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MEETING ABSTRACTS

A1 'Changing the World': The Africa Regional Sexual and Gender-Based Violence Network
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Editorial: The last thirty years have been characterized by tremendous growth in the number of existing health networks world-wide: yet, little is known about why such networks emerge, what their effects are, and their roles in the governance of health [1]. The 'Africa Regional Sexual and Gender-Based Violence (SGBV) Network' emerged in the East and Southern African region in 2006. Led and coordinated by the Population Council, this network materialized as a consequence of the landscape of SGBV work in the region. At the time, while discourse and initiatives related to SGBV prevention were not unheard of, far less attention was being given to programmatic response to the service needs of SGBV survivors. With initial funding from the Swedish-Norwegian Regional HIV and AIDS Team for Africa, Embassy of Sweden, Lusaka, Zambia, the Population Council identified a number of implementing partner organizations in East and Southern Africa to facilitate collective action around the issue of responding to the needs of SGBV survivors in the region. Since then, network partner organizations have continued to work on fostering a multi-sectoral response (centered on those who have already experienced SGBV) in their countries and beyond - exploring what such a response means in low-resource settings, what it can mean, and what it should mean, given the constraints and realities. Each partner contributes toward the network by strengthening the capacities of the medical, legal, and/or justice sectors to care for survivors of SGBV, and by building an evidence base for SGBV programming. Partners develop, implement, and evaluate core elements of a multi-sectoral response model that incorporates the overlapping and complementary responsibilities of the health, police and justice, and social service sectors. The ethos of the Africa Regional SGBV Network centers on the conviction that survivors require access to all services, but that it may not be feasible, appropriate, or cost-effective to deliver all services in one location. Through their interventions over the years, network partners have not taken the conventional understanding of a multi-sectoral approach for granted, but have instead allowed other viewpoints and actions to emerge in regard to such an approach. Where necessary, partners have conceived programmatic response to survivors’ service needs differently, testing out innovative and, sometimes, daring approaches.

On December 4, 2013, for the first time ever, the Africa Regional SGBV Network convened a meeting in Washington, DC, USA. The meeting commemorated the 16 Days of Activism Against Gender Violence and raised awareness of interventions for survivors of SGBV in low-resource contexts. The forum reflected a culmination of efforts from seven years of grounded research and practice-building in the field of SGBV, and brought together network partner organizations from Kenya, South Africa, Swaziland, and Zambia, in addition to policy, practitioner, and researcher audiences from the Washington, DC area. This volume of extended abstracts summarizes network partner presentations delivered during the meeting. The presentations centered on each partner’s interventions and main results, coupled with the effectiveness of partners’ endeavors in responding to the needs of survivors. The notion of ‘effectiveness’ as employed here draws on Shiffman’s [1] definition of the concept in regard to networks and their policy consequences. As he explains:

Effectiveness refers to the extent to which networks are able to change the world to meet their members’ perceptions of what reality should look like [2]. We examine effectiveness by considering ... policy consequences ... Policy consequences pertain to the global policy process, including international resolutions, funding, national policy adoption, and the scale-up of interventions (emphasis added).

Accordingly, this collection of extended abstracts highlights the nature of policy consequences that the efforts of the Africa Regional SGBV Network have engendered in the East and Southern African region. The current volume appears during an exciting time of ‘climate change’ in SGBV work, where SGBV prevention initiatives in particular are receiving mounting attention in the East and Southern African region. While there is good reason for this near-singular focus on prevention, this volume will remind readers that any supposed dichotomy between ‘prevention’ and ‘response’ is artificial, at best. Both are closely interconnected and critical, and work hand in hand with one another. In responding to SGBV, we prevent it - and in preventing SGBV, we respond to it. Furthermore, compared to other parts of the world, SGBV ‘prevention’ and ‘response’ alike are in their infancy in East and Southern Africa. In responding to SGBV, and in bringing about policy consequences (as defined above), the Population Council and its partners are changing the way the world thinks about the critical health and development issue that SGBV represents in East and Southern Africa. Indeed, as each of the extended abstracts in this volume demonstrates, in diverse ways, the Africa
Regional SGBV Network is ‘changing the world’ to meet its members’ perceptions of what reality should look like in regard to programmatic response to the needs of survivors in the region.

References

A2 Documenting medico-legal evidence in Kenya: Potential strategies for improvement
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Background: Sexual violence (SV) remains a global public health problem and a violation of multiple human rights. It can negatively impact on the short- and long-term physical, social and mental health of survivors and is associated with many adverse health outcomes [1-3]. It is assumed that some of the negative outcomes of SV can be addressed through the provision of appropriate post-rape care services [4]. The latter include the collection and documentation of medico-legal evidence, which is central to the success of prosecution efforts and positive legal outcomes. In Kenya, where one in five women has experienced SV [5] and where the criminal justice system relies heavily on medico-legal evidence collected by health care providers, significant gaps exist in how medico-legal evidence is collected and recorded by providers [6]. One of the main gaps identified is a lack of understanding among health providers and police of the national documentation forms to be used in capturing survivor data. In response to this barrier, this study aimed to improve the documentation of medico-legal evidence in Kenya in order to facilitate improved health and legal outcomes for SV survivors.

Materials and methods: Study design: This was an operations research study that used a pre- and post-intervention design with a comparison arm to test the hypothesis that medico-legal evidence documentation in the intervention site would show greater improvement than would be the case in the comparison site by the end of the intervention period. The study was carried out in two districts in Kenya - Kitui and Rachuonyo - with Kitui District Hospital and Kitui Police Station acting as the intervention sites, while Rachuonyo District Hospital and Rachuonyo Police Station served as the comparison sites.

Intervention: The intervention was conducted over a 7-month period in police, officers and prosecutors; the introduction of a locally-assembled rape kit into the health facility; and the revision of the national clinical algorithm chart used for guiding providers in the collection and documentation of medico-legal evidence at different service delivery points.

The training of health providers (doctors, nurses, clinical officers, and laboratory technicians), police (officers station at the Gender Desk and Crime Unit), and prosecutors was conducted by a team of resource persons drawn from the Division of Reproductive Health, the laboratory of the Government Chemist, the Director of Public Prosecution’s Office, and LVCT Health post-rape care program officers. The training session included modules on forensic examination, utilization of the rape kit, completion and utilization of the national documentation forms (the post-rape care [PRC] form (also referred to us Ministry of Health form 363) and the Kenya police medical examination [‘P3’ form], and referrals between the police station and health facility. According to the national sexual violence guidelines, both forms must be filled out for each survivor and attached to one another to facilitate any intended legal outcomes [1-3]. The P3 form contains sections to be filled in by providers at both health facilities and police stations. The training therefore also aimed to equip police officers and health providers with knowledge of their role in providing post-rape care services, including their joint responsibility in enlightening the survivors about the importance of having the completed forms returned to the police before being forwarded to the prosecution office.

To aid intervention site health providers in proper documentation of medico-legal evidence, the national clinical algorithm chart used for this purpose was revised. The revisions included clarifications on the types of information to be documented by health providers, and the tools to be used at different service delivery points for collecting evidence from survivors. A primary tool used for evidence collection was the locally-assembled, pre-packaged rape kit, which brought together various simple tools (e.g., powder-free gloves, speculum, seal lock bags, stick swabs, pregnancy testing kit, etc.) in one packet to permit evidence collection from the survivor in one location and by one health provider. Ensuring that evidence collection largely happened in one location was also meant to ease the documentation process.

Data collection and analysis: Retrospective record reviews of post-rape care forms and P3 forms in health facility and police station files were conducted at baseline and endline. Data from these reviews were entered into Epi info 7 and analyzed through cross tabulations using SPSS version 13, and taking into account the study objectives.

Results: Provider completion of P3 forms: By the endline period, the intervention site was more than three times as likely as the comparison site to have the police station and health facility sections of the P3 forms accurately filled in (Figure 1). It is noteworthy that this seeming improvement in the completion of P3 forms in the intervention site describes the number of forms correctly filled, rather than the proportion of survivors whose forms were correctly filled. The unavailability of data on actual proportions is a limitation of this study, as such information would have provided a more accurate picture of the intervention’s effect. A review of the police station sections (of the P3 form) alone, and of the health facility sections alone, also indicated that the intervention site was more likely to complete these sole sections than the comparison site.

Provider completion of PRC (post-rape care) forms: At baseline, the intervention and comparison sites started off on unequal footing, with 64% of SV survivor cases being documented on PRC forms in the comparison health facility site, versus no documentation at all on PRC forms in the intervention health facility site (Figure 2). Earlier provider trainings conducted about two years before the present study at the comparison health facility site explain this discrepancy. Although this earlier training was also offered at the intervention site, policy changes at this site severely limited the cadre of providers that could fill out PRC forms. This policy was abolished during the intervention period, when the health facility administration was sensitized on the revised national post-rape care guidelines, which allow the examining doctor, nurse, or clinical officer to perform this function.

By endline, the proportion of PRC forms that were accurately filled in by health providers in the intervention site rose from 0% to 88%. The comparison site also recorded a slight (but comparatively much lower) improvement in documenting survivor SV cases on the PRC form (from 64% to 88%).

Conclusions: Findings from this study suggest that multi-sectoral provider training sessions focused on existing national documents for use in the management of reported SV cases, or for the referral of survivors from one sector to the next, can potentially help improve the level of documentation of such cases by providers. This strategy is particularly important in settings where national documents have been developed and are used as medico-legal evidence in SV cases.
Since the completion of this study, Kenya's national post-rape care form and the 2nd edition of the National Guidelines on Management of Sexual Violence in Kenya were officially revised, drawing on the study findings, and the multi-sectoral provider training approach described here has been adopted by Kenya's Sexual Offences Act Task force. Further funding was also obtained to explore and strengthen mechanisms for medico-legal evidence across sectors.

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References

A3 Assessing the feasibility of police initiation of HIV post-exposure prophylaxis for sexual violence survivors in Lusaka, Zambia
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Background: Globally, more than 1 in 3 women have experienced physical or sexual violence (SV) from intimate partners or SV from non-partners [1]. Furthermore, over 10% of all girls are estimated to have experienced a forced sexual act, with the highest rates of SV against girls found in sub-Saharan Africa [2]. Although public recognition of SV is growing in Zambia, reliable data on the nature and extent of such violence is limited. Approximately 20% of Zambian women aged 15 to 49 have experienced some form of sexual violence; however, this is likely underestimated due to underreporting [3]. Previous research in Zambia suggests that exposure to SV is equally pervasive among adolescent girls [4,5].

The risks associated with SV, especially among young women, are numerous. Immediate health consequences include unwanted pregnancy, physical trauma, mental distress and acquisition of HIV and other sexually-transmitted infections. The linkage between sexual and gender-based violence (SGBV) and risk of HIV has been well documented in Africa and is especially pronounced in countries with high HIV prevalence, such as Zambia [3,6-8].

Growing awareness of these negative consequences of SGBV led the Government of Zambia to develop a set of national guidelines for the management of SGBV, highlighting the need for a response system linking the health, police, and social services sectors. A critical component of this response is the prevention of HIV infection in SV survivors through the provision of preventive anti-retroviral therapy, or HIV post-exposure prophylaxis (PEP). The initial dose of PEP must be taken within 72 hours of exposure to HIV [9].

Given the time sensitivity of PEP and the fact that police and health services are often the first points of contact for SV survivors, strong coordination between these two sectors is central to the effective medical management of SV cases in Zambia [10]. Building on the results of previous research in Zambia, which demonstrated that trained Victim Support Unit (VSU) police officers could effectively administer the emergency contraception pill to SV survivors, the Population Council, Zambia Police Service, and Ministry of Health aimed to assess the feasibility of having trained VSU police officers safely and effectively provide a PEP starter dose to SV survivors with immediate referral to comprehensive medical services [10].

Materials and methods: Study sites: The feasibility study was conducted at two police stations and four associated police posts in two high-density, low-income communities in Lusaka. The combined catchment area population of the two communities is approximately 296,000. These sites were purposively selected to represent urban areas with high SV prevalence rates.

Intervention: The intervention involved two complementary components: (i) multi-sectoral training sessions to create an enabling environment for effective SV case management and (ii) VSU police officer provision of a 3-day PEP starter dose to SV survivors.

Service providers and policy makers in the police, medical, and social services sectors were trained on what constitutes SGBV; risks associated with SGBV; the rights of SV survivors; the Zambian government’s multi-sectoral approach to managing SV cases; and specific interventions available to SV survivors, including PEP.

VSU police officers and medical personnel also received additional training on how to safely and effectively initiate SV survivors on PEP at the police station with immediate referral to the nearest tertiary hospital for forensic evidence collection and comprehensive medical assessment and treatment. A screening checklist was developed to guide VSU officers in assessing PEP eligibility. Individuals were considered eligible for police-initiated PEP if they met the following criteria:

i. Reported an SV incident involving penetrative sex.
ii. Presented to the VSU within 72 hours of the incident.
iii. Age ≥10 years.
iv. Not currently on antiretroviral therapy (ART).

Children aged less than 10 years were excluded due to the complexities of calculating ART dosages based on weight for this age group. These children were referred directly to the nearest One-Stop Centre, where they could receive child-focused medical, psychosocial, and police services.

Data collection and analysis: Each police station and post was provided with a survivor log book where information on client demographics and the date, time, and type of SV incident was recorded. Monthly monitoring visits were conducted at all participating police stations and posts to review the survivor screening checklists for cases reported during the previous month and to transcribe service data from the survivor log books. Descriptive statistical analysis of the service data was performed using Stata 13 software.

Results: Case reports: A total of 207 SV cases were reported at 2 police stations and 4 police posts during the project period. All 207 cases were female. Of note, 85% of cases involved girls under the age of 16 years, with the mean age of report being 13 years.

Referrals: The intervention protocol mandated that all SV cases be referred to the nearest tertiary hospital for further testing and treatment. According to the survivor log book records, 96% (n = 199) of survivors...
who reported to the VSU were given the appropriate medical report form for referral to the hospital. However, only 25% (n = 26) were accompanied to the hospital by a police officer, as stipulated by the national SGBV case management guidelines. Since so few cases were accompanied to the hospital, the proportion of cases that actually received additional medical services is unclear.

**PEP delivery:** Approximately 50% (n = 104) of the 207 case reports were eligible to receive PEP (Figure 1). Only 23% (n = 26) of eligible survivors were initiated on PEP by the police. Notably, less than half (n = 49) of all eligible cases reported at police stations or posts during the VSU officers’ official working hours. While 33% of eligible survivors who reported during official working hours received PEP, only 18% of those who reported on nights or weekends received PEP. No adverse events were reported as a result of trained VSU police officers providing PEP during the study period.

**Conclusions:** The results from this feasibility study demonstrate that police officers can safely and effectively provide SV survivors with a 3-day starter pack of PEP and refer them to health services for follow-up. However, the study also highlights challenges that inhibit greater access to police-initiated PEP. There is a need to restructure VSUs to ensure that they are open 24 hours per day and adequately staffed. Training in SV and the provision of PEP could be extended to non-VSU officers to enhance staffing. Given the profile of SV survivors seeking services at police stations and posts in Zambia (with the vast majority being aged 16 and below), police and health services must also be tailored to meet the unique needs of child survivors of SV. Additional funding has since been obtained to begin to explore how to address this issue in police stations in Zambia.

**References**


**A4**

The ‘Zero Tolerance Village Alliance’: A promising intervention for addressing sexual and gender-based violence in rural communities

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**Background:** Worldwide, few countries have higher rates of sexual and gender-based violence (SGBV) than South Africa [1]. From 2013 to 2014 alone, nearly 50,000 rape incidents were reported to the police in the country [2]. This predilection affects the young and the old: the majority of sexual violence survivors presenting at Thuthuzela Care Centers are less than 18 years of age (60%), and 40% of all rape survivors are pre-teens under the age of 12 [1]. Nonetheless, annual reporting rates of rape in the country are comparatively low, with only 1 in 9 rapes reported each year [3]. Furthermore, the issue of sexual violence in South Africa is compounded by the linkages between such violence and HIV seropositivity [4]. Given these realities, this study sought to assess the effects of an intervention geared toward positively influencing negative community norms related to SGBV.
Materials and methods: Study design: The study used a pre- and post- intervention design with a comparison group, covering villages in the Thohoyandou region of Limpopo Province in South Africa. Two villages (Lunungwi and Tshiombo) served as the intervention sites, while one village (Mangondi) served as the comparison site.

Intervention: The intervention was implemented by the Thohoyandou Victim Empowerment Programme in rural South Africa over a 9-month period from May 2011 to January 2012. Referred to as the ‘Zero Tolerance Village Alliance’ (ZTVA), the intervention was premised on the notion that changing SGBV norms would require the involvement of all community members (particularly men and women), and that, ultimately, a village would have to take ownership of the issue of SGBV, understand the need to ensure a ‘zero-tolerance’ environment against SGBV, and demonstrate motivation to have their community branded in this way. Addressing these issues would be likely to reduce levels of SGBV in communities, lessen stigma around admitting personal experiences of SGBV, and increase awareness of where to obtain care for SGBV. Being branded as a ‘zero-tolerance’ village might also help ensure the sustainability of any gains made as a result of the intervention.

The ZTVA model comprised several different components geared toward mobilizing communities to come together in a united effort against SGBV. These components included:

- a series of community dialogues to introduce and promote ownership of the ZTVA model,
- the appointment of a Stakeholders Forum representative of community structures and agencies (e.g., traditional authority, churches, schools, businesses, and civil society agencies), and responsible for facilitating and monitoring intervention activities,
- the development of a Memorandum of Agreement (MoA) outlining the criteria for a village’s induction into the Zero Tolerance Village Alliance,
- the development of community maps to highlight opportunities for partnerships to enhance SGBV service provision, and to disseminate SGBV messages,
- training of Stakeholder Forum members on SGBV good governance procedures and policies, rights and responsibilities, and accountability monitoring (this training includes a ‘Training of Trainers’ module to ensure cascading of training to other community groups),
- promoting the attainment of ZTVA criteria, including (but not limited to):
  - participation of at least 1,250 adults and youth per village in a series of five workshops or dialogues, covering SGBV issues and accountability monitoring,
  - adherence of government service providers to their relevant and respective mandates (e.g., police trained in victim empowerment, clinics displaying Victim’s Charter and providing male and female condoms),
  - existence of: a short-term, community-run safe house for victims of domestic violence; and a functioning support group

for people living with HIV and orphans and vulnerable children.

Once the village concerned meets all the induction criteria listed above, the final aspect of the intervention involves a public ceremony during which men of the village are invited to make a public pledge to proactively address the eradication of SGBV in their village. Pledgers are asked to sign a ‘Roll of Honor,’ and given a ‘Badge of Honor’ to identify them as men who have taken a zero-tolerance stance. Women are given a ‘Badge of Courage’ to promote their agency to report abuse. The ceremony culminates in the unveiling of a large billboard in the inducted village, declaring its zero-tolerance status.

Data collection and analysis: Household survey data were collected from women and men via structured questionnaires before and after the intervention in all study sites. Descriptive statistics on each variable at baseline and endline constituted the principal procedure for data analysis, in addition to comparison of baseline and endline information from intervention and comparison villages. The data were analyzed using the Minitab Release 14.20 statistical software package.

Results: A total of 1,134 and 1,180 women and men participated in the baseline and endline household surveys, respectively, from all 3 villages combined. Selected results presented in this paper center on self-reported experiences of SGBV, knowledge of where to access post-rape care services, and gender beliefs about sexual refusal in intimate partnerships.

Self-reported experiences of SGBV: Self-reported experiences of SGBV increased in the two ZTVA intervention villages and decreased in the comparison village (Figure 1). The observed changes in the intervention and comparison sites were not statistically significant, however.

Knowledge of where to access post-rape care: A crucial factor in reporting and seeking care in cases of SGBV hinges upon the knowledge of where to seek such care. Knowledge of where to obtain this kind of care increased in the ZTVA villages (Figure 2). This increase was statistically significant in both intervention sites. In the comparison village, on the other hand, a slight decline in knowledge was observed among women, while a slight, non-statistically significant increase was observed among men.

Gender beliefs: By endline, there was a statistically significant increase in the proportion of female and male respondents in Lunungwi (one of the ZTVA intervention villages) who strongly agreed with the notion that women had the agency to refuse sex with their partner. Slight increases in this regard were also observed in Tshiombo (the second ZTVA village), but these were not statistically significant.

In contrast, the comparison village (Mangondi) saw a reduction in the proportion of men who believed a woman has the power to decline sexual advances from her partner. There were also reductions in the comparison village in the proportion of women and men alike who agreed (as opposed to ‘strongly agreed’) with this statement. None of the changes observed in the comparison village were statistically significant.

![Figure 1](abstract A4) SGBV Self-Reporting Data. LF=Lunungwi females; LM=Lunungwi males; TF=Tshiombo females; TM=Tshiombo males; MF=Mangondi females; MM=Mangondi males

% YES Baseline 1.50% 5.60% 2.70% 3.20% 4.60% 6.30%
% YES Endline 6.40% 6.60% 8.20% 4.70% 3.40% 3.90%

PERCENT OF COHORT
Conclusions: The study findings suggest that the ‘Zero Tolerance Village Alliance’ model holds promise for changing community norms around SGBV, including potentially countering stigma related to reporting SGBV experiences, increasing awareness of where to access SGBV care, and promoting gender equality. As community-based interventions often require a lengthy period of implementation before significant improvements are observed [5], it is plausible that the ZTVA implementation period of 9 months was too brief for more of such improvements to be registered in the area of SGBV. Nonetheless, as few SGBV-focused, community-wide interventions exist in the sub-Saharan African region, efforts should be made to strengthen the ZTVA model and to implement it over a longer period of time in order to understand its full potential. Doing so is particularly important as the Thohoyandou Victim Empowerment Programme has received requests from several village elders in Limpopo Province to be inducted into the Zero Tolerance Village Alliance. Furthermore, since the completion of this study, the organization has received funding to replicate the ZTVA approach in 4 additional villages, and to adapt the ZTVA model to the needs of children in school, and of refugee populations. The organization has also been contracted by donors (including the South African government) and to train a total of 10 community-based organizations in South Africa in the implementation of the ZTVA methodology.

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References
School-based girls’ clubs as a means of addressing sexual and gender-based violence in Swaziland

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Background: Sexual and gender based violence (SGBV) is a global health and human rights problem which is of particular concern in sub-Saharan Africa because of the compounding effects of high HIV prevalence. In Swaziland — a small, land-locked country of just over one million people - women and girls face the disproportionate burden of both SGBV and HIV: Nearly half (46%) of those aged 13-24 years reported having experienced some form of sexual violence (including rape, threat of rape, unwanted touching or groping), and among those of secondary school age (13-17), only 37% reported that their first sexual experience was voluntary [1]. Although available evidence suggests that most SGBV cases occur in the home or community, schools are not entirely safe places for girls. For example, from a national survey on violence against children in Swaziland indicate that among incidents of sexual violence experienced before age 18 in Swaziland, 10% occurred at school and another 10% on the way to and from school [1].

There is growing evidence of direct and indirect links between SGBV and HIV, with violence being both a cause and outcome of HIV infection [2,3]. The national HIV prevalence among adults (15-49) in Swaziland is among the highest in the world, at 26% [4]. This study aimed to assess the effectiveness of a girls’ empowerment intervention in regard to changing in-school girls’ knowledge, attitudes, and practices related to SGBV.

Materials and methods: Study design: The study used a pre- and post-intervention design without a comparison group and included three co-educational secondary day schools in the Lubombo Region of Eastern Swaziland.

Intervention: The intervention was implemented over a 12-month period from July 2012 to July 2013, and involved three main activities, namely: revising existing girls’ club resources, training club mentors, and running weekly, SGBV-focused club sessions with girls in school. Existing girls’ empowerment club resources of the Swaziland Action Group Against Abuse (SWAGAA) were revised to ensure an emphasis on SGBV. Specifically, SWAGAA’s training curriculum (used to train girls’ club mentors) and training manuals (used by trained mentors to facilitate girls’ club sessions) were amended to incorporate an ‘asset-building approach’ [5] for girls (particularly focused on building girls’ social assets, such as friendship and participation in extra-curricular activities), and to include comprehensive information on gender and SGBV, how to identify a risky situation; and how to report incidents of violence.

The revised training curriculum was used to train mentors on their roles and responsibilities over a three-day period. A total of 15 female mentors aged 18-25 years were recruited from the communities surrounding the participating schools. Their training focused on an overview of SGBV and its relevance for girls, modalities for recruiting girls for the clubs and for handling SGBV reporting and referrals, and on SWAGAA programs and resources. Mentors were responsible for running the girls’ clubs once a week. They reported directly to SWAGAA and were compensated for their time based on local rates for equivalent work.

In each school site, all girls aged 16 and above were invited to participate in the weekly girls’ clubs, which were structured around groups of about 20 girls per club. Club sessions took place in a pre-identified ‘safe space’ (in this case, a class room). Club activities included interactive discussions facilitated by a mentor and guided by the revised club manual.

Data collection and analysis: Data collection involved baseline and endline self-administered quantitative interviews with in-school girls aged 16 and above who participated in the girls’ clubs. These data were entered in Excel and analyzed using STATA and Excel. Analysis entailed simple frequencies, percentages and cross-tabulations with Chi-square tests, as well as significance tests of proportions, and a comparison of baseline and endline results.

Results: At both baseline (n = 247) and endline (n = 143), the majority of students were aged 16-18 years, were in Form 4 (the 4th year of a five-year secondary school), had two living parents, and had no sexual partner.

The effectiveness of the SGBV-focused girls’ clubs is examined in terms of changes between baseline and endline in girls’ social assets, awareness about SGBV; practices and experiences related to SGBV; and attitudes towards SGBV. Results around these four areas are summarized below.

Social Assets: There were significant increases between baseline and endline in the proportions of girls that reported that they were engaged in an income-generating activity (from 6% to 13%), had many friends in the neighborhood (from 41% to 52%), had two or more close friends they could confide in (from 60% to 74%), or that they were taking part in extra-curricular activities (from 68% to 100%).

Awareness about SGBV: There were significant improvements in the levels of SGBV awareness among girls. The proportion of students who reported the following events or experiences significantly increased between baseline and endline: other girls in their school being teased or subjected to verbal sexual harassment (from 24% to 38%); personally being subjected to sexual comments by fellow students at their school (from 19% to 34%); and ever experiencing any form of SGBV either at school or in the community (from 50% to 67%).

SGBV-Related Practices: The proportion of girls that indicated they would report incidents of sexual comments by another student to authority figures (teachers, the school principal, or the police) significantly increased from 41% at baseline to 57% at endline. However, there was no significant change in the proportion of girls that indicated that they would report sexual comments by a teacher to authority figures (from 38% at baseline to 40% at endline). Nor was there any significant change in the proportion of girls that reported they would decline sexual advances from a student (69% at baseline and a similar proportion at endline) or from a teacher (47% at baseline and 43% at endline).

Attitudes towards SGBV: There were significant positive changes in the attitudes of girls regarding SGBV. Girls’ responses in this area indicated significant positive changes in 13 out of a total of 21 items used to measure attitudes towards SGBV. The changes were characterized by significant increases between baseline and endline in the proportions of students that disagreed with statements that justified SGBV, as well as significant increases in the proportions that agreed with statements promoting the rights of women and girls in society.

Conclusions: The study findings show high levels of reported abuse among in-school girls in Swaziland, and demonstrate the overall ability of the intervention model to contribute to improved SGBV outcomes among this population. While the SGBV-focused girls’ clubs were effective in improving girls’ social assets, increasing their awareness, and positively changing their attitudes towards, and potential practices against, SGBV, they were less successful in improving the odds that girls would decline sexual advances from fellow students or teachers. This suggests that the interventions could further be strengthened by incorporating components aimed at enhancing self-efficacy among girls. With new funding, the Swaziland Action Group Against Abuse is currently working on enhancing this intervention by incorporating a self-efficacy component into the girls’ clubs.

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References


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What women think: hypothetical notions of screening for intimate partner violence in Kenyan hospital settings
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Background: Although screening for intimate partner violence (IPV) is current health policy in northern countries [1], developing country contexts such as Kenya have yet to adopt this practice. There are good reasons for this hesitation, given that strong health systems should ideally be in place prior to the introduction of such screening. However, the current emergence of one-stop centers for gender-based violence in African countries now provides an opportunity to explore the utility of screening in a region where IPV has become an increasingly prevalent public health concern [2]. It also creates room for considering the opinions of women - a population for whom IPV is the most common form of violence experienced globally [3] - in order to inform models of care for IPV survivors in African contexts. This study examined the hypothetical utility of IPV screening (coupled with referral for IPV care) from the perspective of women seeking services at Kenyatta National Hospital in Nairobi, Kenya - the oldest and largest public referral, teaching, and research hospital in the East African region.

Materials and methods: The study involved 68 semi-structured, in-depth interviews with purposively-selected women aged 18 years and above, who sought services at one of four clinics at Kenyatta National Hospital during the data collection period of April to June, 2011: the antenatal care clinic, the HIV comprehensive care clinic, the Gender-Based Violence Recovery Center (a one-stop center for gender-based violence), and the Youth Center (a youth-friendly reproductive health and HIV clinic). Data were collected by two female interviewers who were not involved in the clinical management of the respondents. These data were generated in response to hypothetical questions posed to women to assess the extent to which IPV screening would be acceptable to, and useful for, them. The in-depth interviews were hand-recorded verbatim and typed up in MS Word. Data were analyzed using content analysis techniques primarily, with codes developed and configured along lines of topical inquiry. Additional codes were developed based on emerging themes that seemed important for determining the utility of IPV screening. Dominant themes depicting women’s main thoughts about IPV screening are presented here.

Results: what women think: Qualitative analysis suggested that women’s opinions about hypothetical IPV screening protocols in this Kenyan context are shaped by their concerns about confidentiality: the need to raise awareness around IPV and available care; gaps in the health care system that translate to unmet needs of survivors; and the need for clear-cut responses to IPV that do not promise more than can be realistically offered. While there is some overlap between these themes, each is presented separately, and women’s quotes from respondents are labelled according to the location at which the respondent sought care.

Provider distance could help facilitate screening: The women in this study perceived that the involvement of health providers (particularly - but not solely - doctors) in the screening and referral process would serve to greatly enhance the chances of survivors complying with referrals for IPV care. Providers in hospital settings were seen by respondents as highly respected due to their specialized training, and able to maintain professional distance and confidentiality. Consequently, a provider’s recommendation that a survivor access IPV services was viewed as particularly persuasive: You can use doctors to convince [survivors] to come [for IPV services]. Patients really respect doctors and they will listen to them (Client, Gender-Based Violence Recovery Center).

A survivor can tell the doctor or nurse about her IPV experience and [they] will not gossip about her because they are strangers (Client, Antenatal Care Clinic).

Screening would enhance awareness of IPV: Another major feature of respondents’ narratives had to do with women regarding the screening process as educational: whether one was experiencing violence or not, screening would inadvertently alert those screened to the health implications of IPV, while enhancing awareness of where assistance and services can be obtained. Respondents strongly perceived that women (survivors and non-survivors alike) would be likely to help others by sharing information received during screening with others. Even if I’m not experiencing violence right now, those services will help other women, and some of them could be my friends. And if you know about these services, you can tell other women who may not know about [them] (Client, Antenatal Care Clinic).

You never know about life. I may go through it in [the] future and I’ll be able to know where to go for help. I can also tell my friends about it and they will be able to get help before something serious happens to them (Client, Youth Center).

The screening process would be cathartic: Overwhelmingly, the perceived cathartic effect expected from a successful IPV screening and referral process was highlighted by respondents as a factor that would make screening worthwhile. This hypothetical process was viewed by participants as a rare opportunity for survivors to speak to someone about a taboo issue. This prospect was strongly viewed as sufficient to motivate any survivor to hold a positive view of screening protocols.

I know many women will not refuse [to be screened]... because most women experience [IPV], but they may have never had an opportunity of someone asking them about it in a hospital set-up (Client, Antenatal Care Clinic).

Women have many problems and they are just waiting for an opportunity for someone they can share with so as to release the stress they have been carrying (Client, HIV Comprehensive Care Center).

There is already hidden demand for IPV services: The sheer desire for assistance as a catalyst toward IPV services uptake emerged as a recurrent theme among respondents. Here, women highlighted the fact that IPV screening holds potential for capturing those survivors that represent a ‘low hanging fruit,’ in the sense that they are ripe for intervention and require no coaxing beyond the provision of information about the availability of services.

If a woman is suffering because of her husband and she wants to be helped, she will go [for IPV care] because she wants somebody to help her (Client, Antenatal Care Clinic).

Being clear about any post-screening benefits would be important: Some women conceptualized help for IPV in the form of non-medical responses, presuming that presenting for IPV care would accrue particular benefits to survivors. These imagined benefits ranged from rapid legal assistance, to marriage counseling, and financial assistance.

I can also get help because of what I’m going through ... in my marriage. ... Maybe you are setting up small businesses for women who are being abused and I can be helped through that (Client, HIV Comprehensive Care Center).

Some will think that women will be given money for food or school fees, or get benefits like ... money for business (Client, Antenatal Care Clinic).

The need for clarity around what a survivor can expect to gain from following through with IPV referrals was overwhelmingly emphasized by respondents in order to avoid misconceptions and to underscore IPV as a health issue for which medical attention should be sought.

Conclusions: The perspectives generated by this study - although hypothetical - suggest that various facilitators to potential IPV screening processes in Kenya exist: Women are highly amenable to being screened by doctors or nurses (who, incidentally, would be the most likely candidates to take on screening roles in this setting). Women appreciate the role that IPV screening would inadvertently play in creating awareness of this phenomenon as a health issue, and of available services for addressing it. The women interviewed in this study were convinced that
there was latent demand among their peers for IPV services, and that accessing such services after identification through screening would be cathartic for survivors. Lastly, women strongly emphasized the need to clarify the content of services available to survivors early on in the screening process, in order to avoid misconceptions and unrealistic expectations.

The perspectives of Kenyan women on conducting IPV screening in Kenyan health care settings support the findings of studies in non-African contexts that highlight the critical importance of women's voices in planning for female-centered screening interventions. The voices shared in this paper point to the potential value of IPV screening in health care settings in the sub-Saharan Africa region, while also highlighting the need for a cautionary approach in designing such screening interventions. Findings from this and other studies centering on the acceptability and feasibility of IPV screening in East African countries [4-7] were presented as part of a special panel at the 6th Best Practices Forum in Health of the East, Central and Southern Africa (ECSA) Health Community in August 2012. Deliberations over these findings led to the passage of a resolution (in December 2012) by Health Ministers from the ECSA region, calling for the integration of gender-based violence screening into sexual and reproductive health and HIV and AIDS services in the region, coupled with support for Member States to effect such integration (ECSA/HMC6/R2, Number 5 [ECSA Secretariat] and Number 7 [ECSA Member States]). Since that time, findings from this exploratory study have been used to inform the development of an IPV screening intervention at Kenyatta National Hospital, which was proven to be feasible and effective [8]. Further funding was obtained to adapt this screening intervention for humanitarian settings in Uganda, and to the needs of child survivors of sexual violence in Kenya. Both efforts (in Uganda and Kenya) involve assessments to determine feasibility and effectiveness of the screening intervention in new settings.

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