From Relief to Development: Gender-Based Violence Interventions in Conflict and Post-Conflict Contexts

Wednesday, June 4, 2008
Woodrow Wilson International Center for Scholars

Edited Transcript – Ian Askew

Good morning everybody. Excuse me. For my presentation I'm going to focus on looking at what we've been learning recently about addressing sex and gender-based violence in stable populations, in amongst the general population. And I'm doing this because, in actual fact, it's kind of a rapidly changing field at the moment, so I wanted to review some of the lessons we're learning and what's going on at the moment, and to try to sort of stimulate a discussion about how that can also be influenced by and influence and interact with what's happening in emergency and humanitarian settings.

So first let's just remind ourselves that in the general population, sex and gender-based violence is pretty prevalent in most African countries. The slide shows data from three African countries, from DHS data, and it's remarkable how similar it is across the countries. Approximately half of the women report ever experiencing sexual or physical violence, and these are ever-married women, and about a quarter in the last year. So it's fairly similar across countries from East, Southern and West Africa.

So today what sort of responses are we seeing in Africa and beyond? Primarily there have been responses in two areas to this issue: one in terms of prevention and the other in the area of criminal justice procedures.

In terms of prevention, there's a range of activities happening, but I guess, you know, I'm trying to sort of summarize things here and you can probably summarize them in three broad areas. In most countries you'll find civil society advocacy groups working to try to raise the profile of this problem in the country and these are more or less active depending on the countries, but in recent years, there's a series of networks establishing themselves in various countries and between countries, trying to put across the message to their government, to other actors in society about how important the issue is.

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

You'll also find a range of community-based programs primarily implemented by NGOs, and some of you may have heard of some of the more well-known ones like Raising Voices, Stepping Stones and approaches like this that seek to generate behavior and attitudinal changes at the community level. So there's quite a few of these activities going on, and again there are some regional networks establishing themselves to try to share lessons and understand better what's happening.

And then more recently in some countries we begin to see governments becoming much more involved and much more engaged. In at least two or three countries you'll see government sponsored media campaigns advertising and providing education about this, and in several countries there's now a move towards mainstream, not just gender issues specifically but issues around gender-based violence within some of their ministries. So in terms are the areas of prevention, these are some of the activities that we're seeing happening in the region.

From the angle of criminal justice, we're seeing -- this is an area which has been established for quite a while. Most countries have laws and have legal procedures, either formal or traditional, for prosecuting and criminalizing physical, sexual and other forms of gender-based violence. And these vary greatly between countries. In many situations they're inherited from the previous colonial authorities, and so what you'll find in Anglophone and Francophone and Lusophone countries tend to depend on the colonial power. But there has been a move recently, in the last decade or so, for countries to take another look at those laws and try to update them and make them more relevant to the current situation.

Most countries have some certain procedures and protocols for collecting evidence, forensic evidence, and processing it through the system. And these again, we're finding a lot of countries now revisiting these because again they tend to be based on outdated forms and formula and procedures that don't always reflect what's going on or collect the data in a way which doesn't easily lend itself to enabling prosecutions to be followed through.

And then the third area to note here is the types of justice delivered in such cases, and these can vary. Inevitably, the major type of justice given out is in terms of criminal sentences for jail sentences, but in some countries these are beginning to be questioned as to whether they are the right approach, and other procedures are being used. In those countries which use, side-by-side, a traditional justice system, then there are other forms of justice being used. And this is a tension in several countries, and I can speak particularly from my experience in

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

Kenya where we have a tension between the Islamic courts and the civil courts, and they each have their own approach to dealing with gender-based violence. And this is a discussion going on in those countries where there are traditional justice systems in place.

What I want to focus on primarily, though, is the issue around the health sector's engagement in addressing sexual and gender-based violence because of these three broad areas of prevention, criminal justice and health, it's the health sector that's lagged the furthest behind in until most recently. But there are some exciting and interesting developments going on now, which I wanted to sort of raise and we can perhaps discuss more fully as a group.

There are at least two main reasons why the health sector needs to be more fully engaged. The first one, as you see on this slide, is the tremendous number of health consequences and the range of health consequences that can come out of gender-based violence, ranging from the fatalities through, well I don't need to go through them, but you can see them here. There's a wide range, and I'm putting them up here because, quite often, and certainly at the country level I think a lot of people underestimate the range of health consequences that there are. Obviously, depending on the type of violence and the severity and how often and so on, but it's quite often underplayed. I think in many African countries gender-based violence is not seen so much as having health consequences. It's seen as more of a social partner and power issue in general populations, and so there is a need, at the moment, to try to get more education, give more people information about the wide range of health consequences that can be associated with gender-based violence.

And then the second main reason is that the health sector itself is very well-placed to be able to respond for a number of reasons. As you saw in the first slide, if between one half of the women that generally come to the health facilities have experienced any type of violence and one quarter have experienced it in the last 12 months, then this is -- clearly the health personnel are interacting with these women on a regular basis and have the chance to either identify women at risk or who are currently being abused.

Secondly, we have to bear in mind that given that previous slide, the mandate of the health sector is there to try to address the majority of those health consequences. All of those consequences are within the mandate of the health sector, so there is there already, a large responsibility for the health sector to get more engaged in addressing that range of consequences.

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

The other reason related to this is that most of the skills required for that do exist in the health system somewhere. The problem is at the moment they tend to be dispersed throughout the system, physically, geographically by a cadre of worker. And so one of the challenges is to try to bring together the appropriate packages of skills and the infrastructure required for addressing this.

And then fourthly, we shouldn't forget that in most communities, health staff can be quite influential, and they can play an important role in advocating against violence and be engaged in preventive activities.

So there are a number of areas where the health sector can work more thoroughly, and I just put them together in this diagram to try to put a visual display of the sort of areas, and I'll just quickly go through some of these. There are probably some others, but these, I mean, as a way of trying to organize thoughts, most of the areas that are currently being explored seem to fall into these five main areas.

In terms of behavior change and prevention messaging and so on, there are at least four areas where the health sector can and is beginning to get more engaged. What we are seeing is that where there are community-based structures and NGOs available, and that are already themselves getting these issues, then bringing health personnel in to give the messages both about the health consequences and about the availability of medical services to treat and support them is a good entry point to try to raise the profile of the issue in the communities, and as well as making people aware of what services are available.

And this can be done either as you see here with the first, through the first bullet, existing structures like community health committees, like Chief Speraza's [spelled phonetically] and other groups and so on, or with NGOs working in the communities. But it can also be done through orienting and training community-based health workers that are already in the system. Virtually every health program in Africa, in fact most countries, have community-based health workers of some sort or another, and there's an interesting challenge there as to how they can become more engaged.

Then within the clinics and in the interactions with the clients they see, there are at least two areas here which can be, and I guess should be more actively explored. The first is that most clinics around the world generally have a group health education session first thing in the morning. Usually it lasts anything from ten minutes to half an hour, and it can be on a range

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

of topics. And so this is one opportunity to try to bring the issues of gender-based violence into the clinic environment. And then the other is the issue of doing individual consultations, during a woman's consultation, raising the issue and providing education.

But that brings us to the second area, which is quite a contentious issue, and this is whether or not health sectors, the health system, should become involved in routine screening or routine inquiry into experience with or suffering consequences of physical and sexual violence amongst its clients.

In principle, it's a real missed opportunity, and this is why, as you know, probably in the States and other countries with strong health systems it's now becoming a routine procedure. That's a routine part of the consultation. It's one of the questions or series of questions that are asked. But there is still a lot of concern about whether this is feasible and ethical in weaker health systems, and the trouble is at the moment it that there hasn't been any real attempt to try this out at any scale, and it's an area, I think, that we do need to look at and carry out some basic pilot testing to see what's feasible, how safely can it be done? Because we do have to worry about whether or not a woman's safety can be guaranteed if she discloses this information, whether it's ethical to raise and ask about this experiences if the system then cannot respond to it, cannot provide any treatment for her, and whether the provider's attitudes enable them to be supportive and without taking on and trying to victimize the woman. So this is an area which I think is something which we do need to address much more thoroughly in countries with weak health systems because it's proved feasible and effective in strong systems, so it is something we should be doing, at least on a pilot basis in weaker health systems?

The major area, I guess, where you focus on the attention of what the health sector can do is in treatment and support at health facilities. This diagram briefly summarizes the types of treatments and support that can be made available. The box in the middle there tends to -- that's what's pretty much being available at most places at the moment: injury treatment for physical abuse and for sexual abuse, clinical assessments to determine what other issues are there, and the collection of forensic evidence for prosecution. The other four boxes are beginning to emerge. There's some experience with these areas, but particularly with an increasing interest in addressing issues of sexual violence and the realization of the interaction between certainly sexual violence and STIs, HIV, exposure to pregnancy and so on. These other services are providing emergency contraception, prophylaxis for STIs, PEP, and counseling and testing for HIV, and trauma counseling. These are areas which some

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

countries are beginning to experiment with and to work out how best to provide these services, how feasible they are, whether they can be integrated into a broad model of treatment and support. But it's -- again, we're just at the beginning of this and just seeing where these can go. But being around -- being built around that core group of treating injuries and doing assessments and collecting evidence.

But one thing we do have to bear in mind is who does present for sexual assault services? We know a lot of people that are assaulted do not report either to the police or to the health facilities. But our data show here -- that we've collected from Zambia; we have similar data from Kenya, similar data from South Africa -- show a number of interesting things. First of all, if you look at the numbers here, these data were collected over a four-year period in a district in Zambia, and you'll see that the numbers here; 1800 police records, 1000 hospital records. So the people presenting here are more likely to present to the police first rather than the hospital. And so this is an important thing to bear in mind when were thinking about providing services for survivors.

And secondly, take a good look at the age distribution: 60% are children, at least, and the majority of those, ten and under, so this -- the services here need to be able to respond to the fact that those who are presenting -- this may not receive reflect, obviously, what's going on in the general population, but those coming for services, either legal services or health services are very young. These are children, and consequently the services do need to be set up that way.

We've also found, from the data, that the children are more likely than the adults to report knowing the perpetrator, and this is a difference in terms of -- for example, data we have from South Africa that shows that 80% of the children knew the perpetrator, compared with 30% of the adult women. So there's a big difference here. You're dealing with a clientele that knows who did this to them. But having said that, only a small proportion, and this is adults and children, mention that this is within the extended family. This is someone who is related to them. So we have to bear these things in mind when configuring the services either at the police or at the hospitals.

So my question here for the audience and for the field as a whole is, how should we, how can we best organize services? And especially services for sexual assault because at the moment, most African countries have no dedicated medical or legal services. And those that do have

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

some services, they tend to be organized poorly, organized separately, and it's very hard for a person to get the full range of services that are needed.

There are some emerging approaches which are beginning to be documented, but we need far more documentation to learn what's going on, and the list of them here. The first one is the approach of trying to integrate everything into one center: the medical aspects, the legal aspects, the social, psycho-social aspects, and one of the best-known examples of this is from South Africa, the Thuthuzela Care Centers, and this model is currently inspiring a number of countries: I think Zambia, Uganda, certainly places I'm aware of, where this model is being rolled out. And clearly it has a lot of advantages that everything can be provided in a survivor-friendly setting, but at the same time, obviously, being a single center, it can only reach, it can only be available to a relatively small number of people, and we've yet to see any evidence about the cost-effectiveness of this approach compared with other approaches that are maybe more decentralized.

So some of the other approaches that are being looked at: the second one is an area that ourselves -- we're working with quite a few partners here on this -- is looking at trying to integrate and provide a more comprehensive package of health services based around the district health, the district hospital or that level of facility. And there's examples here across South Africa, Ethiopia, Zambia and Kenya that we're working on.

Another approach, which is being tried by one of our partners in South Africa is to have a help desk at a clinic. So if a woman comes to the emergency department reporting rape, then there's a desk, literally a person sitting at a desk, who can provide legal aid, can get them linked up with the police, can help them to find trauma counseling and so on. So this is sort of another model to look at and to consider, that isn't sort of the full-blown integrated model, but it brings it together there.

A fourth area which we're exploring, particularly in Zambia, is looking at trying to strengthen the police response. Some countries, certainly Zambia and South Africa, now have either what they call Victim Support Units or Victim Empowerment Programs so they have set up programs to work with survivors of violence. But these are very few and far between, and so far a lot of it has been on the legal aspect, on trying to help them to get legal justice and prosecution. What we've been doing in Zambia is try to get the police more engaged in some of the health aspects. So we've been giving them some basic training in counseling and also

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

getting them to be trained as providers of emergency contraception, so we're just trying to get them to become stronger first points of contact, offering not just the legal service.

And then, I guess sort of more overarching, and the general goal here is to try to establish bi-directional linkages between the police and the health facilities. The vast majority of people that are going to report an experience of violence, be it physical or sexual, will report to police or health, and so the trick here is to try to set up linkages between the two, and how can that best be structured given the setting for each country?

So if the challenge is out there, how best to organize and improve and strengthen response? What are some of the issues to be looking at? This is obviously, by no means, a comprehensive list, but it's some of the key issues that in our work we're finding across-the-board. These are the sorts of questions that every group interested in trying to organize a more integrated, more comprehensive response should be looking at and asking. I'll go through them very quickly, but they should be fairly self-explanatory.

The first one, what types of services are appropriate for the survivors presenting? As I mentioned earlier, the evidence seems to suggest that those presenting at the moment are primarily children, primarily girls. But we do have situations where there are young boys presenting. We have adult women, we have adult men presenting. And as the services become more widely known then that demographic may well change to reflect the situation in the general population. So we have to think about what type of services are appropriate for this clientele, for these people coming to the health and to the police and organizing them accordingly.

Secondly, one of the real challenges is to consider this concept of first point of contact. Where someone goes is very, very important, and the type of care they receive is critical to determining what will happen to them from then onward, whether they have an awful experience and just run away or whether they have a good experience and want to follow through, both from a health and a legal and a counseling perspective. So the types and the quality of the care at the first point of contact is critical. And that's something we do need to understand more fully and to work with governments and others to work out what should be the standard of care, and what range of services should be available at the first point of contact.

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

Which then leads to the third point there: if you're not able to provide every service as you would in the Thuthuzela model, then which -- how can you set up referrals for the other services? So if someone comes to a police station, they open a case, and within 72 hours they have to go to get their medical treatments, how can you set up a referral so that they get to the nearest available spot for those services?

Then if you're looking at the hospitals, how best to integrate the medical services within the hospitals? The work we've been doing shows that, in most hospitals, all the services are there somewhere. But both in Kenya and in South Africa, we were finding that, on average, a woman coming to report sexual assault saw 12 providers -- 12 different people -- and she would have to basically find her way around the hospital to go for all these different services. So an obvious thing is just to try to bring all these services into one spot, one place and ideally, just one or two providers. And, you know, we've been successful in one hospital in South Africa in setting it up that way, where we now reduce the number of contacts down to an average of about four, rather than 12. And the time, consequently, reduces as well. But it's a major challenge, but, you know, the good news is the services are there. The bad news, the challenge is how to bring them all into one package so that there's a smooth flow between them.

The fifth point there is the one I raised earlier: what is the capacity of the health system to offer screening routinely? If it's something we think we should be trying to do, what capacity is needed and how best to get -- what training is needed, what investments are needed to get that level of capacity where we feel comfortable offering a quality and ethically sound service?

Number six is an interesting one which really came through when we made a visit to Uganda to find out what's going on there. In Uganda it's an absolute requirement that anyone presenting for a rape must then open a case in the police. There's no ifs or buts. You have to do it, and this is proving to be a real block because a lot of people don't want to open a case. They just want the treatment. But it's showing itself to be a block to treatment, that women are not going for treatment and/or providers are not providing the treatment because of the whole expectation that as soon as it's written down as sexual assault, it has to be reported and a case has to be opened. Other countries are taking a more lenient view on that, but it's an issue to be discussed in each country's situation, obviously. But it's something to bear in mind because it does have, you know, a considerable bearing on how services are organized.

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

The seventh point there: role of forensic evidence. This is, again, proving to be difficult both in terms of what type of evidence is acceptable and convincing and plays a role in preceding a case through, but also how is that evidence collected? How is it preserved? How is it processed from the hospital or the clinic or the police station through to the central courts where the case is heard? And a couple of countries are experimenting with what they're calling rape kits, where basically it's a cardboard box about this big that has inside it all the necessary supplies needed to collect the evidence, and you then put the box, seal the box and it goes off that way. That's one approach, but it's a major problem with the quality of forensic evidence getting lost along the way or disappearing mysteriously along the way. That happens very frequently, and it's a big issue that needs a lot more attention. And we're working with our partners, Liverpool VCT, in Kenya to try to strengthen this chain of evidence from where the point of collection through to prosecution.

And then finally, the major challenge, I guess, underlying all of this is that, as you can tell, this is clearly a multi-sector response. It involves the health sector. It can involve social services. It can involve the Justice Department, home affairs. It can, depending on the structure within a country, then you're looking here at many sectors, and how to organize cooperation across the sectors is a massive challenge because any government trying to have a multi-sector response to an issue -- it's a challenge, and that applies whether it's the U.S. or an African country. And it's something which we're struggling with to trying to work out how that can be done in each country.

So we are just at the beginning. Some of the issues here that are sort of important: I think we do have to acknowledge there has been a rapid increase in awareness of the importance and the extent of sex and gender-based violence in the general populations. We are now realizing that it is a problem, a substantial problem. Governments are taking it onboard as being something that they do need to address. An increasing number of countries are passing laws around this, which gives legitimacy to the efforts and provides a basis for funding allocations, for setting up structures and so on. And particularly in East and Southern Africa, the clear link with HIV is adding both an extra urgency, but also it's opening up funding opportunities for providing services, given the high level of funding going to HIV in that part of the world.

However, there's still a huge lack of experience with providing these services in a development context, which is hampering a lot of the response efforts, and as I just mentioned, the multi-sectoral approach tends to often mean that it falls between the cracks.

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP

One sector will assume another one is looking after it so when you start talking to people in the health field, they'll say, "That's the police's responsibility," and you talk to the police, and they say, "Yeah, we're doing it. We're fine. We don't have to link up with the health people. What are you talking about?" So it's something which needs to be sort of a bringing together of the sectors if this is going to work, and how that can happen in each country is a major challenge.

Just a couple of slides to end with. What I put here, which is probably a bit difficult to read, but I've got some handouts for you that'll be interesting. We've got a program of research going on at the moment which is jointly supported by PEPFAR and by Sweden and Norway, and what we're trying to do here is work with a series of partners in East and Southern and West Africa, too, trying to look at what would a comprehensive response look like? What are the key issues to be considered in these three broad areas of community-level prevention, medical management and the criminal justice system. And some of those bullets there give you an indication of the sorts of issues that we're looking at across-the-board, so our starting point is to work with an organization, and in most cases, with the Ministry of Health or the police or in some cases, NGOs, and then to help them to think through, what would it take to expand what they're currently doing to work with these other groups, to be able to address these other issues and link up either direct linkages, referrals or organizing things amongst themselves.

So this is our network. These are the countries we're working in, and at the moment we're focusing on pilot efforts to try to sort of demonstrate and document what's feasible, what sort of effects they have in the immediate term. But we do -- we are realizing as we're going through, that we need a lot more operations, research around determining effectiveness and particularly the cost-effectiveness across those different types of models that I mentioned. Because quite often, one approach may make a lot of sense or be very attractive, but people tend to then not focus on the alternatives, so either there'll be a lot of focus on community-based approaches or on these one-stop centers or on the strengthening the legal systems and so on. So a lot of our work is just try to get a better understanding of what's feasible, use that both for advocacy at the national/international levels to try to get an understanding, but this does take a multi-sectoral response if it's going to work, and we're going to improve the quality of care for women and males suffering from sexual and gender-based violence in this region. So, thank you.

ONE WOODROW WILSON PLAZA, 1300 PENNSYLVANIA AVENUE, NW, WASHINGTON DC 20004-3027 T 202.691.4000 F 202.691.4001
E-MAIL: ECSP@WILSONCENTER.ORG WEB: WWW.WILSONCENTER.ORG/ECSP