

CHILD-FRIENDLY MODELS FOR PREVENTION AND RESPONSE TO VIOLENCE IN EASTERN AND SOUTHERN AFRICA



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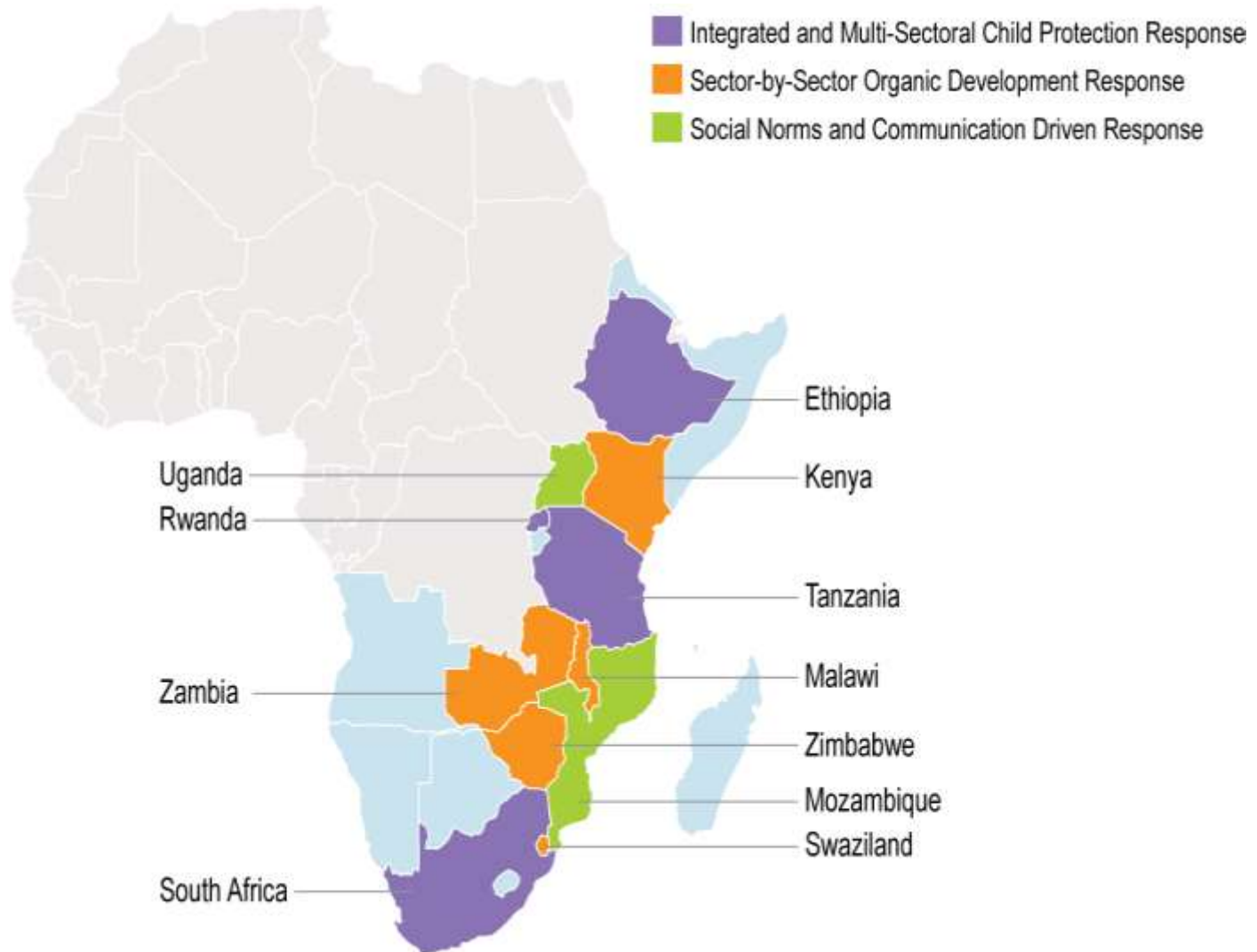


Global: Violence Against Children (VAC)



- Global and regional studies on the prevalence of physical and sexual violence indicate that many survivors of violence are under the age of 18 years.
- UNSG Study on Violence (2006): 133 governments, civil society and children
 - 150 million girls and 73 million boys worldwide raped or subject to sexual violence each year, usually by someone in their family circle
 - 133 and 275 million children annually estimated to witness domestic violence

Regional: ESAR VAC Programmes



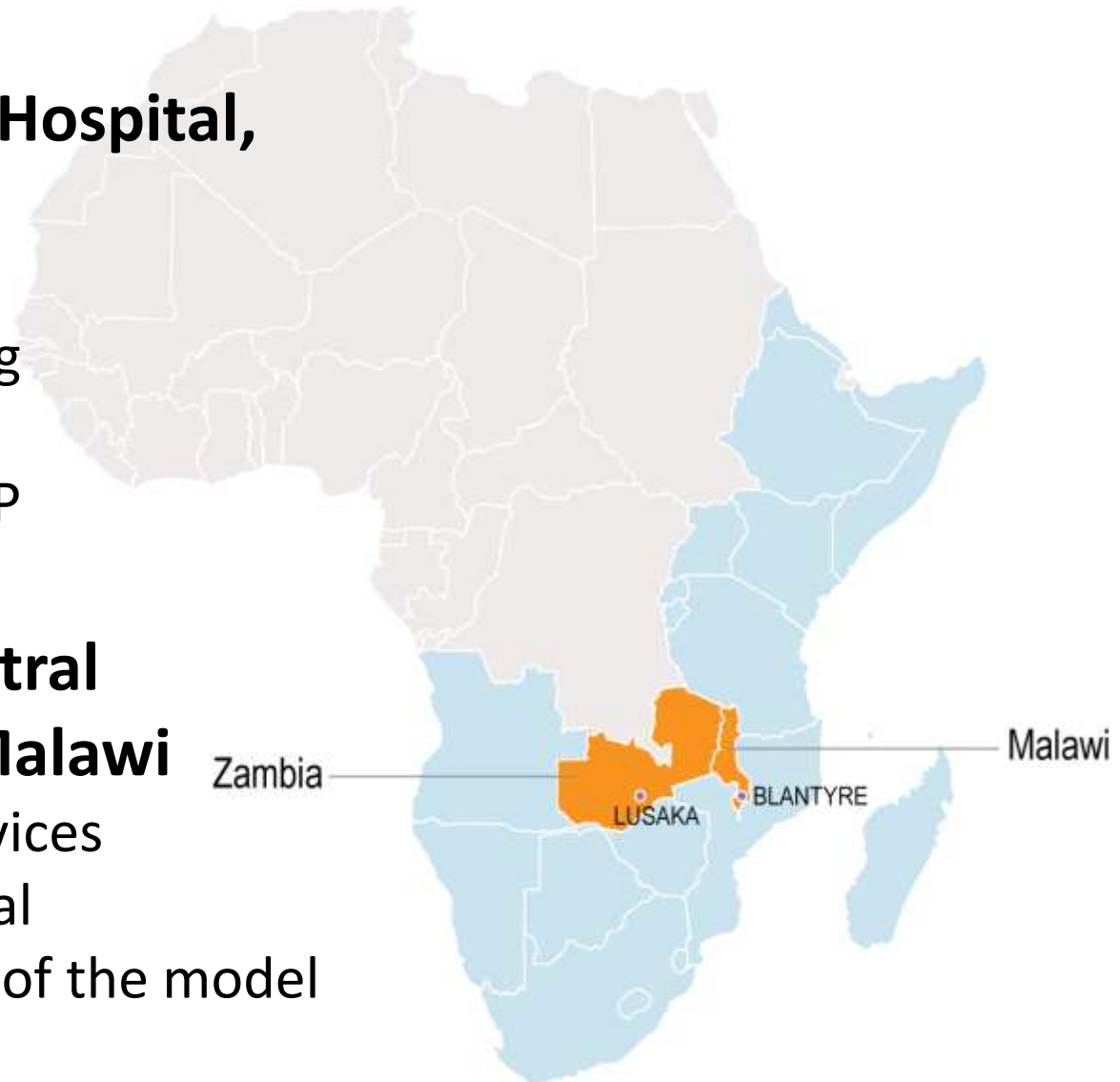
Child-Friendly Service Models: Two Case Studies

University Teaching Hospital, Lusaka, Zambia

- 2006
- OSC in a hospital setting
- High HIV setting—60% of children complete PEP

Queen Elizabeth Central Hospital, Blantyre, Malawi

- 2005 PEP, 2010 full services
- OSC attached to hospital
- 1 of 4 OSC; 14 versions of the model planned



	ZAMBIA (2010)	MALAWI
Avg clients/month	<16 years: 90	< 18 years: 15-20
Mean age	8 years	7 years
Facility staff	Doctor, 3 nurse/counselors , VSU police and social worker	Doctor, nurse, counselor and CF social worker
Follow-up psycho social	<1%	40%
Follow-up medical	5%	< 5%
Follow-up community	100% referred to NGOs	15% CF SW, others SWO
Follow-up prosecution	~18%	15-20%
Management team	Initially per month, now on special basis	Every 1-2 months
CF protocols/guidelines	Multidisciplinary manual for CSA; also in MOH guidelines	MoH Guidelines & CF OSC guidelines
Data base & monitoring	Hospital records: abuse, PEP, court cases & outcomes	Yes, though no national data base

Prevention & Service Response Frameworks

Adult Women (and Girls)



Children



Essential Elements of Child-Friendly Services

- One size does NOT fit all—geography, undeliverable policies, staffing, etc.
- **Coordinated ‘team’ approach** in both management and practice:
 - **Referrals**: by phone and with accompaniment for child or available in the OSC
 - **Minimize repetition**: medics and CP Social Worker examine together to avoid repetition or 2-way mirror & microphones
 - **Quality CF counseling**: immediate, encourages return visits or effectively resolves trauma and NGOs follow-up
 - **Home visits and re-integration**: assessed by social workers (CP and Community) or referred to NGOs
 - **Legal follow-up**: SW officers, VSU, court rep make a joint decisions, with Juvenile Justice Programme monitoring and direct contact with local prosecutors office

Essential Elements (con't)

- **Specialized staffing** and specialized service:
 - **Core group of pediatricians** trained and rotating--
consequences of the evidence/exam are immense
(ensure that medical students receive lectures and CSA guidelines)
 - **CF exam + CF counseling** help the child process immediately and 'kids get back their power'
 - **Child Protection Social Worker**, dedicated on site and overseeing the welfare of the child from the start (assigned by Ministry)
- **Emergency plan** in the community, referrals begin there, chiefs/elders play a central role to enhance family involvement and NGOs can supplement this process

Key challenges



- **Schools** not part of the system
- **Early Childhood Development** warrants prevention
- VSU may be strong but **intra-police communication** weak; lack of transport and human & financial resources
- **Financial and human resources** staffing is not priority in tertiary/acute care settings
- **Hostile legal systems** for children but also for doctors & nurses who dislike testifying

Next Steps

- Further documentation of specialized pediatric services so that they are commensurate with levels of violence against children in ESAR
- Ensure that GBV models have child friendly guidelines and protocols for girls & boys
- Urban OSC models must be adapted to district and primary care centre levels:
 - CO designated for forensic evidence (CSA in the curriculum)
 - Nurse makes links to VSU and social welfare (push for generic SW in *all* health care facilities)

