Expanding the Evidence Base and Networks for Sexual Violence Response in East and Southern Africa

Completion Report

for the Period May 2014–February 2018

SWEDEN

Norad

POPULATION COUNCIL

Ideas. Evidence. Impact.

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Submitted to:

The Regional Team for Sexual and Reproductive Health and Rights
Embassy of Sweden
Lusaka, Zambia

Submitted by:
The Population Council
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List of Abbreviations

AHA	Africa Humanitarian Action
CBO	Community-Based Organization
COPUA	Coalition on the Prevention of Unsafe Abortion
DHO	District Health Officer
EAC	East Africa Community
EC	Emergency Contraception
ECSACON	East, Central and Southern Africa College of Nursing
ECSA-HC	East, Central and Southern Africa Health Community
FP	Family Planning
GBVRC	Gender-Based Violence Recovery Centre
GEC Plus	Girls Empowerment Clubs - Plus
ICEC	International Consortium for Emergency Contraception
ICGLR	International Conference on the Great Lakes Region
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
IPV	Intimate Partner Violence
KNH	Kenyatta National Hospital
LWF	Lutheran World Federation
RH	Reproductive Health
RTF	Regional Training Facility
RWPC	Regional Women's Parliamentarian Caucus
SAAG	Safe Abortion Action Group
SADC	Southern Africa Development Community
SGBV	Sexual and Gender-Based Violence
SIPV	Sexual and Intimate Partner Violence
SOP	Standard Operating Procedure
SRGBV	School-related Gender-based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SVRI	Sexual Violence Research Initiative
SWAGAA	Swaziland Action Group Against Abuse
TA	Technical Assistance
TfG	Together for Girls
TVEP	Thohoyandou Victim Empowerment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
VAC	Violence Against Children
WHO	World Health Organization
WLSA	Women and Law in Southern Africa
ZTSA	Zero Tolerance School Alliance
ZTVA	Zero Tolerance Village Alliance

Background

The Population Council's cooperation with Regional Team for Sexual and Reproductive Health and Rights (SRHR), and Embassy of Sweden, Lusaka ('the Team') on sexual and gender-based violence (SGBV) in East and Southern Africa has spanned over a decade, emerging in late 2006 in response to high levels of SGBV in the region, coupled with minimal understanding of how to respond to the issue in the low-resource settings that this region includes.

The *Expanding the Evidence Base and Networks for Sexual Violence Response in East and Southern Africa* program was a nearly four-year agreement (3 years and 10 months) between the Team and the Population Council, representing the final phase of funding within an 11-year period. From May 2014 through February 2018, the program sought to mitigate the consequences and occurrence of sexual and gender-based violence (SGBV) by strengthening the capacities of the medical, legal, and justice sectors to care for survivors of such violence. This approach was intended to serve the Team's larger development objectives of preventing HIV transmission in sub-Saharan Africa and promoting the sexual, reproductive and human rights of survivors across the region. It also aligned with the Team's emphasis on regional integration, collaboration, and solutions.

Over this nearly four year period, the program aimed to achieve three outputs and one major outcome:

Outputs

1. Adaptation of SGBV interventions in East and Southern Africa to the needs of children;
2. Adaptation of SGBV interventions in East and Southern Africa to the needs of refugees; and
3. Fostering accessibility of safe abortion and pregnancy prevention services for SGBV survivors.

Outcome

1. Improved regional policies and programs on SGBV.

This report provides an overview of the results achieved under this program, and the impact observed in regard to national and regional SGBV issues by the completion of the program.

Output 1: Adaptation of SGBV Interventions in East and Southern Africa to the Needs of Children

Prior to the current phase of the program, children repeatedly emerged as a population requiring special attention, given that most survivors of sexual violence who seek services from health facilities and police stations in the region fall in this category. Nonetheless, there was a noted dearth of responses for meeting the needs of child survivors. A network of implementing partners across East and Southern Africa (known as the 'Africa Regional SGBV Network') has served as the core of the program since 2006. For over a decade, the Africa Regional SGBV Network has designed, implemented, and tested a variety of innovative interventions found to be feasible for adult survivors (ages 18 and older) in SSA. These interventions were adapted for children in the current phase of the program, and tested for acceptability, feasibility, and effectiveness.

A total of five partners were supported by the program to adapt SGBV projects developed under previous phases of the program to the needs of children. These partners implemented adapted, child survivor-focused projects during this period. The best practices from these projects are summarized as outlined in Table 1 (following page).

Table 1: Implementing Partners, 2014-2018

Country	Best Practice	Focal Populations	Implementing Partners
Kenya	Using a case manager/advocate model and SOPs to enhance children's access to comprehensive post-rape care in Kenya	Girls and boys in health facilities	LVCT Health
	Screening for child sexual abuse to promote survivor detection and response in Kenya	Girls and boys in primary schools	Kenyatta National Hospital Population Council
South Africa	Harnessing the prestige of alliances and labeling to prevent school-related SGBV in South Africa	Girls and boys in secondary schools	Thohoyandou Victim Empowerment Programme
Swaziland	Addressing SGBV in schools through girls' clubs in Swaziland	Girls in secondary schools	Swaziland Action Group Against Abuse
Zambia	Strengthening transportation services and training for police to expand adolescents' access to post-rape care in Zambia	Girls and boys in police stations	Zambia Police Service, Population Council

Through this structure, five best practices in SGBV service provision for children were tested in 4 countries in East and Southern Africa, with their processes and findings rigorously documented. A commonality shared by these best practices is their innovation (given the paucity of responses for children in the region), coupled with their applicability for low-resource settings which characterize the contexts in which many survivors in sub-Saharan Africa live. Each best practice embraces the ethos of the Africa Regional SGBV Network ('the Network'), which recognizes that survivors require access to multi-sectoral services, while also acknowledging that it may not be feasible, appropriate, or cost-effective to deliver all services in one location.

The best practices are described below, and detailed reports documenting each of these practices may be accessed via the Network's web page on the web site of the Sexual Violence Research Initiative (www.svri.org/who-we-are/networks/africa-regional-sgbv-network), and on Population Council's web site (www.popcouncil.org/research/addressing-sexual-violence-among-vulnerable-populations-in-east-and-souther).

Best Practice 1: Using a Case Manager/Advocate Model and Standard Operating Procedures to Enhance Children's Access to Comprehensive Post-Rape Care in Kenya

LVCT Health's initial focus under the Network was on developing a locally-assembled rape kit for survivors presenting at health facilities, and combining this product with joint training for health providers and police. The training in question aimed to support health providers and police in properly documenting rape cases using national post-rape care forms to promote successful legal action on the part of survivors. Findings form these efforts showed that the majority of survivors presenting for post-rape care in Kenyan health facilities were children below the age of 18—yet, post-rape care service delivery in the country had been designed with adult women alone in mind. Under the current project, therefore, LVCT Health implemented and evaluated an intervention geared to enhance children's access to post-rape care.

The intervention involved integrating qualified trauma counselors to accompany child survivors through the health system and make follow up phone calls for adherence to future post-rape care appointments at a health facility. In collaboration with the Ministry of Health, LVCT Health developed Standard Operating Procedures for attending child survivors of sexual violence presenting at two County hospitals; determined the minimum package of care for child or adolescent survivors in resource-constrained health facilities (including drug regimens, psycho-social assessment, counseling, evidence collection, and documentation for minors); developed an algorithm guiding child survivors through different service delivery points and referrals outside a facility; and developed IEC materials targeting child survivors and their caregivers.

These IEC materials highlighted the availability of post-rape care services for such survivors, and outlined the full package of care they should expect to receive.

Findings from the evaluation of this intervention showed an increase in the proportion of child survivors receiving various components of post-rape care services after the introduction of case advocates into the health care system, despite a four month national strike by health care providers in Kenya during the study period. Increases were observed in the receipt of the following post-rape care services by child survivors: HIV post-exposure prophylaxis (from 63% to 75%), trauma counseling (from 33% to 87%), HIV testing (from 55% to 67%), and sexually-transmitted infection treatment (53% to 68%). The proportion of child survivors receiving emergency contraception (EC) as part of post-rape care did not vary much over time, however (from 54% to 53%), perhaps due to continuing uncertainty by providers about the minimum age at which EC may be provided.

Importantly, child survivors and their caregivers found the case advocate role to be highly acceptable, as they helped ensure timely receipt of time-bound post-rape care services, and eased the health facility encounter (ensuring better communication, shorter waiting times, and relieving the burden of revisiting the rape incident at each service delivery point), as they act as liaisons between child survivors and health providers. Health providers also valued the task-shifting that case advocates symbolized, particularly as case advocates perform roles such as properly documenting cases in the national SGBV register and retrieving child survivors' test results from the laboratory. As a result, health providers felt more empowered to concentrate on clinical work and counseling, and reported the capacity to provide the full package of post-rape care in one day rather than over a period of several days.

Best Practice 2: Screening for Child Sexual Abuse to Promote Survivor Detection and Response in Kenya

In the previous phase of the program, Population Council and Kenyatta National Hospital (KNH) worked collaboratively to test a screening intervention for identifying and responding to the health needs of women survivors of intimate partner violence (IPV). In 2017 to 2018, both institutions adapted this intervention to the needs of child survivors, implementing and testing it in primary school and health facility settings.

The intervention involved training KNH psychologists to appropriately screen children in public primary schools (grades 6 to 8) and at KNH (ages 11 to 17 presenting at the Casualty Department) for child sexual abuse, by using a screening tool developed by the project for this purpose. Child survivors detected in schools via this process received school-based counseling and, in the case of rape, accompanied referrals to KNH's Gender-Based Violence Recovery Centre (GBVRC), while those detected at KNH were accompanied to the GBVRC for care. These aspects of the intervention were supported by a series of parent dialogues in schools to sensitize parents on the screening intervention and obtain consent for their children's participation. In addition, a series of sensitization sessions for students during school assemblies informed them about the roles of school-based psychologists and the screening exercise.

Findings from this study show that screening for child sexual abuse is highly acceptable, to parents and children, for both school and health facility settings. In the two primary school settings involved, 81 percent of parents were willing to have their children screened, and gave written consent. Of the children whose parents gave consent, 96 percent also assented to screening. Out of a total of 456 children screened in primary schools, about half (49%: 59% of which were girls and 41% of which were boys) disclosed having experienced some form of sexual violence. The principal kinds of sexual violence disclosed by children in primary schools (some of whom disclosed more than one type of sexual violence) were genital touching (64%), attempted rape (22%), forced viewing of pornography (12%), rape (7%), attempted genital touching (5%), and other forms (6%) such as forced touching of others' genitals and oral sex.

The perpetrators mentioned by children who disclosed ever experiencing sexual abuse (some of whom disclosed more than one perpetrator) were most often fellow students (55%), followed by neighbors (31%), relatives (11%), strangers (10%), and friends (5%).

The vast majority of child survivors identified in school through the use of the screening tool were willing to receive care, and did so (97%), as a result of the identification. School-based counseling was the form of care required by most survivors (95%), while three percent of child survivors were accompanied to KNH for comprehensive care due to their experience of rape.

The study concluded that screening for child sexual abuse in low-resource school and health facility settings is not only feasible, but is also highly effective for enhancing child survivors' access to care.

Best Practice 3: Harnessing the Prestige of Alliances and Labeling to Prevent School-related Gender-Based Violence (SRGBV) in South Africa

The Thohoyandou Victim Empowerment Programme's (TVEP's) Zero Tolerance Village Alliance (ZTVA) model mobilizes communities for collective stands against SGBV, through educational workshops, dialogues, and campaigns in communities. Communities willing to undertake these activities that meet criteria demonstrating their amenability to fostering a 'zero-tolerance' environment are formally inducted in the 'Zero Tolerance Village Alliance' during a ceremony with a traditional pledge-taking rite (against SGBV) by traditional rulers and other male members of the community. Fostering such a 'zero tolerance' zone is designed to change social norms about violence in these communities, and to address stigma around SGBV reporting.

TVEP's 'Zero Tolerance Village Alliance' (ZTVA) intervention is a violence prevention model designed to inspire communities to brand themselves as 'zero tolerance' zones for SGBV. The branding process involves intensive training and work by a community to meet a series of criteria granting them entry into a prestigious 'alliance' of villages with a public stand against SGBV. Intervention activities include educational workshops, dialogues, and campaigns in communities, and culminate in an award and pledge-taking ceremony (against SGBV) by community members. The ZTVA model was developed, refined, and evaluated from 2007 to 2012, with promising results. From 2014 to 2018, the project aimed to adapt this tested, adult-focused SGBV response to school-aged children's needs, and to assess the effect of the adapted intervention on this new population (secondary school students in rural South Africa). Dubbed 'the Zero Tolerance School Alliance (ZTSA), the intervention involves SGBV dialogues with school students, school personnel, and community members; the development of criteria that serve as benchmarks for communities to achieve desired goals in violence prevention (induction into the 'Alliance' is contingent upon a community meeting each of the benchmarks by the end of the intervention period); the establishment of a school stakeholder forum (including students) to ensure a school is meeting the established criteria; and training school stakeholder forum members on SGBV. The intervention culminates in a public pledge and award ceremony for students and school staff, during which students pledge to proactively address the eradication of violence in their school and community, and the participating school receives a billboard declaring its 'zero tolerance' status against SGBV.

An evaluation of the ZTSA intervention demonstrated that the model reduced bullying for girls in school; reduced perpetration of sexual violence by girls in school; enhanced students' knowledge of whom to report school-related gender-based violence (SRGBV) when it occurs; broadened students' sources of information on children's SRGBV rights; and increased their actual knowledge of their SRGBV rights. Nonetheless, in its tested form ZTSA did not show an effect on decreasing the proportion of students afraid of walking to school or addressing their experiences of violence on their way to school, of moderating students' feelings of lack of safety in school, nor reducing boys' experience of bullying in school, of reducing the *experience of unwanted sexual touching* for boys **and** girls in school, reducing *perpetration of bullying* by boys **and** girls, reducing the *perpetration of unwanted sexual touching* by boys, and increasing the *reporting of and help-seeking for SRGBV* among boys **and** girls. Thus, while the model is promising, it requires strengthening in certain areas to more fully address the consequences of SRGBV.

Best Practice 4: Addressing SGBV in Schools through Girls' Clubs in Swaziland

From 2011 to 2013, the Swaziland Action Group Against Abuse (SWAGAA) tested the feasibility and effectiveness of a school-based, girls' empowerment Safe Spaces project ('Girls Empowerment Clubs-Plus' or 'GEC-Plus') to help prevent SGBV in secondary schools in Swaziland. Project interventions sought to change SGBV knowledge, attitudes, and practices among girls in school; to enhance knowledge of other related health topics; improve girls' social assets and leadership skills; and increase girls' SGBV reporting. While evaluation findings demonstrated significant post-intervention increases for a wide range of indicators, the intervention had no effect on the likelihood of girls' reporting of incidents of sexual harassment by a teacher or declining sexual advances from teachers or fellow students.

SWAGAA's project in Phase III of the program was thus dedicated to strengthening the original intervention by incorporating components for enhancing self-efficacy among girls ages 16 to 18 in three secondary schools. SWAGAA's intervention involved developing, incorporating, and implementing a self-efficacy module within the GEC-Plus program; training GEC-PLUS* mentors and teachers; facilitating GEC-PLUS* sessions with girls; and engaging teachers and school principals, to enhance their knowledge of SRGBV through sensitization workshops.

Study findings show that the program: enhanced girls' social assets (i.e. increased the likelihood of girls reporting many friends in their neighborhood, or being involved in extra-curricular activities); increased girls' awareness of various forms of SRGBV in schools; moderated some negative gender attitudes and beliefs of girls; enhanced girls' self-efficacy for reporting SRGBV to authority figures (teachers, principals, police); enhanced school personnel knowledge of SRGBV; did not sufficiently build girls' self-efficacy to decline unwanted sexual advances, nor to report them when a perpetrator is a teacher; did not moderate the perpetration of sexual comments by girls on others; and, only having been implemented for a short period, one month (due to delays in government approval of the club curriculum), it requires longer-term delivery to fully assess its effects on girls' self-efficacy.

Best Practice 5: Strengthening Transportation Services and Training Police to Expand Adolescents' Post-Rape Care Access in Zambia

The project's efforts in Zambia have involved four studies since 2006. The first study focused on fostering pregnancy prevention for SGBV survivors by training police to provide EC to such survivors presenting at police stations, coupled with referrals to health facilities for comprehensive care. After the feasibility of this intervention was established, the project responded to government requests to test the feasibility of having trained police provide survivors with a starter dose of HIV post-exposure prophylaxis, along with referrals for further care. This police-led response was also found to be feasible. Both studies indicated that the bulk of rape survivors presenting at police children were children (85% were girls below the age of 16, with 13 being the mean age of report being 13 years). These findings led to an initial, formative study to gain a better understanding of the composition of the available package of sexual violence services at police stations in Zambia, the extent to which these services are designed to meet the needs of child survivors in the country, and possible solutions for enhancing care in police station settings for this population.

Findings from this study demonstrate that although Zambia's *National Guidelines for the Multidisciplinary Management of Survivors of Gender-Based Violence* outline specific procedures for care of child and adolescent survivors at police stations, police attending to such survivors do not adhere to these guidelines, due to lack of awareness and training. The national guidelines offer instructions for EC provision to eligible survivors (including adolescents) by police, but it was found (under the overall program) to be inconsistently applied due to the lack of monitoring and follow up. Lack of transportation at police stations means that adolescent survivors' access to a range of health services is curtailed at that setting. According to the guidelines, survivors reporting to police stations should be accompanied to a health facility by trained police, to ensure access to comprehensive care and access to justice. With police unable to play this critical and mandated role, few survivors can achieve these goals. These limitations affect adolescent survivors' access to quality care at police stations and health facilities alike.

Prompted by these findings, Zambia Police Service and the Population Council developed an intervention involving police and health provider sensitization and training around the national guidelines and child sexual abuse; and the introduction of transportation services for child survivors from police stations to and from the hospital for post-rape care services.

Findings from the evaluation of this police-led post-rape care model confirmed the feasibility of the intervention, and its effect in enhancing child survivors' access to comprehensive care. Police and health provider training and sensitization on the national guidelines helped strengthen the multi-sectoral response to the needs of child survivors of rape, as participants in the training gained a deeper understanding of, and appreciation for, their intended individual and collaborative roles under the guidelines. As a result of this process, children's access to post-rape care was enhanced. The vast majority (90%) of caregivers of child survivors who presented at the police stations during the study period were willing to accept police accompaniment and transportation services; and police accompaniment of child survivors and their caregivers from police stations to the health facility site eased the health facility encounter for child survivors and caregivers: Of those accompanied to the health facility by police, 95% received same-day SGBV care.

The study concluded that while this package of interventions enhances child survivors' access to comprehensive services, post-rape care service delivery in health facilities must be strengthened for greater efficiency of the overall intervention package.

Output 2: Adaptation of SGBV Interventions in East and Southern Africa to the Needs of Refugees

The *Expanding the Evidence Base and Networks* program was also devoted to meeting the SGBV needs of refugee populations—an important, underserved group in the region. In the last couple of years, the growing, global refugee crisis has placed refugee settings at the center of international discourse and has indeed become one of the defining challenges of the 21st century. In 2015, UNHCR recorded the highest number of displaced people in history, including a considerable proportion of unaccompanied minors. These realities underscore the importance the program extending its focus to the issue of SGBV in refugee and emergency contexts.

Working in partnership with UNHCR's Regional Service Center in Nairobi, Kenya, the program aimed to support the operationalization of UNHCR's current strategy for *Action against Sexual and Gender-Based Violence* in order to reduce the occurrence and consequences of sexual violence for survivors in refugee settings.

UNHCR's strategy includes recommended actions in three key areas in order to strengthen UNHCR's individual capacity and expertise in addressing SGBV, namely: 1) *Data collection and analysis* (Improve the quality of programs by adopting and maintaining appropriate SGBV data collection and analysis tools and working with institutions and partners on researching and documenting SGBV), 2) *Knowledge management and capacity-building* (Strengthen the management of SGBV programs by investing in capacity-building and expertise across the organization), and 3) *Partnerships and coordination* (Working with UN agencies, governments, non-governmental organizations, and displaced communities, strengthen SGBV prevention, response, and coordination mechanisms for effective service).

Given the alignment of this strategy with the undertakings and experience of the Network, and the fact that similar structures harnessed by the Network (medical, psychosocial, police, etc.) exist in refugee settings, UNHCR's Regional Services Center has been keen to learn from the program's experience, to determine how to adapt existing models to the refugee context in particular, and to expand the program regionally, where potential for this exists. Indeed, in 2014, UNHCR's Regional Service Center established a technical cooperation with the Council's Kenya office, focusing on 'improving evidence-based programming for SGBV in refugee operations in the East and Horn of Africa region.'

The Africa Regional SGBV Network also adapted two of its interventions (selected by UNHCR Regional Service Centre) for implementation among refugee populations, in collaboration with UNHCR and UNHCR's implementing partners in Uganda and Rwanda. The models were also tested in these settings for feasibility and effectiveness. Further, Network partners (who pioneered the implementation of the interventions) provided technical assistance (TA) to UNHCR implementing partners to adapt and implement these models in these new contexts.

The two best practices from the Network that were adapted for this purpose are summarized in Table 2.

Table 2: Implementing Partners (Refugee Settings), 2014-2018

Country	Best Practice	Focal Populations	UNHCR Implementing Partners	Network TA Partners
Uganda	Screening for SGBV to promote survivor detection and response in refugee settings	Women and girls in health facilities	African Humanitarian Action	Kenyatta National Hospital; Population Council
	Harnessing the prestige of alliances and labeling to prevent SGBV in refugee communities	Women and men in communities (household level)	Lutheran World Federation	Thohoyandou Victim Empowerment Programme; Population Council
Rwanda	Screening for SGBV to promote survivor detection and response in refugee settings	Women and girls in health facilities	American Refugee Committee Plan International	Population Council

Best Practice 1: Screening for SGBV to Promote Survivor Detection and Response in Refugee Settings in Uganda

In Uganda, the Network's efforts focused on Rwamwanja Refugee Settlement, situated in the southwestern part of the country, and populated primarily by refugees from the Democratic Republic of Congo during the program period. In collaboration with Network partner Kenyatta National Hospital, the Population Council facilitated a training session for providers at Rwamwanja Health Centre in 2015, focused on routine screening for SGBV. The training session was held with a total of 17 providers from various clinics within the health center, and a cascade training session was subsequently conducted with 12 more providers by the SGBV Coordinator at Africa Humanitarian Action (AHA) – the UNHCR implementing partner in charge of implementing the intervention.

Two health facilities were selected for the intervention, and trained providers screened over 8,000 female clients aged 15 and above over a 5-month period. The Council and KNH provided guidance on the selection of the most appropriate screening sites (clinics) within the two participating health facilities, based on ethical considerations (e.g., privacy and confidentiality for clients). Other forms of technical support involved guidance on violence forms to screen for, given the capacity of health facilities; strengthening referral mechanisms for survivors detected via screening who required comprehensive SGBV care, and establishing documentation systems for monitoring the screening intervention.

Key findings from the evaluation of this intervention demonstrated its high acceptability and feasibility. These findings are summarized below:

Survivors were willing to disclose SGBV

- 10 percent of those screened disclosed that they had experienced some form of SGBV
- Of this 10 percent, 84 percent disclosed current exposure to IPV

Providers achieved high rates of screening, survivor detection, and survivor referral

- 8,462 clients were screened in the two health facilities within a five-month period[1]
- 96% of survivors were referred for comprehensive SGBV care.

There were good rates of referral adherence

- 63 percent of referred clients went for further SGBV care: This adherence rate is 23 percent higher than among the general population in a similar intervention in Nairobi, Kenya[2]
- More than half the referrals who did not come for SGBV care were first seen at a health center that did not have an SGBV Response Unit on site. This systemic barrier to referral adherence is resolvable.

Survivor satisfaction with SGBV services was high

> "When I came here, it was as if my heart was bleeding and I was so hurt. When I was asked questions about violence, I got a chance to express myself, and now I am very relieved, since this is the first time I have ever talked about it. I had no option but to go [to the SGBV Response Unit]: I felt I needed help, and after counselling, it was such a big relief."
>
> *SGBV Survivor, Maternity Department*

Provider satisfaction with implementing screening protocols was high

> "[Screening] takes some time…but the truth is, time taken [today] while you are assisting someone will save your time tomorrow, because you will get the correct diagnosis. If you don't take time, you will [prescribe] Panadol, and tomorrow, the client will come back because the problem was not what you treated—it was psychological. So, it is better to take those two minutes [to] address…the real problem. Then, you will save more time."
>
> *Provider, Antiretroviral Therapy Department*

Many survivors were experiencing multiple traumas simultaneously

Polyvictimization (the experience of multiple kinds of violence at the same time) was a key characteristic of the violence experienced by clients. Nearly half (45%) of all survivors disclosing IPV indicated experiencing more than one form of IPV (physical, psychological, or sexual) simultaneously. Nearly 20 percent of those disclosing current experience of IPV also disclosed non-partner sexual violence within their lifetimes. Survivors in humanitarian settings present with complex psychological traumas that responders must be aware of, and have the capacity to address.

The high screening, disclosure, referral, and referral adherence rates in the study reveal a real need and demand for SGBV screening in emergency settings. Recommendations for strengthening SGBV screening protocols, and for addressing gaps in SGBV programming more broadly in humanitarian settings include:

- *Ensure screening is coupled with referral services **at the same site***—this will ensure better referral adherence and greater access to comprehensive SGBV care.
- *Integrate SGBV screening and services* into RH care and general health service delivery where possible, so SGBV screening becomes a standard procedure. Rape-related pregnancies must also be addressed in these contexts.
- *Increase the number of trauma counselors* and improve the training curricula for counselors. Training curricula need to address the specific SGBV realities of emergency contexts (e.g. polyvictimization, rape-related pregnancies, physical IPV, psychological counseling for male perpetrators, and SGBV-focused couples' counseling).
- *Involve men in strategies to address SGBV*. Many women and health providers interviewed stressed the importance of involving men, with suggestions including couples' counseling, screening and counseling for men, and interventions at the community level to reach both men and women.

[1] This rate is relatively high, given that a 2013 study by the Council and KNH in 3 clinics at Kenyatta National Hospital showed that providers screened a total of 1,210 clients over a 7-month period.

[2] Undie, C., C.M. Maternowska, M. Mak'anyengo, I. Askew. 2016. Is routine screening for intimate partner violence feasible in public health care settings in Kenya? *Journal of Interpersonal Violence* 31(2): 282-301.

Best Practice 2: Screening for SGBV to Promote Survivor Detection and Response in Refugee Settings in Rwanda

At the request of UNHCR Regional Service Center and the UNHCR country office in Rwanda, Population Council provided technical assistance (TA) to UNHCR Rwanda and its implementing partners for scaling up tested SGBV screening and response protocols at health facilities in humanitarian settings. Council TA involved selecting appropriate screening sites, building health care providers' capacities to screen for SGBV and offer appropriate responses, establishing documenting and monitoring systems, close process monitoring, and conceptualizing and leading a 'lessons learned' workshop for UNHCR stakeholders to promote further institutionalization of the intervention in refugee settings in Rwanda and the wider region. In addition to UNHCR, the Council worked closely with two UNHCR implementing partners—the American Refugee Committee (in charge of UNHCR's Health interventions in 2017) and Plan International (in charge of UNHCR's SGBV and Protection programming in 2017).

Population Council collaborated with the Regional Psychosocial Support Initiative to train 63 health providers in two refugee camps in Rwanda (Gihembe and Nyabiheke) for SGBV screening and psychosocial response. Following the training sessions, providers routinely screened clients for SGBV for over five months. Although this intervention was evaluated in refugee settings in Uganda prior to its introduction in Rwanda, screening service statistics were still collected in Rwanda to evaluate how the intervention worked outside an actual study setting.

Key findings drawn from the service statistics demonstrate the high impact of the intervention in a short period of time:

- In a five-month period (September 2017 to January 2018), providers screened 1,464 women
- Of those, eight percent disclosed current experiences of SGBV
- Of those disclosing current experiences of SGBV, providers referred 80 percent for SGBV care
- Of those referred for SGBV care, over one third (36%) adhered to their referrals and received SGBV services, and
- Prior to screening, UNHCR's SGBV response partner (Plan International) had an annual target to respond to a total of 45-60 SGBV clients. Once SGBV screening was introduced, however, the response partner attended to 33 survivors in the first two months alone.

Based on these findings, UNHCR requested support to scale up of this intervention to other refugee camps in the country. Population Council plans TA and financial support with other funding for such scale up.

Best Practice 3: Harnessing the Prestige of Alliances and Labeling to Prevent SGBV in Refugee Communities

In 2015, a community baseline survey by Population Council in Rwamwanja Refugee Settlement helped further understanding of this context in preparation for adapting the 'Zero Tolerance Village Alliance' model for refugee populations. Two study villages in Rwamwanja Settlement were selected, and baseline data were collected from a total of 601 male and female household heads in these villages. Nearly all respondents (99%) were from the Democratic Republic of Congo, and the largest proportion (38%) were 20 to 29 years old.

Key findings from the survey proved useful not only for adapting the intervention, but for UNHCR's SGBV operations in general. The baseline survey demonstrated that half of all respondents (69% of women and 34% of men) had no formal education and were non-literate. Many SGBV responses in Rwamwanja Settlement had been developed for literate populations (e.g. large billboards describing the referral pathway for SGBV survivors and sources of SGBV care, posters and leaflets with similar descriptions and information, etc.), and unsurprisingly, therefore, women were over twice as likely as men to be unaware of SGBV information campaigns in Rwamwanja—despite their greater need for such information. A recent and growing SGBV intervention by UNHCR in the region (including Rwamwanja) supplied women with briquettes

to use in place of firewood, with the assumption this would help mitigate SGBV, as women were said to experience rape while hunting for firewood. While women do experience rape outside the home, 73 percent of women interviewed in the baseline study reported rape within their homes: implying more investment needed for protecting women within their homes than outside them.

Eighty percent of female respondents reported that it was normal to be forced to have sex in Rwamwanja, and nearly half (46%) of women interviewed indicated that a non-partner in Rwamwanja Settlement had forced them to have sex at some point. Of those who reported sexual coercion by a non-partner, 56 percent became pregnant as a result. A large proportion (63%) of female respondents also reported sexual coercion by an intimate partner, with 68 percent of these indicating they had become pregnant as a consequence. These findings help emphasize the needs of an otherwise 'hidden' population in refugee settings—survivors who experience unintended pregnancy due to rape.

In 2015, findings from the baseline survey informed the adaptation of the Zero Tolerance Village Alliance intervention and its messaging in Rwamwanja. The intervention was implemented by UNHCR implementing partner (and new Network partner), the Lutheran World Federation, with TA from the Thohoyandou Victim Empowerment Programme, a longstanding Network partner.

In 2016, a community endline survey in Rwamwanja Refugee Settlement assessed the effectiveness of the Zero Tolerance Village Alliance' (ZTVA) model in refugee settings.

Key findings showcased the ZTVA model as a highly effective means of fostering SGBV prevention in refugee contexts.[3] The model proved to be particularly effective in:

- Moderating negative gender attitudes and beliefs related to SGBV;
- Positively changing perceptions of community SGBV norms;
- Improving understanding of what rape is, as well as its consequences for women, girls, and the community;
- Increasing awareness of existing SGBV interventions; and
- Reducing the occurrence of:
  - Physical intimate partner violence (IPV) for women (from 69% to 38%) and men (from 6% to 2%)
  - Sexual IPV for men (from 4% to 0%)
  - Non-partner physical violence in the last one month for women (from 12% to 4%) and men (from 34% to 6%)
  - Non-partner sexual violence in the last one month for women (from 13% to 5%).

The intervention was less effective in:

- Changing negative male attitudes toward women's sexual autonomy in intimate partnerships, and
- Reducing the occurrence of sexual IPV for women.

It is important to note that the adapted intervention was implemented for a six month period (in its original iteration, it is designed to be implemented over a 12- to 18 month period), and it is plausible, given more time, that further positive effects of the intervention might be observed.

Following dissemination of these findings to UNHCR, its implementing partners, and the Department of Refugees (Office of the Prime Minister), the ZTVA model was introduced in three additional refugee settlement sites in Uganda in 2016 and 2017 with other funding obtained by UNHCR and its implementing partner.

[3] Final evaluation report available at: www.popcouncil.org/uploads/pdfs/2016RH_SGBVPreventionUgandaZTVA.pdf

Output 3: Fostering the Accessibility of Safe Abortion and Pregnancy Prevention Services for SGBV Survivors

An important nested study in Phase II focused on rape survivors' access to EC and safe abortion services, by reviewing national sexual violence guidelines, national legislation, and grey and published literature in 16 African countries. This desk review was coupled with key informant interviews in 10 out of the 16 countries, and highlighted gaps and inconsistencies across many countries in the region in relation to the Maputo Protocol. It concluded that countries would benefit from support to update and consolidate guidance, given the findings that: EC provision was recommended in all national sexual violence guidelines, but the details and accuracy on how to provide it were variable; pregnancy testing was also recommended, although with variable timing; pregnancy counseling guidance was vague and variable; and safe abortion guidance was found to be confusing or vague.

In 2016, project staff collaborated closely with the Reproductive Health and Research Department of the World Health Organization (WHO) and with the International Consortium for Emergency Contraception (ICEC) to convene a three-day regional technical meeting aimed at helping participating countries meet their obligations under the Maputo Protocol to protect and promote the RH rights of women and girls, with a special emphasis on survivors of SGBV and IPV. Participants included representatives from six countries in sub-Saharan Africa (Botswana, Ethiopia, Kenya, Malawi, Rwanda, and Zambia) as well as international and regional experts on reproductive health, law, and human rights. Presentations and discussions focused primarily on the prevention and management of pregnancy in the context of sexual violence and IPV, as well as the broader requirements of Maputo relating to EC and safe abortion services.

The regional meeting was the first activity in a joint project of TA by Population Council, WHO, and ICEC, aimed at strengthening access to EC and safe abortion for survivors of SGBV within the context of comprehensive post-rape care.

The following recommendations arose from the deliberations over the three-day period:

- Increase public education around pregnancy prevention, EC, safe abortion, and how to access available SGBV services.
- Update national post-rape care guidelines and training to reflect most recent WHO guidance on EC and safe abortion and pregnancy management; ensure that issues of EC, pregnancy counseling, and safe abortion are fully integrated into existing SGBV and family planning (FP) training, protocols, and documents.
- Develop and implement strategies to strengthen access to EC both inside and outside the clinical context.
- Countries in the region that have not done so already, should amend their national laws to legalize abortion, consistent with the Maputo Protocol.
- Countries in the region that already permit abortion in certain circumstances need to revisit existing or proposed legislation in light of the new interpretive guidance provided by the African Commission General Comment 2. In particular, the General Comment states that countries should eliminate or revise any provisions in the law that may impede access to safe, legal abortion where authorized, or that run contrary to the idea of an 'enabling environment.' These include, for example: evidentiary requirements that force women to 'prove' eligibility for services; third party authorization requirements and procedures, such as approval by a judge or panel of doctors; and overly restrictive requirements regarding how and where abortions may be performed, and by what level of health provider.
- Countries should also take into account the expansive definition of 'health' and 'life' adopted by the Commission in the interpretation of Maputo, which supports access to safe, legal abortion in a broader number of circumstances than is currently recognized or practiced in the region.

- In support of these efforts, countries should take steps to: 1) research and establish an evidence base to inform policy decisions, improve programming, and support advocacy efforts, 2) create forums for discussion that include individuals and organizations from both government and civil society, and 3) draft proposals and country-specific action points to improve access to pregnancy prevention and safe abortion services, particularly for survivors of SGBV and IPV.

The meeting culminated in the development of action plans by participating countries, and also helped identify countries for further technical and financial support for expanded access to pregnancy prevention and safe abortion services for SGBV and IPV survivors. Three countries were selected for such support—Kenya, Malawi, and Zambia—based upon the perceived feasibility of implementing their proposed action plans within a limited time period, and the availability of strong champions to implement the proposed plans.

Kenya's action plan focused on pregnancy prevention for SGBV survivors and EC service reorganization in the public sector, to enhance survivor confidentiality. Malawi's action plan involved a legal test case of abortion rights for SGBV survivors, for ensuring greater access to abortion rights for survivors. In Zambia, stakeholders devised an action plan to inform health providers about the country's legal framework for safe abortion, thereby increasing survivors' access.

The three countries received TA from Population Council (and from ICEC in Kenya) in 2017 and 2018, to effect their plans, in addition to financial support from the Council.

By the end of the reporting period, the program had achieved several important advances in abortion advocacy in Malawi in particular, as well as in pregnancy prevention advocacy for survivors in Kenya. These efforts are described below:

Kenya

In 2017, drawing on evidence generated from this program, Population Council worked to bring constraints to EC access for survivors in Kenya to the Ministry of Health's attention. On 7 February 2018, Kenya's Director of Medical Services disseminated a Ministerial Circular (MOH/ADM/1/1/2) to all 47 County Health Ministers and Directors, and all health facility management committees in the country, mandating that EC be made available 24 hours a day, seven days a week in all departments where sexual violence services are provided, including the outpatient, inpatient, and comprehensive care centers for HIV. This reorganization of EC distribution in public health facilities and clinics is designed to improve access and uptake by SGBV survivors. EC was previously available in FP clinics that only operate during normal business hours, and that restriction served as a barrier—particularly for younger survivors uncomfortable with accessing FP clinics.

The Council of Governors (county administrative and political leaders) also endorsed the circular. Their approval was critical as the provision of health services is devolved to the counties according to Kenya's 2010 Constitution.

Zambia

The Population Council provided TA and financial support for Zambia's Safe Abortion Action Group (SAAG)'s informational meetings with health care providers (medical officers, police, SGBV One Stop Center providers) on Zambia's legal framework for safe abortion. These meetings occurred in 2018 three provinces—North-Western (Solwezi), Northern (Kasama), and Eastern (Katete)—and in each district a total of 25 to 30 providers participated, along with senior district providers and District Health Officers (DHOs).

In addition to clarifying Zambia's Termination of Pregnancy Act, advocacy for provincial domestication of the Zambian legal and policy framework was stressed. District Health Officers stressed the significance of inadequate staffing at public health facilities, given the legal requirement that three doctors must sign a Termination of Pregnancy certificate prior to abortion services.

Participants in all three meetings were urged to read the law on Termination of Pregnancy and other SRHR matters (including SGBV), for conveying accurate information in addition to providing confidence in offering services when confronted with survivors in need of them.

In addition to convening sensitization meetings, SAAG also worked to incorporate a stronger SGBV focus in its 2018 work plan. Among its planned SGBV-related activities for 2018 were the systematic tracking and reporting of rape-related pregnancies in the country, and proactive linking of survivors to comprehensive abortion care services.

Malawi

Although One Stop Centers for SGBV are meant to offer comprehensive SRH services to sexual violence survivors, pregnancy management services are not offered to such survivors in Malawi and elsewhere in the region. Malawi's Penal Code allows lawful abortion, and in other countries with similar laws, the latter have been interpreted to include cases of pregnancy resulting from rape or defilement. In Malawi, therefore, efforts focused on developing a strategy for litigation to integrate safe and legal abortion within health services for SGBV survivors.

Population Council provided TA and financial support to the Women and Law in Southern Africa Research and Educational Trust (WLSA)'s initiation of court advocacy—a process that involves litigating a test case. WLSA activities in 2017 and 2018 included consultations with lawyers with a history of working with the country's Coalition on the Prevention of Unsafe Abortion (COPUA). At COPUA's suggestion, WLSA convened a symposium on rape-related pregnancy, abortion, and the law in Malawi, to generate ideas on how to proceed with a test case, through interaction with various stakeholders including health care providers, courts, legal practitioners, academicians, and civil society.

As a result of the meeting, a legal team of practitioners with an interest in abortion was formed. The resultant team comprises two academics with a legal background, two practicing lawyers from private firms with extensive experience in working with COPUA, and two non-governmental organization legal practitioners (including a WLSA representative). The legal team reasoned that, while courts in Malawi are quite progressive, asking for a radical change of the law would probably invite strong government opposition and backlash. It was thus decided that a test case should be more circumscribed, to encourage the court's interpretation of current law—to be clearer and more transparent for survivors in need of abortion services, as well as for providers who attend them.

A potential client was identified with the help of staff at the One Stop Centre in Blantyre, Malawi: a 13 year old girl who was defiled and impregnated by a 20 year old man, and whose request for an abortion at the One Stop Centre was denied on the grounds that the procedure would be illegal. By the end of the program period, two legal practitioners from the legal team were appointed by WLSA to draft court application documents. These documents will be filed using other funding sources to facilitate the test case process.

Other Activities

The transition of the initiatives described previously from pilots to actual best practices required focused efforts in the form of TA between network partners in the global South between 2014 and 2018. During this period, the seven core partner projects were supported through Population Council expertise in areas such as intervention and research design, research proposal writing, developing data collection tools, training data collectors, monitoring data collection, data analysis, report writing, designing advocacy and communication initiatives to promote utilization of results, and preparing scientific presentations for delivery at high impact regional and international conferences.

In addition to these efforts, three key TA activities were built into the Network to foster peer-to-peer learning in innovative and engaging ways: partner exchange visits, annual network meetings, and the hosting and maintenance of a network website. These activities are described in further detail in the following sub-sections.

Partner Exchange and Learning Visits

To promote more in-depth South-South TA during the program period, partners were given the opportunity to request learning exchanges with other partner projects. This primarily involved visits to partner project sites, and on site TA (by the hosting partners) as visiting partners adopted the strategies they observed during their visits.

All partner exchange and learning visits occurred in 2015, with nearly all partners. The focus on new, vulnerable populations seemed to motivate partners to proactively seek appropriate learning sites, in close collaboration with project staff. All partner exchange visits were also appropriately timed, prior to any intervention activities, or soon after their initiation, which allowed for learning and reflection in advance of implementation of full intervention responses.

The Table outlines the various learning visits in 2015:

Visit Date	Visiting Network Partner	Learning Visit Host
March 2015	TVEP (South Africa)	*Population Council, Kenya* Pioneer of the internationally-acclaimed 'Safe Spaces' model, which TVEP included as a component of the 'Zero Tolerance Schools Alliance' program.
June 2015	LVCT Health (Kenya)	*The Teddy Bear Clinic; and* *Nthabiseng Thuthuzela Care Centre, South Africa* Both clinics offer specialized health care services for child survivors of violence, and LVCT Health's focus was on expanding access to such services for child survivors in health facilities in Kenya.
July 2015	SWAGAA (Swaziland)	*Raising Voices, Uganda* Pioneer of internationally-acclaimed 'The Good School' program, which addresses violence against children in schools. SWAGAA's intervention focused on school-based, SGBV-focused girls' clubs.
August 2015	Lutheran World Federation (LWF) (Uganda)	*TVEP, South Africa* Pioneer of 'Zero Tolerance Village Alliance' model, which LWF adapted for implementation in Ugandan refugee settings, with TA from TVEP.
November 2015	AHA, UNHCR, Office of the Prime Minister (Uganda)	*Kenyatta National Hospital (KNH), Kenya* Oldest, largest, public referral and teaching hospital in East & Central Africa, with a 'one-stop' SGBV Recovery Centre on site. Pilot site for Phase II intervention by Population Council and KNH on routine screening for IPV intervention—adapted for implementation in Ugandan refugee settings, with TA from KNH and the Council.

Each exchange visit included sessions for the hosts to learn from network partners as well, and the SGBV responses that they employed in their own settings. Partners returned from their visits having forged new relationships outside their usual contexts, and brimming with new ideas for approaches to incorporate into their interventions, and strengthening their own existing models.

Annual Network Meetings

The Council regularly convened network meetings, promoting South-South exchange, as well as the strengthening partners' program implementation. In December 2015, a small network meeting on humanitarian settings was convened in Rwamwanja Settlement, in partnership with UNHCR's Rwamwanja and Mbarara offices. Various UNHCR implementing partners working in Rwamwanja Settlement attended: the Commissioner for Refugees, Office of the Prime Minister, UNHCR staff, and Population Council staff. Program experiences and findings from Rwamwanja were disseminated by AHA, LWF, and Population Council, coupled with lively discussions, as UNHCR and its implementing partners sought ways to enhance their programs using the evidence. The meeting concluded with a decision by UNHCR Rwamwanja for a

separate meeting with LWF and AHA, to incorporate recommendations from the Rwamwanja studies into their 2016 Action Plan. In addition, UNHCR committed funds to LWF to introduce the 'Zero Tolerance Village Alliance' intervention in one more village in 2016, while LWF received funds from the Church of Sweden to include yet another village in the intervention during the same year.

In September 2016, an unprecedented network meeting was convened in Stockholm, Sweden, with the support of the Regional Team for SRHR in Lusaka and SIDA's Africa Office in Stockholm. The impetus for the meeting derived from the 10-year anniversary of the network, established in 2006. The network used its annual partners meeting as an opportunity to commemorate its decade of existence and raise awareness within SIDA Headquarters of innovative and effective interventions for SGBV survivors in low-resource settings in East and Southern Africa for the first time.

All current Network partners attended—eight organizations from five countries, representing both humanitarian and non-humanitarian organizations. Additionally, SIDA invited Swedish stakeholders (donor, university, and NGO representatives). Experiences and findings from the program's three phases were disseminated by Network partners. The value of a coordinated network for generating such findings, and for building a cohesive body of regional SGBV work was also emphasized. Lively discussions ensued as attendees sought to learn more about what works to prevent and respond to SGBV in low-resource settings in the region, and the nature and scope of research uptake in this context.

The 2016 annual network meeting culminated in an interview[4] by a SIDA journalist to further raise awareness of the network's activities. The meeting also facilitated the expansion of the program's networks to include potential new partners. The Church of Sweden met with project staff in person three times since the meeting to discuss possible collaboration mechanisms in humanitarian settings, given the high effectiveness of the ZTVA project in Ugandan humanitarian contexts. Network partners also spent a day with Uppsala University staff, students, and partners (and visited an SGBV response center), to discuss their work more in-depth, while also learning about responses to SGBV in Sweden.

Website Maintenance and Hosting

The program's collaboration with the Sexual Violence Research Initiative (SVRI) for the network's web site (www.svri.org/who-we-are/networks/africa-regional-sgbv-network) continued to be strategic, high-profile, and beneficial. The Network's web site, accessible from the SVRI homepage, served as a central repository for partner products and other resources generated by network partners over the life of the program. As a leading SGBV resource, the SVRI web site also regularly used its international Twitter base to publicize emerging work from the Network among its followers. These tweets were also highlighted on SVRI's homepage. New resources generated by the program were featured on SVRI's influential listserv as well. The network web page was updated regularly with new documents throughout the project period.

Outcome: Improved Regional Policies and Programs on SGBV

The ultimate purpose of this program is improving SGBV policies and programs in the region, by developing and disseminating a strong, regionally-relevant evidence base of best practices (described in preceding sections). Although best practices can be slow to diffuse, they tend to after success is demonstrated. Even then, however, lack of awareness of current best practices, lack of motivation to make changes required for their adoption, and lack of knowledge and necessary skills required are key barriers to their adoption.[5] Thus, over the life of the program, Council staff remained actively engaged in regional and international SGBV dialogues, and widely shared program evidence (*see* Appendix 1 for detailed list of Network presentations and publications). As a result, the best practices tested under this program have had remarkable influence on national and international programming and policy, as well as on donor funding

[4] The full interview is available at: www.sida.se/English/press/current-topics-archive/2016/african-network-uses-information-to-fight-gender-based-violence

[5] Rouse, M. 2007. Definition: Best practice. http://searchsoftwarequality.techtarget.com/definition/best-practice

decisions. The Network's efforts influenced the development of improved policy and programs in the region in myriad ways, as highlighted in this section and in Appendix 2 (outlining specific policy and program impacts).

2014

In 2014, regional and international bodies were mainly influenced through this program's recognition by others, in addition to targeted program communications by the Council and selected Network partners.

World Health Organization (WHO)

WHO released a publication, *Ethical and Safety Recommendations for Intervention Research on Violence Against Women*, citing the work of Network partner Kenyatta National Hospital, as well as the Council, on IPV screening, recommending some of the processes for facilitating safe, informed consent of survivors in research.

United States Institute of Medicine

In August 2014, the same set of studies on IPV screening was cited as a background resource for the Joint Workshop of the United States Institute of Medicine Forum on Global Violence Prevention and the Ugandan National Academy of Sciences on Preventing Intimate Partner Violence in Uganda, Tanzania, and Kenya. Program staff were nominated to serve on the planning committee for this successful workshop in Kampala, Uganda in August 2014, as well as participating as speakers and session chairs.

Sexual Violence Research Initiative (SVRI)

Program staff also accepted invitations to serve on the SVRI Board and Coordinating Group, and on the Kenya Technical Advisory Group of the DfID-funded *What Works to Prevent Violence Against Women and Girls in Conflict and Humanitarian Emergencies* research consortium (led by the International Rescue Committee).

UNESCO

Program staff also collaborated with UNESCO in November 2014 to co-convene a global consultation on early and unintended pregnancy in East and Southern Africa. By the end of the consultation, SGBV was determined to be a priority area in responding to early and unintended pregnancy in the region.

East African Community (EAC)

The Council also collaborated with the EAC's Department of Peace and Security to convene a regional meeting of national police and health sectors from all five partner states (Burundi, Kenya, Rwanda, Tanzania, Uganda), in addition to delegates from Zambia (Zambia Police Services and MoH), and selected network partners, from December 3rd through 5th, 2014 in Kigali, Rwanda, of nearly 40 participants, primarily from training and planning units, gender desks, and health and medical services of partner states' police services and post-rape care departments of Health ministries. The meeting provided a forum for Police and Ministry of Health stakeholders to interact and explore ways of strengthening SGBV interventions in EAC. The meeting also provided an opportunity for participants to explore expansion of two tested network models across EAC to meet the needs of the region's SGBV survivors. Network models that were focused on at the meeting were: 1) police provision of EC to survivors of sexual violence (tested in Phase I in Zambia) and 2) the multi-sectoral provider training model to improve collection, documentation, and utilization of medico-legal evidence among health and police providers (tested in Phase II in Kenya).

Recognizing the useful models tested under this program, EAC solicited presentations from the Network's Zambia team (Police Services, MoH, and Population Council) and Kenya-based network partner LVCT Health. Program staff worked with these implementing partners to prepare the solicited presentations, and supported their attendance of the regional meeting. The Council also provided TA to EAC for organizing the forum, and made a financial contribution.

The EAC symposium culminated in a series of recommendations to be presented to EAC chiefs of Police at their next regional meeting. Population Council continued to follow the process carefully, in a bid to sustain this collaboration with EAC, should the police chiefs vote positively for any Network response models discussed. Recommendations generated at the forum from all partner states for the impending chiefs of Police meeting were:

1. Direct the EAC Secretariat to mobilize resources and facilitate multi-sectoral trainings, at national and regional levels, on SGBV to enhance national and regional responses;
2. Direct the Secretariat to organize a learning exchange visit of the EAC police to Zambia Police Services or Kenya Police Service to facilitate the adaptation of the [two network] models to suit the EAC context, or individual country contexts;
3. Direct the Secretariat to convene a meeting of experts from partner states to develop a regional training manual and Standard Operating Procedures (SOPs) on SGBV;
4. Organize command post exercises in response to SGBV upon finalization of the manual and SOPs;
5. Direct partner states to consider incorporating police provision of EC into EAC Partner States' Police Training Curriculum;
6. Direct partner states to incorporate SGBV education into the community policing function;
7. Direct partner states who have not established One Stop Centers on SGBV to do so;
8. Direct the Secretariat to adopt the EAC Police Chiefs Cooperation Organization's SOPs on SGBV into EAC instruments;
9. Direct the Secretariat to establish a thematic working group on gender to address SGBV issues in the region; and
10. Direct partner states police services to collaborate closely with other stakeholders to foster strong multi-sectoral coordination.

2015

UNHCR Regional Service Centre

In 2015, project staff engaged UNHCR's Regional Service Centre with findings from the program's humanitarian setting studies. The emerging issue of unintended pregnancy due to rape led the Regional Service Centre to introduce project staff to its RH experts. These UNHCR experts reviewed and commented on the draft baseline report and affirmed their readiness to work with the Population Council to ensure that UNHCR interventions are evidence-based. The Regional Service Centre also agreed to co-convene a regional meeting of its SGBV focal points in the following year, to give the humanitarian setting study findings a wider hearing, and to determine how to incorporate the evidence into UNHCR's programming.

UNESCO

Program staff also maintained close contact with UNESCO's Regional Office for East and Southern Africa (ESA) after an initial collaboration in 2014, a desk review study of six ESA countries' education sector's response to early and unintended pregnancy. In 2015, after areas for further collaboration were discussed, it was decided to test models in 2016 for strengthening health and education sector links to expand adolescents' access to SRH services, including SGBV services. UNESCO committed a total of US $220,000 to this initiative, which was eventually implemented in Zambia—beyond the auspices of this program.

Southern Africa Development Community (SADC)

Project staff were invited by SADC to provide TA for conceptualizing a regional meeting, *SADC Women Parliamentarians Roundtable on Early and Unintended Pregnancy: Policy and Legal Barriers*. This roundtable provided a forum for reviewing existing evidence and information on early and unintended pregnancy in the SADC region, and generating appropriate recommendations for mitigating this problem,

while also protecting adolescent girls' human (including education and RH) rights. The roundtable also helped build the capacity of the SADC Regional Women's Parliamentarian Caucus (RWPC) to effectively interrogate early and unintended pregnancy in the region, and to work towards greater policy coherence and political will for it. Project staff were also asked to give a presentation before the 10 member states represented at this meeting, at Cape Town, August 24th and 25th, 2015.

Findings on SGBV from the region formed part of the message in the final communiqué from this regional meeting, including the fact that sexual violence against children and young people are major contributors to the high incidence of early and unintended pregnancy. By the end of the meeting, RWPC agreed on action to address the poor enforcement of laws protecting young girls from SGBV, female genital mutilation and cutting (FGM/C), child marriage, and other harmful traditional practices.

Sexual Violence Research Initiative (SVRI)

The program co-sponsored the fourth SVRI Forum in 2015. Every two years, the SVRI Forum convenes researchers, gender activists, funders, policy makers, service providers, practitioners, and SGBV survivors from around the world to discuss innovations for ending SGBV, IPV, and child abuse, as well as strengthening responses to survivors in low- and middle income countries. Network partners featured prominently at the 2015 Forum, featuring their activities, findings, and new directions for Phase III in two satellite sessions—*The Missing 'C': Addressing Violence Against Children in Sub-Saharan Africa*, and (co-convened with the SVRI and GIZ's SGBV Networks Project) *Making Networks Work: Lessons from the Field*. The first satellite session stimulated dialogue on the unique challenges of violence-related research in Africa when children are the population of interest. The second satellite session interrogated networks, their different permutations in the region, their added value for SGBV work, and their challenges. Both sessions were well-attended, generated useful discussions, and created broad awareness of the Network's new focus on children and refugees.

U.S.-based Institutions

A number of U.S.-based institutions with high-impact, international SGBV work contacted the program in 2015. USAID's Interagency Gender Working Group (www.igwg.org) requested a presentation of the program's evidence to raise international awareness for effectively involving the public sector in addressing SGBV. After learning about the program's 'network approach' to addressing SGBV, the Health Policy Project's *Community of Practice on Scale-Up and Gender, Policy and Measurement* (www.healthpolicyproject.com/index.cfm?id=gpm) invited project staff to share more about this approach, and its added value, with an international audience through a webinar presentation. Futures Without Violence (www.futureswithoutviolence.org/) also asked program staff to contribute to global discussions on screening for IPV in low- and middle income countries during its national conference on Health and Domestic Violence. All presentations were well-received by international audiences, stimulating important questions and lively discussions, and contributing to knowledge in the field.

Together for Girls

A priority of the program was documenting emerging evidence and ensuring that such documentation is accessible through the program's web site (www.svri.org/popcouncil.htm) and web sites of the Council or other Network partners, as well as via open access publications and printed reports and briefs. Network partners' demonstration of the effectiveness of their intervention approaches through such documentation often leads to new funding sources. In 2015, SWAGAA's Phase II final evaluation report was noted by Together for Girls (TfG, a global public-private partnership to end SGBV against girls). TfG proposed a collaboration with SWAGAA and Population Council for scaling up SWAGAA's Phase II work nationally, building on lessons from this phase, coupled with rigorous evaluation. The three organizations jointly developed a successful Expression of Interest in 2015, and by the end of the year, the consortium was informally informed that the proposed four-year initiative would be funded by the Bill and Melinda Gates Foundation in 2016, representing the largest amount of funding SWAGAA received to date.

UNESCO's Global Working Group to End School-Related Gender-Based Violence

In commemoration of the 16 Days of Activism Against SGBV, the Council collaborated with the Global Working Group to End School-Related Gender-Based Violence to develop a Call to Action document for ending school-related SGBV (www.globalpartnership.org/content/call-action-16-steps-end-school-related-gender-based-violence). The document outlines 16 steps for ending school-related SGBV in is available in Arabic, English, French, and Spanish.

2016

In 2016, the program's work continued to influence regional and international bodies, with most forms of influence emerging through actual adoption of models designed and tested under the program.

East, Central and Southern Africa Health Community (ECSA-HC)

Participation by project staff in dialogues with ECSA-HC led to the passage of a 2012 resolution by ECSA region Health ministers calling for the integration of SGBV screening in SRH and HIV services. In 2016, ECSA-HC fully adopted the training manual developed by the Council and KNH to facilitate SGBV screening by health providers. The manual was published that year as a regional ECSA-HC training document,[6] and project staff were asked to conduct a Training of Trainers session for the ECSA region. This regional training session was a platform for strengthening regional dialogue on the value of SGBV screening. The session trained 44 master trainers from 13 ECSA countries, primarily SGBV focal persons from ministries of Health, in addition to relevant staff from regional bodies.

As a result of this forum, project staff were invited by the East, Central and Southern Africa College of Nursing (ECSACON) to give a keynote speech on SGBV at ECSACON's 12th Biennial Scientific Conference, and to provide TA for the International Conference on the Great Lakes Region (ICGLR)'s SGBV training meetings (including conceptualization, facilitation, and identification of other trainers). ECSACON also requested TA for training its nurses in selected countries to integrate screening protocols into practice.

UNHCR Regional Service Centre

In 2016, project staff collaborated with the Regional Service Centre of UNHCR to convene a meeting of UNHCR's country offices in the East, Horn of Africa, and Great Lakes regions. The meeting targeted UNHCR's SGBV focal points, implementing partners in charge of SGBV interventions in humanitarian settings in the region, and international NGOs, with 50 participants from 13 countries, to promote utilization of the Council's two response models on SGBV prevention and response (the 'Zero Tolerance Village Alliance' model and routine screening for SGBV in health facilities). The meeting also evaluated other community-based SGBV responses currently used in UNHCR's field operations, and facilitated regional technical exchange on community engagement in SGBV among UNHCR and partners.

After the 2016 UNHCR regional meeting, over half of UNHCR country offices represented (8 out of 13) declared interest in receiving TA and financial support for implementing at least one of the Network's response models shown to be effective in humanitarian contexts in 2016 (the ZTVA model and SGBV screening). The Regional Service Center selected Rwanda, and (as described earlier) the Council supported UNHCR implementing partners' adoption of SGBV screening in Rwanda in 2017.

Finally, in 2016, the response to the findings about the scale of SGBV in Rwamwanja (from the ZTVA baseline survey in Rwamwanja Refugee Settlement), an SGBV expert from UNHCR Geneva was sent to Rwamwanja for ongoing support in strengthening and coordinating SGBV response. That same year, UNHCR Uganda's implementing partner for community SGBV response (Lutheran World Federation, LWF) received funding from two sources (UNHCR Uganda and the Church of Sweden) to implement the Zero Tolerance Village Alliance model in two new humanitarian sites in the country.

[6] Odoyo, O., C. Undie, M. Mak'anyengo. 2016. Routine screening for intimate partner violence: A guide for trainers. ECSA-HC, Population Council, and Kenyatta National Hospital. www.popcouncil.org/uploads/pdfs/2016RH_IPV-manual.pdf

International Conference on the Great Lakes Region (ICGLR)

ICGLR is an inter-governmental organization of countries in the African Great Lakes Region promoting sustainable peace and development in this region with political instability and conflict, convening 12 Member States. ICGLR commissioned a Regional Training Facility on the Prevention and Suppression of Sexual Violence in the Great Lakes Region ('RTF'), based in Kampala, Uganda. The RTF's mandate centers on SGBV-related training, curriculum development, and data collection to support a range of high level stakeholders in the region. In 2016, project staff worked to co-convene a regional meeting of about 60 Member representatives (from medical, legal and justice, and social work sectors) of ICGLR. The meeting, *Utilization Meeting on Documentation, Investigation, and Reporting of Sexual Violence in the Great Lakes Region*, featured the Africa Regional SGBV Network as a regional resource: Network partner LVCT Health presented lessons from their SGBV documentation work in Kenya. Project staff drew on regional and international protocols used by ICGLR stakeholders to emphasize the utility of a multi-sectoral response, of training providers in proper documentation, and SGBV screening protocols.

Following the meeting, ICGLR's RTF decided to incorporate ECSA-HC and the Council's regional IPV training manual into their training programs. As the Regional Training Facility's mandate is to support high-level stakeholders in the region with SGBV-related training and curriculum development, the anticipated curriculum is likely to have wide regional impact in the future.

Citations by Influential Publications

The evidence emerging from the program was promoted for programming by influential international bodies in numerous ways. A 2016 WHO publication[7] highlighted the Council's referral model for women disclosing IPV following screening by trained providers in health facilities. A 2016 USAID publication referenced the interventions of three network partners (Population Council/KNH, SWAGAA, TVEP) as examples of approaches that can help respond to the needs of children and adolescents who have experienced sexual violence.[8] A 2016 Population Reference Bureau publication referred to the feasibility of IPV screening, drawing on findings from a Population Council/KNH intervention.[9]

2017

In 2017, the program's influence was manifested in the work of international organizations, and culminated in a UNHCR report, as well as a series of three nested studies.

A UNHCR report based upon the 2016 convening of UNHCR country offices (described above) was released in 2017.[10] In addition to providing a summary of the meeting's proceedings, the report is a compendium of SGBV prevention and response interventions currently being implemented in humanitarian settings in the region. Importantly, the report lists two Network models (the ZTVA and SGBV screening intervention) among the few that have been rigorously assessed and proven effective in humanitarian settings in the region.

In 2017, project staff were approached by the International Planned Parenthood Foundation and its Member Association (Family Health Options Kenya) in Kenya to design and evaluate a program integrating the Council's IPV screening tool at FP clinics in Kenya. Project staff prepared research protocols for this purpose, and the nested study began in early 2017.

An additional nested study implemented in 2017, in collaboration with Engender Health Tanzania, explored adolescent mothers' access to SRH and HIV services in Tanzania. With Council guidance, the study

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[7] WHO. 2016. Ethical and safety recommendations for intervention research on violence against women. Building on lessons from the WHO publication. *Putting women first: ethical and safety recommendations for research on domestic violence against women*. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/251759/1/9789241510189-eng.pdf

[8] Levy, M., L. Messner, M. Duffy, J. Casto. 2016. Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents Who Have Experienced Sexual Violence: A Companion Guide. Arlington: Strengthening High Impact Interventions for an AIDS-Free Generation (AIDSFree) Project. https://aidsfree.usaid.gov/sites/default/files/2016.2.1_aidsfree_comp_guide_gender_tagged.pdf.

[9] Gilles, K. 2016. Intimate partner violence and family planning: Opportunities for action. Population Reference Bureau Policy Brief www.prb.org/pdf15/intimate-partner-violence-fp-brief.pdf

[10] Mirghani Z., J. Karugaba N. Martin-Archard, C. Undie, H. Birungi. 2017. Community engagement in SGBV prevention and response: A compendium of interventions in the East & Horn of Africa and Great Lakes Region. Nairobi: Population Council.

investigated their SGBV experiences. Findings show that nearly 70 percent of adolescent mothers (ages 12 to 19) in the study reported IPV during pregnancy. Half did not seek help, while about one third sought non-facility-based help, mainly from relatives. The project's final evaluation report was made publicly available at the beginning of 2017.[11]

A report based on findings of a 2016 study was developed in 2017. The third nested study in 2016 involved the Sexual Violence Research Initiative (SVRI)—the largest global network on sexual and intimate partner violence (SIPV) and related types of violence. SVRI manages the largest conference on SIPV and violence in childhood, and provides funding and capacity building to its members and networks. By 2016, SVRI had also arrived at an important juncture in its history: After substantial growth and success in its work of supporting a committed network of researchers, policy makers, activists, and donors, the organization was ready to assess whether a shift in organizational structure would help it meet its goals and grow as a vibrant and sustainable organization—and, if so, how that shift might best be managed. Given the critical importance of SVRI in the region, and internationally, the third nested study centered on investigating this issue and on identifying organizational structure options.

An additional priority of the program was to document emerging evidence and ensure such documentation is accessible through the program's web site (www.svri.org/who-we-are/networks/africa-regional-sgbv-network), web sites of the Council or other Network partners, as well as open access publications and printed reports and briefs. In commemoration of the *16 Days of Activism Against SGBV*, in 2017, the Council released a series of seven learning briefs from the project's new Phase III evidence of violence against children and SGBV in humanitarian settings. The learning briefs were designed to highlight early findings about these two vulnerable populations to keep stakeholders abreast of our results, rather than waiting until the end of the various projects to share lessons. The availability of the briefs was publicized through the Council's social media platforms, including Twitter and Facebook.

Discussion and Conclusion

Over the years, the *Expanding the Evidence Base and Networks for Sexual Violence Response* program has enabled regional partners to collectively test and document experiences in tackling violence against children and SGBV in humanitarian contexts. To foster SGBV prevention, and ensure that responses to SGBV are effective, the program has targeted a range of stakeholders, including influential regional bodies, the health, education and justice sectors, and children and refugees—both as survivors and as members of communities where prevention is being promoted.

The program has helped to change the way people in the region think about SGBV, and how to respond to it, evinced by the responses of regional bodies such as the UNHCR Regional Service Centre in Nairobi, which established technical cooperation with Population Council's Kenya office at the beginning of the program, to ensure utilization of evidence-based programming in refugee operations in the region. UNHCR and many other organizations (e.g. EAC, ECSA-HC, ICEC, IPPF, SVRI, WHO) have solicited evidence generated by this program, referenced it, recommended it, asked for technical support in using it, and solicited partnerships to promote it on a larger scale, or developed policies around it.

Programs and policies have changed as a result of this initiative. We see this clearly at the national level, where, in each core Network partner country, interventions have been developed in direct relation to this program, or new policies have resulted. There is no country in which pilot projects developed by this program have not expanded beyond their initial contexts.

[11] Obare, F., A. Almeida, G. Odwe, J. Mwanga, C. Undie, M. Hiza, F. Mwanga. 2017. Access to reproductive health and HIV services among young mothers in Tanzania. Dar es Salaam: EngenderHealth, Population Council, and Ministry of Health and Social Welfare.

Policy and Program Change

In a relatively short period, we have witnessed actual policy and program change within and beyond our focal countries (see Appendix 2 for a complete outline of such changes). For example, in Kenya, where the Population Council and KNH tested the feasibility of screening children in schools and health facilities for sexual violence, the Ministry of Health is currently in the process of adopting the screening tool developed under this study for use in public health facilities. The Council is continuing to provide technical support to facilitate this process with other funding. Furthermore, Kenya's revised (2018) draft National School Health Policy and Guidelines now includes child sexual abuse screening as a key intervention to be carried out in schools. The original screening tool developed under this program in Phase II (to screen for intimate partner violence) was also officially integrated into client in-take protocols within selected clinics (the Youth Center and the Mental Health Unit) at KNH in 2018, as well as in several public health facilities in Rwandan refugee settings.

Still in Kenya, where LVCT Health assessed a case manager model and Standard Operating Procedures (SOPs) for improving children's access to post-rape care, an enhanced version of these SOPs were adopted by the Ministry of Health. Referred to as the *National Standard Operating Procedures for the Management of Sexual Violence Against Children*, this document was launched and disseminated by the Ministry of Health in February 2018. The Centers for Disease Control in Kenya commissioned a training session on these SOPs for its SGBV partners, and LVCT Health facilitated this session in 2017. Since the end of the project, the case manager model has been institutionalized in the post-rape care department in one of the two public hospitals in Kenya where the model was initially tested.

In South Africa, where TVEP adapted its community-based SGBV prevention model (the Zero Tolerance Village Alliance) to the needs of children in school, this adapted model (the Zero Tolerance School Alliance) has been replicated in three additional schools in South Africa since the end of the study. Furthermore, the Zero Tolerance Village Alliance model was taken up by UNHCR during the program period, and has so far been implemented in at least 5 humanitarian settings in Uganda and Rwanda.

In 2017, Swaziland's Ministry of Education instructed SWAGAA to develop comprehensive manuals to be used for both girls and boys in both primary and secondary schools, including topics such as sexual and reproductive health, HIV and AIDS, and self-efficacy. The new manuals borrow heavily from the SWAGAA's girls' club curriculum (developed under this program) and are currently the only manuals officially approved by the Swaziland Government to be used in schools for extra curricula activities related to gender and GBV Prevention. The new, government-approved manuals are currently used in SWAGAA's school-based girls' clubs across the country.

Finally, in Zambia, where the Population Council and Zambia Police Service have collaborated for years to respond to survivors by strengthening the capacity of police and police stations (e.g., training police to provide eligible survivors with emergency contraceptive pills [ECPs]; post-exposure prophylaxis for HIV; and with transportation to health facilities for comprehensive care), the provision of ECPs by trained police to eligible sexual violence survivors is has now (since 2015) been incorporated into the national pre-service training curriculum of police officer recruits.

The constant demand from organizations for our project staff to deliver presentations to their staffs, based on evidence from this program, is yet another indicator of how programs in the region are changing. Network partners have received requests from organizations such as the Centers for Disease Control, IPPF, and UNHCR Regional Service Centre for presentations on our program processes and findings to improve their own programming on violence against children and SGBV in refugee settings.

Overview of Social Change

It is from survivors themselves, however, that we have seen the most important change. Children and adults in humanitarian and non-humanitarian contexts have demonstrated social norm change in their communities as a result of this work. Due to their participation in the program's interventions and research, we have witnessed demonstrations of their new abilities to disclose SGBV and seek services, to

take a personal stand against violence, to refrain from violent behavior (leading to a reduction in the proportion of those experiencing violence), and—from providers—to confidently play a role in effectively addressing SGBV. Each evaluation report from this program tells different parts of these stories, which boys and girls, men and women have shared with us (*see* Appendix 1 for links to the program's evaluation reports, which provide detailed descriptions of social change in each individual study context.).

In Rwamwanja Refugee Settlement, Uganda, we heard from women survivors about the positive effects that a simple screening tool had on their ability to disclose their experiences of SGBV – many for the very first time:

> *[The screening questions] gave me insight, and this is the first time I was able to open up and talk about what I have been going through in marriage. No woman will ever talk about their issues until they have been asked about them, and this is a very good program that will help women in this community. … This is a very good step because these questions will address the issues that most women and girls have been going through, and they don't talk about it unless they are asked, like me. People don't talk about violence and rape here at all. They keep it to themselves, and given this kind of opportunity, it was very easy to express myself.*
>
> *You are also able to talk about personal issues that nobody bothers to ask you about because of the beliefs we have; we think it's very normal to be [violated]. So, when I was asked these questions by the doctor, it was an eye-opener – especially when I sat down with the counselor and told her what I have been going through with this man. She took her time with me, and I am telling you, today, I am going home a different person. … I will be coming here whenever I have an issue and I need help. I will also be coming for my [antenatal care appointments] and counseling services since you can never find such a program anywhere else in the whole of Rwamwanja. This is a very good thing to start in Rwamwanja since many women here are suffering … [T]his will help them know there are people who care about us.*
>
> *[I]t is very important to be asking these questions in the hospital regularly. … This is because people have their own issues that they have kept for so long without talking about them, but when it's triggered [by a question], you get a chance to talk to someone about it. … [Y]ou can't go telling people you have a problem unless they asked you. At times, you even don't know it's an issue until you start talking about it. I had never told anybody about my rape case since no one has ever asked me about it. Today, I had a chance for the first time to pour it out and cry for the first time[.] I am fine now.*
>
> *I will come back [again] for counseling and guidance. … Counseling heals more than medicine.*

We also learnt from providers that this tool for detecting SGBV survivors and linking them to comprehensive care was helpful in pinpointing accurate diagnoses, and in improving provider-client relations:

> *[Screening] takes some time…but the truth is, time taken [today] while you are assisting someone will save your time tomorrow, because you will get the correct diagnosis. If you don't take time, you will [prescribe] Panadol, and tomorrow, the client will come back because the problem was not what you treated—it was psychological. So, it is better to take those two minutes [to] address…the real problem. Then, you will save more time.*
>
> *[The screening process] has created good friendship with our clients since we are so friendly and confidential. For instance, the lady I screened yesterday was so happy that she referred her colleague directly to me. She said she was going to send her friends over to me to get help and she did.*
>
> *[When] you ask someone [the screening] questions, [the person] gains confidence. Like, someone thinks, 'This health worker cares about me. He even wants to know about my home, my problems.' Sometimes, [the client] even becomes your friend because…they know you care about them. The client even opens up about other things which you don't*

ask about. They talk about [every] other thing, meaning that you have gone an extra mile, making someone to open up.

From child survivors in Kenya, we learned that a screening tool designed to facilitate disclosure of sexual violence did much more than this. The entire screening process served to strengthen parent-child relations: children who had never discussed sexuality issues with their parents began feeling safe enough to do so, as these narratives from children demonstrate:

> *[T]he girl was very happy because she got courage to disclose to her mom how this man has been trying to rape her and the mother really protected her by confronting the man. The man apologized, saying he didn't mean that and her dad also went to warn him. 'I think you people helped our parents a lot by telling them to talk to us, because this is something I was not going to tell my mom, who is very strict. We are very free nowadays and we talk so much about sex. You have helped us a lot.*
>
> *[T]he girl came to tell me she disclosed to her mom about this neighbor's behavior of wanting to rape her, and the man got into trouble. 'My dad took him to the chief and the man was to be taken to the police. He begged and he was very shocked because he didn't know I would ever tell anybody. After that, I saw him once and I have never seen him again. Thank you very much for helping me tell my parents, who supported me so much.' The girl is very happy and relaxed.*

The screening process also sparked community action, as the following quotes from our psychologists' field notes indicate. Community members began to realize that they did not have to respond to SGBV on their own, as a critical mass of parents, teachers, community leaders, children, and others had been developed under this particular project:

> *I told my mother how this neighbor used to force me to [look at] pictures of people having sex, especially the boys to boys, or men to men kind. My mother and other people in our neighborhood approached him and took him to the Chief's office. Some of my friends in the neighborhood also confessed that the same man had had sex with them. My father was equally happy that I told my mother about it and encouraged me never to keep quiet should someone do anything like that to me. He looked at me calmly and firmly told me that they are my parents and I shouldn't fear them. Sincerely speaking, I used to fear them, but since that time, I am very free with them. Thank you.'*
>
> *After the meeting, a few parents came to talk to us [psychologists] on how we have been of great help to their children and they are able to open up these days when someone attempts to rape them. The parents thanked us very much for the good work we are doing in the school … [O]ne of the teachers also pulled us aside and asked if we could help one of her former students. The young man had been volunteering at the school during the term and he asked her what we were doing at the school. She explained to him that we were there to screen children for sexual abuse. He then asked her if we could help him, even though he was not one of the students. [He was a sexual violence victim and did get help].*

In Zambia, the sensitization of police and health providers to the national guidelines on managing survivors boosted their confidence in their role, thus improving child survivors' access to post-rape care. As some police and health providers under the program explained:

> *Even our in-charge now understands that when I'm escorting a survivor of sexual violence…it's actually [part of my job] – something the government wants me to do as a VSU [Victim Support Unit] officer.*
>
> *I remember a situation where we had a disagreement with the police on how to approach or deal with these [rape] cases. Luckily, we had the Guidelines, so we opened it up to the exact section and it was a done deal.*

> *Once in court, the judge asked me why I was escorting the survivor to [the hospital] and said that maybe I did something [wrong] along the way … I responded that I was mandated by the law and referred to the National Guidelines, since it gives me the authority to escort survivors to the hospital for medical examination.*

The 'Zero Tolerance School Alliance' (ZTSA) intervention in South Africa – a school-related GBV prevention model – sparked change within the school setting in which it was implemented, from the perspectives of students, teachers, and parents alike:

> *I have noticed that the incidents of bullying have stopped because, before, you would find a teacher bullying you by mocking you through your family situation, but such things have since stopped. (student)*

> *We have noticed a significant reduction on some behaviors that students had before, such as fights within school premises. Students used to fight a lot but now they are no longer fighting because they are aware that this program also involves the police. Knowing that this program involves police scares them off because they are aware that the law will always side with their victims. (teacher)*

> *Since the arrival of ZTSA we are now able to openly talk about issues. ZTSA also helped our students gain self-confidence to speak out when they are being abused. Even the cases of bullying have significantly gone down, even those that took place outside the school gates because students know that the case can still be reported the following day and ZTSA would definitely take action against the perpetrator. (parent)*

Anecdotally, we have also heard from implementing partners about changes that they had noticed in their programming. For example, after implementing the 'Zero Tolerance Village Alliance' model in humanitarian settings in Uganda with unprecedented results (see Output 2 [Best Practice 3] above), a Lutheran World Federation implementer remarked: 'We have been working *so hard* all these years, and didn't understand why we weren't getting the results we expected. The Zero Tolerance intervention has changed that story. It caused a drastic change in just six months!'

Male Involvement

A key question for this regional program has to do with exact the role of men/boys and of male involvement in SGBV interventions. This program deliberately embraced a gender-synchronized approach, in that its activities were designed to engage both girls and boys, and/or women and men, from the inception. This approach acknowledges the importance of female empowerment, without forgetting that if boys and men are not simultaneously empowered, only limited progress can be made in addressing gender equity issues. The program therefore worked to ensure that, wherever possible, boys *and* girls (and women and men) played an integral part as beneficiaries or service deliverers. In this way, the hope was that a balance of male-female responsibility would be fostered in the intervention contexts.

In Kenya, where LVCT Health worked to improve children's access to post-rape care, the interventions were designed for both male and female child survivors (although those presenting for services during the study period happened to be exclusively female). Furthermore, training provided under this study included both male and female providers of post-rape care. This situation mirrors that of the Zambian context, where the Council and the Zambia Police Service worked with police offers to enhance children's access to post-rape care: Although the study was designed for all child survivors, regardless of gender, only one child survivor presenting at police stations happened to be male.

The child sexual abuse screening study implemented in Kenya by the Population Council and Kenyatta National Hospital demonstrated that the proportion of male child survivors is actually high – and that employing the proactive method of screening for violence in schools promotes disclosure of sexual violence among male and female child survivors alike. Men as fathers were engaged in primary schools through 'Fathers Only' dialogues to promote fathers' support for child survivors in the home.

Male involvement was incorporated into the program's interventions carried out in South Africa and Swaziland, as well. The Zero Tolerance School Alliance engaged boys and girls in secondary schools (and their teacher, parents, and wider community) to promote the prevention of school-related GBV. SWAGAA's girls' clubs involved the training of school principals and teachers (the vast majority of whom were male) in SGBV and the country's Code of Conduct for educators.

Finally, in our humanitarian setting work, the Zero Tolerance Village Alliance model is designed to engage men at all levels much more than women, and our SGBV screening intervention engaged male and female providers alike to carry out the screening and response.

These kinds of involvement by men/boys have highlighted certain important issues. For example, our sexual violence screening work with children demonstrated that the 'face' of child survivors is almost as much male as it is female. Through screening, came to disclose that they had experience (or were currently experiencing) some form of sexual violence. Out of a total of 456 children screened in primary schools, about half (49%) disclosed having this experience. Of these, 59% were girls and 41% were boys.

By involving men as study participants under the Zero Tolerance Village Alliance project in humanitarian settings in Uganda, we learned more about the scale of non-partner physical violence for me (34% of men had experienced this in the last one month), and about how even this form of violence could be significantly reduced in these contexts by this particular intervention (by endline, the proportion of men reporting this experience had reduced to 6%). Still in this humanitarian setting, we learned that male perpetrators of SGBV responded well to counseling after their wives had been detected as survivors through screening and requested couples (marital) counseling. Counselors reported to us that many of the men that counseled had simply never been informed that there were alternative, non-violent ways of engaging with their partners. Thanks to such women survivors, we have also begun to think of more innovative ways of engaging men further: A recommendation from several women survivors in this refugee setting was for the Council to develop a similar screening intervention for men – specifically, for male perpetration of SGBV, coupled with counseling for men that disclose their own perpetration of violence.

In summary, roles for men and boys were deliberately built in to every intervention under this program in various ways. By including men and boys, we are more cognizant of the critical role that men can play as champions against SGBV, whether as community members or providers. We also have a deeper understanding of the vulnerabilities of men and boys to violence. We also know that men require information, and once informed, are eager to serve as champions against SGBV. This information was helpful in adjusting interventions to ensure that project goals were met.

Challenges

Given its strong focus on South-South technical assistance, this regional program was essentially structured to attend to the challenges that would normally be encountered in a multi-country initiative. Consequently, many of the 'challenges' experienced by the program were viewed as opportunities to build capacity and were handled as project activities. As program was designed with the expectation that Network partners would require technical support for a range of activities, the main challenge encountered during the program period had more to do with ensuring the maintenance of a coherent, regional program, despite the varying levels of capacity within various countries represented within the network, and the simultaneous focus on SGBV among children and among refugee populations.

The program experienced some contextual challenges within individual countries, nonetheless. A key challenge in some countries had to do with obtaining local ethical approval to carry out research involving children or refugees. In two countries, it took over a year to obtain these important approvals due to various bureaucracies. These delays affected project timelines and left much less time that desired to implement planned interventions and evaluations. In addition, given that the majority of interventions under the program were child-focused, designing studies for this vulnerable population on a sensitive subject such as SGBV posed its challenges as well. Studied had to be designed and re-designed in ways that would allow ethical/institutional review boards to grant ethical clearance. For some studies, this

meant simply not including children as research participants (although they were intervention beneficiaries), not including very young children as participants, or finding innovative ways to include children's voices and perspectives, despite the ethical bottlenecks (e.g., in for the child sexual abuse screening study in Kenya, psychologist carrying out the screening were trained to record detailed field notes based on their interactions with children – including verbatim conversations).

As expected, countries also differed in regard to their policy environments and the ease with which certain policy and programmatic gains could be made. Consequently, despite concerted efforts on the part of all partners, some Network countries were able to demonstrate much more with regard to research uptake or policy/program influence than others overall the life of the program.

Lastly, while the Network is composed of implementing partners whose expertise lies in the area of service delivery, it is led by a research organization. This structure presents it challenges in that the requirements of rigorous research are not always well-understood by partners who have always focused purely on delivering services. These tensions were continuously resolved through the various forms of technical assistance by the Council (e.g., intervention design, scientific proposal-writing and proposal defense), as well as through close (onsite and remote) monitoring of intervention and research processes.

Lessons Learnt

We have learned a variety of lessons over the life of this program. We highlight the six main lessons in this report.

Firstly, we have learned that it is possible to work effectively on responses to violence against children in low-resource settings. Violence against children work is still a novelty in the East and Southern Africa region. Researchers and program specialists have often avoided this area of work due to the various ethical challenges that it conjures, particularly in resource-constrained contexts.[12] However, this program has proven that it is possible to work on this issue, and to develop effective solutions to it.

Secondly, we have learned that there is a growing demand for innovative solutions/interventions for addressing violence against children in the region. The national Violence Against Children surveys carried out over the last decade by the Centers for Disease Control and Prevention and its partners have documented the scale of violence against children in the East and Southern Africa region. However, actual responses to the issue have been lacking. The findings generated by the Network are therefore among the first bodies of evidence of what works to tackle this sensitive issue. In response to this reality, the Network continues to receive solicitations for collaboration and partnership from influential regional bodies and local partners alike.

A third lesson emerging from the program has to do with the fact that SGBV interventions developed for the general population seem to be even more effective when implemented among refugee populations. The two Network interventions that were adapted for implementation in refugee settings under this program demonstrated much higher effectiveness in these contexts than in the settings for which they were initially developed. This perhaps simply points to the great need for innovative solutions among this particular population.

Fourthly, we have learned that the rate at which policy change occurs is very contextual, and that evaluating one country's progress against that of another has little utility. In some countries, policy change may occur in a matter of months, while in another, similar changes may take years. We have learned that all efforts to influence policy are critical, regardless of the length of time it takes to see actual change.

Our experience under this program has also taught us that, while funding helps to facilitate policy change or research uptake, relationships with key stakeholders must be invested in, regardless of the availability

[12] Undie, C., Mullick, S., and Askew, I. (2013). The missing 'C': Sexual violence against children in sub-Saharan Africa. *Research Watch,* UNICEF. https://www.unicef-irc.org/article/987-the-missing-c-sexual-violence-against-children-in-sub-saharan-africa.html.

of funds. As policy change is not a linear process, it is usually the consistency of a relationship that keeps important issues on the radar of policy makers, which eventually leads to needed changes.

Finally, we have learned that social norm change around violence is possible. This program set out to answer difficult questions about the sensitive issue of violence: Will parents be amenable to having their children screened for sexual violence? Will children be willing to disclose violence? Will Congolese refugees in Uganda be willing to disclose intimate partner and non-partner violence and receive services for it? Will male partners in refugee settings be willing to dialogue about violence and take a public stand against it? Will parents trust police enough to have police escort them to health facilities to obtain care for child survivors? What each of our studies has shown is that persistent norms around violence are amenable to change if one is bold enough to decide to work on them.

We credit the Population Council's 'Network approach' for the achievements under this program. Historically, the Africa Regional SGBV Network has had opportunities to reflect on what sets this particular Network apart from a sole institution.[13] Conclusions emerging from these discussions indicate that the structured South-South learning that occurs under the Network render it unique, productive, and effective. The intensive, face-to-face forms of South-South interaction characteristic of the Africa SGBV Network are of paramount importance to Network partners, who have cited myriad examples of being inspired to take action in their individual countries after being afforded undistracted time and space to learn about other partners' work (through annual partner meetings, exchange visits, on-site and remote monitoring, joint conference preparation and attendance, etc.), and to realize what is doable in their own settings.

As one participant put it:

> *There's something about interacting with the Network that inspires partners to push for similar things in their countries after they've compared themselves to other countries. There's more of a 'how-to' approach with this Network. It's much more practical so that partners are able to benchmark themselves against what's happening regionally – and it's hard to really do that without this sort of network structure that we have. Without this Network, one tends to think one is doing enough, [or that] one is doing it right.*[14]

In summary, the face-to-face exchanges (including technical assistance by and among partners, annual partner meetings, partner exchange visits, and other learning opportunities) that are made possible through the Network's approach are seen by its partners and other stakeholders as setting it apart markedly from other approaches. The Network's approach is also seen as an efficient, non-duplicative means of generating a coherent body of multi-sectoral evidence on SGBV in the region within a similar time frame.

Final Reflections

As the program comes to a close, it is also telling that other funders have sought to build upon this work. This program permitted the Africa Regional SGBV Network to expand its reach to new populations—children and refugees—and to be one of the first groups in the region to really begin to investigate what works to address violence against children. Unsurprisingly, the Council will be implementing Kenya's second national Violence Against Children Survey in 2018, in collaboration with Network partner LVCT Health, and with funds from the Centers from Disease Control and Prevention. The Council will also continue to lead the Africa Regional Network until 2020—this time, with new funding that supports the scale up of selected Network models in refugee settings, in collaboration with the UNHCR Regional Service Center. These developments demonstrate the appreciation and understanding of these issues that the Network has built.

The Network approach supported by the Regional Team for SRHR continues to serve as an efficient means of generating a coherent body of evidence on SGBV in the region. The support provided by the Regional Team has permitted the Network to develop expertise in new and important areas, and Network partners

[13] Population Council, Kenya (2012). The Africa Regional SGBV Network Annual Partners Meeting: June 26-27 2012, Mombasa, Kenya: Meeting Report. Nairobi: Population Council.
[14] Ibid.

are ready to use this expertise to address SGBV on a larger scale in refugee settings, and within violence against children research and programming in the region.

Appendices

Appendix 1: Reports and Papers Published and Presented under the Expanding the Evidence Base and Networks for Sexual Violence Response in East and Southern Africa Program

2014

Technical Reports and Published Papers

Thompson, J., C. Undie and I. Askew. 2014. **Access to emergency contraception and safe abortion services for survivors of rape and defilement in sub-Saharan Africa: A regional overview.** Nairobi: Population Council.

Undie, C., M.C. Maternowska, M. Mak'anyengo and I. Askew. 2014. **Is routine screening for intimate partner violence feasible in public health care settings in Kenya?** *Journal of Interpersonal Violence*.

Conference Presentations

Manzini-Henwood, C. 2014. **Community-based advocacy and activism: Profiling the SWAGAA Girls' Empowerment Club Programme.** Government of Swaziland, UNICEF, and Together for Girls Global Violence against Children Meeting: From Research to Action: Advancing Prevention and Response to Violence against Children. Ezulwini, Swaziland, May 28-30, 2014.

Mak'enyengo, M. 2014. **Feasibility of screening for IPV in public health care settings in Kenya.** Oral presentation at the 6th Annual Kenya Psychiatric Association Conference, Mombasa, Kenya, June 12-14 2014.

Undie, C. 2014. **Screening for intimate partner violence in the East African region.** Oral presentation at the Preventing IPV in Kenya, Uganda, and Tanzania: A Joint Workshop of the Uganda National Academy of Sciences and the U.S. Institute of Medicine. Kampala, Uganda, August 2014.

Undie, C. 2014. **What are we learning about addressing IPV across the lifespan?** Oral presentation at the Preventing IPV in Kenya, Uganda, and Tanzania: A Joint Workshop of the Uganda National Academy of Sciences and the U.S. Institute of Medicine. Kampala, Uganda, August 2014.

Undie, C., J. Thompson and I. Askew. 2014. **How does emergency contraception feature in post-rape care guidelines in sub-Saharan Africa?** Oral presentation at the 2014 EC Jamboree of the American Society for Emergency Contraception and the International Consortium for Emergency Contraception. New York, September 2014.

Undie, C. 2014. **Sexualities, intimate partner violence, and sexual and reproductive health in the African region.** Solicited virtual presentation at Quest University, British Columbia. September 24, 2014.

Mak'anyengo, M. 2014. **GBV and impact on HIV transmission.** 9th HIV Transmission Workshop. Cape Town, South Africa, October 25-26, 2014.

Birungi, H., C. Undie and F. Onyango. 2014. **Education sector response to early and unintended pregnancy: A review of country experiences in East and Southern Africa.** Global Consultation on Education Sector Response to Early and Unintended Pregnancy, Johannesburg, South Africa, November 4-6, 2014.

Birungi, H., P. Mwacharia, C. Undie and M.C. Njelesani. 2014. **Education sector response to early and unintended pregnancy: A review of country experiences in East and Southern Africa.** High Level Task Force for Women and Girls, OAFLA and Together for Girls. Adolescent Sexual and Reproductive Health Rights and in Africa Symposium. Lusaka, Zambia, December 7-10, 2014.

Ajema, C. and L. Digolo. 2014. **Management of survivors of sexual violence in Kenya: Lessons learnt from a joint training of police and health care workers.** East African Community-Population Council Forum on Meeting the needs of sexual violence survivors in the East African region through working with the law enforcement-police sector. Kigali, Rwanda, December 3-5, 2014.

Dennis, M., J.K. Mwansa, G. Phiri and M. Zama. 2014. **The Copperbelt Model of Integrated Care for sexual violence survivors.** East African Community-Population Council Forum on Meeting the needs of sexual violence survivors in the East African region through working with the law enforcement-police sector. Kigali, Rwanda, December 3-5, 2014.

Undie, C. 2014. **Introduction to the Africa Regional SGBV Network.** East African Community-Population Council Forum on Meeting the needs of sexual violence survivors in the East African region through working with the law enforcement-police sector. Kigali, Rwanda, December 3-5, 2014.

Undie, C., M. Mak'anyengo, M.C. Maternowska and I. Askew. 2014. **The power of asking: What happened when women in a public, Kenyan hospital were routinely asked about IPV.** USAID Interagency Gender Working Group and Pan-American Health Organization Panel and Discussion: Setting the stage: Asking women about violence and responding within health settings. Washington, D.C., December 4, 2014.

Dennis, M., M. Zama, J. Price and S. Topp. 2014. **Police Victim Support Unit officers as first responders to adolescent survivors of sexual violence.** Adolescent Sexual and Reproductive Health Rights and in Africa Symposium. Lusaka, Zambia, December 7-10, 2014.

Manzini-Henwood, C. 2014. **Community-based programmes for advocacy and activism to prevent violence against girls.** Adolescent Sexual and Reproductive Health Rights and in Africa Regional Symposium. Lusaka, Zambia, December 7-10, 2014.

Undie, C. 2014. **Making change happen, making it stick: Experiences from the Africa Regional SGBV Network.** Population Council Telebriefing: Global perspectives on addressing sexual and gender-based violence. New York, December 8, 2014.

2015

Technical Reports and Published Papers

Undie, C., Birungi, H., Askew, I. 2015. **'Changing the world': The Africa Regional SGBV Network.** *BioMed Central (BMC) Proceedings* 9 (Supplement 4).

Ajema, C., Mukoma, W., Kotut, R., Mulwa, R. 2015. **Documenting medico-legal evidence in Kenya: Potential strategies for improvement.** *BMC Proceedings 9* (Supplement 4).

Zama, M.T., Dennis, M., Price, J., Topp, S.M., 2015. **Assessing the feasibility of police initiation of HIV PEP for sexual violence survivors in Lusaka, Zambia.** *BMC Proceedings 9* (Supplement 4).

Nicholson, F., Carty, C. 2015. **The 'Zero Tolerance Village Alliance': A promising intervention for addressing SGBV in rural communities.** *BMC Proceedings 9* (Supplement 4).

Manzini-Henwood, C., Dlamini, N., Obare, F. 2015. **School-based girls' clubs as a means of addressing SGBV in Swaziland.** *BMC Proceedings 9* (Supplement 4).

Undie, C., Maternowska, M.C., Mak'anyengo, M., Askew, I. 2015. **What women think: Hypothetical notions of screening for intimate partner violence in Kenyan hospital settings.** *BMC Proceedings 9* (Supplement 4).

Conference Presentations

Undie, C. 2015. **A 'network approach' to addressing sexual and gender-based violence: Introducing the Africa Regional SGBV Network.** Webinar organized by the Health Policy Project's Community of Practice on Scale-Up and Gender, Policy and Measurement. Washington, DC, USA. February 4, 2015.

Ajema, C., Mukoma, W., Obbayi, M., Mugyenyi, C., Meme, M., Kotut, R., Oduor, S., Mulwa, R. 2015. **Improving the collection, documentation, and utilization of medico-legal evidence.** Oral presentation at the 4th African Society of Forensic Medicine Annual Scientific Conference, Nairobi, Kenya. March 3, 2015.

Undie, C. 2015. **If I only had 10 minutes: What I would say to key stakeholders about IPV screening in low and middle income settings?** Pre-Institute Faculty Panel Presentation on *GBV and the Global Health and Development Agendas: New Research and Innovative Programs* at the Futures Without Violence National Conference on Health & Domestic Violence, Washington, DC, USA. March 19-21, 2015.

Dennis, M. 2015. **Mitigating the consequences of sexual violence by decentralizing emergency medical responses: Feasibility study on police provision of post-exposure prophylaxis for HIV (PEP) in Zambia.** Oral presentation at the Population Council Scientific Symposium, Lusaka, Zambia. April 9, 2015.

Undie, C., Birungi, H., Obare, F., Machawira, P. 2015. **Education sector response to early and unintended pregnancy: A review of selected SADC countries.** Oral presentation at the SADC Women Parliamentarians Roundtable on Early and Unintended Pregnancy, Cape Town, South Africa, August 24-25, 2015.

Undie, C., Namwebya, J.H., Birungi, H. 2015. **Adapting and testing comprehensive models for addressing SGBV in emergency settings: Preliminary findings from a baseline survey conducted in Rwamwanja Settlement.** Oral presentation at the Department for Refugees, Office of the Prime Minister, Kampala, Uganda, August 31, 2015.

Undie, C., Namwebya, J.H., Birungi, H. 2015. **Adapting and testing comprehensive models for addressing SGBV in emergency settings: Preliminary findings from a baseline survey conducted in Rwamwanja Settlement.** Oral presentation at the Office of the Commandant, Rwamwanja Settlement, Rwamwanja, Uganda, September 1, 2015.

The Africa Regional SGBV Network (all partners). 2015. **Conveners of and panelists for *The Missing 'C': Addressing Violence Against Children in Sub-Saharan Africa* Satellite Session.** 4th SVRI Forum, Stellenbosch, South Africa. September 15, 2015.

The Africa Regional SGBV Network (all partners). 2015. **Co-conveners of and panelists for *Making Networks Works: Lessons from the Field* Satellite Session.** 4th SVRI Forum, Stellenbosch, South Africa. September 16, 2015.

Mak'anyengo, M., Kosgei, R.J., Haberland, N., Kalibala, S., Ndwiga, C., Undie, C. 2015. **Intimate partner violence in Kenya: An overview of responses at Kenyatta National Hospital.** Panel presentation at the *Key Reproductive Health Concerns in Africa* session, AFOG Scientific Session, FIGO Word Congress of Gynecology and Obstetrics, Vancouver, Canada. October 4-9. 2015.

Mwansa, J.K., Phiri G. 2015. **The police as part of the public health response to SGBV: An exploration of task-sharing in Zambia.** Oral (videoconferencing) presentation at the USAID Inter-Agency Gender Working Group Panel Discussion on Addressing GBV in Health Care Settings: Involving the Public Sector, Washington, DC, USA. October 27, 2015.

Dartnall, E. 2015. **Making networks work: Examples from the field.** Oral presentation at GBV Prevention Network Advisory Group meeting. Pretoria, South Africa. November 17, 2015.

Undie, C., Birungi, H., Odwe, G., Namwebya, J. 2015. **Adapting and testing comprehensive models for addressing SGBV in emergency settings: Project overview, history, partnerships, and initial results.** UNHCR Implementing Partners' Meeting, Rwamwanja Settlement, Rwamwanja, Uganda. December 8, 2015.

Ayebale, P. 2015. **Establishing a 'Zero Tolerance Village Alliance' against SGBV in Rwamwanja Settlement.** UNHCR Implementing Partners' Meeting, Rwamwanja Settlement, Rwamwanja, Uganda. December 8, 2015.

Maate, L. 2015. **Routine screening for SGBV at Rwamwanja Health Centre.** UNHCR Implementing Partners' Meeting, Rwamwanja Settlement, Rwamwanja, Uganda. December 8, 2015.

2016

Technical Reports and Published Papers

Ajema, C., Ngunjiri, A., Ouko, J., Karuga, R., Digolo, L. 2016. ***Health facility responsiveness to the needs of child survivors of sexual violence:*** *Case study of Nyeri and Nakuru Counties, Kenya*. Nairobi, Kenya: LVCT Health. http://www.popcouncil.org/uploads/pdfs/2016RH_ChildAbuseMgmt_LVCT.pdf

Odiyo, O., Undie, C., Mak'anyengo, M. 2016. ***Routine screening for intimate partner violence: A guide for trainers.*** ECSA Health Community, Population Council, and Kenyatta Hospital. www.popcouncil.org/uploads/pdfs/2016RH_IPV-manual.pdf

Population Council (The Africa Regional SGBV Network). 2016. ***Fostering a multisectoral response to violence against children in East and Southern Africa. Learning Updates from South Africa*** **(Brief 1):** www.popcouncil.org/uploads/pdfs/2016RH_LearningBrief1_SouthAfrica.pdf

Population Council (The Africa Regional SGBV Network). 2016. ***Fostering a multisectoral response to violence*** **against children in East and Southern Africa.** ***Learning Updates from Kenya*** **(Brief 2):** www.popcouncil.org/uploads/pdfs/2016RH_LearningBrief2_KenyaLVCT.pdf

Population Council (The Africa Regional SGBV Network). 2016. ***Fostering a multisectoral response to violence against children in East and Southern Africa. Learning Updates from Swaziland*** **(Brief 3):** www.popcouncil.org/uploads/pdfs/2016RH_LearningBrief3_Swaziland.pdf

Population Council (The Africa Regional SGBV Network). 2016. ***Fostering a multisectoral response to violence against children in East and Southern Africa. Learning Updates from Kenya*** **(Brief 4):** www.popcouncil.org/uploads/pdfs/2016RH_LearningBrief4_KenyaKNH.pdf

Population Council (The Africa Regional SGBV Network). 2016. ***Fostering a multisectoral response to violence against children in East and Southern Africa. Learning Updates from Zambia*** **(Brief 5):** www.popcouncil.org/uploads/pdfs/2016RH_LearningBrief5_Zambia.pdf

Population Council (The Africa Regional SGBV Network). 2016. ***Fostering a multisectoral response to SGBV in humanitarian settings. Learning Updates from Uganda*** **(Brief 6):** www.popcouncil.org/uploads/pdfs/2016RH_LearningBrief6_UgandaAHA.pdf

Population Council (The Africa Regional SGBV Network). 2016. ***Fostering a multisectoral response to SGBV in humanitarian settings. Learning Updates from Uganda*** **(Brief #7):** www.popcouncil.org/uploads/pdfs/2016RH_LearningBrief7_UgandaLWF.pdf

Rich, S. 2016. **Preventing pregnancy after sexual assault: Do women and girls have access to emergency contraception?** ***Rights and Realities*** http://rightsandrealities.org/2016/06/08/ec-after-sexual-assault

Undie C., Birungi H., Namwebya J., Taye W., Maate L., Mak'anyengo M., Katahoire A., Kazungu D.A., Kusasira D, Mirghani Z., Karugaba J. 2016. ***Screening for Sexual and Gender-Based Violence in Emergency Settings in Uganda: An Assessment of Feasibility*****. Nairobi, Kenya: Population Council.** www.popcouncil.org/uploads/pdfs/2016RH_ScreeningSGBV-Uganda.pdf

Undie C., Birungi H., Obare F., Odwe G., Namwebya J., Orikushaba P., Ayebale P., Onen, W., Nicholson F., Francis R. C., Netshabako P., Katahoire A., Kazungu D. A., L., Kusasira D., Mirghani Z., Karugaba J. 2016. ***Effectiveness of a Community-Based SGBV Prevention Model in Emergency Settings in Uganda: Testing the 'Zero Tolerance Village Alliance' Intervention*****. Nairobi, Kenya: Population Council.** www.popcouncil.org/uploads/pdfs/2016RH_SGBVPreventionUgandaZTVA.pdf

Undie, C., Maternowska, C.M., Mak'anyengo, M., Askew, I., 2016. **Is routine screening for intimate partner violence feasible in public health care settings in Kenya?** ***Journal of Interpersonal Violence*** **31(2): 282-301.** http://journals.sagepub.com/doi/pdf/10.1177/0886260514555724

Conference Presentations

Undie, C. et al. 2016. **Family planning and IPV screening: Comfortable bedfellows for young people in a youth FP clinic setting in Kenya.** International Conference on Family Planning. Bali, Indonesia.

Undie, C. 2016. **Understanding intersectionality. Panel presentation: Seeing the 'invisible': What we can learn about gender inequality (and power) by exploring intersecting identities.** Bill & Melinda Gates Foundation Grantees Meeting. Nairobi, Kenya.

Undie, C., Birungi, H. 2016. **Adapting and testing comprehensive models for addressing SGBV in emergency settings.** Meeting of DFID-Kenya and DFID-UK Representatives. Nairobi, Kenya.

Amin, A. 2016. **What are the reproductive health consequences of sexual violence? Pregnancy prevention and management as an essential element of sexual violence care.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Amin, A. 2016. **Providing psychological first aid/first line support.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Country Team—Botswana. 2016. **National health responses to SGBV: A focus on provision of EC and safe abortion.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Country Team—Ethiopia. 2016. **National health responses to SGBV: A focus on provision of EC and safe abortion.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Country Team—Kenya. 2016. **National health responses to SGBV: A focus on provision of EC and safe abortion.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Country Team—Malawi. 2016. **National health responses to SGBV: A focus on provision of EC and safe abortion.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Country Team—Rwanda. 2016. **National health responses to SGBV: A focus on provision of EC and safe abortion.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Country Team—Zambia. 2016. **National health responses to SGBV: A focus on provision of EC and safe abortion.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Rich, S. 2016. **Technical updates on emergency contraception.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Thompson, J., Undie, C. 2016. **Treatment of pregnancy prevention and management in national policies and SGBV guidelines: Key findings and recommendations from a regional review.** Population Council-WHO-ICEC regional technical meeting on Harmonizing National Abortion and Pregnancy Prevention Laws and Policies for Survivors of Sexual Violence with the Maputo Protocol. Lusaka, Zambia.

Undie, C. 2016. **Empowering women and girls to tackle STIs and poverty: Responses of the Africa Regional SGBV Network.** Plenary address at IUSTI World Congress. Marrakesh, Morocco.

Undie, C. 2016. **Responding to the needs of child survivors of sexual violence in Kenya.** MoH Technical Working Group Meeting for Child Survivors. Nairobi, Kenya.

Undie, C. 2016. **Routine screening for IPV**. Regional training and planning workshop of East, Central and Southern Africa Health Community. Nairobi, Kenya.

Undie, C. 2016. **Positioning SGBV care as a nursing priority in the ECSA region.** Keynote address at ECSACON 12th Biennial Scientific Conference. Nairobi, Kenya.

Mwanzia, M., Kotut, R. 2016. **Medico-legal challenges of SGBV: Perspectives on documentation.** ICGLR training in documentation and investigation for sexual violence cases. Kampala, Uganda.

Chelwa, N., Phiri, G., Mbizvo, M. 2016. **Enhancing post-rape care for child survivors in the context of police stations in Zambia.** 2016 Meeting of Africa Regional SGBV Network. Stockholm, Sweden.

Digolo-Nyagah, L., Ajema, C. 2016. **Enhancing children's access to comprehensive post-rape care services in Kenya.** 2016 Meeting of Africa Regional SGBV Network. Stockholm, Sweden.

Mak'anyengo, M., Undie, C., Birungi, H. 2016. **Routine screening for child sexual abuse in Nairobi, Kenya. 2016** Meeting of Africa Regional SGBV Network. Stockholm, Sweden.

Ngwenya, D., Makama, S. 2016. **Strengthening the Swaziland education sector response to SGBV in schools.** 2016 Meeting of Africa Regional SGBV Network. Stockholm, Sweden.

Nicholson, F., Masikhwa, T. 2016. **Adapting and testing a comprehensive model for addressing violence against children in South African schools.** 2016 Meeting of Africa Regional SGBV Network. Stockholm, Sweden.

Orik, P., Ayebale, P. 2016. **Routine screening for child sexual abuse in Nairobi, Kenya.** 2016 Meeting of Africa Regional SGBV Network. Stockholm, Sweden.

Taye, W., Maate, L. 2016. **Testing the 'Zero Tolerance Village Alliance' model in humanitarian settings in Uganda.** 2016 Meeting of Africa Regional SGBV Network. Stockholm, Sweden.

Ayebale, P. 2016. **Youth Pyramid Structure for SGBV prevention in Uganda.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

HIAS. 2016. **Safe housing for SGBV survivors: An urban model for refugees.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

Kotut, K. 2016. **Community-based protection.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

Undie, C. Maate, L. 2016. **Screening for SGBV in emergency settings in Uganda: An assessment of feasibility.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

Undie, C., Nicholson, F. Ayebale, P. 2016. **The 'Zero Tolerance Village Alliance' model: As assessment of effectiveness.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

UNHCR. 2016. **Engaging Men in Accountable Practices (E-MAP): Roll-out.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

UNHCR. 2016. **Community engagement case study: Kakuma refugee camp, Kenya.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

UNHCR. 2016. **Male engagement on SGBV in South-South Sudan.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

UNHCR. 2016. **Religious leaders' role in the fight against FGM/C: UNHCR SO Jijiga.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

UNHCR. 2016. **Youth group for SGBV prevention and response: Shagrab camps, Eastern Sudan.** Community Engagement in SGBV Prevention and Response: A UNHCR-Population Council Workshop. Nanyuki, Kenya.

Chelwa, N., Phiri, G., Mbizvo, M. 2016. **The Zambia SGBV project (2006-2016).** Presentation to Regional Team for SRHR, Embassy of Sweden, Lusaka, Zambia.

Ajema, C. and Wairimu, G. 2016. **Documentation, investigation, and reporting: A case study from Kenya.** ICGLR Colloquium on *Documentation, Investigation, and Reporting of Sexual Violence in the Great Lakes Region*. Entebbe, Uganda.

Undie, C. 2016. **Regional responses emanating from regional and international instruments on sexual violence.** ICGLR Colloquium on *Documentation, Investigation, and Reporting of Sexual Violence in the Great Lakes Region*. Entebbe, Uganda.

Undie, C. 2016. **We can't ignore the needs of sexual violence survivors.** Plenary address at the Africa Regional Conference on Abortion. Addis Ababa, Ethiopia.

Undie, C. 2016. **Identifying and documenting sexual violence through screening by medical personnel: Lessons from the region.** ICGLR Colloquium on *Documentation, Investigation, and Reporting of Sexual Violence in the Great Lakes Region*. Entebbe, Uganda.

2017

Technical Reports and Published Papers

Chelwa, N., K. Hemal, G.M. Phiri, M.T. Mbizvo, C. Undie. 2017. **Enhancing access to post-rape care for child survivors in the context of police and health services in Zambia: Report on a police response model tested in Zambia.** Lusaka: Population Council.

Kiruki, M., C. Ajema, C. Undie, J. Kyongo, K. Owuor, C. Mbugua, R. Kotut, L. Digolo. 2017. **Enhancing access to post-rape care services for children in Kenya.** Nairobi: LVCT Health.

Mirghani Z., J. Karugaba N. Martin-Archard, C. Undie, H. Birungi. 2017. **Community engagement in SGBV prevention and response: A compendium of interventions in the East & Horn of Africa and the Great Lakes Region.** Nairobi: Population Council.

Obare, F., A. Almeida, G. Odwe, J. Mwanga, C. Undie, M. Hiza, F. Mwanga. 2017. **Access to reproductive health and HIV services among young mothers in Tanzania.** Dar es Salaam: EngenderHealth, Population Council, and Ministry of Health and Social Welfare.

Silverman, J., S. Boyce, S. Challa, N. Carter, C. Undie, W. Liambila. 2017. **ARCHES: Reducing adolescent and adult unintended pregnancy: Formative research report.**

Thompson, J., C. Undie, A. Amin, R. Johnson, R, Khosla, I. Askew, L. Ouedraogo, T. Nkurunziza, S. Rich, E. Westley, M. Garcia. 2017. **Harmonizing national abortion and pregnancy prevention laws and policies for sexual violence survivors with the Maputo Protocol.** Regional Technical Report. Nairobi: Population Council, WHO, & ICEC (hosted by Management Sciences for Health [MSH]).

Undie, C., R. Khosla, K. Blanchet. 2017. **Improving family planning service delivery in humanitarian crises.** Family Planning Evidence Brief.

Conference Presentations

Undie, C., M. Mak'anyengo. 2017. **Feasibility of routine screening for child sexual abuse in Kenya.** Research Utilization Symposium. Nairobi. 6 December 2017.

Undie, C. 2017. **A 'network approach' to addressing SGBV in humanitarian settings: Introducing the Africa Regional SGBV Network.** Technical Briefing at the Bureau of Population, Refugees, and Migration. State Department, Washington, DC, 9 November 2017.

Undie, C. 2017. **Responding to SGBV in East and Southern Africa through 'the Africa Regional SGBV Network.** Technical Briefing at the USAID Global Health Bureau, Office of Population and Reproductive Health. Washington, DC. 9 November 2017.

Undie, C. 2017. **Responding to SGBV in East and Southern Africa through 'the Africa Regional SGBV Network.** Technical Briefing at Together for Girls. Washington, DC. 9 November 2017.

Undie, C. 2017. **How to collect and make use of meaningful evidence to better understand school-related GBV and its impact.** UNESCO-UNGEI SRGBV Symposium. Dakar, Senegal. November 2017.

Odwe, G., C. Undie. 2017. **Population Council interventions in post-conflict settings in the Great Lakes Region.** HEARD SGBV Prevention Workshop. South Africa. September 2017.

Ajema, C., R. Karuga, L. Digolo. 2017. **Availability and quality of comprehensive post-rape care services for children in Kenya.** Presentation at 2017 SVRI Forum. September 2017.

Silverman, J., N. Carter, C. Undie, S. Wendoh. 2017. **Adaptation of a clinic-based model to reduce reproductive coercion, intimate partner violence, and unintended pregnancy: ARCHES Kenya.** Presentation at 2017 SVRI Forum. September 2017.

Undie, C., M. Mak'anyengo. 2017. **Feasibility of routine screening for child sexual abuse in Kenya.** Ministry of Health Workshop for the Development of SOPs for the Management of Child Survivors of Violence. Nairobi. 9 October 2017.

Undie, C., H. Birungi, M. Mbizvo. 2017. **Research Impact of the Regional SGBV Project in East, Central, & Southern Africa.** Population Council Board of Directors Meeting. 26 June 2017.

Undie, C., J.H. Namwebya. 2017. **Routine screening for SGBV in East Africa: Preparation for implementation in humanitarian settings in Rwanda.** UNCHR Program and Partners Meeting. Kigali. 14 June 2017.

Undie, C., H. Birungi, F. Obare, G. Odwe. 2017. **Delivering solutions for more effective SGBV programming in humanitarian settings in Uganda.** Reproductive Program Webinar, Population Council. 12 April 2017.

Undie, C., F. Nicholson. 2017. **The 'Zero Tolerance Village Alliance' (ZTVA): Effectiveness of a community-based SGBV prevention model.** Webinar organized by UNHCR on Community Engagement & Evidence-Based Programming. Nairobi. 30 March 2017.

2018

Technical Reports and Published Papers

Ajema, C., C. Undie et al. 2018. **Health sector inadequacies in attending to child survivors of sexual abuse in Kenya: An operations research.** *Child Abuse Review*.

Digolo, L., C. Ajema, M. Kiruki, R. Kotut, C. Undie. (under review). **Use of lay health workers (case advocates) to improve uptake of clinical services by child survivors of sexual violence in public health facilities in Kenya. Special Issue of *Child Abuse and Neglect*.**

Undie, C., M. Mak'anyengo. (in process). **Feasibility and effect of screening for sexual violence against children in school and health facility settings.** *Journal of Child Sexual Abuse*.

Ajema, C. et al. 2018. **Addressing the dual health epidemics of HIV and sexual abuse among children and adolescents in Kenya: Uptake of HIV counseling and post-exposure prophylaxis.** *Adolescent Health, Medicine, and Therapeutics* 9: 1-9.

Nicholson, F., T. Mukaro. 2018. **The effectiveness of a model for addressing school-related gender-based violence in South Africa: An evaluation of the 'Zero Tolerance School Alliance.'** TVEP: Limpopo Province, South Africa.

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Appendix 2: Evidence of Impact Under *Expanding the Evidence Base and Networks for Sexual Violence Response in East and Southern Africa*

Kenya

Kenyatta National Hospital (KNH) and Population Council

Project synopsis: This project involved testing the feasibility of routine screening, referral, and response for child sexual abuse in schools and within the oldest, largest national public referral hospital in the East and Central African Region (Kenyatta National Hospital).

Policy/program impact at service delivery/national/international levels

- Since June 2018, Kenya's MoH has been in the process of adopting the child sexual abuse screening tool developed under this study for use in public health facilities, nationally. The Council continues to provide technical support to facilitate this process with other funding in 2018.
- In June 2018, Kenya's MoH prescribed child sexual abuse screening within the (draft) revised version of the country's National School Health Policy and Guidelines.
- Findings from this screening study are currently being used by the 4Children consortium (a USAID-funded project providing technical support for vulnerable children in PEPFAR programming) to inform development of two resources that seek to enhance the identification, prevention, and response to all forms of violence against children (VAC) in HIV clinical settings: an in-service health care worker training curriculum, with supporting job aids, to support health care workers' identification, prevention, and response to all forms of VAC in HIV clinical settings, and an identification tool to facilitate identification and support for children at risk of, or experiencing, violence in HIV clinical care settings in sub-Saharan Africa.
- Study findings are currently strengthening SGBV services for adolescents by the International Planned Parenthood Federation (IPPF). Both IPPF's Africa Regional Office in Nairobi and IPPF's headquarters in London have sought Council presentations and dialogues with their SGBV staff, as well as TA from the Council and KNH for an SGBV workshop for IPPF's African Member Associations.
- The IPV screening model which preceded and informed the child sexual abuse screening intervention was highlighted in a 2017 UNHCR Regional Service Centre compendium as an evidence-based model being implemented by UNCHR implementing partners in sub-Saharan Africa.
- The IPV screening tool was officially integrated into client in-take protocols within selected clinics at KNH in 2018 (the Youth Center and the Mental Health Unit).
- UNHCR Rwanda has requested and is awaiting the project's technical and financial support for scaling up SGBV screening in Rwandan refugee settings.
- The child sexual abuse screening project is currently being documented by a donor (Wellspring Philanthropic Fund) as a case study in successful policy engagement.
- In 2018, Population Council obtained funding of US $1,400,000 from the Centers for Disease Control in Atlanta, through the University of California San Francisco, to implement Kenya's second national Violence Against Children Survey.

LVCT Health

Project synopsis: This project involved enhancing child survivors' access to post-rape care services in health facilities by introducing standard operating procedures for attending to such survivors, and incorporating case managers into the health system specifically to support child survivors.

Policy/program impact at service delivery/national/international levels

- Kenya's MoH adopted the SOPs developed by this project for its health facilities' support for child survivors. The official guidelines, *National Standard Operating Procedures for the Management of Sexual Violence Against Children*, were launched by MoH in Nairobi in February 2018.

- The Centers for Disease Control (CDC) in Kenya commissioned a training session by LVCT Health on these SOPs for its SGBV partners in 2017.
- Since the end of the project, the case advocate model has been institutionalized in post-rape care in one of the two public hospitals in which it was introduced.
- The 4Children consortium (a USAID-funded project providing technical support on vulnerable children in PEPFAR programming) seeks to develop a violence against children screening tool and provider training manual to inform the development of two resources that seek to enhance the identification, prevention, and response to all forms of violence against children (VAC) in HIV clinical settings: an in-service health care worker training curriculum, with supporting job aids, to support health care workers' identification, prevention, and response to all forms of VAC in HIV clinical settings, and an identification tool to facilitate identification and support for children at risk of, or experiencing, violence in HIV clinical care settings in sub-Saharan Africa. Given its experience with VAC under the current project, LVCT Health has been commissioned to develop these materials.
- Since 2017, LVCT Health has served as CDC's subject matter partner (on HIV testing and SGBV response) on Kenya's second-ever national Violence Against Children Survey. LVCT has developed the response plan for violence against children under this national research project. Funding was obtained from CDC Atlanta, through the University of California San Francisco, to facilitate this work.

South Africa

The Thohoyandou Victim Empowerment Programme (TVEP)

Project synopsis: This project involved testing the effectiveness of a 'Zero Tolerance Village Alliance' (ZTVA) concept, adapted for children in schools (and referred to as the 'Zero Tolerance School Alliance'), on social norm change and violence prevention.

Policy/program impact at service delivery/national/international levels

- The ZTSA model has been replicated by TVEP in three additional schools in South Africa since the end of the study.
- In 2017, TVEP conducted a training session in the ZTSA methodology for seven community-based organizations (CBOs) from two municipalities in South Africa. These CBOs are expected to contribute to further scale up of the model by implementing it in their respective localities, with TA from TVEP.
- The ZTVA model has been taken up by UNHCR, and has so far been implemented in a total of 4 humanitarian setting communities in Uganda.
- The ZTVA model was highlighted in a 2017 UNHCR compendium as an evidence-based model being implemented by UNCHR implementing partners in sub-Saharan Africa.
- To further inform UNHCR staff on the ZTVA model, the Regional Service Center organized an international webinar for its staff in Mach 2017. Population Council and Network partner TVEP were invited to present evaluation results based on this model.
- Drawing on the evaluation report of the ZTVA model in humanitarian settings, UNHCR Geneva also developed a mini-guide on community mobilization and behavior change communication (BCC) on SGBV in humanitarian contexts (final version still to be made publicly available).
- The ZTVA model is currently taught at the University of Venda as part of their Bachelor of Laws course.
- In 2018, the Foundation for Human Rights (a South Africa-based donor) commissioned and funded the rolling out and testing of the ZTVA model in two informal settlement sites in South Africa.

Swaziland

Swaziland Action Group Against Abuse (SWAGAA)

Project synopsis: This project involved incorporating a self-efficacy module within an existing, SGBV-focused girls' club intervention, and combining this with the sensitization of school personnel to school-related GBV in to foster violence prevention for girls.

Policy/program impact at service delivery/national/international levels

- In 2017, Swaziland's Ministry of Education instructed SWAGAA to develop comprehensive manuals to be used for both girls and boys in both primary and secondary schools, including topics such as sexual and reproductive health, HIV and AIDS, and self-efficacy. The new manuals borrow heavily from the SWAGAA's girls' club curriculum (GEC-PLUS* curriculum) and are currently the only manuals officially approved by the Swaziland Government to be used in schools for extra curricula activities related to gender and GBV Prevention.
- The new, government-approved manuals are currently used in SWAGAA's school-based girls' clubs across the country.

Zambia

Zambia Police Services, Ministry of Health, and Population Council

This project involved enhancing child survivors' access to post-rape care services in police stations by introducing training for police and health providers on the national guidelines for managing child survivors, strengthening transportation services within police stations, and strengthening the provision of EC by trained police to survivors presenting at police stations.

Policy/program impact at service delivery/national/international levels

- Since 2015, EC provision by trained police to sexual violence survivors has been incorporated into the pre-service training curriculum of police officer recruits, and is being taught.
- Zambia's police provision of EC model was highlighted by the International Consortium for Emergency Contraception: www.cecinfo.org/icec-publications/emergency-contraception-simple-part-post-rape-care-not-routinely-provided