ONE-STOP MODEL OF SUPPORT FOR SURVIVORS OF GENDER-BASED VIOLENCE: LESSONS FROM CARE ZAMBIA

LESSONS LEARNED

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INTRODUCTION

From 2005-2011, CARE led the development of a "one-stop" model of comprehensive support services for survivors of gender-based violence (GBV) in Zambia. For the first time in Zambia, survivors could access medical, psychological and legal support under one roof at Coordinated Response Centers (CRCs). This work was funded by USAID and the EU.[1] This document focuses on CARE and our partners'[2] experiences and learning from implementing this one-stop model of service delivery, including recommendations for further strengthening the model to better assist survivors of gender-based violence.

BEST PRACTICES FOR THE ONE-STOP MODEL

- Capacity building of local service providers must accompany broadbased GBV awareness-raising on GBV, including support and mentoring on specialized GBV issues.
- Centers placed in government buildings and integrated into existing services pose less risk of exposure and stigma for those seeking services than stand-alone sites.
- Programs should be careful not to rely too heavily on or overburden volunteers.
- At a minimum, any stand-alone centers without 24-hour services should aim to have a counselor on-call during off hours and/or offer a safe place for survivors to stay overnight until services are available.
- Centers should lobby for permanently assigned police support officers.
- Integration with national strategies, government ministries, and NGOs is critical.

[1] The bulk of this work was carried out under the ASAZA ("A Safer Zambia") project from 2007-2011, funded by the United States Agency for International Development (USAID), and the Sexual and Gender Based Violence (SGBV) pilot project and Expansion of Coordinated Response to Sexual and Gender Based Violence in Zambia project from 2005-2011, funded by the European Union (EU).

[2] The ASAZA project was implemented in partnership with World Vision, AFRICARE, Catholic Relief Services, International Justice Mission, Young Women Christian Association, and Women in Law in Southern Africa and collaborated with Government agencies such as Zambia Police Victim Support Unit, Judiciary Child Justice Forum, Gender in Development Division, Department of Social Welfare and Ministry of Health.

Context

Gender-based violence (GBV)[3] is a widespread and deeply entrenched problem in Zambia, with one of the highest rates of intimate partner violence in the world.[4] According to the 2007 Zambia Demographic and Health Survey, 47% of women in Zambia have experienced physical violence since age 15—77% by a current/former husband/partner—and one in five have experienced sexual violence in their lives, 64% of which is perpetrated by an intimate partner. Yet less than half (46%) of abused women and girls seek help for various personal, economic, and social concerns, especially fear of stigma.[5] Survivors of GBV face serious and often life-long health problems, such as HIV and other sexually transmitted infections. Survivors may develop subsequent mental health problems, and are stigmatized and often rejected by their partners, families and communities.

The Government of Zambia joins other governments across the globe that increasingly recognize the need to both prevent and respond to GBV as a public health problem, a human rights violation, and an impediment to development. At its core, GBV is rooted in the imbalance of power between males and females, yet progress has been slow in changing deeply entrenched inequitable social norms and gender discrimination that sustain inequality and GBV. Organizations have sought the best way to respond to sexual forms of gender-based violence in particular, often focusing on rape. Responses have included prevention efforts such as social norm change, linking GBV screening and response to existing sexual, reproductive and maternal health services, building capacity of the police, judicial, and social service sectors, and strengthening shelters and safe houses.[6] Coordination and follow-up on cases among these various sectors presents a challenge, but is essential to integrated and comprehensive care for survivors.

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Background: Comprehensive and Coordinated Response for GBV Survivors

Coordinated response models, or "one-stop" services represent a promising model for providing comprehensive care to survivors of gender-based violence, offering medical, legal and psychosocial services either within one location—a hospital or a stand-alone center—or through a referral system that links services.[7] The main aim of the coordinated response model is to increase survivor safety and perpetrator accountability by coordinating and linking core services, including providing immediate to longer term health care, access to police and legal services, and culturally and age appropriate counseling services. Although one-stop models are used in regions across the world, they are becoming an increasingly popular approach for addressing gender-based violence, particularly sexual violence, in Southern and Eastern Africa, with South Africa and Kenya leading the way.

[3] Gender-based violence refers to any harm perpetrated against a person's will on the basis of gender – the socially ascribed differences between males and females. It includes physical, sexual, and psychological abuse, early marriage, property grabbing, and harmful traditional practices such as female genital cutting. While gender-based violence is an inclusive term, most of the Coordinated Response Centers surveyed in the literature tend to primarily treat survivors of sexual violence.

[4] UN Statistics Division shows that out of 83 countries with data on the prevalence of physical and/or sexual violence from intimate partners in their lifetime, there are only six countries with surveys reporting higher rates than Zambia: Bangladesh, Tajikistan, Uganda, Solomon Islands, Democratic Republic of the Congo and Ethiopia (The World's Women 2010: Trends and Statistics, Table 6.A).

[5] Central Statistical Office, Ministry of Health, Tropical Diseases Research Centre, University of Zambia, and Macro International Inc. 2009. Zambia Demographic and Health Survey 2007. Calverton, Maryland.

[6] Population Council, "Comprehensive Responses to Sexual Violence in East and Southern Africa: Lessons Learned from Implementation," Population Council Policy Brief 1 (2011).

[7] Jill Keesbury and Ian Askew, Comprehensive Responses to Gender Based Violence in Low-Resource Settings: Lessons Learned from Implementation (Lusaka: Population Council, 2010), 3.

A review of models of comprehensive, integrated care led by Population Council found various models that have proven feasible.[8] One-stop models can be located in hospitals or as stand-alone sites. In South Africa, the Thohoyandou Victim Empowerment Programme (TVEP) established trauma centers adjoining hospitals, offering 24-hour medical and legal services, as well as on-site safe houses. Other models may actually entail more than "one-stop", in that all services may not be located in the same facility, but are rather linked through referrals. Most commonly, medical and counseling services for survivors of sexual violence are provided within hospitals, and referrals are made to police (e.g., special victim units), legal services and shelters (e.g., South Africa's Tintswalo Hospital and Kamuzu Central Hospital in Malawi).[9] Some models have also piloted the feasibility of providing some immediate medical care at other service points of entry to improve response, such as Zambia's Copperbelt Model of Comprehensive Care (CMIC), in which police provided emergency contraception to survivors and accompanied them to the hospital for further care.[10]

Program Description

Building on similar models of comprehensive care in South Africa, Kenya, Malawi, and Uganda, CARE and partners developed a successful one-stop model of Coordinated Response Centers (CRCs) through a pilot GBV project funded by the European Union from 2005 to 2007. For the first time in Zambia, the two initial pilot centers established through this project served as single sites where survivors could access medical, psychological and legal support. This model was then expanded and further developed through 'A Safer Zambia' (ASAZA), a CARE-led project funded by USAID and

[8] Ibid, 17.

[9] In the Tintswalo Hospital in South Africa, GBV services are integrated within the hospital through management protocols for sexual assault and a designated and unmarked room for survivor care. In the Kamuzu Central Hospital in Malawi, sexual violence services are centralized in one hospital unit.

[10] Jill Keesbury and Ian Askew, Comprehensive Responses to Gender Based Violence in Low-Resource Settings: Lessons Learned from Implementation (Lusaka: Population Council, 2010), 17.

the European Union (EU) grant for the Expansion of the Coordinated Response to Sexual and Gender Based Violence in Zambia project, which ran from September 2007 to December 2011.[11]

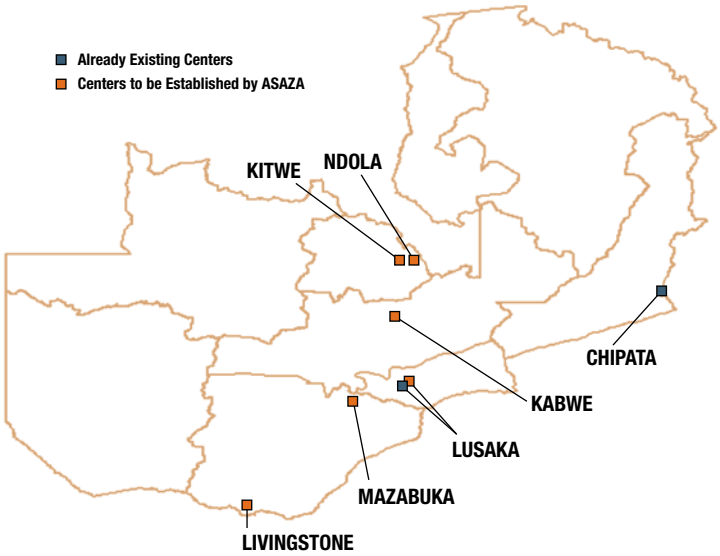
The ASAZA project sought to reduce the incidence of GBV in Zambia through a combination of greater knowledge of and changed attitudes towards gender inequalities, as well as access to comprehensive services for GBV survivors to meet their medical, psychological and legal needs.

PREVENTION

Incorporating vital community outreach and preventive work into CRC service provision represents an innovative aspect of the ASAZA model.[12] The prevention element consisted of an intensive three-year period of media awareness campaigns, community education and mobilization activities designed to increase knowledge and change attitudes and behavior regarding gender among men, women, service providers, leaders, youth, and children. Participants found the multi-faceted community mobilization platforms helped bring attention to GBV issues and reduce stigma for women who reported abuse.

SERVICES

Eight one-stop Coordinated Response Centers (CRCs) were set up in seven districts (see map on right) to help survivors of GBV access a comprehensive package of integrated medical, legal, and psychosocial support. CRCs are embedded into a network of government (health and police) and non-governmental (counseling, legal, shelter) services. CRCs provide direct services which focus primarily on medical services, psychosocial and paralegal counseling, and also refer clients to social services, support groups, and shelters. Between January 2008 and September 2011, **18,246 GBV survivors received services at these eight CRCs.** Spousal battery was the most common case of GBV reported across the CRCs, accounting for 54% of all GBV cases, followed by child sexual abuse (21%).



The eight CRCs include two CRCs operating outside the hospital set up in Lusaka and Chipata, and six CRCs in hospital settings in Lusaka, Kabwe, Mazabuka, Ndola, Kitwe, and Livingstone.[13] Each model had advantages and disadvantages, for example, the stand-alone setting is more private and more flexible in terms of use of space than hospital settings, and can be located in remote areas where other health centers or hospitals may not be easily accessible. However, in the stand-alone model, medical staff are not available 24 hours a day,[14] and survivors need to be driven and escorted to a health facility for services not available at the stand-alone centers (e.g., surgery, stitches, x-rays), also during which time evidence may be lost. The hospital-based model, alternatively, has 24-hour guaranteed medical staff on site and more direct access to medical services, such as Post Exposure Prophylaxis (PEP) and antiretroviral drugs.

[11] The support from USAID came from the Presidential Women's Justice and Empowerment Initiative (WJEI) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

[12] USAID/Zambia Gender-Based Violence Evaluation Report (2010).

[13] CRCs were integrated into different levels of health facilities, including clinics, district hospitals, and provincial hospitals (e.g., Ndola), with the most comprehensive range of services available at the provincial level (e.g., clinics do not have surgery theaters). Clinics were linked to the main hospital and patients were easy transferred by ambulance. Hence, once clients were within the health system, linkages were effective among health facilities.

[14] When the stand-alone centers first opened, they operated 24 hours a day. However, this operating model was found to be cost ineffective, as the centers often only received one client per night.

volunteer community caregiver

The main focus of the CRCs was counseling and follow-ups by other service providers, especially the police. The CRC counselors continuously followed up with clients and kept track of the process of service delivery for each survivor. These services include trauma prevention, HIV pre- and post-test counseling, and PEP adherence counseling. CRC paralegals, trained by one of CARE's local partners, Women in Law in Southern Africa, also provided counseling to prepare survivors for the justice system.

Each CRC was equipped with specialized medical kits for the proper collection, documentation, and preservation of evidence, and a vehicle to provide transportation to clients living ten or more kilometers away. 1,111 caregivers, who are volunteer community members trained in providing home-based care to people living with HIV, were also trained to manage GBV cases and were engaged as a primary mechanism to identify GBV survivors at the household level, provide care and support, and refer as necessary to CRCs. Sixteen survivor support groups were

formed to provide support to fellow survivors through group therapy, and also to work together on economic initiatives, such as the sale of fish, sale of secondhand clothes, rearing and sale of chickens, vegetable gardening and sale of produce.

ASAZA supported Police Victim Support Unit (VSU) Officers assigned to CRCs to help survivors file a police report at the CRC if they decide to do so. 1,945 cases were taken to court, of which 204 resulted in conviction. The remaining cases were still pending in court at the close of the project. Towards the end of the project, Life Line Zambia, a 24-hour toll free telephone counseling service, provided telephone counseling services, accessible throughout the country from all mobile and landline telephone networks. 737 survivors received free telephone counseling through this service.

The project also participated in and supported the process of developing the National Guidelines for the Multidisciplinary Management of Survivors of Gender Based Violence in Zambia, and oriented 1,115 professionals at the CRCs on the guidelines. These are the first multi-sectoral GBV guidelines in Africa, and were developed through a comprehensive, multi-stakeholder process that was led by the government.

ASAZA staff also participated in the process of adapting the In Her Shoes Toolkit, spearheaded by the GBV Prevention Network (a network of GBV activists in the Horn, East and Southern Africa). In Her Shoes is an interactive, educational tool originally developed by the Washington State Coalition on Domestic Violence to raise awareness among service providers and community members about the day-to-day reality for women experiencing abuse. The exercise allows participants to "walk in the shoes" of women as they seek help from a variety of resources, including family and friends, health, legal and counseling services, religious leaders and others, and to gain a deeper understanding of the numerous challenges and barriers they face.

ASAZA set up mechanisms to facilitate information sharing among service providers and to ensure that services are provided in an integrated and coordinated manner. CRC Advisory Councils, consisting of representatives from district government and civil society organizations, were established to oversee the operations of CRCs at the district level to encourage local involvement and ownership. CRC Service Provider Networks, composed of both government and local community structures involved in provision of services to GBV survivors, were also established to provide a platform for sharing, learning and a coordinated referral system for survivors.

The USAID external evaluation of ASAZA conducted by a team of international gender, education and evaluation experts found the current coordinated response approach, which aimed to provide survivors with an integrated service provider (one-stop) support system, to be an effective model, providing direct services to individuals. Evaluators found the system to "provide the survivor with a more comprehensive, victim-centered service experience than if the services were provided piece meal from each service provider individually."[15]

KEY EVALUATION FINDINGS INCLUDED:

- High level of client satisfaction with the quality and manner of services provided.
- Engaging (inclusive) and consultative service processes, contributing to clients' feeling of empowerment.
- Strong institutional linkage with government in providing key services, which strengthened linkages to other key services providers.

[15] USAID/Zambia Gender-Based Violence Programming Evaluation (2010), 2.

CRC CLIENT SATISFACTION SURVEY

A client satisfaction survey was also conducted in 2011 to collect views from GBV survivors regarding the quality of services at various service points (reception, counselors' office, VSU police officer, social worker/paralegal and medical staff) at the CRC. Five CRCs (Chipata, Kabwe, Mazabuka, Mtendere and Livingstone) were selected for the survey after considering the rural-urban mix and provincial distribution. Data was collected from clients that walked into CRCs for a week by research assistants and was entered online using SurveyGizmo. During the week of data collection, the CRCs recoded a total of 197 survivors, indicating that, on average, about 200 people walk into five CRCs in one week. The client satisfaction surveys provided valuable feedback on the quality of services at various service points and on what contributed to client satisfaction (see text box).

FACTORS THAT CONTRIBUTE TO CLIENT SATISFACTION:

- Friendly and welcoming environment
- Cases treated with privacy and without bias
- Positive and respectful interactions with staff
- Consistent follow-ups on cases
- Handling cases without corruption or bribery
- Free services that anyone could access
- Linkage to safe houses for certain cases

Several areas for improvement were also reported:

- In certain CRCs, there were too few rooms for counseling and other services. This contributed to long queues outside the CRC instead of inside seating. Others felt that some counseling rooms were too small.
- Some survivors felt uncomfortable in the counseling sessions and felt that they lasted too long.
- Clients raised the importance of a clear case handover process among counselors so that clients are not left waiting when their counselor is not in the office.

SUSTAINABILITY

ASAZA engaged with the Ministry of Health (MoH) through a number of discussions about the eventual handover of CRCs to the MoH and lessons learned from the program. Additionally, ASAZA staff and local government representatives held meetings with other key stakeholders, such as the Police Victim Support Unit, the Department of Social Welfare and the Judiciary, to ensure smooth and coordinated transition among service providers. It was further agreed that in the short term the best handover approach would be the integration of GBV support services into the existing health system, but in the long term the creation of specialized GBV units should be considered by Government. The required staff to cover the CRCs were identified and oriented, and the CRCs were officially handed over to MoH on November 17, 2011, at a function held at Mtendere Clinic in Lusaka.

Lessons Learned on One-Stop Models of Survivor Services

The CRCs present a promising one-stop model for addressing the problem of gender-based violence, particularly sexual violence, in Zambia and other African countries. Examining one such project in depth, ASAZA, CARE has identified the following good practices as well as lessons learned to inform and improve quality of future programming.

1. With broad-based awareness-raising on GBV, there also must be commensurate broad-based capacity building of local service providers so that survivors can receive quality care within their localities, without having to travel a significant distance to the nearest CRC. Due to the sensitizations in the communities, especially through radio and TV, the number of survivors coming to CRCs from distant places (outside the ASAZA districts) increased, and therefore the CRCs did not have adequate resources to follow-up on these cases. At the same time, survivors coming from outside the ASAZA districts refused to be referred to service providers in their home districts, such as clinics, hospitals and Victim Support Units, because the level of service provision there was perceived as ineffective.

2. There is a need for additional training, support and mentoring for counselors, particularly on topics such as child counseling, couples counseling and addressing HIV-related issues.[16] Specialized support tailored to the needs to child survivors is especially important. Consistent with data from other GBV service centers across the region,[17] children make up a large percentage of survivors seeking services at CRCs. Paralegals also need periodic refresher training, as well as mentoring and backstopping support.

   Staff should receive ongoing and refresher training, mentoring and support to provide the best possible care to survivors, to inform staff of emerging issues and approaches and to increase staff knowledge and reduce burnout. Specialized training on developmentally appropriate and empathetic support to children should be standardized in training curricula for all service providers (e.g., police, medical staff, counselors), and carried out widely.

3. Clearly marked, stand-alone centers offering services exclusively for GBV survivors are likely to be known as such within communities, and thus risk stigmatizing people who are seen entering these premises. One-stop centers for GBV support services that are located within government buildings or departments with other functions, such as health clinics and hospitals, and integrated into existing services, such as for sexual and reproductive health, are less likely to expose and thus stigmatize those who access services.

[16] USAID/Zambia Gender-Based Violence Evaluation Report (2010).

[17] Population Council, "Comprehensive Responses to Sexual Violence in East and Southern Africa: Lessons Learned from Implementation," Population Council Policy Brief 1 (2011), 2-3.

4. Evaluations of ASAZA highlighted the problematic reliance on volunteers to provide core services (counseling and paralegal), given the challenges of retaining volunteer staff and keeping them motivated in the face of high time demand, heavy case loads and potential secondary traumatization. More research is needed to evaluate promising practices to improve the retention of community health workers, caregivers, and other community volunteers. One promising practice to address these challenges is to link these actors into local partnerships for livelihoods and savings and loans groups to help offset the economic costs of their time spent on volunteer activities, while at the same time monitoring any unintended effects, such as further burden on workload through additional group activities. In addition, there may be opportunities to formalize the role of volunteers by aligning them with the Ministry of Health's broader plan for sustainable health human resources, e.g., Zambia's National Community Health Worker Strategy.

5. To ensure quality of care in CRCs, quality assurance mechanisms should be built into program design and adapted or enhanced as necessary during implementation. Examples of quality assurance mechanisms that proved effective in ASAZA include: client satisfaction surveys to assess client experiences of care, CRC Advisory Councils, ongoing training and mentoring of counselors, developing standard protocols for counseling sessions, and developing safety plans for survivors. Developing and using standard protocols for counseling, client surveys, safety plans for survivors and oversight mechanisms can help to regulate and improve the services that each survivor receives.

6. An ongoing challenge is that most CRCs do not provide 24-hour care, which can have negative implications for survivors, particularly with regard to accessing timely medical services. There is a need for greater linkages with the health sector to provide survivors with immediate access to PEP and EC, e.g., by locating GBV services or one-stop centers within hospitals and government health facilities. At a minimum, any centers without 24-hour services should aim to have a counselor on-call during off hours and/or to offer a safe place where survivors can stay overnight to receive services in the morning.[18]

7. The lack of permanently assigned police and other government officers to support CRCs negatively impacted case follow-up. There is need to lobby for permanent personnel from these institutions.

8. To ensure the sustainability of future GBV programming, it is critical to engage with local government ministries as well as non-governmental organizations and community-based organizations to integrate these activities into the national GBV response plan.[19] This requires significant coordination among stakeholders. It is important for the government to create a funding line in the national budget to sustain and expand these services, as well as a separate line item for coordination. Allocations for coordination should not be assumed to be covered through other budget lines related to service delivery.

[18] USAID/Zambia Gender-Based Violence Evaluation Report (2010).

[19] Ibid.

www.care.org

Headquarters

CARE USA
151 Ellis Street, NE
Atlanta, GA 30303-2440
USA
T) 404-681-2552
F) 404-589-2650
genderandempowerment@care.org

CARE Washington DC
1825 I Street, NW, Suite 301
Washington, DC 20006
USA
T) 202-595-2800
F) 202-296-8695
genderandempowerment@care.org

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