explain the process step by step, obtain informed consent for the process in the facility and do follow-ups.

"Staff must have a passion for working with victims of GBV. This is an essential quality." says a health care provider at a one-stop facility in South Africa.

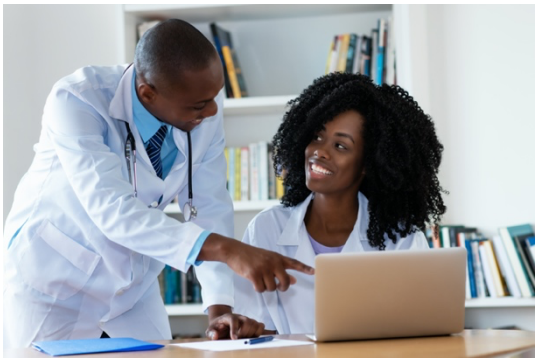
Health care professionals working in GBV are selected on their professional qualifications and their interest in the field. Furthermore, experience and training in the GBV field are essential.

Half of the facilities indicated that they have adequate staff to provide services, while all facilities reported that they have at least two to three staff members available at any given time. The facilities report that it is crucial to have the minimum staff available to provide quality services to victims of GBV. Health care staff are trained at least once per year, but most facilities update staff at regular weekly meetings. These meetings are used to monitor the work at the facilities and conduct in-service training. The content of the training includes GBV, sensitisation and forensic medicine. All the facilities require more structured training which includes training of nurses and doctors to collect forensic evidence, trauma counselling, how to provide evidence in court, ethics, general GBV, sign language for assisting deaf victims, post-violence care and the use of medical equipment such as the colposcope.

About 90% of facility-based staff including security guards, cleaners and administrative personnel, are sensitised regularly in dealing with survivors of GBV. Almost all facilities (93%) report that age-sensitive and gender-sensitive engagement with victims of GBV are included in general GBV training of health care workers.

Table 11: First responders received at least 60 hours training

	Yes	No
Lesotho	1	9
Namibia	9	1
Rwanda	8	1
South Africa	3	0
Zambia	7	3
Total	28	14



Graphic 8: Example of a doctor and nurse in training.

Table 12: Staff Trained for the management of cases with sexual assault

Site coordinator	92,9%
Victim assistance officer	90,0%
Lay Counsellors	52,5%
Social Worker	61%
Psychologists	52.5

Most of the site coordinators (92,9%) and the victim assistance officers (90,0%) have been trained in the management of cases of sexual assault. However lay counsellors, social workers and psychologists are not adequately trained.

Table 13: Topics included in the training

Gender-based violence	**100%**
Basic Counselling Skills	80,5%
Crisis intervention and trauma management	75,6%
HIV care and treatment and PHP adherence	78%%
Sexual and Reproductive Health issues	80,5%
Helping a diverse range of survivors	85,0%
Sensitisation to the contexts shaping violence	75,6%
Laws relevant to violence against women and children	80,5%
Personal Development, self-care and stress management	80,5%
Record keeping and report writing	75%

Table 14: Performance of work that the staff member is not trained for

Site Coordinator	**40,5**
Victim Assistance Officer	32,3
Lay Counsellor	19,5
Social Workers	18,6
Psychologist	12,2

5.8. NGO Support at Facilities

Eighty-eight per cent (88%) of the facilities have an NGO affiliated to assist with post-violence services to victims. All these facilities report that the services the NGOs provide are adding massive value to their work and that their relationships with the NGOs are very good. The services the NGOs offer include counselling, provision of shelters and places of safety, follow-up of victims, awareness-raising, provision of life skills training, assisting with transport of victims, HIV treatment management, and social services. The advice of the respondence for cultivating a good relationship with their NGOs include the following:

- Always focus on the victims and the support to the victims;
- The roles of the NGO and facilities should be clearly defined;
- All parties should respect the work that each other is doing;
- If there are any issues, solve them immediately;
- Have regular meetings and training sessions together; and
- Acknowledge NGOs' contributions.

The respondents report that the NGOs impacted on the good performance in post-violence services in the facility, specifically in counselling, follow-up adherence and provision of shelters and places of safety. These facilities reported that they cannot do without the NGO services.

5.9. Awareness-Raising

Most of the respondents said that awareness-raising plays a vital role in making communities aware of their services and provide information and education of GBV. The majority (91%) of facilities participate in the marketing of GBV services and raising awareness of in both formal and informal ways. The marketing actions include talks at public events, sensitisation of community health workers, slots on community radio programmes, awareness at schools, churches, the private sector, taxi ranks, newspapers, drama events, community dialogues, distribution of posters and pamphlets and GBV events like 16 Days of Activism for no violence against women and children. Partnering with stakeholders such as NGOs, other government departments (social development, police and justice) and traditional leaders play an essential role in the awareness campaign.

5.10. Victim Friendliness and Secondary Victimisation

The facilities have dedicated offices, with waiting rooms specifically for victims of GBV. Most of the facilities report that victims are consulted in dedicated rooms. The security guards at facilities ensure that no one can enter the facility without permission. Except for victims, no-one can enter the facility without an appointment. At one-stop facilities, there are separate entrances for victims and alleged perpetrators. Victims of GBV are treated as emergencies, they do not queue with other patients, and they are fast-tracked in the system. However, when victims are referred to a hospital/clinic, the lack of privacy may be a factor in secondary victimisation. It is possible to alleviate secondary victimisation by escorting the victim to relevant departments. All the key informants mention that the facilities place a very high premium on the privacy and confidentiality of victims.

5.11. People with Disabilities, Gender Identity and Children

About half of the respondents indicated that there are no special services for people with disabilities and that there are not many facilities with wheelchair access. People with disabilities are being treated with respect and confidentiality the same way as any other victim. Although staff received training on gender identity with their GBV training, more training is needed. The victim can also request to be assisted by a male or female health care worker. Children, however, are treated differently from adults. A child must be accompanied by a parent/guardian, and social service providers are involved in the case from the start. More than half (64.4%) of the facilities offer differentiated care within its post-violence care services with specific services catered to young children, pregnant women, and homeless women.

Graphic 9:Picture of a nurse with a patient in a wheelchair

5.12. Reporting of GBV

All the respondents indicate that their facilities have a legal obligation to report GBV. It is, however, not always the case. If an adult does not want to open a case of GBV, they cannot be forced. This is a contradiction as all the respondents said that GBV is a crime in their countries. With regards to children, it is a different matter as the facilities are legally bound to report abuse against minor children. When reporting GBV of a child to the police, the department of social development plays

an important role. The social worker, in consultation with the police and the medical staff will investigate the child's situation and assess how to proceed. A child victim presenting at the police or the health facility will be prioritised and fast-tracked.

5.13. Repeat Attendance by a Victim

When a victim is a recurring client at a facility due to repeated GBV the facilities have a variety of ways to respond to the situation. Most of the facilities advise these victims of the options available to them that could include opening a case at the police, reporting the case to the social worker, assisting with issuing a protection order against the abuser, issuing a warning against the abuser, ongoing counselling, referral to the victim support officer and referral to a safe house. However, if the victim is a child, the staff at the facility are obliged according to law to involve the police and social worker for immediate action. If a repeat victim does not want to leave the abusive environment the services available to them include counselling services, informing the victim of her/his rights, the involvement of the victim's family, and referral to a psychologist/social worker. If the victim is a child or if children are also harmed in an abusive relationship, the respondents all agree that action is taken immediately. Children could be removed by a social worker and moved to a place of safety or with a family member, and both parents can be charged with a criminal act. If the victim is unable to return home after being attended to at the facility, 64,4% of the facilities have places of safety/shelters to refer victims. Many of these places of safety/shelters are run by NGOs affiliated to the facility based on an informal agreement. In circumstances where there is no place of safety available for victims, the facility, in consultation with the social worker and or the police, could admit the victim to the hospital for a few days.

> "We used to admit victims to the hospital, but that option is no longer available. So, the police and social worker must make a plan." - Facility in South Africa

The options of where to refer victims and their children are limited at most facilities. The places of safety and shelters that are available are managed by NGOs with limited funding. Facilities that do not have a shelter make a plan for victims. It varies from housing victims at staff's own homes, asking family members to help, keeping victims overnight at police stations, admit the victim to a hospital, or to not being able to assist at all. If a place of safety is not available, it means that victims are sent back to their homes where the abuse took place in the first place.

The help available for victims with children who are living with the perpetrator includes the following:

- Involve the social development department as well as the police
- Counselling services to victims
- If children are in danger, they can be removed from the household
- Issue verbal warnings to the perpetrator
- Advise the victims on protection orders
- Advise the victim that she and her children can be housed at a place of safety
- If a place of safety is not available, ask the victim's family to assist

Only two (4%) facilities indicated that there is no help available for victims and their children. The rest of the facilities have either a place of safety to refer the victim and her children or they make a plan.

> The one-stop centre counsel perpetrators too. In the counselling, they are warned on possible consequences if they persist with their actions - Health Care Facility in Zambia.

5.14. Support Services and Accessibility

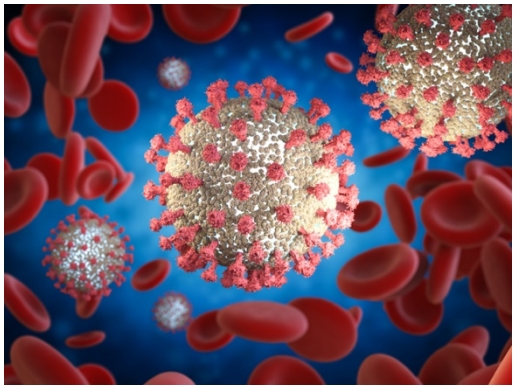
- **Police and case managers:** All the facilities responded that they can link a victim of GBV to the police to report and open a case. The way the police get involved differs from facility to facility:
  - The victim goes to the police first (22.2%) and they bring the victim to the facility for services;
  - After a victim has been treated and provided with post-violence services, they are referred to the police (22.2%);
  - 55.6% of the facilities have an office in the facility that forms part of the comprehensive services offered.
- 13.3% of the facilities mentioned that they had experienced challenges with the police. Challenges include:
  - Limitations of police in addressing GBV cases
  - Police do not have vehicles/fuel to transport victims
  - Not enough knowledge and training in the field of GBV
  - Police can be insensitive to the victims
  - Corruption: in some cases, police ask for a bribe to work on the case
- 11.1% of the respondents said that there are delays when working with the case managers. This is because they have offices in police stations; therefore the survivors need to find transport to go to the police station and yet not all the facilities have transport available for survivors.

Facilities ensure adherence to protocols through weekly monitoring of the cases, debriefing sessions with staff, appraisal of staff, and training and mentorship.

6. Challenges and Limitations

All possible effort was made to administer the survey at facilities and conduct interviews with facility managers. A few challenges were experienced, which also relate to the limitations of this study.

- A factor affecting the strength of the study design and report findings is that the data are self-reported. This introduced bias into the design as there was a strong reliance on the honesty of key informants and their recall accuracy when answering certain questions. The data collection instrument required validation of some of the questions through actual observation and the results were reported in the study.
- In drawing up the sample contact details for the facilities were collated from different lists. Despite this cross-referencing, contact details for facilities were not always accurate which meant that data collectors had to visit a facility to make an appointment later to administer the survey, rather than making such an appointment over the phone. This meant data collection took longer.
- The study did not permit an interview of victims of violence due to the sensitive nature of the research. Secondly, the focus of the study was on the ability of facilities to provide post-violence care. Although this is appropriate for the study design and focus, it implies that the study did not test the perceptions of clients on the victim friendliness and appropriateness of the services provided.
- It was not always possible to get ethical clearance at a local level. In South Africa ethical clearance was achieved at a national and provincial levels. However, at a district level, major challenges were experienced. Intergovernmental processes do not always work in a consistent manner. One level can approve and the other deny ethical clearance.
- COVID-19 made it very difficult to continue to collect data in South Africa. The social distancing (lock-down) meant everyone had to remain indoors, except for essential activities. This made it difficult to pursue any more data collection efforts.
- In Malawi, the major challenge was the requirement for financial contribution at each facility selected to be part of the study. The budget did not include extra payment beyond the ethical clearance and data collection. Consequently the Malawian part of the study was abandoned.



Graphic 10: Picture of COVID-19

- In the initial proposal the decision was taken that Eswatini (formerly Swaziland) should be included. The researchers were informed that data from Eswatini cannot be sent outside of the country. For this reason, another site was selected to replace Eswatini.

7. Conclusion

The original project proposal was set out to review evidence and collect primary level data to provide evidence on the effectiveness of health facility-based coordinated (one-stop) centres that offer services for gender-based violence/violence against women and girls in all the Commonwealth countries. The plan was to develop a road map to establish evidence- and rights-based health sector response to this menace. This can be achieved after all the regions

are included in the study. Therefore, the decision was taken to focus on the six African countries and achieve the four objectives.

Data were collected from 43 facilities across five countries: Lesotho, Namibia, Rwanda, South Africa and Zambia. The facilities under review were situated in hospitals, health care centres, GBV Protection Units and one-stop centres. All the countries have laws, policies and plans in place to govern responses to violence against women and children. It is important to note that GBV policies should be aligned with international frameworks and standards. GBV demands a multisectoral response and every sector has its role to play. In countries where there is visible political will and leadership (Namibia and Rwanda), the GBV programmes are successful. South Africa has strong political support; however only three facilities were included in the study due to COVID-19 as well as delays from civil servants to approve local ethical clearance. Public healthcare-based facilities such as in Rwanda provide a holistic service that is managed and resourced by the government; they are not dependent on donor funding (that can be unpredictable and not sustainable). The reason why GBV services are successful at a specific location (hospital, protection unit one-stop centre) is all about political support and the government taking charge.

Overall the facilities reported that the key to excellent service delivery is well-resourced facilities. Furthermore, good infrastructure, well-stocked medical and other supplies, adequate number and trained staff and a responsive referral system are key to success. The lack of transport, both to take survivors to referral services and for police to do their work was an issue in Lesotho and Zambia.

The Government of Rwanda has made ending Gender-Based Violence a national priority, and so in South Africa.

Although almost all the facilities provided essential services, such as health care, counselling, social services, police and legal services, it is the additional services offered at some facilities that make it and excellent GBV center. The passion and dedication of staff to deliver the best possible service are evident. The follow-up of survivors includes many angles. Below are some but not all.

Figure 3: Examples of follow up services

The essential services are forensic medical examinations, HIV and STI testing, prophylaxis treatment for HIV and STIs, Hepatitis B antigen testing and Hepatitis C vaccination, taking complete statements from survivors and preparing survivors for court.

The referral systems of survivors to external and specialised services need attention.

The follow-up services mentioned by the respondents were mostly regarding psychosocial follow-up and adherence to medication. The researchers could not detect a follow-up system to check that the survivors went to the referred service.

All the facilities stressed the importance of minimising secondary victimisation and ensuring the confidentiality of survivors. The facilities have security guards that are dedicated to the GBV facility, providing both survivors and staff's safety.

NGO support is important as they mostly provide counselling and psychosocial support, as well as manage shelters for survivors. It is worth mentioning that not all the facilities reported that they have access to shelters or places of safety for survivors and children. This is a great need that needs to be investigated further. The NGOs' work has been described as invaluable.

Hospital-based services with a one-stop function (as in Rwanda) seems to be a good model providing health care, social services, psychological support, police services, legal support, victim support. Hospital-based facilities are easily accessible for health care and psychosocial support. Referral to the police and legal support could provide some delays if the transport is not available.

There are not enough GBV focused facilities available to serve all the GBV victims because the incidence of GBV in all the countries under investigation is high. GBV services can be integrated into routine primary health care work. In sub-Saharan Africa, GBV services can be integrated into HIV, STI and TB programmes. Staff at these health care facilities must be trained to deliver post-violence services.

8. Recommendations

8.1. Recommendations Related to GBV

Throughout the respondents stated how important post-violence care is and expressed their willingness to support victims of GBV. It is recommended that this willingness be supported by equipping staff better to provide post-violence care. Based on the findings of the study the following recommendations are made:

The findings of the study, though small, suggests in Southern African Commonwealth Countries that aim to establish health sector coordinated response to GBV is best if the facility is located in a hospital or a hospital premise. It should also be linked to a sexual offences court. Furthermore, it should operate 24 hours a day and attend to victims in less than an hour. The facility should deliver a comprehensive set of services that include medical forensic examinations that should provide evidence in court. The facility should also assist with case reporting and court preparation with statements taken by investigating officers. The facility should offer psychological first aid services or psychological support. Given the association of gender-based violence, particularly sexual violence, each facility must have testing for HIV, STI and pregnancy as well as the provision of prophylaxis for these conditions. The facility should refer immediately those who test positive for HIV care and

treatment. The victims will need a referral to long-term counselling and support to enable them to become survivors of gender-based violence. Each facility should have security to prevent these women and children from secondary victimisation and also victimisation by the perpetrator.

Analyse the effectiveness of the health facility-based coordinated responses to GBV, within the national, cultural and socio-economic contexts across the Commonwealth.

For those who want to set up an effective health facility coordinated response to GBV should have clinically equipped facilities. It means they must ensure the facilities have equipment for examining victims of sexual offences such as those used to examine the cervix, vagina and vulva. They should also have kits they can use to collect evidence for crime or rape; they will need paper bags for evidence collection as well as a ground sheet. Furthermore, they should have all they need to take samples such as blood tubes, syringes and needles, and they should also ensure each facility has testing kits for sexually transmitted diseases and pregnancy. Such facilities should prevent nosocomial infection by having sterilising equipment, clean bed linen and gown, handwashing facilities with soap and running water. It should be possible to set up effective health facility-based coordinated response because most of these countries spent more than 8% of their GDP on health.

The model to recommend for other countries is Rwandese. This model is suggested to other countries to learn from in that it provides services 24 hours a day and seven days a week in a facility that is located within the hospitals. Victims are attended within 45 minutes to one hour upon arrival and receive an explanation regarding the process that will be followed. Victims are offered clean clothes upon arrival. They receive first aid psychological support. They are provided most of the services that are expected at a health coordinated GBV centre, including clinical guidelines. The model includes a functional disabled-friendly environment. What is also interesting is that the model includes a functional private room for children to play.

As seen in Rwanda, the development of an integrated health sector response to GBV requires political will and leadership. Due to the multi-sector response to victims of GBV, senior level support at ministerial and hospital level is critical for an integrated health sector support.

There are clear gaps in the way of record keeping of survivors of GBV. For example, upon referral there is no way of knowing if the victim reported at the referral organisation or not. It is recommended that a system be put in place for all facilities to keep a record of the survivors who have reported at the facility, where they have been referred to and what service or treatment they received. This will facilitate greater and more accurate knowledge about the true number of victims of sexual violence who report at health facilities, but to track these victims to determine if they received treatment as well as decreasing loss to follow up.

It is recommended that all vacant posts regarding post-violence services be filled. All staff working with survivors must participate in an ongoing training programme. This training programme should include further training and refresher courses. Security guards and cleaners should be sensitised on how to interact with survivors. Support and supervision play an important role to the staff of GBV facilities. It is recommended that a formal programme be developed to debrief all staff to prevent burn-out.

Community awareness of the services offered at GBV facilities is important. A barrier to accessing care is the ‘hidden’ nature of gender-based violence in the community. This relates to a lack of awareness of what is GBV, the stigma attached to it, and poverty and related economic dependence - all resulting in victims not reporting cases. Although some of these challenges are structural and

therefore harder to address, such as women being financially dependent on abusive partners, it is recommended that more awareness raising is done on GBV.

Facilities have limited space to render good quality post violence services. Facilities should have a private, separate examination room and counselling room to safeguard the privacy and confidentiality of victims. Additionally, facilities must be provided with bathrooms containing at least a shower, a toilet and a washbasin with running water. The GBV facilities must also be accessible to people with disabilities, including a wheelchair ramp.

8.2. Recommendations Related to the Data Collection

The data collection solution was developed using a digital-only principle. While this required additional effort to be made to ensure wi-fi access and access to data collection devices, the approach guaranteed that no data loss occurred. Analysis was also streamlined due to all data existing in a single entity. Although data were collected from 5 countries, a more comprehensive list of countries needs to be analysed in a similar fashion. This will allow any roadmaps and recommendations to be based on comprehensive information that is relevant to each country. We also recommend the creation of a communication / information portal that can serve as the online home of the tools created from this initiative. This would serve as a place to house data, a place to house results / recommendations, a secure portal for accessing toolkits, and also a collaborative space to provide support to countries as they work through their road maps. Such a portal can also serve as a tool to provide knowledge sharing communication tool between countries as they continue to strengthen their GBV programs.

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