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Gender-Based Violence (GBV) Rapid Assessment and Service Mapping Report for MCSP-supported Facilities in Kogi and Ebonyi States, Nigeria

Abridged Version



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EXECUTIVE SUMMARY

Gender-based violence has severe impacts on health and well-being, particularly for pregnant women and their children. As part of efforts to strengthen the Nigerian health system's response to gender-based violence (GBV) and to mitigate its impacts on reproductive, maternal, neonatal, child and adolescent health (RMNCAH), the USAID Maternal and Child Survival Program (MCSP) carried out a rapid assessment to determine the availability of GBV prevention and response services; and perceptions and knowledge of GBV among health workers. A service mapping to assess the availability of GBV referral services was also conducted in both states.

MCSP carried out field assessments over a period of 10 days in 30 MCSP-supported facilities in Ebonyi and Kogi states, based on client load and senatorial geographical spread. Key informant interviews were conducted with the following stakeholders:

- State Ministry of Women Affairs and Social Development (SMOWASD),

- State Ministry of Health (SMOH)
- Local Government Areas (LGAs),
- Heads of Community Based Organizations (CBOs),
- Faith Based Organizations (FBOs),
- Gender officers at legal and law-enforcement agencies,
- Officers-in- charge of health facilities,
- Community Leaders

Summary of Findings:

This rapid assessment and service mapping provides strong evidence on the total absence of systematic strategies or a coordinated strategy for GBV prevention and response in both Ebonyi and Kogi States' health systems:

- Stakeholders were generally aware of GBV issues, including widespread GBV occurrence, existence of national and state laws on GBV, but with limited understanding on GBV prevention and response strategies;
- Women in Kogi and Ebonyi states do experience high rates of GBV, particularly rape and IPV, but there is a low level of reporting of GBV cases both for healthcare and law-enforcement;
- There are huge gaps in the existing knowledge base and infrastructure for prevention and response of GBV in both states. Health providers were found to generally lack the capacity to provide basic first-line support to GBV survivors (defined as counseling, safety planning and referrals) as very few service providers were aware of, or ever referred GBV survivors to referral services. Most health workers have never received any form of training on gender-based violence, and limited their care to treating physical injuries only.
 - Essential services required to effectively provide post-GBV care at health facilities are conspicuously non-existent, for example a private room for safe counseling, post-exposure prophylaxis for HIV prevention within 72 hours of an assault, etc.
 - GBV prevention and response responsibilities are shared by the state and local governments, police, and community-based organizations. However, there is a lack of coordination, knowledge, funding, communication and collective action.

INTRODUCTION

MCSP Nigeria works to improve the quality and utilization of maternal, newborn, child and adolescent health interventions including post-partum family planning and addresses gender-related barriers that affect service uptake within healthcare facilities in Kogi and Ebonyi states. One of MCSP's targeted interventions includes strengthening post-GBV care services at selected MCSP-supported health facilities. Beyond commonly-cited barriers that hinder the uptake of available health services, the lack of routine post-GBV care poses a great risk in the delivery of quality healthcare to women and children in Ebonyi and Kogi States.

In Nigeria, acts of violence against women cut across religion, social class and ethnic groups. IPV is said to be the most common and pervasive form of GBV in Nigeria¹. Though several small-scale research has been carried out in different regions, there is a paucity of data to determine state-specific prevalence of IPV. Female genital mutilation is widely practiced in southern Nigeria with Ebonyi state having the second highest number of females circumcised (74%) while Kogi has one of the lowest around 1%¹. The most affected survivors usually are of low socio-economic status. They can hardly afford transport money to access referral services in the cities.

The 2016 WHO Global Plan for Action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children, advocates for and encourages member states to strengthen the role of the health system in order to effectively respond to violence against women and children. The Government of Nigeria has committed to numerous international and national goals to reduce the prevalence and impact of GBV, including the Sustainable Development Goals, requiring an elimination of all forms of violence against women and girls, and passed the Violence against Persons Prohibition Act in 2015. Civil Society in Nigeria has also increased social and legislative advocacy, established gender and family units in the police, advocated for male participation in violence prevention, and provided GBV support services. However, government efforts at the federal and state levels have failed to keep pace, particularly in terms of health services, linkages between the health and justice sectors, and social/ mental health support services for survivors.

At the most basic level, if a survivor of GBV discloses experiencing violence to a health provider, or displays obvious signs and symptoms of experiencing GBV, the provider and health system must be equipped to provide basic care in a private, compassionate, and evidence-informed manner.

- Treatment of acute injuries;
- Provision of HIV post-exposure prophylaxis (PEP) within 72 hours of a sexual assault;
- Provision of emergency contraceptives within 120 hours of a sexual assault;
- Empathetic counseling and safety planning;
- Referrals to support services (police, emergency shelter, mental health, economic empowerment, etc.)

However, facilities and the health systems in Ebonyi and Kogi states are under-equipped and providers are insufficiently trained to offer this care. The lack of services, combined with survivors' concerns about their safety and avoiding stigma, have resulted into very few survivors currently seeking services. In other MCSP countries such as Rwanda, once the quality and coverage of GBV services has improved and communities are made aware of them, the caseload of GBV survivors has dramatically increased, giving them the opportunity to mitigate the harms perpetrated by GBV on their health, well-being and livelihoods.

OBJECTIVES

The overall objectives of the assessment were;

- 1) To understand the GBV situation in Kogi and Ebonyi states, including knowledge and attitudes, prevention and response strategies, and barriers to accessing services;
- 2) To map the availability of GBV services and develop a referral directory for selected 30 MCSP-supported health facilities.

METHODS

MCSP used a purposive sampling procedure to select respondents by convenience, and conducted a rapid assessment of GBV using qualitative and quantitative methods. This activity lasted from 3rd-25th July, 2017. A team of three consultants and the MCSP Nigeria Gender Advisor held planning meetings from 3rd-5th July and presented a detailed plan for field work to the MCSP technical team on 7th July at Jhpiego office, Abuja. The 10-day field visits were held from 10th-21st July in both Kogi and Ebonyi States.

RESPONDENTS

MCSP interviewed a total of 63 respondents (25 female/ 38 males) in Kogi State and 78 (54 females/ 24 males) in Ebonyi State. The respondents include key informants at the SMOWASD, SMOH and LGA councils; Service providers at MCSP-supported health facilities; Contact persons at identified government agencies and NGOs with GBV-related functions; and Community leaders.

ASSESSMENT TOOLS

MCSP developed and used semi-structured questionnaires for key informant interviews for selected state and local government officers, health facility heads and heads of organizations performing GBV services or referrals. The tools for assessing health facility staff were pre-tested prior to the field visit at the National Hospital, Abuja, and findings were incorporated.

SITE SELECTION

MCSP visited 30 health facilities in Ebonyi, and 27 in Kogi.

Type of health facilities visited

FACILITY TYPE	KOGI (n=27)	EBONYI (n=30)
PRIMARY	10	19
SECONDARY	14	10
TERTIARY	3	1

DATA COLLECTION

MCSP conducted face-to-face interviews with providers to collect quantitative and qualitative data about GBV knowledge and perceptions, the existence of GBV services in their facilities, and what the providers would need to improve (or begin delivering) basic GBV care. MCSP also gathered contextual information from community leaders who provided detailed information on GBV situation within their communities.

DATA ANALYSIS

MCSP transcribed responses from recordings and field notes, and coded responses across different categories of respondents, groups, and the two states using bivariate analysis and simple frequencies for comparisons between the two states.

LIMITATIONS

- Difficulty in meeting with government officials due to non-payment of staff salaries in Kogi, as some offices had to be visited up to 3 times before interviews could be conducted.
- Difficulty in accessing some communities delayed the process and telephone interviews were done where face to face visits were impossible.

MAJOR FINDINGS

GBV Health Services:

Health service providers interviewed in both states had a fair knowledge of GBV (57% in Ebonyi and 44% in Kogi), and knowledge seemed to increase with facility type as primary health facilities had the least knowledge, followed by the secondary and tertiary facilities. Provider’s knowledge of GBV were measured by asking whether they had been involved in a GBV sensitization/training course, directly managed any GBV cases, or if they were aware of any GBV-related programs in their communities. However, there was limited knowledge on effective strategies to prevent GBV and to care for survivors.

GBV knowledge among service providers: Comparing Kogi and Ebonyi states

GBV KNOWLEDGE AMONG SERVICE PROVIDERS	EBONYI	KOGI
VERY GOOD	1 (3%)	2 (8%)
GOOD	6 (20%)	11 (41%)
FAIR	17 (57%)	12 (44%)
POOR	6 (20%)	2 (8%)

The medical director at GH, Idah remarked, *“it is not culturally acceptable here for a doctor [man] to ask a woman if her husband beat her”* GBV cases, especially IPV, are perceived as ‘family matters’ and not requiring unnecessary intrusion from outsiders. Respondents in both states also cited religious beliefs and inability of some men to cater for their families due to recent economic conditions as pre-disposing factors exacerbating GBV prevalence. From the chats with community leaders and CBOs, culture is identified as an important factor affecting GBV. Male dominance especially in mutual relationships, seems to be accepted as a norm.

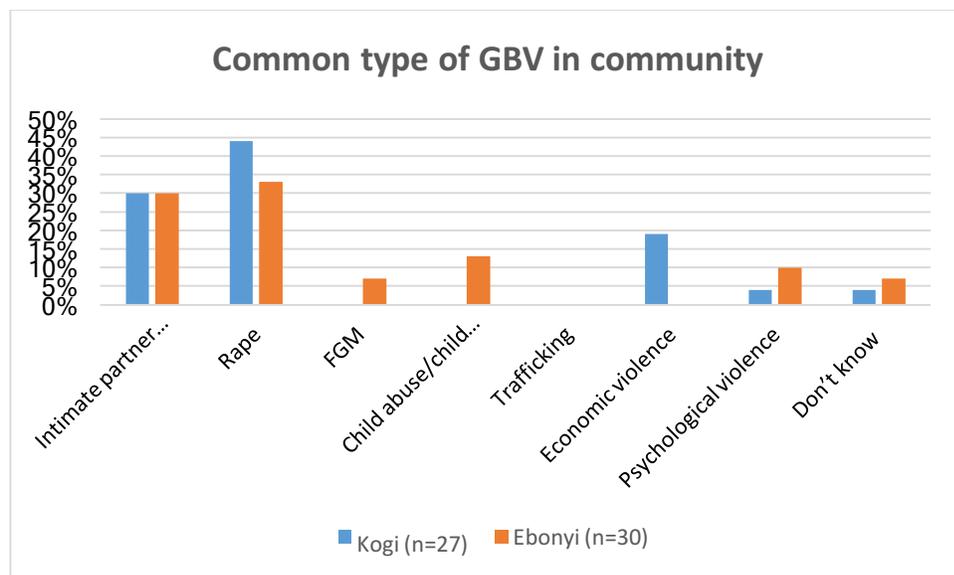


“Most times women are the source of their violence, some women are lazy and have subjected themselves to the mercies of men”
 - Women Leader, Afikpo South, Ebonyi

Common forms of GBV

Findings showed “rape” to be the most common form of GBV in the communities according to 44% of clinic respondents in Kogi and 42% in Ebonyi, with the second most common type, as Intimate Partner Violence (IPV). Service providers in secondary and tertiary health facilities reported more rape than providers in primary health facilities. GBV affects mostly female minors in Ebonyi and adult females in Kogi. Female genital mutilation (FGM) is a cultural practice in some places in Ebonyi State and it is a gross violation of human rights and results in numerous adverse health consequences, but stakeholders reported that it is on the decline.

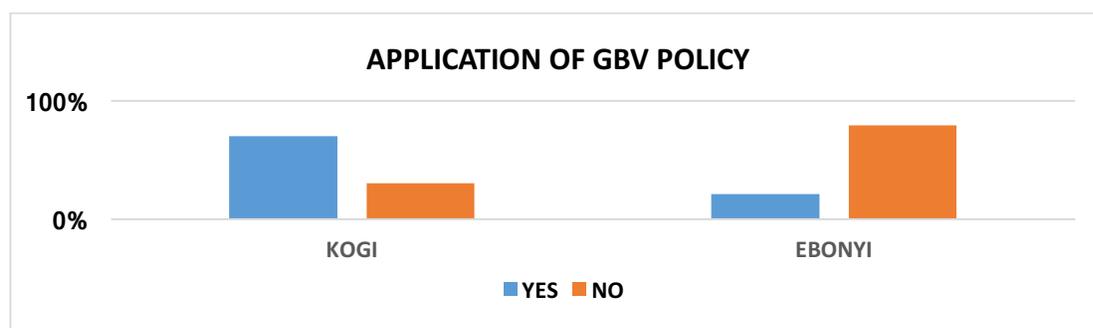
Common types of GBV occurring in the community



GBV Policies and laws

Ebonyi has a legislation against GBV called Ebonyi State Protection against Domestic Violence Law, 2005. Kogi state on the other hand, is still in the process of domesticating the Violence against Persons Prohibition (VAPP, 2015) Act. At the State ministries and LGA offices, there was a general knowledge of the existence of national and state laws/policies pertaining to GBV, though none of these policy documents were available to be sighted. Among the non-governmental organizations, almost all were aware of GBV laws/policies, but application of any of the policies was higher in Kogi (70%) than Ebonyi (13%) where more NGOs confirmed having utilized the national GBV guidelines and referral standard.

Application of GBV Policy



Post-GBV care provided at the health facilities

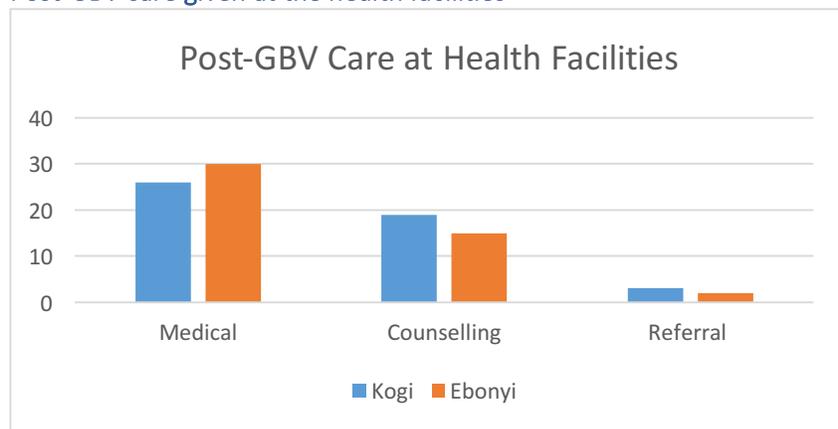
GBV Survivors usually seek care when they sustain physical injuries and need medical attention as a result of GBV. When rape cases are presented at the primary health facilities, they are usually referred to higher-

Even when survivors present at the clinic with obvious symptoms of GBV, they rarely opened up to the service provider

level facilities (secondary or tertiary). Facility staff interviewed in both states admitted that the rate of seeking health care among survivors is very low.

“I remember when one of our staff was beaten up by the husband, she told us she hit her head on the wall” - Nurse, Kogi State

Post-GBV care given at the health facilities



No service provider interviewed had ever referred a GBV case to the social welfare department for long term psychosocial support

Though GBV has serious health consequences including death, disability, miscarriage, fistula, stillbirth, etc., service providers do not feel they have a role in the management of survivors besides treating physical injuries. Doctors at secondary health facilities usually encounter GBV survivors amidst very tight clinic schedules, and social welfare officers are unavailable in the secondary facilities to counsel them, rather the social welfare officers are situated at the local government headquarters. Some service providers expressed concern adding ‘extra work load’ to their already strained manpower, if they have to look out for GBV survivors.

Current GBV programs and services

In Ebonyi, the State Ministry of Women Affairs and Social Development (SMOWASD) and Ebonyi State Community and Social Development Project performed GBV-related activities such as providing seed grants for women to start businesses, community mobilization and skills acquisition while in Kogi State, most GBV-related activities in the SMOWASD were on hold due to lack of funds. The SMOH and SMOWASD are responsible for GBV activities such as community mobilization or seed grants even though there was a lack of funds for some activities, however, the gender focal persons in the ministries in both states had few GBV responsibilities as their Directors provided most of the information gathered during the assessment. One of the deficits for post-GBV response identified in both states was lack of a state-owned emergency shelter for GBV survivors, though a couple of organizations run safe houses. The social welfare units of the LGAs (situated in the LG councils) in both states are poorly funded and ill-equipped to carry out GBV-supportive functions and difficult to access by far away communities.

Social services, which the SMOWASD promoted to be available widely in every LGA through the social welfare offices, were found to be erratic and skeletal. At the SMOWASD, designated gender officers did not seem to be in the know of GBV activities in the state, and poor coordination between officers and their Directors was evident. The LGA social welfare unit may not be adequately functional to provide long-term psychosocial counselling as they are usually situated far away from the communities in the LGA council; besides they have no offices within the health facilities.

GBV Activities by other government agencies:

The Nigerian Police Force and National Security and Civil Defense Corps (NSCDC) handle mostly IPV and rape of minors. The National Agency for the Prohibition of Trafficking in Persons (NAPTIP) cater for trafficked persons by offering rehabilitation and re-integration. The officers interviewed had just fair knowledge of GBV and associated laws and policies as cases were handled by alternative dispute resolution or prosecution by law. Financial constraints, weak laws and stigmatization were mentioned as barriers to performing their GBV functions and solicited that partnership with donor organizations would augment their efforts.

GBV Activities by non-governmental organizations (CSOs, CBOs and FBOs)

There was high level of awareness of both national and state-level GBV-related laws among CSOs, CBOs and FBOs that handle women and child right issues, in both states. There was a higher rate of usage of GBV policies and guidelines among the organizations in Kogi (70%) than Ebonyi (21%). Most organizations visited were found to be performing more than one GBV referral service but majorly focusing on community mobilization and advocacy with a very minimal combination of other functions such as psychosocial counselling, social integration, economic empowerment, legal and law enforcement services for post-GBV survivors. However, where these services or functions exist, they are located in urban areas, which makes it very difficult for GBV survivors to access due to distance and transportation costs. It is worth noting that the few services available through some NGOs are mostly international donor-driven and donor-dependent, portending huge funding gaps for post-GBV care.

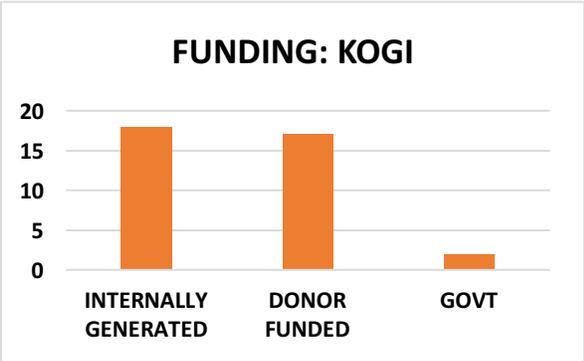
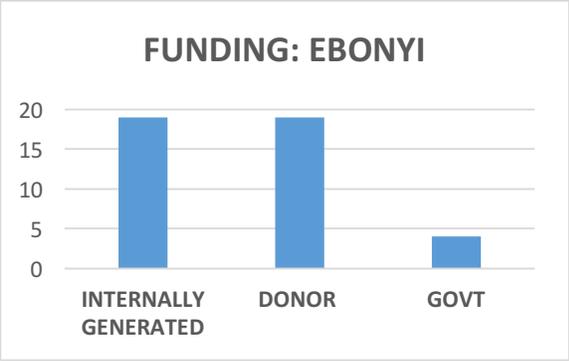
Summary of GBV referral services available in Ebonyi & Kogi

GBV REFERRAL SERVICE	EBONYI	KOGI
Long-term psychosocial counselling	<ul style="list-style-type: none"> • Available in some health facilities for sexual violence victims • Services rarely offered for other types of GBV • Provided by social welfare unit situated in LGA 	<ul style="list-style-type: none"> • Available in some health facilities for sexual violence victims • Services rarely offered for other types of GBV • Provided by social welfare unit situated in LGA
Law enforcement	<ul style="list-style-type: none"> • Police not adequately funded and trained to respond to GBV • Not linked with health facility 	<ul style="list-style-type: none"> • Police not adequately funded and trained to respond to GBV • Not linked with health facility • Require sensitization on working with GBV survivors
Safe house/emergency shelter	<ul style="list-style-type: none"> • No state-owned yet • SMLAS, NSCDC have shelter 	<ul style="list-style-type: none"> • No state-owned • DACA & DCI have shelter • SMOWASD staff volunteer

	<ul style="list-style-type: none"> • NAPTIP & Family law center staff volunteer 	
Economic empowerment	<ul style="list-style-type: none"> • Seed grants through 'Women wey get sense' cooperative (State Govt. project) • Some NGOs provide 	<ul style="list-style-type: none"> • No identified state project currently • Some NGOs provide with donor-funded projects
Social re-integration	<ul style="list-style-type: none"> • Skill acquisition projects at LGA are not steady, depend on available funds • Some NGOs provide with donor-funded projects 	<ul style="list-style-type: none"> • No state/LGA skill acquisition currently functional • Some NGOs provide with donor-funded projects
Community mobilization & advocacy	<ul style="list-style-type: none"> • SMOH, SMOWASD, LGA Councils, health facilities, all NGOs 	<ul style="list-style-type: none"> • SMOH, SMOWASD, LG councils, health facilities, all NGOs
Referrals	<ul style="list-style-type: none"> • SMOWASD, most NGOs (see referral matrix) 	<ul style="list-style-type: none"> • KONGONET, AYON, Child Protection Network Committee, most NGOs (See referral matrix)

Referral organizations

MCSP used inclusion and exclusion criteria to select referral organizations in the referral directory. Twenty (20) organizations were contacted in Kogi and 21 in Ebonyi based on identified organizations and none was found to handle purely GBV cases. All the organizations interviewed in both states performed community sensitization and advocacy as a direct service, and usually referred GBV survivors for medical, legal and law enforcement services. Other services such as social and economic empowerment projects and IEC sensitization were found to be donor-dependent.



Source of funding for referral organizations

Usually GBV occurs at night or on the weekends, and timely care is essential, particularly to prevent HIV and pregnancy for sexual assault survivors. It is important to ensure 24 hour care is available in at least one or two secondary or tertiary hospitals in each state but all organizations interviewed offered free services and typically operate between **8am to 4pm, Mondays to Saturdays**. Collaboration amongst referral organizations was common and most of them offered direct services and also referred when necessary. However, most organizations, including CBOs, have their operational offices in the state capital with field officers that visit rural sites on scheduled visits. NGOs were found to identify survivors by outreach to communities, referrals from the public, other organizations and volunteers from the community, or by the survivors coming themselves. They reported challenges such as insufficient funds,

ignorance around GBV issues, weak enforcement of laws, low level of reporting cases due to stigma, fears for safety and fears of GBV-related poverty, poor collaboration etc.

CSOs and CBOs are usually situated in the urban centers

The majority of the NGOs, though operational in the communities, have offices in the state capitals. These are difficult to access by survivors coming from far-away health facilities and none of the organizations interviewed offered pick-up or free transportation.

“The cost of responding to GBV is higher than the cost of prevention so why not stop it from happening in the first place” – Program Manager, Ebonyi Humanity Foundation

7.0. Recommendations

- Engage and sensitize all relevant stakeholders through an expanded stakeholder advocacy meetings involving state officials, selected service providers, community heads, police, legal officers, community leaders, CSOs, CBOs and FBOs, etc.
- Establish contact persons and phone number from the police divisions, buy-in of NGOs to support linking of referral services to clinics and increased GBV awareness.
- Carry out massive sensitization at state, local government and community levels.
- Design and develop information, education and communication materials on GBV.
- Build capacity of health staff to respond adequately to GBV and to make referrals to support organizations through capacity building, supportive supervision and mentoring.
- Map out a clear referral pathway and protocol to monitor clinic referrals and ensure survivors access the required care.
- Advocate to the Govt of Nigeria to extend support to NGO support services, particularly emergency shelter, to protect the safety of women and girls at risk, and to reduce dependency on donor funds.
- Carry out further studies to understand the specific socio-cultural factors that affect GBV in various communities in Nigeria.

8.0. Conclusion

Though most cases go unreported, GBV survivors do seek care in health facilities and have human right to high-quality, compassionate care. Health providers may feel they do not have the time or expertise to respond to GBV, but programs to build their capacity to offer 1st Line Support have demonstrated success and did not prove to be too much of a burden on strained health facilities. The lives saved and the medical costs averted by offering 1st line care well-outweigh the cost of the investments required to engage providers in basic care.

Referral organizations were found to be mostly international donor-funded and hence donor-dependent, with poorly linkages to health facilities. There is a need to link the few existing GBV referral services to the health facilities through engagement with service providers and non-governmental organizations, legal and law-enforcement agencies. The legal and law-enforcement agencies were limited in their response due to weak enforcement of GBV-related laws, financial constraints and an unwillingness or inability of survivors to pursue legal action. The existing government structure for social services through the SMOWASD and LG social welfare departments is skeletal and not properly coordinated. Strong socio-

cultural factors surrounding GBV make isolated medical care inadequate and therefore, there is a need to strengthen capacity of service providers on GBV case management and massive sensitization of all stakeholders and multi-sectoral collaboration amongst GBV actors to ensure optimal health outcome of GBV survivors. These sensitizations on GBV prevention should be carried out at all levels, including the communities, to ensure that citizens and providers are aware of what types of violence constitute GBV, that it violates human rights and is illegal, that there are serious health consequences from GBV, that men and boys have a role to play in preventing GBV and finding non-violent methods to resolve conflict, and that there are services available. Finally, there is strong need to advocate to government for the establishment of routine post-GBV care services at health facilities by establishing avenues or mechanisms where GBV survivors can access services for healthcare and other social services beyond health on a routine basis.