GENDER-BASED VIOLENCE SERVICES MAPPING IN EBONYI STATE, NIGERIA

MOMENTUM Country and Global Leadership

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ABBREVIATIONS

CBO	Community-based organization
CSO	Civil society organization
ECEWS	Excellence Community Education Welfare Scheme
FBO	Faith-based organization
FGD	Focus group discussion
FIDA	Federation of International Female Lawyers
GBV	Gender-based violence
GII	Gender inequality index
IDI	In-depth interview
IPV	Intimate partner violence
LGA	Local government area
ODK	Open data kit
PEP	Post-exposure prophylaxis
SOP	Standard operating procedure
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

Gender-based violence (GBV) is a public health and social development concern with far-reaching consequences for survivors, perpetrators, families, broader society, and economies. It primarily affects women and girls, though boys and men also experience GBV. As part of efforts to address major contributors to maternal mortality and morbidity through the prevention and mitigation of the consequences of violence against women and girls and possible drivers of early and forced child marriage, MOMENTUM Country Global Leadership, in collaboration with the Excellence Community Education Welfare Scheme, carried out a mapping field assessment of GBV service providers to identify available services and assess the quality, functionality, and capacities of service providers in 11 local government areas (LGAs) of Ebonyi State: Abakaliki, Afikpo North, Afikpo South, Ebonyi, Ezza North, Ezza South, Ikwo, Ivo, Izzi, Ohaozara, and Onicha.

Key informant interviews

Key informant interviews were conducted with the following stakeholders and agencies:

- Officers in-charge at health facilities
- Legal aid organizations
- Courts
- Law enforcement agencies
- Temporary shelter homes
- LGA officials
- Community leaders and survivor advocates

The mapping exercise aimed to identify, enumerate, and map existing formal and informal post-GBV services, as well as the readiness of facilities to provide high-quality services across sectors.

To achieve effective and quality mapping/data collection, MOMENTUM recruited 22 research assistants, who attended a five-day training that covered topics such as gender and GBV 101, research ethics, study objectives and methodology, and data collection procedures, and in-depth interview (see the box on the left for a list of those interviewed) and focus group discussion data collection tools, including recruitment and screening procedures for informed consent and study enrollment. The team developed a data collection schedule to support the initiation of data collection activities post-training and finalize data collection supervisory plans and overall schedules.

Two research assistants were deployed to each LGA to carry out the field mapping and data collection. Data collection took place over 15 days, with additional days for mop-up in all accessible public and private facilities. The sectors and stakeholders assessed during the mapping included the state Ministry of Health, Ministry of Women Affairs, and other state-level ministries, departments, and agencies (MDAs), health facilities, legal aid entities, the courts, law enforcement agencies, temporary shelter homes, social support services, LGA officials, community leaders, and survivor advocates.

The mapping included quantitative and qualitative data collection methods. Quantitative data were collected using REDcap and open data kit for facility assessments. Qualitative data were collected through key informant interviews and focus group discussions with specific stakeholders and community members.

SUMMARY OF FINDINGS

The findings demonstrate that Ebonyi State has a high statistical rate of GBV prevalence. Rape, physical assault, intimate partner violence, and sexual violence are the most prominent forms of GBV.

There are significant gaps in the existing knowledge base of service providers and infrastructure for the provision of GBV services in the state across the different sectors. For instance, health care providers were found to generally lack the capacity to provide basic clinical first-line support to GBV survivors (defined as counseling, safety planning, and referrals) and few service providers were aware of, or had ever referred GBV survivors to, referral services. Most health workers have never received any form of training on GBV services and limited their care to treating physical injuries only. Essential services required to effectively provide post-GBV care at health facilities (e.g., a private room for safe counseling) are conspicuously nonexistent. Only 12 (3 percent) of the mapped health facilities met the minimum criteria for post-GBV service provision.

GBV mapping activities revealed that most service providers do not offer specialized services for persons with disabilities or for children. In terms of service availability, health services (443) are the most available, followed by legal aid (20), psychosocial support (15), and economic empowerment (4), while the least available was temporary shelter (1). Referrals seemed to be mostly directed to health facilities, followed by law enforcement units.

INTRODUCTION

Gender-based violence (GBV) is a major public health issue because it has health (for example, severe physical injuries, unwanted pregnancy, HIV, and other sexually transmitted infections) and other outcomes. It is one of the most oppressive forms of gender inequality, posing a fundamental barrier to the equal participation of women and men in social, economic, and political spheres.[1] The lack of routine post-GBV care poses a great risk in the delivery of quality health care to women, adolescents, and children in Ebonyi State.

Ebonyi State has the second highest number of GBV cases in Nigeria after Cross River State.[2] In response to this crisis, on August 3, 2021, U.S. Chargé d'Affaires Kathleen FitzGibbon joined Nigeria's Minister for Humanitarian Affairs Sadiya Umar Farouq, representing Vice President Yemi Osinbajo, and Minister for Women's Affairs Dame Pauline Tallen to ceremonially launch a four-year activity from the U.S. Agency for International Development (USAID) that will prevent and respond to GBV in Ebonyi State. A growing consortium of Nigerian organizations will join MOMENTUM Country and Global Leadership in Ebonyi State in implementing the activity.

OBJECTIVES

- Identify, enumerate, and map existing survivor-centered GBV services, including formal and informal resources/services.
- Assess the quality, functionality, and accessibility of mapped service delivery points using a nationally accepted GBV quality assurance standard and develop recommendations for quality improvement.
- Determine and describe existing referral pathways between services, identify opportunities for improved coordination, and develop referral directories with detailed contact information.
- Identify stakeholders' perceptions of existing facilities and barriers to survivors seeking post-GBV care (including sociocultural/attitudinal, logistical, informational, and multisectoral coordination-related facilitators and barriers).
- Identify capacity needs of first responders across sectors for effective response to GBV survivors.

PREVALENCE OF GBV

According to the 2018 Nigeria Demographic and Health Survey, 50 percent of women and girls in Ebonyi over age 15 have experienced physical violence.[3] Ebonyi has extremely high levels of sexual violence compared to the rest of Nigeria: 20.8 percent of women in the state have experienced sexual violence compared to the national estimate of 9.1 percent. Furthermore, in Ebonyi State, 10.6 percent of women experienced sexual violence in the 12 months preceding the 2018 Nigeria Demographic and Health Survey. Most perpetrators of sexual assault are known to the victim (only 9.7 percent of perpetrators are strangers).[4] Neighbors (25.8 percent) and acquaintances (19.4 percent) were the most common perpetrators. Of ever-married women, 53.9 percent have experienced some form of spousal or intimate partner violence (IPV), the most common forms being emotional (44.4 percent), physical (41.5 percent), and sexual (15.6 percent).[3] Eight percent of ever-married women also reported that they had committed violence against their husbands in the past year.[3]

According to the International Growth Centre, there was a 26 percent increase in cases of rape and a 30 percent increase in cases of domestic violence between 2017 and 2020 in Ebonyi State.[5] Benue, Ebonyi, and Cross River States saw an even larger increase in domestic violence cases during that time period, by a magnitude of 53 percent.

The goal of this study is to add to the body of knowledge on GBV currently available in Ebonyi State. The study's findings can be used to inform future intervention strategies, as well as implementation strategies adopted by MOMENTUM, to help reduce this social crisis.

TABLE 1. COMPARISON OF GBV IN EBONYI STATE VS. NATIONALLY

Description of violence	Ebonyi	National
Physical abuse from husband or partner (ever-married women aged 15–49)	41.5%	19.9%
Sexual abuse from husband or partner (ever-married women aged 15–49)	15.6%	7.0%
Emotional abuse from husband or partner (ever-married women aged 15–49)	44.4%	31.7%
Controlling behavior: percentage of women whose husbands become jealous if they talk to other men	52.0%	44.2%
Controlling behavior: percentage of women whose husbands must know where they are at all times	50.7%	40.7%
Controlling behavior: percentage of women whose husbands limit how often they get to see their families	12.8%	10.2%
Percentage of women who agree that a husband is justified in hitting/beating his wife for at least one specified reason (burns the food, argues with him, goes out without telling him, neglects the children, or refuses to have sex)	39.6%	28.0%

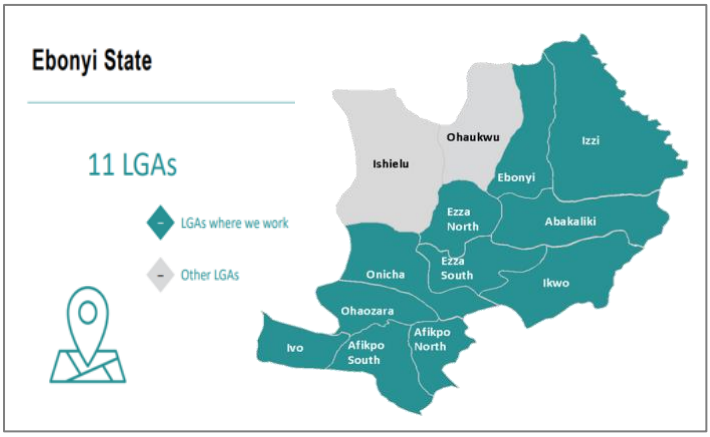
Source: Nigeria National Demographic Health Survey 2018

POLICIES AND GUIDELINES

The Spotlight Initiative, a global, multi-year partnership between the United Nations and the European Union, is working to end GBV in Ebonyi State by responding to all forms of violence against women and girls, with a focus on domestic and family violence and sexual and gender-based violence through a collaborative effort.[2] Evidence indicates that a high level of awareness exists at both the national and state levels regarding GBV-related laws among civil society organizations (CSOs), community-based organizations (CBOs), and faith-based organizations (FBOs) that deal with women's and children's rights.

SCOPE OF WORK AND DEMOGRAPHICS

Data collection and mapping took place in 11 LGAs in Ebonyi State: Ezza South, Ezza North, and Ikwo (Ebonyi Central Zones); Abakaliki, Ebonyi, and Izzi (North Senatorial Zones); and Ohaozara, Onicha, Afikpo North, Afikpo South, and Ivo (South Senatorial Zones).



PREPARATORY ACTIVITIES

Before the GBV mapping, an advocacy and sensitization meeting was organized for various stakeholders across the Ministry of Health, Ministry of Women Affairs and Social Development, legal and professional bodies, CSOs, faith-based organizations (FBOs), traditional ruler's council, local governments council, local partners, and MOMENTUM team members, among other actors.

The meeting aimed to sensitize stakeholders to the GBV services mapping underway, identify relevant stakeholders, and solicit their support for research assistants who will collect data from the communities. Presentations and discussions at the meeting centered on the mapping design and targets. Stakeholders provided vital feedback and suggestions on how to improve the GBV service mapping activity. Questions and concerns were also raised related to the plan, which were recommended to be taken into consideration during the final program design.

The MOMENTUM team, which included members of the Excellence Community Education Welfare Scheme, conducted interviews with the shortlisted research assistants. During the interviews, participants were assessed on their knowledge of GBV, academic/professional background, related work experience in carrying out surveys, relevant skills, familiarity with the implementing LGAs, and ability to communicate in the local language. After the interviews, panelists submitted their score sheets, which were used to calculate the participants' scores. The team selected 22 candidates based on their performance during the interview, in particular, their ability to communicate in the local language.

PRE-MAPPING TRAINING

In conjunction with the state and national supporting ministries, the MOMENTUM team conducted a four-day pre-mapping training for the 22 research assistants on June 9–12, 2021. All sessions were facilitated using adaptive and learner-centered methodologies through the use of flip charts, sticky notes, practical demonstrations, group discussions, and a mix of fun learning activities. Throughout the four-day training, COVID-19 precautionary measures were emphasized and all nonpharmaceutical preventive measures were duly observed. Key messages were delivered accurately during the training, taking into consideration the participants' levels of assimilation.

The training had the following objectives:

- Orient the data collection team on gender and GBV 101, research ethics, study objectives and methodology, and data collection proceedings.
- Discuss the IDI and FGD data collection tools, including the recruitment and screening procedures for informed consent and study enrollment.

- Develop an immediate data collection schedule to support the initiation of data collection activities post-training.
- Finalize data collection supervisory plans and overall schedules.

Participants were engaged in role plays and discussions as they practiced recruitment and use of consent tools to administer surveys to women through FGDs and IDIs in all languages. Two cases were used:

- Case 1: Relatively easy enrollment/consenting process.
- Case 2: Potential participants who were not comfortable explicitly or directly declining participation, but did so indirectly and nonverbally. Pre-test and post-tests were used to ascertain the level of knowledge gained by participants.

Discussions about possible interpretation of some GBV key terms in the Igbo language were identified during the training as follows:

- **GBV**: Mmegide ana emegide nwoke ma obu nwanyi
- **Rape**: Ikwagide mmadu iko n'ike na-abughi uche ya
- **IPV**: Mmegide di na etiti nwoke na nwanyi n'eme mmeko ma obu di na nwunye
- **Child abuse**: Mmegide ana emgide nwatakiri
- **Female genital mutilation**: Ibe nwanyi ugwu

The training ended with a field test of the GBV service provider mapping tools at three different GBV service points for validation. Research assistants were divided into three groups for the field test to visit each of the GBV service units, respectively. These included police headquarters, the Federation of International Female Lawyers (FIDA), and a maternal and child health center. The field visit gave participants hands-on experience and an opportunity to practice the measures put in place for GBV service assessments and data collection. Participants also gained experience with the study tools that will be administered during their field duties at assigned LGAs. Each group then presented their feedback. They highlighted how well interviewers interacted with respondents, including their approach for seeking consent, and that respondents handled the questions well. They also noted adequate communication through body language among the interviewer team.

The researchers were then equipped with the necessary collection tools for the GBV data collection/assessment exercise and dispersed to the 11 LGAs in pairs.

KEY FINDINGS

Below is a summary of the findings from the GBV service mapping exercise in Ebonyi:

- A high prevalence of GBV (prevalence estimate) was found, with the most prominent forms of GBV reported and addressed across the facilities including physical assault, IPV, sexual violence, and physical and sexual violence against children.
- Low capacity was observed on medico-legal reporting, forensic examination, handling of evidence, and testifying in court.
- It was observed that the majority of facilities offer 24-hour services to both adults and children, thus allowing for management of all age levels throughout the state.

- A quarter of service providers were providing GBV services using standard policies, protocols, and operating procedures. However, many of the GBV service providers operate without policies or standard operating procedures (SOPs).
- The outcome of the mapping, as reported by service providers, shows that seven out of 10 (69.2 percent) GBV survivors have the right to choose their treatment or to refuse to be treated.
- The proportion of trained GBV focal persons was found to be low.
- Several providers reported that they verbally refer survivors to other GBV services without necessarily giving them appropriate referral documents. Also, the majority of providers reported that survivors are not often escorted to care. Greater referrals are directed to health sectors, followed by law enforcement units, and then to limited psychosocial structures.
- The stakeholders working to put an end to GBV at the state and LGA levels include the Ministries of Health, Information, Women Affairs, and Justice, FIDA, EU-Spotlight, United Nations Population Fund, USAID Integrated Health Program, State Emergency Management Agency, CBOs, and CSOs.
- 61.3 percent of the security providers reported that they do not follow up with GBV survivors to ensure their well-being.
- Survivors of GBV pay for case investigation and safety/security planning and enforcement.
- Although some health care providers have undergone GBV training, many of the facilities were found to have a low proportion of trained providers.
- Most of the services provided at the health facilities are free; however, 37.9 percent of the facilities reported that GBV survivors pay for services received.
- Out of 73 health facilities that provide post-exposure prophylaxis (PEP), 84.9 percent reported that PEP is available and administered within 72 hours of an emergency. However, less than half (48.5 percent) of the facilities offered emergency contraception within 120 hours.
- Primary health care facilities dominated (84.9 percent) the type of facilities across the 11 LGAs. Only 5.2 percent were secondary health care facilities, 0.5 percent are tertiary, and 9.5 percent were other types of facilities.
- More than half (59.1 percent) of the facilities reported that they had not updated their referral directories. While 35.7 percent update the referral directory at least every six month, 5.3 percent of the facilities claimed they update it every year.
- It is important to note that most of the service providers do not provide specialized services for persons with disabilities. About 86.8 percent of the facilities do not have specialized services designed/adapted for persons with disabilities, while 13.2 percent of the facilities offer specialized services. Half (50.7 percent) of the facilities reported that all staff signed codes of conduct.

METHODS AND APPROACHES

METHODOLOGY

The research assistants conducted a rapid assessment on purposively selected key informants (respondents) using qualitative and quantitative questionnaires or interview guides. REDcap and open data kit (ODK) application tools were deployed for quantitative tasks, whereas the qualitative tasks were carried out using an open-ended, semi-structured questionnaire with health facilities, police/civil defense, legal aid, court, social support, temporary shelter homes, community leaders, identified survivor advocates, and LGA officials.

MAPPING DESIGN

- Qualitative methods: IDIs for identified key stakeholders at state, LGA, and community levels and separate FGDs for community-based men and women.
- Quantitative methods: Surveys for facility mapping/assessment and provider capacity assessment.

Qualitative data were collected through in-depth interviews (IDIs) and focus group discussions (FGDs). The IDIs targeted relevant officers in selected facilities across key sectors. Other individuals interviewed with this method were community leaders and key stakeholders at the state level. For FGDs, participants were selected based on their gender. Two FGDs were held in each LGA, one for men and another for women.

The quantitative data were collected through service provider interviews and facility surveys. Participants were identified and recruited using an iterative process that involved input from states, LGAs, community stakeholders, and the mapping team. Following consultations with several stakeholders, a range of service providers and stakeholders were identified and interviewed across the mapping areas. An initial listing of facilities (by category of service) was developed in collaboration with LGA officials in the state. During the actual data collection, a snowballing method was used to identify additional facilities and map them accordingly, thus the data collectors were able to cover all areas in the focus LGAs.

The mapping included 509 facilities providing services such as legal, law enforcement, health, temporary shelter, and social support. To be included, facilities had to be functional with basic infrastructure (a roof and at least items such as chairs and tables) and staff, and capable of providing GBV services, which could be legal, law enforcement, health, social support, or temporary shelter.

For the mapping, the team used the WHO/Jhpiego GBV QA Mapping Tool, adapted to include additional questions. MOMENTUM also developed an addendum tool for capacity assessments as well as tools for the FGDs and IDIs. The FGD tool helped to discern community members' perceptions of the most common forms of GBV in the community and what typically happens when GBV occurs, especially when incidents are reported, the existence of informal services for GBV survivors, and so on. IDIs were used to understand help-seeking behavior and services available within the state, LGA, or community, as appropriate.

SAMPLE SIZE BY SECTOR/ STUDY POPULATION

Quantitative surveys (through two data collection applications: REDcap and ODK)

Tool	Health	Social services	Shelter homes	Law enforcement	Legal aid	Total
Facility assessment	All available facilities in each of the sectors					N/A
Provider capacity assessment	All GBV focal persons					N/A

Qualitative surveys—IDIs (participant category)

#LGAs	Health	Social service staff	Community leaders	Safe home staff	Law enforcement agents	Magistrate/ customary court	Legal aid workers	# per LGA	Total
11	2	2	2	2	2	2	2	14	154
Add 10 IDIs for government officials from various ministries/departments and state-level stakeholders									10
Combined total # of IDIs									164

Qualitative surveys—FGDs (participant category)

FGDs	Number conducted	Total participants
Women	1	8
Men	1	8
Total number of FGDs per LGA	2	16
Overall total for all LGAs	22	176

DATA COLLECTION

Face-to-face interviews with service providers enabled collection of quantitative and qualitative data about facility readiness, GBV knowledge and perceptions, the existence of GBV services in their facilities, and what the providers would need to improve (or begin delivering) for delivery of basic GBV care. Also, contextual information was gathered from community leaders and survivor advocates who provided detailed information on the GBV situation within their communities. The qualitative information of responses from IDIs and FGDs were further transcribed from recordings for further data analysis.

DATA MANAGEMENT

DATA CLEANING

During the mapping activity, the cleaning process removed incorrect, corrupt, incorrectly formatted, duplicated, or incomplete data within each reported dataset to ensure reliable data for analysis.

The data-cleaning process involved the following:

- Removing duplicate or irrelevant data captured during data collection.
- Fixing structural errors such as name conventions.
- Correcting typos or incorrect capitalization to avoid inconsistencies that can cause mislabeled categories or classes.
- Filtering unwanted outliers, such as improper data entry, to fit within the data that are being analyzed and help the performance of the data being worked on.

To ensure data accountability, the research assistants were advised about the observed missing data for re-input/capturing. At the end of the data-cleaning process, data quality was assured before data analysis commenced.

DATA ANALYSIS

Responses from qualitative surveys were transcribed from recordings and field notes. In addition, qualitative survey data were drawn from submitted transcripts and content analysis was done to code responses across different categories of respondents and sectors for the 11 project LGAs in Ebonyi State. A team of six coders was involved in this process. Coders attended a pre-analysis workshop during which they participated in group coding to assess inter-rater reliability and ensure common interpretation of themes.

QUALITY ASSURANCE

Routine measures were used to assure data quality across the 11 LGAs in Ebonyi State. These measures included resolving identified quality issues observed during routine cross-checks, ensuring reliability of data during data collection and while analyzing documented findings, checking margin of error reported along with the data to ensure data accuracy, and ensuring adequate dependence in key data collection, management, and assessment procedures. Data cleaning was performed to prevent data errors. Ensuring timeliness of data was also necessary to inform program management decisions and assist in interpretation of the data. Performing routine cross-checking during supervision helped to respond effectively to emerging problems and ensure data accountability. Before the field exercise, research assistants received financial resources and logistical support for training and travel to ensure timely performance.

IMPLEMENTATION CHALLENGES

- Insecurity was a challenge in some LGA communities due to inter-communal crises.
- The intensity and length of time required for some of the interview tools overwhelmed some respondents.
- Poor roads and network coverage caused delays for staff in assessing facilities.
- Private clinics in Izzi LGA did not comply and found it difficult to give us an audience to conduct interviews and map their facilities.
- Some research assistants experienced technical glitches in submitting data to the server on their tablets. However, this issue was promptly resolved.
- Most LGAs do not have temporary shelter homes and social support service providers, making it difficult to reach the set targets.
- Some police personnel and courts declined to consent to being recorded.
- Most private facilities were not functional while some had relocated to another state.
- A few facilities could not be accessed due to poor terrain and rainfall cutting off roads.

MAJOR FINDINGS

MAPPING ASSESSMENT/FINDINGS

FACILITIES ASSESSED BY LGA

Table 2 shows the number of facilities visited in each LGA and the percentage each represents. In the 11 LGAs, research assistants visited 509 facilities, which cut across different service sectors.

TABLE 2. SUMMARY OF FACILITIES VISITED BY LGA

LGA	Frequency (N = 509)	Percentage (%)
Abakaliki	62	12.2
Afikpo North	37	7.3
Afikpo South (Edda)	33	6.5
Ebonyi	58	11.4
Ezza North	34	6.7
Ezza South	44	8.6
Ikwo	51	10.0
Ivo	29	5.7
Izzi	64	12.6
Ohaozara	43	8.4
Onicha	54	10.6

Table 3 shows the services provided by facilities/organizations assessed. Of the 509 unique sites assessed in Ebonyi State, health services are available in 443, law enforcement services in 31, psychosocial support in 15, legal aid in 20, temporary shelter in three and economic empowerment in four. Data show gaps in some LGAs, such as Ikwo, Ohaozara, and Ezza South. Only Ebonyi LGA has all the required services.

TABLE 3. SUMMARY OF FACILITIES VISITED BY SERVICES PROVIDED ACROSS LGAS

LGA	Health	Law enforcement	Legal aid	Social support	Temporary shelter	Economic empowerment/ livelihood
Abakaliki	54	3	0	5	0	0
Afikpo North	31	3	1	2	0	0
Afikpo South (Edda)	30	1	0	2	0	0
Ebonyi	34	6	10	5	1	4
Ezza North	32	1	1	3	0	0
Ezza South	40	0	1	3	0	0
Ikwo	49	0	0	2	0	0
Ivo	24	2	0	3	0	0
Izzi	60	1	1	2	0	0
Ohaozara	41	1	0	1	0	0
Onicha	48	2	1	3	0	0

SOURCES OF FUNDING

Table 4 illustrates the sources of funding, showing that the main source was from the Nigerian Government (71.9 percent), with the two next highest sources being private donors (13 percent) and fee for services (13.2 percent).

TABLE 4. DISTRIBUTION OF FACILITIES VISITED BY SOURCES OF FUNDING

Source of funding	Frequency	Percentage
Nigerian Government	366	71.9
Foreign governments	9	1.8
International organizations	10	2.0
Private donations	66	13.0
Fee for services	67	13.2
Other	22	4.3

DISTRIBUTION OF AGE GROUP SERVED BY FACILITIES/ORGANIZATIONS

Findings presented in Table 5 show that most of the facilities largely serve adults and children (97.6 percent).

TABLE 5. AGE GROUPS THAT THE FACILITY/ORGANIZATION SERVES

Age group facility serves	Frequency	Percentage
Only adults (18 and over)	11	2.2
Only children (under 18)	1	0.2
Adults and children	497	97.6
Total	**509**	**100**

During the interviews, the providers mentioned that they serve a diverse population of survivors without giving a specific age group. One person interviewed commented, *"We don't have any specific age range. It cuts across all ages and genders."* (Stakeholder IDI, State Ministry of Women Affairs)

FACILITY HOURS OF OPERATION

Table 6 shows that 90 percent of the facilities reported operating 24 hours a day, seven days a week, while 10 percent operate only a few days a week.

TABLE 6. FACILITY OPERATING HOURS

24 hours open and accessible	Frequency	Percentage
No	51	10.0
Yes	458	90.0
Total	**509**	**100**

FACILITY WORKING DAYS

Table 7 shows that many of the facilities that do not operate 24/7 are open mainly during the week. Eight out of every 10 facilities visited indicated that they operate between Monday and Friday, with only a few open on weekends.

TABLE 7. DAYS OPEN FOR FACILITIES NOT OPERATING 24/7

Days open (n=51)	Frequency	Percentage
Monday	45	87.5
Tuesday	40	79.2
Wednesday	42	83.3
Thursday	42	83.3
Friday	45	87.5
Saturday	13	25.0
Sunday	6	12.5

FORMS OF GBV REPORTED AND ADDRESSED

Table 8 shows the distribution of various forms of GBV addressed at the facilities visited. Physical assault (46.2 percent), IPV (42.4 percent), and sexual violence (rape and sexual assault) (40.7 percent) were the most prominent types of the GBV cases at these facilities. Interview data also revealed rape and IPV as common forms of GBV in the state. Of physical abuse and IPV, one provider said, *"Some husbands bully their wives for no reasonable cause [husband beating] even denial of women's right."* (Social Support Service Provider, IDI)

Of rape, a stakeholder interviewed said, *"Both girls and boys are at risk. At times, married women do force young boys to sleep with them [. . .]."* (Stakeholder, IDI)

TABLE 8. FORMS OF GBV REPORTED AND ADDRESSED ACROSS SERVICES

Forms of GBV addressed by the facility (N=509)	Frequency	Percentage
Physical assault	235	46.2
IPV	216	42.4
Sexual violence (rape, sexual assault)	207	40.7
Violence against children (including physical or sexual abuse of children)	154	30.3
Early childbearing	127	24.9
Female genital mutilation	119	23.4
Early marriage	82	16.1

AVAILABILITY OF PROTOCOLS AND POLICIES FOR PROVISION OF GBV SERVICES

Table 9 illustrates the different types of policies, protocols, or SOPs that are in place for the delivery of GBV care. These findings showed that a higher proportion of the GBV health care providers operate without any known policies or SOPs. Also, many facilities were not able to show the handbook. Thus, the findings suggest that most of the service providers were not guided by any SOPs, policies, or protocols on the provision of GBV care, rather, staff provide services to GBV survivors based on their own experience and training.

TABLE 9. AVAILABILITY OF POLICIES, PROTOCOLS, OR SOPs THAT STAFF FOLLOW TO PROVIDE SERVICES TO SURVIVORS OF SPECIFIC FORMS OF GBV

Availability of policies, protocols or SOPs	Health (n=443)	Legal aid (n=20)	Psychosocial (n=15)	Law enforcement (n=31)	Shelter (n=1)	Economic empowerment (n=4)
	F (%)	F (%)	F (%)	F (%)	F (%)	F (%)
Availability of policies, protocols	98 (22.1)	16 (80)	11 (73.3)	24 (77.4)	1 (100)	4 (100)
Yes, seen	33 (11.1)	4 (25)	1 (9.1)	4 (16.7)	1 (100)	1 (25.0)

Note: F = frequency.

POLICIES, PROTOCOLS, OR SOPS

Table 10 shows the different forms of GBV for which policies, protocols, or SOPs are available at the facilities visited. Of the facilities where staff follow policies, protocols, or SOPs in GBV care, a higher percentage have these guidelines in place for responding to sexual violence, IPV, and domestic violence by family members other than an intimate partner than for early marriage or female genital mutilation. Only the one shelter/temporary housing organization has policies, protocols, or SOPs for all of these GBV-related services

TABLE 10. FORMS OF GBV FOR WHICH POLICIES, PROTOCOLS, OR SOPs EXIST FOR STAFF TO FOLLOW TO PROVIDE GBV SERVICES

Form of GBV	Health facilities (n=443)	Legal aid organizations (n=20)	Psychosocial services (n=15)	Law enforcement (n=31)	Shelters/ temporary housing (n=1)	Economic empowerment (n=4)
	F (%)	F (%)	F (%)	F (%)	F (%)	F (%)
Sexual violence (rape, sexual assault)	98 (22.1)	17 (85.0)	9 (60.0)	27 (87.1)	1 (100)	2 (50.0)
IPV	98 (22.1)	16 (80.0)	9 (60.0)	25 (80.7)	1 (100)	2 (50.0)
Domestic violence by other family members	97 (21.9)	17 (85.0)	9 (60.0)	25 (80.7)	1 (100)	3 (75.0)
Early marriage	46 (10.4)	5 (25.0)	2 (13.3)	7 (22.6)	1 (100)	1 (25.0)
Female genital mutilation	57 (12.9)	9 (45.0)	4 (26.7)	8 (25.8)	1 (100)	3 (75.0)

POLICIES FOR GBV DATA MANAGEMENT

Table 11 shows the reported availability of policies and protocols for prosecuting GBV cases affecting children. It also shows the reported availability of policies and protocols for data collection, management, and referrals as well as the availability of forms used to collect patient information.

TABLE 11. AVAILABILITY OF POLICIES AND PROTOCOLS FOR GBV CASES AND DATA COLLECTION

Availability of policies and protocols for (N=509)	Health (n=443)	Legal aid (n=20)	Psychosocial (n=15)	Law enforcement (n=31)	Shelter (n=1)	Economic empowerment (n=4)
	F (%)	F (%)	F (%)	F (%)	F (%)	F (%)
Dealing with cases of GBV affecting children	67 (15.2)	16 (80.0)	10 (66.7)	22 (71.0)	1 (100)	3 (75.0)
Data collection and management	151 (34.1)	16 (80.0)	12 (80.0)	22 (71.0)	1 (100)	2 (50.0)
Providing referrals and coordination	154 (34.8)	16 (80.0)	11 (73.3)	21 (67.7)	1 (100)	2 (50.0)
Collecting patient information	271 (61.2)	14 (70.0)	14 (93.3)	24 (77.4)	1 (100)	2 (50.0)

DATA PROCESSING AND STORAGE

Table 12 shows how GBV data are processed and stored in the facilities visited. Findings revealed that nine out of every 10 (91.1 percent) service providers only store physical data, while only 1 percent store all data electronically and 7.9 percent use both electronic and physical storage of data.

TABLE 12. METHOD OF DATA PROCESSING AND STORAGE AT THE MAPPED FACILITIES

Method of data processing and storage (N=509)	Frequency	Percentage
Only physical (paper) data are stored	464	91.1
Only electronic storage of data	5	1.0
Both electronic and physical storage of data	40	7.9
Total	**509**	**100.0**

BASIC INFRASTRUCTURE

As Table 13 shows, the majority of service providers reported that GBV survivors have the right to choose their treatment and/or to refuse treatment. Approximately seven out of every 10 service providers reported sufficient space to ensure GBV survivors' privacy during counseling sessions; only 11.4 percent of the service providers reported to have ever asked questions about GBV in the presence of another person. The findings revealed that many GBV service providers consistently protect GBV survivors' privacy.

TABLE 13. BASIC INFRASTRUCTURE

Variables (N=509)	Frequency	Percentage
Data stored in a secure and locked location	398	78.2
All electronic files stored on a password-protected computer	50	9.8
Survivors have the right to choose their treatment and/or to refuse to be treated	352	69.2
Sufficient space to ensure survivor's privacy	352	69.2
Privacy of survivors during counseling sessions	345	67.8
Ever asked questions about GBV in the presence of another person	58	11.4

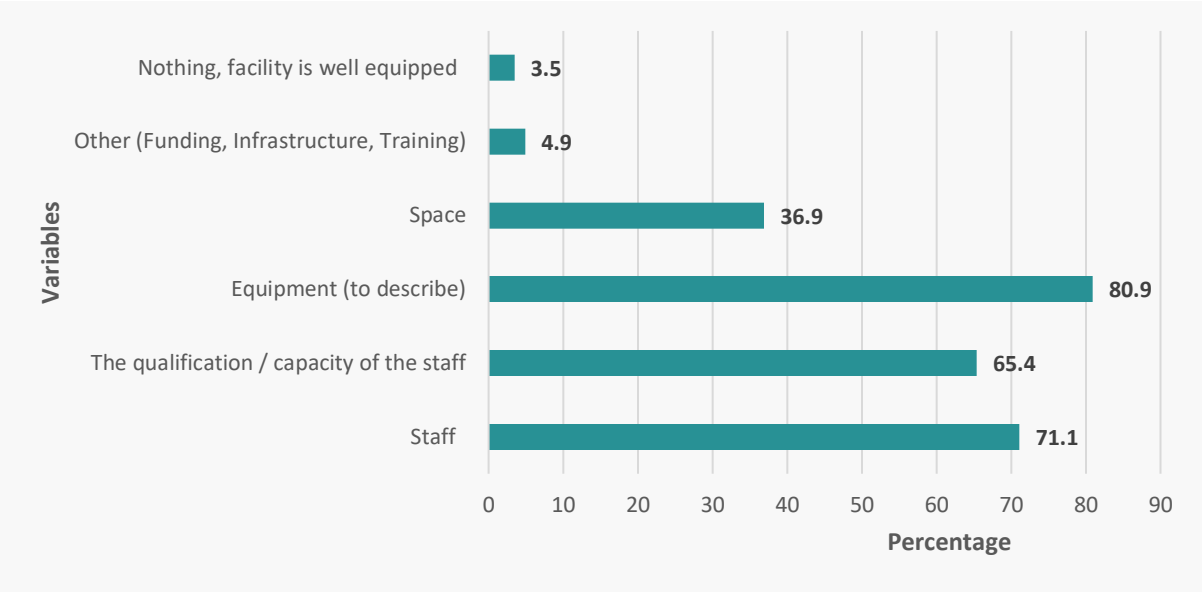
REPORTED GAPS IN QUALITY GBV SERVICE PROVISION

Table 14 shows that facilities visited were missing equipment or qualifications needed to provide quality care to GBV survivors. More than 65 percent of the facilities reported a lack of staff or qualifications and capacity for service provision. They also noted the lack of equipment such as angle lamps for pelvic exams, resuscitation equipment, and tongue depressors for inspection of oral frenulum and injury. Only 3.5 percent of the facilities stated they are well equipped (see also Figure 1).

TABLE 14. GAPS IN FACILITY READINESS TO PROVIDE QUALITY CARE TO SURVIVORS OF GBV

	Frequency (N=509)	Percentage
Trained staff	362	71.1
Qualification/capacity of staff	333	65.4
Equipment	412	80.9
Space	188	36.9
Other (funding, infrastructure, training)	25	4.9
Nothing, facility is well equipped	18	3.5

FIGURE 1. FACILITY READINESS TO PROVIDE QUALITY CARE TO SURVIVORS OF GBV (N = 509)



PROVISION OF SPECIALIZED SERVICES

Findings revealed that only 67 (13.2 percent) of the 509 facilities visited provide specialized services designed or adapted for people with disabilities. Half (50.7 percent) of the facilities reported that all staff signed codes of conducts.

AVAILABILITY OF CODE OF CONDUCT

As Table 15 shows, although half of the 258 facilities (50.4 percent) claimed that codes of conduct were available, they could not provide it, with just 19 percent of the facilities able to provide it.

TABLE 15. PRESENCE OF CODE OF CONDUCT

A copy of the code of conduct (N=258)	Frequency	Percentage
No, not present	79	30.6
Yes, seen	49	19.0
Yes, did not see	130	50.4

GBV FOCAL PERSON

Findings showed that fewer than 25 percent of the facilities visited have GBV focal persons, as indicated in Table 16. Of the facilities that do have GBV focal persons, most of them are not trained.

TABLE 16. AVAILABILITY OF GBV FOCAL PERSON

Availability of (N=509)	Frequency	Percentage
GBV focal person	114	22.4
Trained GBV focal person	73	14.3

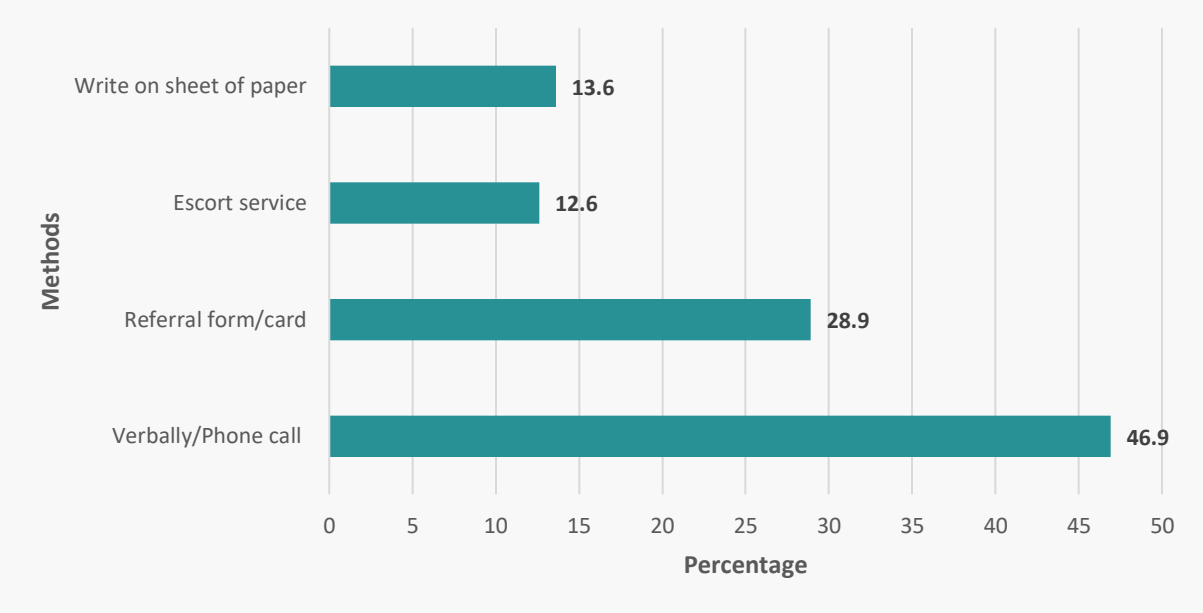
REFERRAL DIRECTORY

Only a third of facilities (33.4 percent) have a referral directory.

METHOD OF CARRYING OUT REFERRALS

The facilities visited use various approaches to refer GBV survivors to other services. As Figure 2 illustrates, verbal referral or referral through phone calls dominated other methods across the facilities. One key stakeholder said, *"In referring, after taking care of the victim, and we want to refer, we have to go with that person, and we follow up the case until the case is ended. It is not even when we refer, we don't forget about it, we have to be asking or calling them, so that we will know the extent [of the follow-up]. If it needs you going there, … if the person is in police, we have to be following that person and know how the police will do it."* (Stakeholder, IDI, LGA Department of Education/Social Welfare)

FIGURE 2. METHOD OF CARRYING OUT REFERRAL FOR GBV SURVIVORS (N = 509)



REFERRAL AMONG SERVICES

Table 17 shows referral frequency among different services. As the findings show, about 71.5 percent of facilities always or sometimes refer GBV cases to health facilities. However, only 23.2 percent always or sometimes refer GBV survivors to law enforcement (see also Figure 3).

Below are some responses about referral from the qualitative interviews:

"Yes: we refer to the appropriate people that will handle mostly child protection and women affairs. One-time incident I was referred to the police headquarters." —Stakeholder, IDI

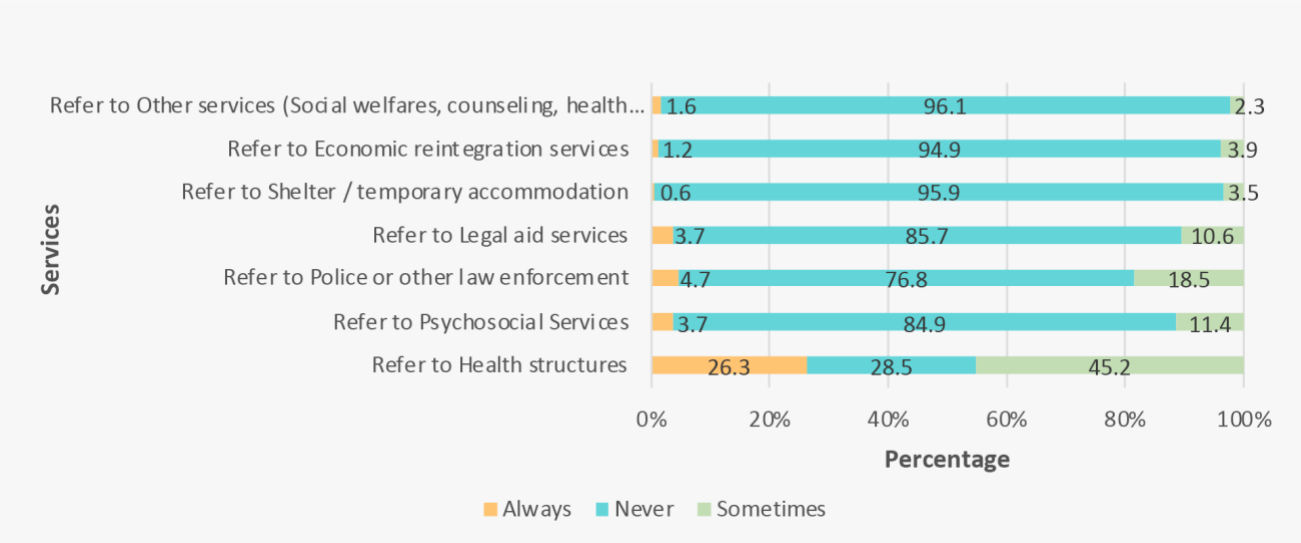
"We don't have a committee apart from the traditional ruler of the community, and he handles it. It is only when it is too severe that he refers a case to either welfare or government agencies." —Male, FGD

"Yes. We refer to general hospitals and social welfares and police." —Stakeholder, IDI

TABLE 17. REFERRAL AMONG SERVICES

	Always		Never		Sometimes	
	Freq	%	Freq	%	Freq	%
Refer to health structures	134	26.3	145	28.5	230	45.2
Refer to psychosocial services	19	3.7	432	84.9	58	11.4
Refer to police or other law enforcement agency	24	4.7	391	76.8	94	18.5
Refer to legal aid services	19	3.7	436	85.7	54	10.6
Refer to shelter/temporary accommodation	3	0.6	488	95.9	18	3.5
Refer to economic reintegration services	6	1.2	483	94.9	20	3.9
Refer to other services (social welfare, counseling, health structures)	8	1.6	489	96.1	12	2.3

FIGURE 3. REFERRAL AMONG SERVICES (N = 509)



REFERRAL TRACKING

Findings show that the tracking of referrals is largely carried out through verbal communication or phone calls, as indicated in Table 18. This was also corroborated in the qualitative responses as shown below.

REFERRAL FEEDBACK:

> *"Through referral feedbacks, and through phone calls and home visits."* —Stakeholder, IDI

ESCORT SERVICE AND PHYSICAL VISIT:

> *"One: immediately we refer, we go to the office, not calling on phone. You go in person, if it needs calling, maybe after reporting, because any referral has to be there to know what is happening. Maybe calling them after 2–3 days. Then the following time, you will be invited, not calling again. Then use WhatsApp to know what is going on."* —Stakeholder, IDI

REFERRAL WITH NOTES:

"We write on a referral note, then we guide the person to the next level, then after such, they can give us feedback, because you cannot just write and give the person to start going, you have to follow it up and ensure that the person reaches where [the person is] supposed to be." —Stakeholder, IDI

TABLE 18. REFERRAL TRACKING

	Frequency	Percentage
Had any way to track whether or not a referred survivor has contacted the receiving organization (n=509)		
Yes	252	47.5
No	257	50.5
Methods of tracking whether or not a referred survivor has contacted the receiving organization (n=252)		
Verbally/phone call	191	75.8
Referral form/card	22	8.7
Escort service	37	14.7
Other	2	0.8

UPDATE OF REFERRAL DIRECTORY

Findings revealed that more than half (59.1 percent) of the facilities have never updated their referral directories, with 35.7 percent indicating that they update it every six month or less (see Table 19).

TABLE 19. FREQUENCY OF UPDATING REFERRAL DIRECTORY

Directory update (n=252)	Frequency	Percentage
Every six months or less	90	35.7
Every year	8	5.3
More than a year	5	1.9
It has never been updated	149	59.1

FINDINGS BY FACILITY TYPE

HEALTH CARE

FACILITIES VISITED

As Table 20 shows, primary health care facilities made up the majority of the facilities, with far fewer secondary, tertiary, and other health care facilities.

TABLE 20. TYPE OF HEALTH FACILITIES

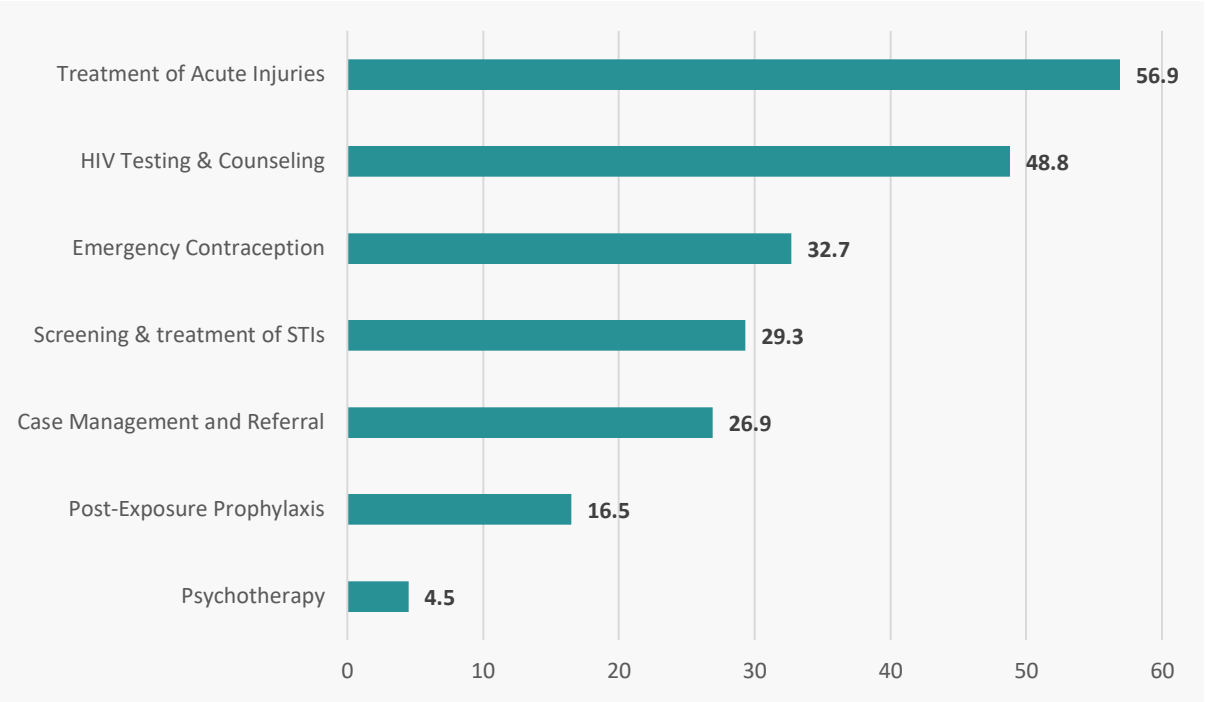
Types of health facility	Frequency (n=443)	Percentage
Primary health care facility	376	84.9
Secondary health care facility	23	5.2
Tertiary health care facility	2	0.5
Others	42	9.5

PROVISION OF MINIMUM PACKAGE OF CARE TO GBV SURVIVORS

According to the WHO GBV quality assurance tool, the standard minimum package of services that should be available in a typical health facility for sexual assault includes HIV PEP (within 72 hours of sexual assault); emergency contraception (within 120 hours of sexual assault); HIV testing, counseling, and linkage to treatment; STI testing and treatment; treatment of acute injuries; basic psychosocial counseling; and referrals to other services as appropriate (police, legal, shelter, economic empowerment, child protection, community-based support organizations). Only 12 (3 percent) of the mapped health facilities met the criteria.

In terms of provision of specific subcomponents of the services, as shown in Figure 4, 56.9 percent of the facilities can treat injuries, 48.8 percent provide HIV testing and counseling services, and 32.7 percent offer emergency contraception. However, just 4.5 percent of facilities provide psychotherapy services to GBV survivors.

FIGURE 4. FACILITIES PROVIDING MINIMUM CARE PACKAGE FOR GBV SURVIVORS (N = 443)



PROVISION OF POST- EXPOSURE PROPHYLAXIS AND EMERGENCY CONTRACEPTION ACCORDING TO STANDARDS

Findings in Table 21 show that out of 73 health facilities that claim to provide PEP services, 84.9 percent of them reported that PEP is available and administered within 72 hours of an emergency. However, less than half (48.5 percent) of the facilities offered emergency contraception within 120 hours.

TABLE 21. PEP AND EMERGENCY CONTRACEPTION

	Frequency	Percentage
PEP is available and administered within 72 hours of an emergency		
No	11	15.1
Yes	62	84.9
Total	**73**	**100**
Facilities ensure that emergency contraception is offered within 120 hours		
No	220	51.5
Yes	215	48.5
Total	**443**	**100**

COST OF SERVICES

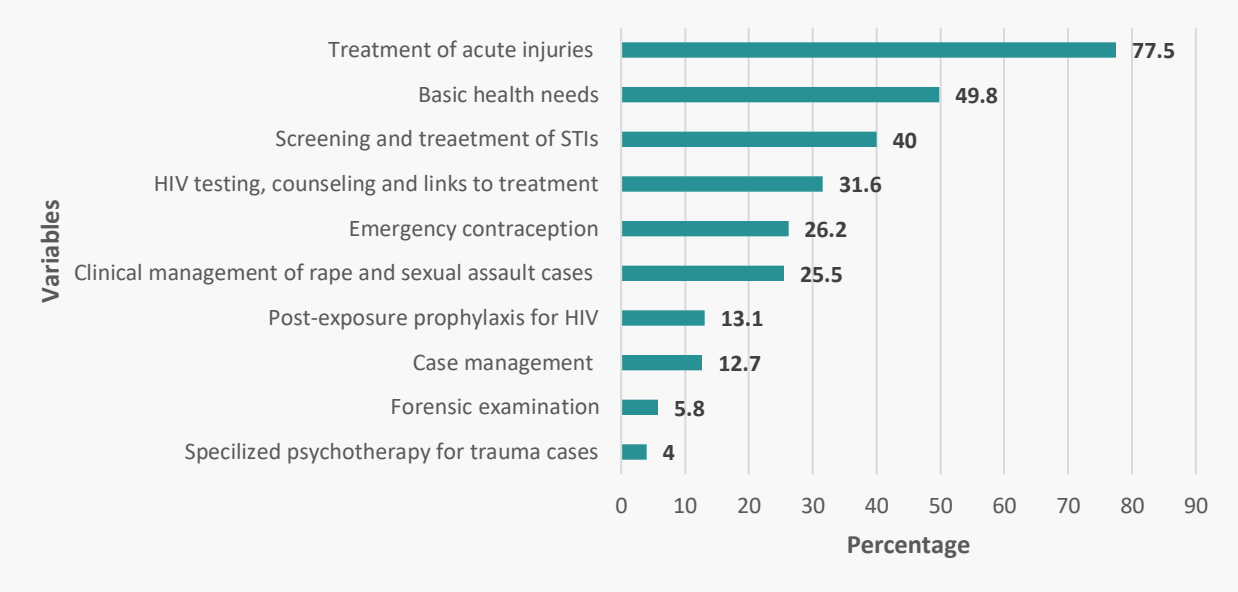
Most of the services provided at the health facilities are free, with 37.9 percent of the facilities reporting that GBV survivors pay for services received.

Although there are eligibility criteria to access free services, it is encouraging to note that only 6.2 percent of the facilities reported that eligibility criteria exist for free GBV services offered.

Among the services requiring payment by the client, treatment of acute injuries (77.5 percent) and basic health needs (49.8 percent) were the most common (see Figure 5). In terms of eligibility criteria, one stakeholder at the LGA level noted:

> *"There is an agency now that renders free medical services to such people. They will pay for their delivery and other treatment and children under five years will also not pay. Also, we have provision for the poor and needy. Those who can`t afford hospital bills and the aged too. If we have such case(s), they won`t demand money for that to be taken care of, they will be treating her free, she will be coming for antenatal free, until she delivers the baby".* —Stakeholder, IDI

FIGURE 5. TYPES OF SERVICES REQUIRING PAYMENT, AMONG FACILITIES THAT REQUIRE PAYMENT FOR AT LEAST SOME SERVICES (N = 168)

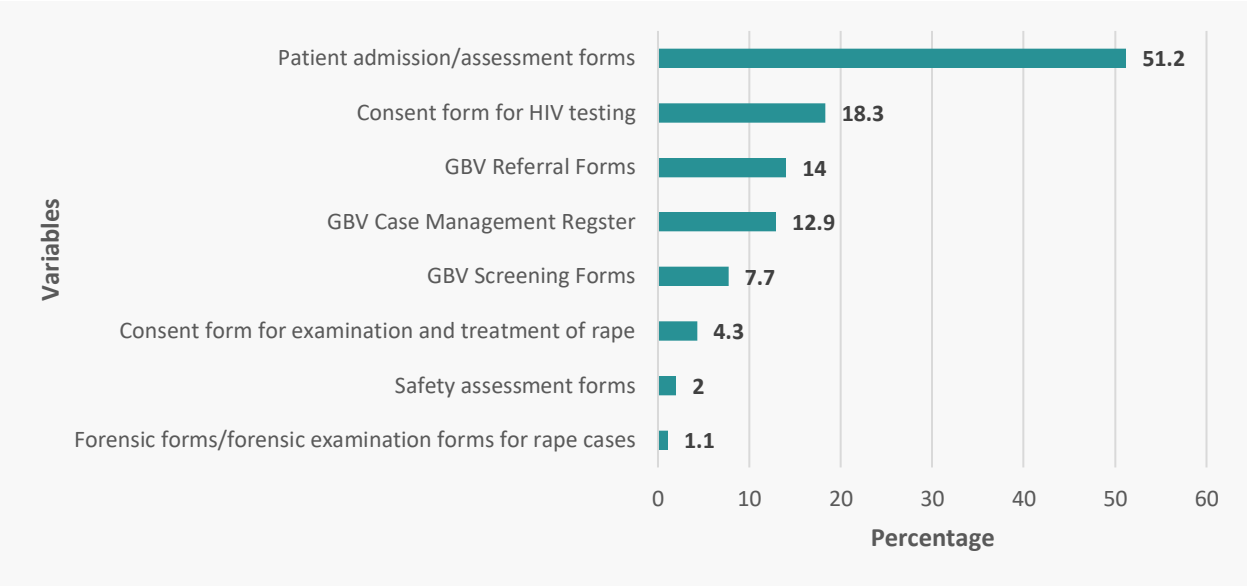


AVAILABILITY OF DOCUMENTATION FORMS

Although more than half (55.3 percent) of the health facilities visited reported availability of health forms, findings revealed that few had the full range of health forms related to treatment of GBV survivors (see Figure 6). Findings from the IDIs conducted supported these findings. Below is one example:

> *"[Brings out form] reads [it]; reporting of violence against female, monthly data collection/incident monitoring. This is it, and, I do this every month. If anybody reports to me, or I find out by myself, I write the person's name, the person that did it, the particular time he did it. Then whether he is employed or not, [whether] they are here. Then I photocopy and give to them."* —Social Support, IDI

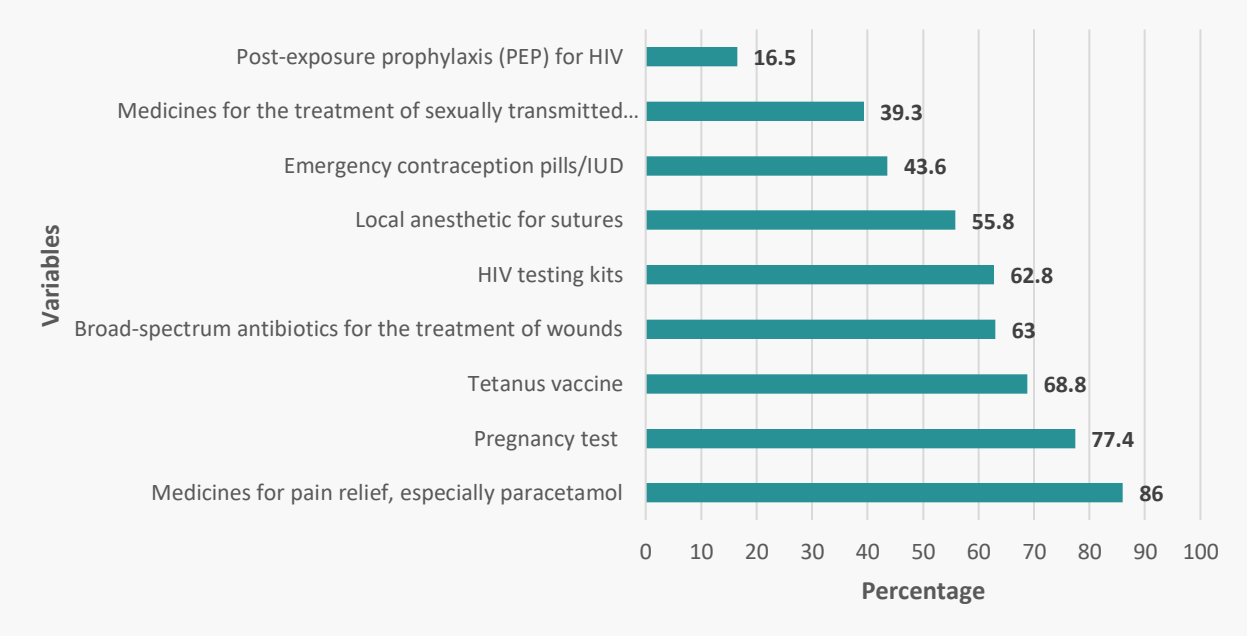
FIGURE 6. AVAILABILITY OF FORMS RELATED TO GBV AT HEALTH FACILITIES (N = 443)



AVAILABILITY OF MEDICINE AND ESSENTIAL SUPPLIES

Most health care facilities reported having medicines and essential supplies available. Figure 7 shows the percentage of health facilities reporting availability of certain medicines and essential supplies.

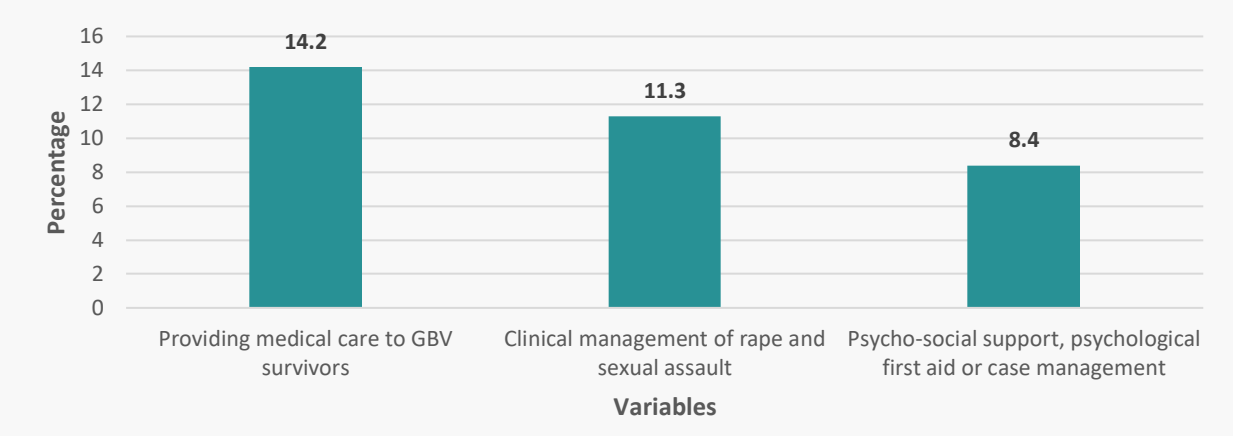
FIGURE 7. AVAILABILITY OF MEDICINES AND ESSENTIAL SUPPLIES AT HEALTH FACILITIES (N = 443)



AVAILABILITY OF TRAINED HEALTH CARE PROVIDERS

Findings showed a low proportion of GBV-trained providers in the health facilities visited, with only 14.2 percent of facilities having staff trained to provide medical care to GBV survivors, 11.3 percent of facilities able to offer clinical management of rape and sexual assault, and just 8.4 percent with staff trained to give psychosocial support or case management (see Figure 8).

FIGURE 8. AVAILAILITY OF TRAINED STAFF (N = 443)

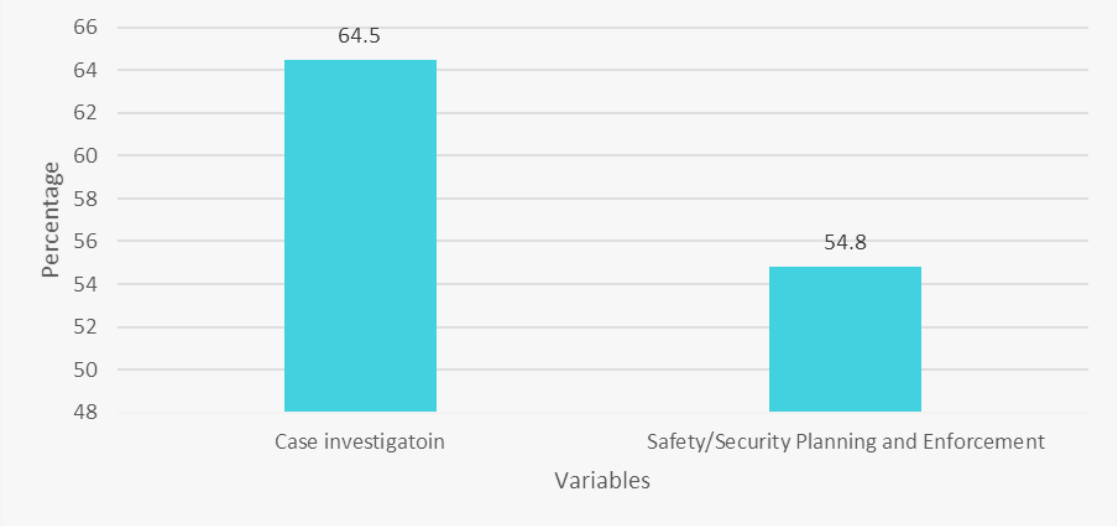


LAW ENFORCEMENT

SERVICES PROVIDED

Law enforcement agencies basically provide two services to GBV survivors. As shown in Figure 9, findings showed that 64.5 percent of the 31 law enforcement agencies visited provide case investigation services to GBV survivors and 54.8 percent provide safety/security planning and enforcement services.

FIGURE 9. SERVICES PROVIDED TO GBV SURVIVORS BY LAW ENFORCEMENT AGENCIES (N = 31)



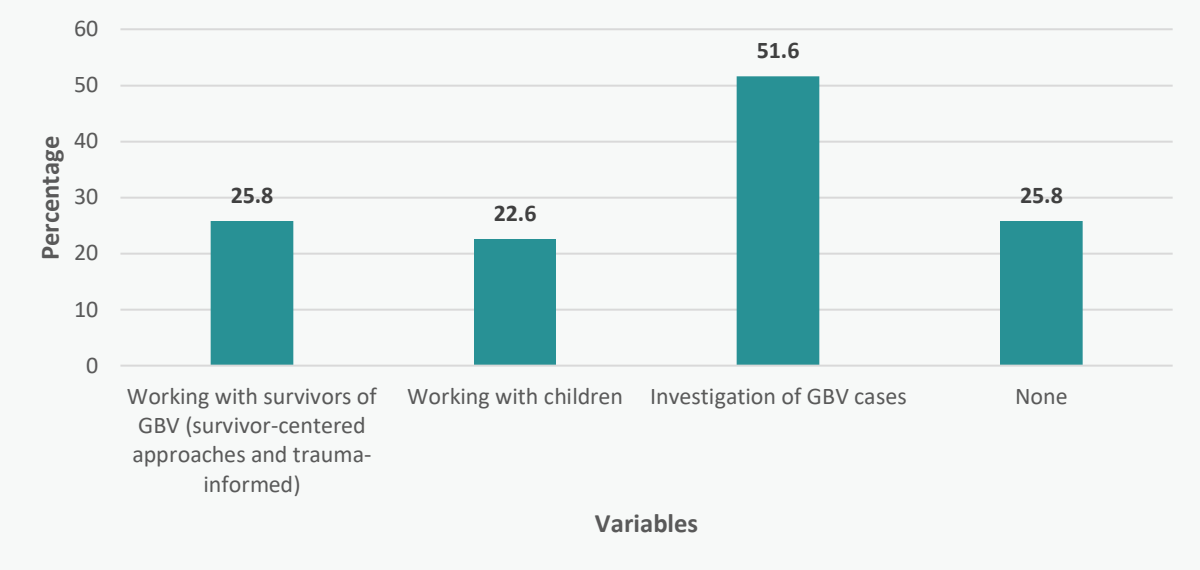
REFERRAL

Half (51.6 percent) of the law enforcement agencies visited refer GBV survivors to other police/NSCDC locations.

AVAILABILITY OF TRAINED PERSONNEL IN LAW ENFORCEMENT AGENCIES

The mapping exercise found that about half (51.6 percent) of the 31 agencies visited have staff trained to provide some services to GBV survivors, with 25.8 percent having staff trained to work with survivors of GBV, and 22.6 percent having staff trained to work with children (see Figure 10).

FIGURE 10. AVAILABILITY OF STAFF TRAINED TO PROVIDE GBV-RELATED SERVICES (N = 31)



PAYMENT FOR SERVICES AT POLICE/CIVIL DEFENSE FORMATIONS

Findings showed that just two out of 31 security facilities (see Table 22) reported that GBV survivors pay for services received. However, this was contrary to qualitative findings that found most survivors have to pay for services, with two examples below:

> *"Yes, it can be a barrier, you can even see in some police case, there's an extent you will go, if you can't follow it up again with money and other things, just money, before the police will discharge whoever you are having problem with, with even telling you, so follow-up is also a barrier."* —Health worker, IDI

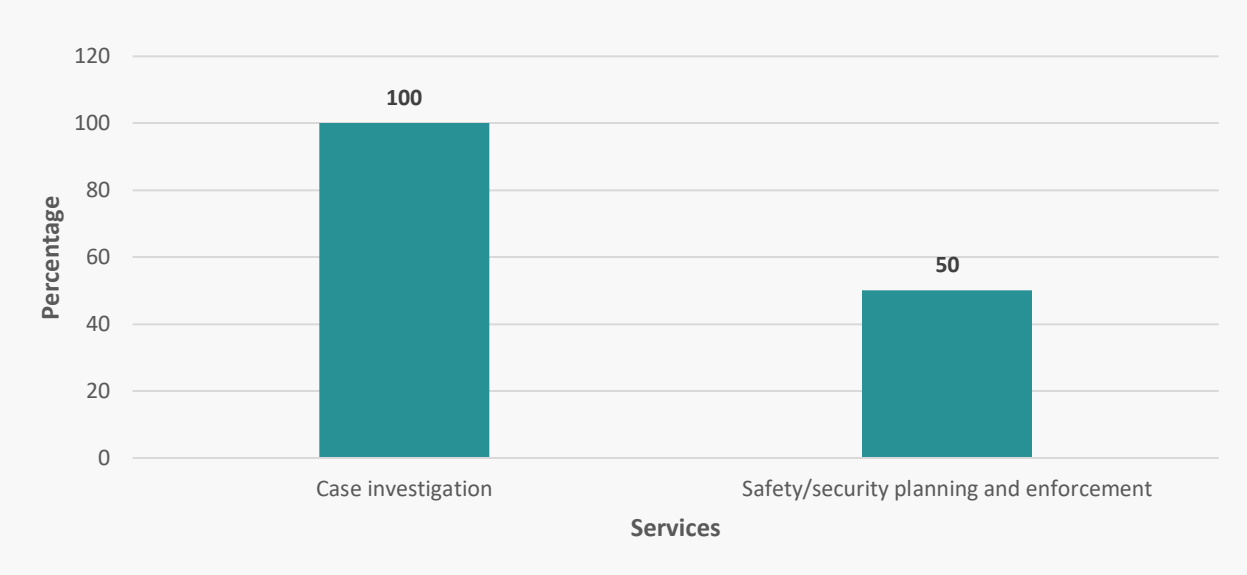
> *"Yes, because the challenge we have with the police, is that if you go there, they demand money from you."* —Social Support, IDI

TABLE 22. PAYMENT FOR LAW ENFORCEMENT SERVICES

Costs for survivors to receive services	Frequency (n=31)	Percentage
Free	29	93.5
Paid	2	6.5

Case investigation and safety/security planning and enforcement are the types of services GBV survivors pay for, as indicated in Figure 11.

FIGURE 11. SERVICES SURVIVOR PAYS FOR AT SECURITY FACILITY (N = 2)



AVAILABLE RESOURCES AT SECURITY FACILITY

Table 23 shows the resources available at different law enforcement agencies. Only one-third (32.3 percent) reported that vehicles are available, and 16.1 percent reported having motorbikes available for use in investigations.

TABLE 23. RESOURCES AVAILABLE AT LAW ENFORCEMENT/SECURITY AGENCIES

Resources available for investigation and follow-up	Frequency (n=31)	Percentage
Vehicles	10	32.3
Motorbikes	5	16.1
Fuel	3	9.7
Other	13	41.9

FOLLOW-UP WITH SURVIVORS

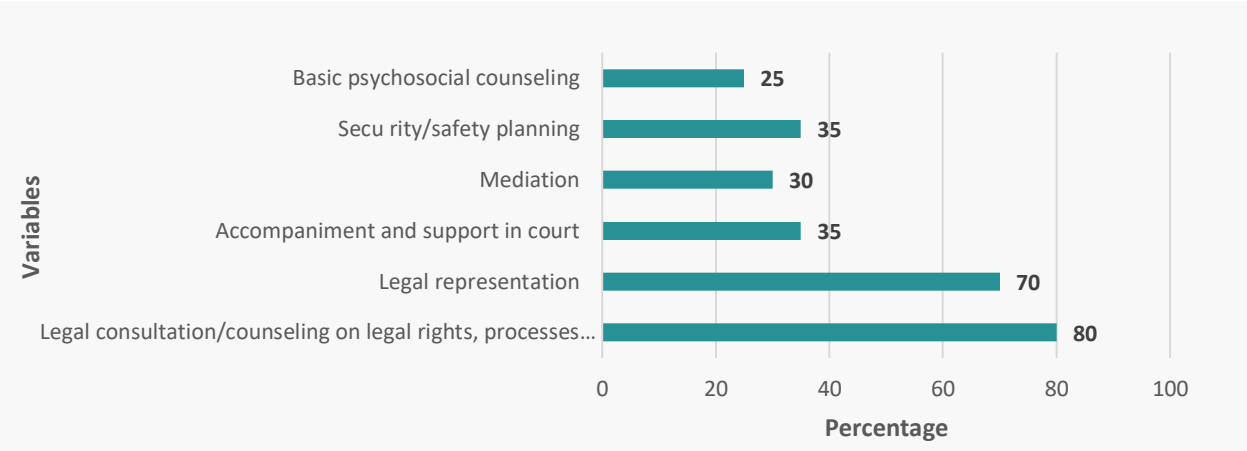
Nearly two-thirds (61.3 percent) of law enforcement agencies/security providers do not follow up with GBV survivors on their well-being, with 38.7 percent reporting that they do follow up with GBV survivors.

LEGAL AID

LEGAL AID SERVICES

Figure 12 shows that the majority of legal aid services available to GBV survivors are legal consultation/counseling on legal rights and processes (80 percent), with legal representation not far behind at 70 percent. Other legal aid services provided are security/safety planning, accompaniment and support in court, mediation, and basic psychosocial counseling.

FIGURE 12. AVAILABLE LEGAL AID SERVICES (N = 20)



PAYMENT FOR LEGAL AID SERVICES

Five of the 20 legal aid organizations require GBV survivors to pay for services; the remaining 15 do not require payment.

GBV survivors paid for different services received (see Table 24). All the GBV survivors paid for legal consultation/counseling on legal rights, and four of the five paid for legal representation. Just one GBV survivor paid for receiving mediation services from legal aid providers.

TABLE 24. PAYMENT FOR LEGAL AID SERVICES

Services	Frequency (n=5)	Percentage
Legal consultation/counseling on legal rights, processes and potential outcomes	5	100
Legal representation	4	80
Accompaniment and support in court	2	40
Mediation	1	20

Table 25 shows the costs of different legal aid services, with charges varying from N2,000 to N20,000 for services such as legal consultation/counseling, legal representation, accompaniment, and mediation.

TABLE 25. COSTS OF PROVIDING LEGAL AID SERVICES TO GBV SURVIVORS

Costs in Naira (US$)	Legal aid services			
	Legal consultation/ counseling	Legal representation	Accompaniment and support in court	Price of the mediation
	Freq. (%)	Freq. (%)	Freq. (%)	Freq. (%)
500–999 ($1–2)				
2,000–4,999 ($5–12)	1 (20)			
5,000–9,999 ($12–24)				1 (100)
10,000–14,999 ($24–36)			1 (50)	
15,000–19,999 ($36–49)	1 (20)	1 (25)		
20,000 and above (≥ $49)	3 (60)	3 (75)	1 (50)	
Total	5 (100)	4 (100)	2 (100)	1 (100)

COURT APPEARANCE SUPPORT AND CONSEQUENCE OF INADEQUATE FUNDS

Only about 45 percent of legal aid entities reported that they provide assistance to GBV survivors for court appearances. Findings revealed that 15 percent of the legal aid providers close cases if there are not enough resources to investigate each case, 25 percent reported that the case is transferred to another organization, and 30 percent of service providers ask survivors to pay.

PSYCHOSOCIAL SUPPORT

SERVICE PROVIDED

Findings showed that facilities offering psychosocial support provide different services to GBV survivors. Of all the services, counseling (80 percent) was the most prominent service. Other services included safety planning (46.7 percent), case management (40 percent), and psychotherapy for trauma cases (33.3 percent). One interviewee made the following comment:

> *"We give them psychosocial services (counseling), economic empowerment (when the ministry has the resources). We also make referrals and follow-ups."* —Social Support, IDI

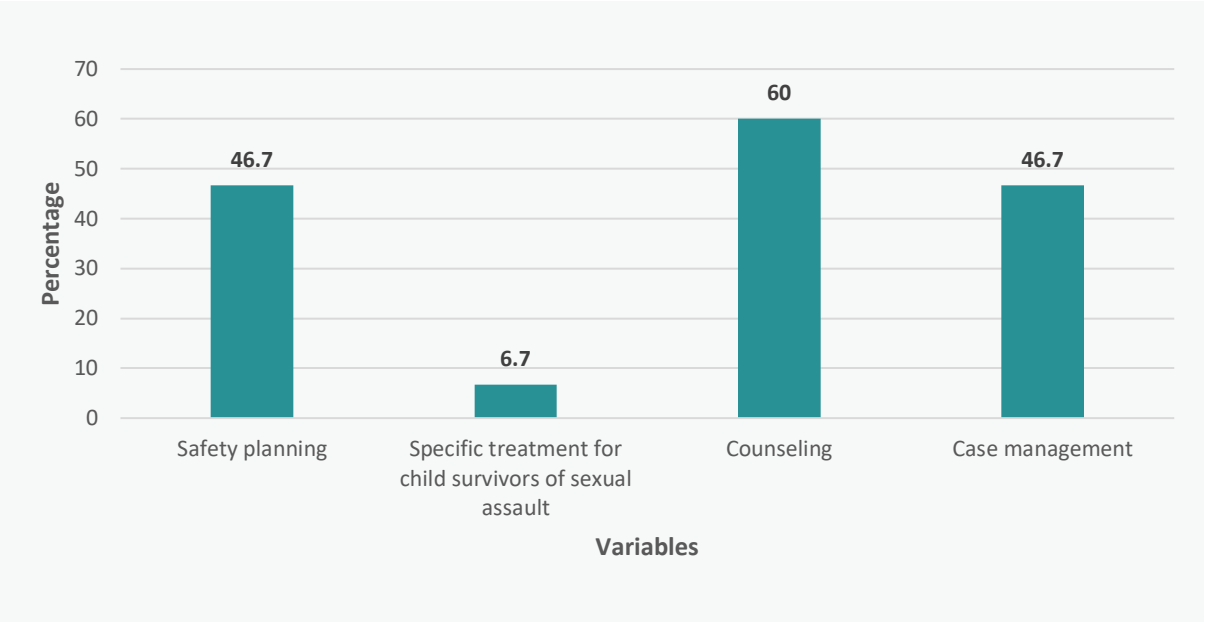
PAYMENT FOR PSYCHOSOCIAL SUPPORT SERVICES

Most psychosocial services were found to be free of charge (93.3 percent), with just one GBV service provider reporting that GBV survivors paid.

AVAILABILITY OF TRAINED STAFF

Findings revealed that facilities providing psychosocial services have trained staff in various areas, with about 60 percent trained on the provision of counseling services. Figure 13 provides a breakdown of all the areas assessed.

FIGURE 13. AVAILABILITY OF TRAINED STAFF (N = 15)



TEMPORARY SHELTER

SERVICES PROVIDED BY SHELTER HOMES

Temporary shelter homes provide a variety of services to GBV survivors. All three of the temporary shelters that providers visited offer safety planning, and two out of three provide shelter/housing and case management services, while only one provides basic psychosocial/counseling to GBV survivors. Findings also showed that two of the three facilities visited allow GBV survivors to bring in their family members. In addition, two-thirds of the providers claimed to have child-friendly space available at their facilities.

SAFETY PRECAUTIONS AT SAFE HOMES

Findings revealed that security providers take some precautions, with two-thirds posting security guards and providing rooms with locks on the doors. One-third reported having security walls.

AVAILABILITY OF BASIC AMENITIES

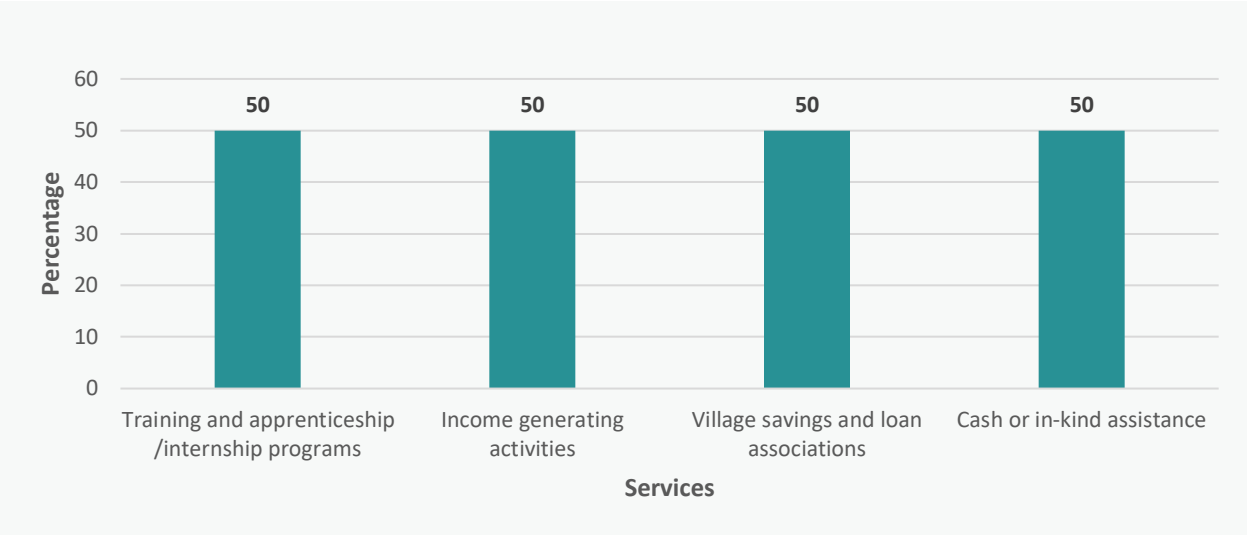
Amenities offered at the secure facilities included sanitary items and showers at all facilities, electricity at one, and both electricity and water at two-thirds.

ECONOMIC EMPOWERMENT/LIVELIHOODS

CAPACITY OF ECONOMIC EMPOWERMENT FACILITIES AND SERVICES PROVIDED

Findings revealed that economic empowerment sectors have the capacity to enroll more women or girls. All four facilities visited have the capacity to enroll more GBV survivors. Figure 14 provides an overview of various economic empowerment services available to GBV survivors. Two out of four facilities provide training and apprenticeship/internship programs, income-generating activities, village savings and loan associations, and cash or in-kind assistance.

FIGURE 14. SERVICES PROVIDED TO SURVIVORS AT EMPOWERMENT FACILITY (N = 4)



NUMBER OF WOMEN WHO BENEFITED FROM ECONOMIC EMPOWERMENT SERVICES

Over the last six months, 25 women benefited from the economic empowerment services at the four facilities visited.

All the economic empowerment facilities reported that they provide programs that identify safe areas for women and girls. However, findings revealed that two of the four facilities had turned away women and girls over the last year due to lack of funding to enroll new people.

HELP-SEEKING BEHAVIOR

Respondents described ways that people who have become victims of GBV seek help. Some of the issues identified in seeking help include the following:

REPORTING TO FAMILY MEMBERS

One of the common lines of action for survivors of GBV is to report the incident to members of their family. This can be parents, siblings, or other relatives.

> *"They go to parents to complain, the parents then may go to the village head to complain, then the culprit may be apprehended or invited, then, the next place is customary court and social welfare." —Stakeholder, IDI*

REPORTING TO COMMUNITY LEADERS/TRADITIONAL RULERS

Another line of action would be to report the incident to someone who has some measure of authority in the community. This includes traditional rulers, youth leaders, religious leaders, and community leaders.

> *"They rush to the government and religious body,… they are seen as people that can be of help to them." —Stakeholder IDI*

REPORTING TO POLICE STATION/SECURITY AGENCIES

Law enforcement agencies and security agencies are often considered to be safe places for GBV survivors to turn to for help in challenging times. These bodies are also useful when the survivor needs to seek redress.

> *"They seek help mostly from the government or police that brings them to the health center. The police tell the health center together with the victims first. Most of the time, the bill is signed out because the victims do not have money to pay." —Stakeholder, IDI*

REPORTING TO GOVERNMENT OFFICIALS

With their proximity to the community, grassroots government officials often are informed about GBV cases. They also tend to have proper information about where best to refer the survivors.

> *"Local government chairperson who refers the survivor to the social welfare department." —Stakeholder, IDI*

REPORTING TO HUMAN RIGHTS ORGANIZATIONS

Another route that survivors can take to report GBV is to go to human rights organizations such as the Ministry of Women Affairs or Ministry of Education. They go with the expectation that these bodies would be able to take up their cases.

> *"They go to the Ministry of Women Affairs. Within the education sector, they come to the Ministry of Education. They also go to the universal education zonal board and area offices." —Stakeholder, IDI (Ministry of Education)*

REPORTING TO SOCIAL WELFARE OFFICE

> *"Yeah, when they have such problems at times they will come here to the social welfare office. Many people have come here to lay a complaint on what happened to them; then we pick it up because it is our*

duty and that is why I welcomed you today because that is what I do and I do it best and I have passion in doing that." —Stakeholder, IDI (LGA Level)

REPORTING TO HEALTH FACILITIES

The respondents also mentioned that survivors can report to health care facilities where they can receive appropriate care. Other parties that survivors may report to also often bring them to health facilities for care.

"Some of them, they'll go to the hospital first. Some will come to me (Ministry of Health, gender desk officer) first to report, if I identify a set of injuries, I'll send them to the hospital. At times, I'll liaise with staff of Women Affairs so that they'll know what they'll do in that situation." —Stakeholder, IDI

BARRIERS TO SEEKING HELP

Survivors of GBV can end up not seeking necessary help for numerous reasons, some of which were identified by respondents during the interviews, as highlighted below.

ACCEPTANCE OF VIOLENCE AS NORMAL

One of the challenges with GBV is that it is common in many societies. Some cultures consider it normal for a man to beat or molest his wife. Hence, survivors of GBV do not think they should report the incident. This belief is also often embedded in the community as a cultural norm.

"No, it's a barrier. Like in our tradition, when a man beats the wife, it's nothing wrong. Even when a man is found cheating on the wife, it's normal, it's acceptable in our culture. It's a normal norm. However, enlightenment is changing things. So, it's a barrier too." —Stakeholder, IDI

DISTANCE AND TRANSPORTATION TO FACILITIES (LOGISTICAL CHALLENGES)

Survivors may have challenges traveling to locations to seek care because of the distance from where they live or lack of money to make the trip. Several respondents indicated that lack of money and distance could be barriers to GBV survivors seeking help.

"At times, if for instance, because some of these things are not really localized, it's done within their environment, most times, they are referred and even at times the people we call our champions in rural areas, if you don't give them money for airtime and all that, and really if they do not have they might not be able to make a shutout to the necessary quarters. So that is it. And at times, transportation and all that might be a kind of hindrance to them." —Stakeholder, IDI (Ministry of Justice)

LACK OF AWARENESS OF SERVICES (IGNORANCE)

Some survivors of GBV do not know where they can report such abuse so they continue to endure the pain. Several respondents identified this in their reports:

"Hmmm that is why I told you they have little knowledge of where the right place is to go, even though there is a law that says [to] protect women." —Stakeholder, IDI

"Lack of awareness of services, lack of coordination between services [and] quality of service." —Stakeholder, IDI

FEAR OF BEING STIGMATIZED

Fear is another major barrier to people who are survivors of GBV, with one of the most common fears that they could be stigmatized by people who hear of their predicament. For instance, rape survivors may not want to disclose their trauma in order to protect themselves. One of the respondents described it in this way:

> *"One of the barriers is stigma. People are afraid of being stigmatized."* —Stakeholder, IDI

FEAR OF REPERCUSSIONS

GBV survivors may also fear the consequences of reporting a crime. A survivor may be afraid that the perpetrator may come back to harm him or her. Even parents of a survivor may be afraid of the perpetrators and not want to report them.

> *"They will be afraid of maybe when they report this case, after all [is] said and done, the perpetrator will come back again and kill them, so that's the thing." —Legal aid, IDI*

LACK OF KNOWLEDGE OF RIGHTS

Some survivors of GBV may not know their rights. They may be unaware that what they are experiencing is illegal. Hence, they do not report it.

> *"Illiteracy—in this community, illiteracy is a major barrier. People don't know their rights. They believe it's a man's world, whatever the man does is right, after all he is the head." —Stakeholder, IDI LGA Level*

FAMILY INTERFERENCE

Sometimes, the family may discourage a survivor of GBV from reporting an incident. The family may be afraid of the perpetrator, as mentioned earlier, or the family is trying to avoid stigmatization.

> *"Family is a strong barrier. They discourage the survivors from reporting, saying it can be settled within the family. Stigma also prevents them from reporting. Logistics, funds, and distance are also barriers." —Stakeholder, IDI LGA level*

RESPONDENTS' RECOMMENDATIONS

The respondents made recommendations on how GBV services could be made more accessible and how services could be improved. These recommendations are captured below.

SERVICE ACCESSIBILITY

Improvements in service accessibility would make it easier for survivors of GBV to seek care.

Increase manpower: One of the issues respondents highlighted was the need for increased capacity among providers of GBV services. This would enable them to cater more efficiently to the needs of survivors.

Financial support: Respondents also mentioned that it would be good for there to be financial support for survivors of GBV.

SERVICE IMPROVEMENT

Respondents made the below recommendations on how to improve GBV services.

Ensure confidentiality: Concerns about victimization or repercussions require that survivors of GBV are assured confidentiality. Service providers should place a priority on confidentiality in the handling of their clients' information.

> *"There should be confidentiality in our health centers." —Male, FGD*

Government intervention: Respondents also considered it imperative that the government intervene in resolving and preventing incidences of GBV.

Peer education: One of the respondents said that peer education should be employed in raising awareness about GBV services.

Punishment of offenders: It was also recommended that people who perpetrate GBV should be punished as a warning to them and to others.

> *"Let those who perpetrate this act be fined and punished." —Female, FGD*

Mass sensitization: It was recommended that there be mass sensitization about GBV in the community so that anyone who is a survivor would be able to receive appropriate help.

> *"Sensitization and awareness creation on GBV in the community." —Female, FGD*

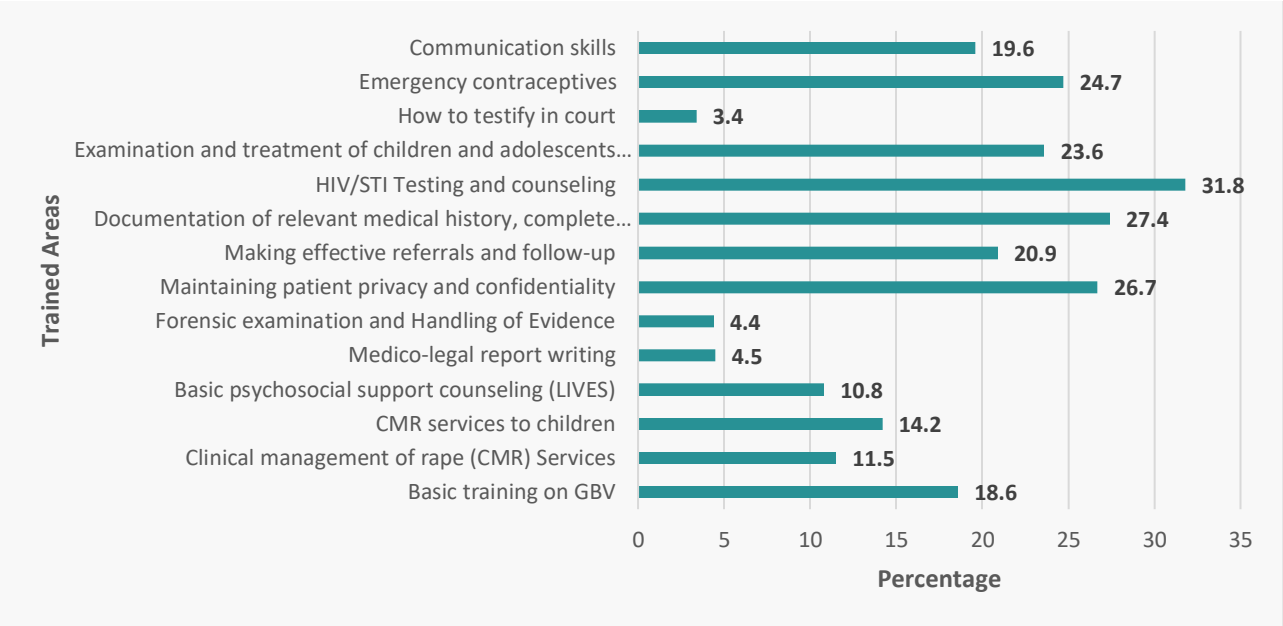
CAPACITY OF SERVICE PROVIDERS

The availability of designated or trained GBV first responders was assessed in various organizations, agencies, and facilities. Of the 334 establishments, 78.7 percent have not been trained on GBV services, although a good number of staff randomly provide GBV services when clients are present. Out of 296 respondents rendering health care services, only 55 (18.6 percent) had undergone training on GBV as designated GBV focal persons for their respective facilities. Nevertheless, a greater proportion of law enforcement agencies had GBV focal persons (36 percent of the agencies assessed). Details about each sector assessed are provided below.

HEALTH SERVICES

Findings from the assessment showed that fewer than 20 percent of health care providers have been trained on the provision of post-GBV care (see Figure 15 for the range of services with percentages of trained health care providers). The findings suggest that a large number of health care providers have not received training on the provision of various services likely needed by survivors of GBV.

FIGURE 15. PERCENTAGE OF HEALTH CARE PROVIDERS TRAINED TO PROVIDE GBV SERVICES (N = 296)



LAW ENFORCEMENT

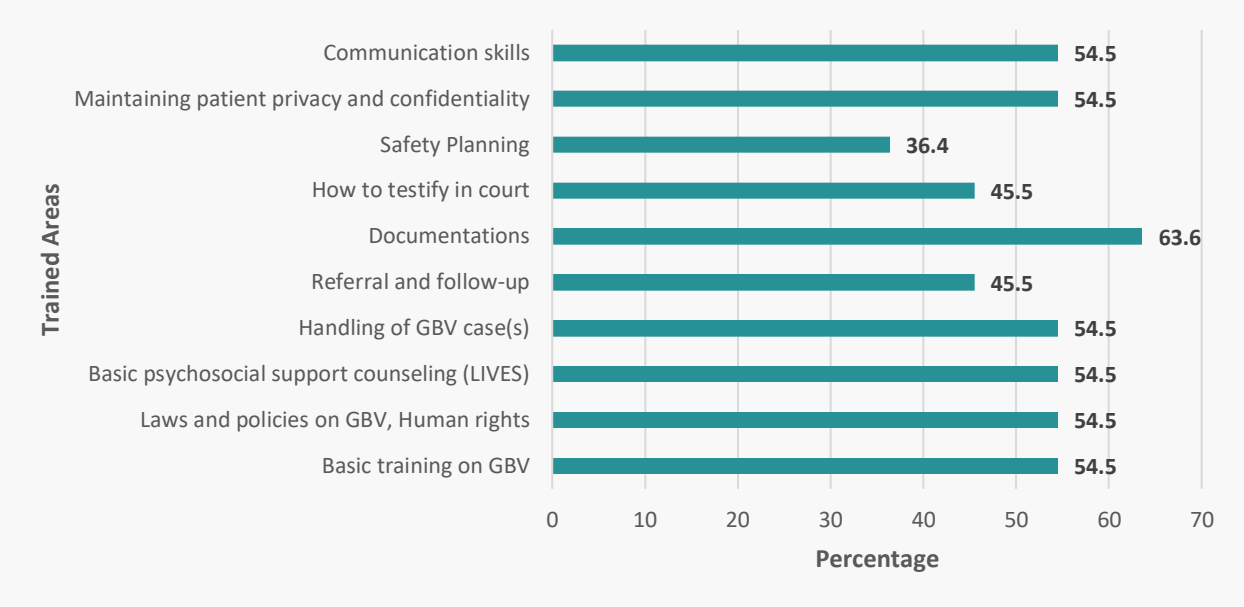
As Figure 16 shows, just 36 percent of law enforcement officers interviewed had received basic training on GBV services. Although 60 percent of officers had been trained on communication skills and 64 percent on how to testify in court, all of the other areas were at 52 percent or below. This lack of training makes it difficult for law enforcement officers to render services adequately. The low proportion of trained officers reflects wide capacity gaps in the law enforcement sector. If a higher proportion of law enforcement is knowledgeable about these important areas, a higher success rate of prosecutions in court could be achieved.

FIGURE 16. PERCENTAGE OF LAW ENFORCEMENT OFFICERS TRAINED ON GBV SERVICES (N = 25)

LEGAL AID

Findings showed that 54.5 percent of the legal aid providers had received training on six of the intervention areas (see Figure 17). A total of 63.6 percent had been trained on proper documentation, with the remaining areas at 45.5 percent or below.

FIGURE 17. PERCENTAGE OF LEGAL AID PROVIDERS TRAINED TO PROVIDE GBV SERVICES (N = 11)



PYSCHOSOCIAL SUPPORT SERVICES/ECONOMIC EMPOWERMENT

One psychosocial support service provider was assessed. The provider had received training on all of the areas of support, which included the prevention of sexual exploitation and abuse, guiding principles of case management and post-GBV, and effective referral pathways.

DISCUSSION

This report builds on existing evidence that Ebonyi State has a high prevalence of GBV, with the most common forms being physical assault, IPV, and sexual violence. Sexual abuse of children, early childbearing, early marriage, and female genital mutilation are not widely reported, despite recent support given by state agencies to report these forms of GBV.

The capacity assessment findings show that a greater proportion of law enforcement agencies have received training on GBV services compared to a much lower percentage of health care service providers. However, it was found that a good number of health care providers provide GBV services when clients seek them. Legal aid providers have a greater proportion of staff trained on GBV services; however, the number of staff identified in the assessment is quite low.

Besides being trained on GBV services, which revolve around maintenance and management of GBV clinical and nonclinical issues, most health care providers have received quantifiable training on different service delivery areas. These areas include testing and treating other health-related issues, maintaining privacy and confidentiality, and using effective communication skills.

Low capacity was observed on medico-legal reporting, forensic examination, and handling of evidence. A greater proportion of law enforcement staff was knowledgeable about forensic examination. Though this survey shows that the Nigerian Government funds most of the facilities, many depend on support from international donors for supplies of drugs and commodities. This dependence results in most drugs not being readily available at health facilities. Thus, the commodity and drug supply must be strengthened within the nation to make it sustainable.

It was observed that a higher number of facilities provide 24-hour service to both adults and children, thus ensuring that efficient room for the management of all age levels across the state is available.

This survey revealed that only a quarter of the service providers provided GBV care using standard policies, protocols, and operating procedures, with the majority operating without them. Of facilities that claimed to have such policies or operating procedures, few were able to provide them. This finding suggests that most service providers offer GBV care based on the best way known to them.

Service providers indicated that a greater proportion of GBV survivors have the right to choose their treatment and or to refuse to be treated, with a large number of facilities offering the space to ensure a survivor's privacy during the provision of services. Service delivery gaps include lack of qualified staff, insufficient equipment, and lack of proper infrastructure. Service providers find ways of giving privacy to GBV survivors during counseling sessions although the proportion of trained GBV focal persons was found to be low, which calls for adequate training for proper service delivery.

The majority of referrals for GBV survivors were made verbally, with fewer providers using referral documents and very few providing escort services. Most referrals are directed to health sectors, followed by law enforcement, and then psychosocial support.

The stakeholders involved in reducing GBV at the state and LGA levels include the Ministry of Women and Children Affairs, Ministry of Justice, Ministry of Education, Ministry of Health, Ministry of Information, Primary Health Care Development Agency, National Human Rights Commission, directors of social services, directors of public health, head of Administrative unit and Social Welfare Department at the LGA level, along with FIDA, the Spotlight Initiative, United Nations Population Fund, USAID Integrated Health Program/State Emergency Management Agency, CBOs, and CSOs.

To utilize GBV services from all the above-mentioned sectors and agencies, improvements must be made in service accessibility by increasing capacity of personnel, financial support, assurance of security, and free services. In addition, improvement of service measures, such as ensuring confidentiality, government interventions, peer education, punishment of offenders, cases being taken seriously, and mass sensitization, can help bridge barriers GBV survivors face in seeking help.

IMPLEMENTATION CHALLENGES

- Some tablets were quite slow and not responsive during data collection.
- Some data collectors had challenges charging their batteries, which led to a delay in completing the work.
- There were repeated and similar questions in the interview guides for IDIs and FGDs, which prolonged the sessions.
- Researchers had little practical knowledge about the working tools before the field activities.

RECOMMENDATIONS

- Build the capacity of GBV service providers on the methods of identifying GBV cases, provision of first-line support, and the minimum package of post-GBV care services for survivors. Capacity-building efforts should cut across the various sectors.
- Strengthen referral and multisectoral collaboration and coordination by ensuring first responders are able to meet periodically, especially at the LGA levels.
- Develop GBV action plans at LGA and state levels, ensuring local ownership through endorsement of local authorities.
- State actors, especially through the State Ministry of Health, should ensure that all LGAs in the state have at least one facility (a one-stop center) that can provide health, law enforcement, temporary shelter, social support, and legal aid services.
- Promote positive social norms to prevent GBV by challenging cultural norms that support IPV, physical assault, and other forms of violence, as well as a culture of impunity to reduce victim blaming and the social stigma that survivors experience and promote help-seeking behaviors.
- Explore the possibility of reducing or eliminating client fees for GBV survivors.
- Provide critical infrastructure in the key GBV sectors such as counseling rooms, consumables in health facilities, secure safe homes, child protection, and economic empowerment support.
- Advocate with the state government to empower and support the Coordinating Ministry—Ministry of Women and Children Affairs—through increased budgetary allocations and release of funds to support survivors with economic empowerment and temporary safe shelters.
- Advocate with the state government to map out budgets that support the State GBV Multi-Sectoral Taskforce to respond to GBV issues in Ebonyi State.
- Train relevant stakeholders on advocacy and communication skills to drive and spearhead implementation of laws and policies related to GBV in Ebonyi State.

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