MALAWI IRISH CONSORTIUM ON GENDER BASED VIOLENCE

Report

Mapping Gender-Based Violence (GBV) Service Provision in Malawi: A GIS-Based Study in Five Districts

Submitted to

The Malawi Irish Consortium on Gender Based Violence

The Mapping Exercise Carried By

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Acronyms

CVU	: Community Victim Unit
CSR	: Corporate Social Responsibility
CVSU	: Community Victim Support Unit
DHIS2	: District Health Information Software 2
DoDMA	: Department of Disaster Management Affairs
DSWO	: District Social Welfare Office
GBV	: Gender-Based Violence
GIS	: Geographic Information System
HMIS	: Health Management Information System
IGA	: Income Generating Activity
KII	: Key Informant Interview
MICGBV	: Malawi Irish Consortium on Gender-Based Violence
MoU	: Memorandum of Understanding
NGO	: Non-Governmental Organisation
OPD	: Organisation of Persons with Disabilities
OSC	: One Stop Centre
PEP	: Post-Exposure Prophylaxis
PVSU	: Police Victim Support Unit
SSF	: Survivor Support Fund
TA	: Traditional Authority
UNFPA	: United Nations Population Fund
WRO	: Women's Rights Organisation

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Executive Summary

This GIS-based study mapped 98 GBV-related service points and analysed three years of referral and case outcome data across five districts; Mzimba, Mchinji, Balaka, Phalombe and Nsanje to understand *where* services are located, *who* can practically reach them, and *how* cases move through the system. The analysis showed a GBV response architecture that was heavily driven by health facilities, Community Victim Units (CVUs) and Police Victim Support Units (PVSUs), with courts playing a very limited role in case resolution. Spatially, services were clustered in a few relatively better-served TAs (e.g. M'Mbelwa, Chindi, Mkanda, Ndamera, Mlolo), while remote TAs such as Nazombe and Nkhulambe faced long distances, high transport costs and extremely low recorded referrals clear signs of suppressed access and unmet need.

Across the mapped providers, 147,905 GBV-related cases were recorded as received over the three-year reference period (2023–2026), of which 96,865 were recorded as resolved, yielding an overall resolution rate of 65.5%. However, resolution rates varied sharply by district, TA and provider type, with Nsanje and Balaka performing strongly, Mchinji and Phalombe lagging, and courts emerging as a systemic bottleneck (only 7.4 % of all cases touched the court system, with a 25.1% resolution rate). At the same time, the study exposed serious weaknesses in GBV data systems: fragmented, paper-heavy registers; inconsistent definitions of "case" and "resolved"; and very limited longitudinal tracking. Taken together, the findings pointed to a GBV system where geography, poverty and weak inter-institutional coordination systematically filter which survivors reach which services, and which cases progress from disclosure to meaningful resolution.

Key Findings

- **Uneven spatial coverage of services**
  - Mzimba and Nsanje hosted over two-thirds of mapped GBV service points; Balaka and Phalombe had fewer facilities and higher vulnerability to single-point failure and localised service disruption.
  - At TA level, facilities clustered in TAs such as Chindi, Ndamera, Mkanda, M'Mbelwa, Mlolo and Mduwa, while other TAs relied on distant service providers or lightly equipped community structures.
  - The TA maps showed that in many areas (e.g. **M'Mbelwa, Mlolo, Ndamera, Mkanda**), GBV service points followed **linear corridors along main roads and valley bottoms**, with **side valleys and upland zones largely unserved**, creating sharp intra-TA disparities.
- **Terrain, rivers and floodplains as structural access barriers**
  - Elevation and hillshade layers highlighted **steep, mountainous terrain** around TAs such as **Nkhulambe and parts of M'Mbelwa**, where services are mostly at lower elevations along main roads, forcing survivors from upland villages to descend long distances to reach care.
  - In **Mlolo and Ndamera**, services clustered along **floodplain roads and river corridors**; the maps showed that key bridges and low-lying road segments are highly exposed to **seasonal flooding**, meaning entire clusters of villages can be temporarily cut off from otherwise well-positioned health clinics, CVUs and PVSUs.
- **Significant distance, time and cost barriers**
  - Survivors typically travelled around 31–34 km one way to reach key services, with median travel times around 45 minutes and means above 50 minutes.
  - Travel-time surfaces indicated an average of about **21 minutes in Mduwa** and **38 minutes in Chindi** to the nearest GBV service provider, compared with **around 73 minutes in Chanthunya/Phalula** and **about 91 minutes in Nkhulambe**. This means survivors in Nkhulambe and parts of Nazombe faced **three to four times longer journeys** than those in better-served TAs like Mduwa, even before considering waiting times and onward referrals.
  - Estimated transport costs averaged MWK 11,600 per trip (median MWK 7,000), with Nazombe and Nkhulambe in the highest cost and distance bands.
  - Nearly 80% of facilities reported hard-to-reach zones in their catchments (poor roads, flooding, hills, river crossings).
- **Heavy reliance on health, CVUs and police services; limited court engagement**
  - **Health clinics** remain the primary entry point, managing **55,512 cases (37.5%)** with a **57.6% resolution rate**, reflecting both high demand and sustained pressure on frontline health services.
  - **Community-based providers** play a critical role: **Community-Based Organisations (CBOs)** handled **32,831 cases (22.2%)** with a strong **73.2% resolution rate**, while **Community Victim Units (CVUs)** managed **13,752 cases (9.3%)**, resolving **70.8%**.

- **Police Victim Support Units (PVSUs)** handled **16,383 cases (11.1%)**, resolving **69.6%**, confirming their importance as second-line responders linking community and formal justice pathways.
- **Courts** engaged with **10,908 cases (7.4%)**, resolving **65.2%** overall; however, their limited share of total cases indicates that only a small proportion of survivors reach the formal judicial stage, reinforcing the justice sector as a downstream bottleneck rather than a primary resolution venue.

- **District and TA performance disparities**
- **Phalombe** carries by far the largest share of the caseload, with **98,496 cases received (66.6% of all cases)** and **64,830 resolved**, yielding an overall **resolution rate of 65.8%**. The sheer volume of cases indicates intense pressure on community, health and police services, and a strong reliance on non-court mechanisms to manage demand.
- **Mzimba** accounts for **11.9% of all cases (17,649)** but records the **highest district-level resolution rate (82.6%)**, resolving **14,576 cases**. This suggests comparatively effective case management and follow-through across provider types once cases enter the system.
- **Mchinji** represents **11.1% of cases (16,400)** and resolves **66.3%**. Despite a moderate caseload, outcomes point to attrition along referral pathways, particularly beyond community and police levels.
- **Nsanje**, with **10.4% of cases (15,445)**, records a similar resolution rate (**66.4%**), indicating broadly comparable performance to Mchinji but with heavier reliance on community- and police-level resolution rather than formal justice mechanisms.
- **Balaka** contributes the smallest share of cases (**6.7%; 9,915 cases**) and records the **lowest resolution rate (63.8%)** among the five districts, reflecting limited service density and higher vulnerability to service interruptions and referral bottlenecks.

- **Referral pathways were multi-layered but weakly coordinated**
- Police and CVUs were the main referral sources (around 70% combined); magistrate courts were rarely primary entry points.
- Referral letters dominated; accompaniment and structured phone follow-up were far less common.
- Feedback loops were inconsistent, and originating facilities often did not know whether referrals resulted in services or justice outcomes.

- **Magistrate jurisdiction and justice attrition**
- TA-level magistrate courts were predominantly 2nd/3rd grade, lacking jurisdiction over criminal GBV cases; all such matters had to be referred to 1st grade district courts.
- This structural design layered extra distance, cost and time onto already burdened survivors, contributing to very low court caseloads and low resolution rates relative to community, health and police services.

- **Serious data management weaknesses**
- GBV data were fragmented across paper registers, ad-hoc spreadsheets and parallel sector systems, with no unique case identifier.
- Definitions of “case” and “resolved” varied by provider; some facilities appeared to count general family disputes as GBV, or treat any closed file (referral, dropout, informal mediation) as “resolved”.
- Outlier caseloads at a few high-volume facilities, missing values and uneven disaggregation limited the precision of the statistics and reinforced the need for stronger data governance.

Key Recommendations

- **Rebalance the spatial footprint of GBV services**
- Prioritise Balaka and Phalombe, and cold-spot TAs such as Nazombe and Nkhulambe, for new or upgraded GBV entry points (CVUs, safe spaces, strengthened health facilities).
- Treat high-burden TAs (M’Mbelwa, Chindi, Phalula, Chanthunya) as GBV “hubs”, consolidating more comprehensive service packages there (medical, psychosocial, basic legal support).

- **Reduce distance and transport cost barriers for survivors**
- A district-level Survivor Support Fund (SSF) should be established to reduce the distance-, terrain- and cost-related barriers that prevent survivors particularly those from hard-to-reach TAs from accessing health, police, psychosocial and court services. The SSF should provide **targeted, time-bound support** covering emergency transport, short-term food or accommodation in acute cases, and safe accompaniment for survivors who would otherwise be unable to complete a referral or justice pathway.
- Expand mobile GBV outreach (health + counselling + legal information) to remote and flood-prone TAs, scheduling visits based on caseload, distance and cost rather than population alone.

- **Strengthen and standardise referral and coordination mechanisms**

- Develop a unified multi-sectoral referral protocol and form (minimum dataset, clear handover rules, feedback requirements) for CVUs, health, police and courts.
- Institutionalise quarterly district GBV case-review meetings using linked referral data to identify bottlenecks, stalled cases and TAs where survivors drop out of the system.

- **Address justice bottlenecks and court accessibility**
- Support circuit or mobile court sessions in high-burden, distant TAs to reduce the number of long, costly trips required for survivors and witnesses.
- Strengthen police–prosecution–court communication and case tracking so that criminal GBV matters referred out of TAs are systematically followed through at district level.

- **Invest in integrated, geospatially aware GBV data systems**
- Agree and adopt a harmonised minimum GBV dataset and data dictionary across sectors, including TA of origin and referral destination.
- Introduce a simple unique case ID and progressively shift from fragmented paper registers to standardised digital tools (e.g. Kobo, DHIS2 modules, or structured spreadsheets) with basic validation.
- Integrate Geographical Positioning System (GPS) and TA attributes into routine registers so that spatial analysis becomes a standard input to district and national GBV planning, not a one-off project output.

- **Institutionalise use of GIS and dashboards for decision-making**
- Host the geospatial database and Power BI dashboards under MICGBV or Government infrastructure and make them mandatory reference tools for annual district GBV workplans and coordination forums.
- Build district-level capacity to interpret maps and indicators (facility density, TA caseload, average distance/cost) and translate them into funding proposals, resource allocation decisions and targeted interventions.

1.0 Introduction and Background

1.1 Introduction

Gender-Based Violence (GBV) remains one of the most urgent public health, human rights, and development challenges in Malawi. While policy and programmatic efforts have advanced significantly, gaps in access particularly in rural and hard-to-reach areas persist due to fragmented service delivery, limited visibility of service coverage, and weak data systems. Survivors often face physical and logistical barriers in reaching support, while decision-makers lack the tools to target resources effectively. This proposed assignment directly addresses these barriers through the use of Geographic Information Systems (GIS) to map the distribution and accessibility of GBV services in five districts: Mzimba, Mchinji, Balaka, Phalombe, and Nsanje.

Tech-Check ICT Solutions implemented a technically rigorous and context-responsive GIS-based mapping study to support MICGBV's mission to strengthen evidence-based GBV response in Malawi. Our proposed approach leverages spatial analysis, local validation, and gender-responsive research to identify and visualise the availability and accessibility of GBV services across five districts. The study has delivered high-resolution data and tools for advocacy, policy influence, and improved coordination, including a geospatial database, travel time models, service gap maps, and district-level policy briefs tailored to TA-level realities.

1.2 Project Context

This assignment directly supported the strategic vision of the Malawi Irish Consortium on Gender-Based Violence (MICGBV), which sought to strengthen GBV prevention and response systems in Malawi through evidence-based planning, targeted resource allocation, and coordinated stakeholder action. The Terms of Reference mandated a comprehensive GIS-based mapping and accessibility study across five districts; Mzimba, Mchinji, Balaka, Phalombe, and Nsanje with a specific focus on identifying the availability, distribution, and accessibility of GBV services at Traditional Authority (TA) level.

Despite years of effort by government and civil society, gender-based violence remained a pervasive public health, protection, and human rights issue in Malawi, disproportionately affecting women and girls across socio-economic groups. Survivors especially in rural and hard-to-reach areas often faced multiple layers of exclusion: long distances to services, weak or seasonal road networks, limited transport options, uneven service coverage, and limited knowledge of where and how to seek help. In this context, effective GBV prevention and response required not only strong programming, but also strategic, location-aware data systems capable of mapping services, exposing gaps, and monitoring accessibility in a systematic way.

The study was designed to close this critical data gap by leveraging Geographic Information System (GIS) technology to systematically map key GBV service points including police Victim Support Units (VSUs), health centres, courts, social welfare offices, community victim support structures and other gatekeepers within the five target districts. The resulting datasets were used to model physical accessibility, including approximate travel time and distance to the nearest provider, taking into account road networks, terrain and population distribution. These outputs were then organised into static and interactive maps, Power BI dashboards and a web-accessible GIS database, intended to enable district and national stakeholders to monitor, plan and coordinate GBV services more effectively over time.

Critically, this mapping exercise was not treated as a purely technical product, but as a core systems-strengthening intervention. The results fed directly into MICGBV's ongoing advocacy, programming and policy engagement by making visible where services were concentrated, where they were absent or thin, and what structural barriers survivors faced in accessing them. By identifying coverage gaps and overlaps at TA level, the study enabled local government, district GBV committees and implementing partners to better prioritise interventions, target under-served TAs, and design more responsive, survivor-centred strategies.

The team worked within a clearly defined scope that included TA-level mapping, travel time and distance analysis, consultation and validation with district stakeholders, and the production of practical outputs:

cleaned datasets, geospatial layers, analytical maps, a district- and TA-level report, and concise policy and programming messages. Throughout, the analysis was aligned with Malawi's national GBV service standards and the operational frameworks of the Ministry of Gender, Community Development and Social Welfare, ensuring that findings could be absorbed into existing planning and coordination mechanisms rather than sitting as a standalone project asset.

Finally, the approach reflected MICGBV's emphasis on shared learning, coordinated action and sustainable capacity building. The work combined geolocation and spatial modelling with collection of non-spatial service attributes (e.g. year of establishment, staffing, functionality, service package), structured validation with local actors, and initial orientation of district staff and partners on how to interpret and use the maps and dashboards. This helped lay the groundwork for longer-term institutionalisation of geospatial GBV data within district and national systems, beyond the life of the assignment.

2.0 Meeting Objectives of the Assignment

2.1 Study Purpose

The main objective was to map and assess the availability and accessibility of GBV-related services in Mzimba, Mchinji, Balaka, Phalombe and Nsanje districts to inform policy and improve service delivery. Specifically, the study aimed to:

- TIdentify and geolocate key GBV service providers (police victim support units, health clinics, courts, social welfare offices and community gatekeepers) within the catchment areas of Traditional Authorities of Mzimba, Mchinji, Balaka, Phalombe and Nsanje districts.
- Assess population distribution and travel time to the nearest GBV service provider using GIS tools.
- Determine service gaps and overlaps within and between TAs in relation to population density and geographic barriers.
- Generate policy-relevant maps and visualizations that support evidence-based advocacy and programming at district and TA levels.

This study represents a strategic opportunity to bridge the knowledge gap in GBV service provision through innovative use of GIS technology. By aligning data with the lived realities of communities, the MICGBV can drive impactful change in service delivery and support a more responsive, equitable GBV prevention and response framework in Malawi. The following were the intended outcomes of the study:

- A comprehensive geospatial database of GBV service providers at TA level across the five study districts.
- Maps illustrating the availability and accessibility of GBV services, including travel time and coverage gaps.
- District and TA-specific policy briefs with recommendations to improve equitable access to GBV services.
- Strengthened capacity of MICGBV member organizations in using GIS tools for planning and advocacy.
- Enhanced coordination between stakeholders involved in GBV prevention and response.

3.0 Methodology and Approach

3.1 Study design

The study used a **mixed-methods that integrated geospatial approach** to assess both the **availability** and **accessibility** of GBV services in five districts Mzimba, Mchinji, Balaka, Phalombe and Nsanje. The work was anchored in three linked questions:

1. Where are GBV services located, and how are they distributed across regions, districts and Traditional Authorities (TAs)?
2. How do survivors move through the system from TA of origin to district-level actors and what does this imply for distance, time and cost of access?
3. How can these spatial insights inform planning, coordination and investment decisions by MICGBV and government?

Two complementary tools were deployed:

1. **GBV Service Provider Mapping Tool (KoboToolbox)** – completed by **98 service points**, including health facilities, police Victim Support Units (VSUs), community victim structures, courts, social welfare offices, One Stop Centres and other service providers. The tool captured:
    - GPS coordinates in **WGS 84**;
    - Facility type and ownership;
    - Services offered and staffing profile;
    - Catchment description and presence of hard-to-reach areas;
    - Cumulative GBV case loads and referrals in/out of the facility.
2. **District-Level GBV Referral Tracking Questionnaire** – completed by **20 district-level GBV actors** (police, magistrate courts, District Social Welfare Offices, One Stop Centres and selected health facilities). This tool focused specifically on:
    - Cases referred from the **TAs of concern**;
    - Referral volumes over the last three years;
    - Perceived distance, travel time and travel cost from TA to facility;
    - Referral pathways, coordination mechanisms and feedback loops.

Together, these tools produced a **multi-scalar dataset**: granular coordinates and attributes at facility level, and systems-level referral dynamics at district level.

3.2 Data collection, cleaning and validation

- **Digital data collection**

  All interviews were conducted using **Kobo Collect/Enketo** on mobile devices. GPS was enabled to support mapping of GBV service provision facilities with high precision and enumerators were trained on GBV-sensitive interviewing, informed consent, confidentiality and distress/referral protocols.

  Data were collected from **98 GBV service providers** across the five districts and covered **approximately three years of retrospective case data** from the date of the exercise. Across the five districts, GBV case data are captured through a **fragmented ecosystem of parallel systems**, including paper registers, ad-hoc Excel files, Kobo forms, and sector-specific information systems (e.g. police registers, health HMIS, and social welfare case books). There is **no single integrated case management system** and **no common unique case identifier** that follows a survivor across providers and sectors. As a result:

  - The totals reported in this study should be interpreted as **episodes of service contact**, rather than counts of unique survivors; the same survivor and case may appear multiple times as they move through the referral chain (e.g. CVU → PVSU → health clinic → court).
  - **Double-counting is likely**, particularly in high-volume TAs such as **Nkhulambe, M'Mbelwa and Ndamera**, where referral activity is more frequent and multi-sectoral.
  - Facility-level and district-level totals **cannot be reconciled into a "one survivor = one record" dataset**, limiting the precision of incidence and prevalence estimates and constraining longitudinal tracking of case outcomes.

Despite these limitations, the dataset remains robust for **operational and systems-level analysis**, enabling identification of spatial inequities, service-use patterns, referral bottlenecks and relative performance across provider types, districts and TAs. The findings therefore provide strong evidence for **planning, prioritisation and system strengthening**, even as they underscore the urgent need for harmonised data standards and integrated case management systems.

- **Data cleaning and harmonisation**
  Kobo's automated reports were used to generate initial frequency tables and spot outliers. The two datasets were then harmonised into a **master geodatabase**. Cleaning steps included:
  - Removing duplicate facility records;
  - Checking coordinate plausibility against base maps;
  - Ensuring consistent coding of districts, TAs and provider types;
  - Reconciling free-text entries ("Other facility type") with standard categories.
- **Geospatial analysis**
  Cleaned data were imported into **QGIS** to:
  - Classify service points by type and owner;
  - Map distribution by **region, district and TA**;
  - Overlay with district/TA boundaries and road networks;
  - Prepare the base for travel-time and catchment analysis.

Spatial analysis combined:

- **Point-based mapping** of 98 GBV service providers (health facilities, police VSUs, CVSUs, community structures, courts, Social Welfare Offices, One Stop Centres) using GPS coordinates (WGS 84 / UTM Zone 36S).
- **Polygon-based analysis** using regional, district and TA boundaries.
- **Basic accessibility metrics** (distance, travel time, transport cost) from the district-level referral survey, linked back to TA of origin.
- **Digital Elevation Models (DEM) of Traditional Authorities were created based on interpolation**

Cleaned coordinates and attributes were imported into **QGIS** and overlaid with district, DEM and TA boundary layers. This enabled analysis at three levels:

1. **Inter-district** – comparing service density across the five study districts.
2. **Intra-district (TA-level)** – identifying "hot spots" and "cold spots" of service provision.
3. **Accessibility** – interpreting distance, travel time and cost from the TAs of concern to district-level GBV hubs.

- **Referral analysis**
  The district-level dataset was analysed descriptively (means, medians, standard deviations) to quantify:
  - Total cases referred per provider and per TA;
  - Distances and travel times from TA to service point;
  - Average transport cost per survivor;
  - Qualitative constraints in referral coordination.

1.3 Limitations

While the study provides valuable insight into the spatial distribution, utilisation and performance of GBV services in the five districts, several limitations constrain the level of precision and generalisability of the findings. These limitations are described below, together with the steps taken to minimise their impact.

- **Dependence on raw, self-reported data**
  Limitation: Figures are drawn from routine registers and Kobo raw exports; despite checks, some outliers and inconsistencies remain.

Mitigation: We ran basic validity checks (range checks, internal consistency, review of extreme values), triangulated with qualitative feedback from providers, and used medians and bands (e.g. 20–30 km) where appropriate instead of relying only on raw means.

- **Fragmented and parallel data systems**
  Limitation: GBV data sit in separate paper registers, Excel sheets, police books, health HMIS and social welfare files with no unique case ID, so totals reflect "episodes of contact" rather than unique survivors.
  Mitigation: The analysis explicitly treats figures as service-contact episodes; we focused on patterns (who handles what share of cases, relative resolution rates, TA differences) rather than absolute incidence, and we highlighted the need for a harmonised case ID and integrated GBV MIS as a core recommendation.
- **Inconsistent definitions of "case" and "resolved"**
  Limitation: Providers differ on what counts as a GBV case and when it is resolved (e.g. informal mediation vs court judgement), which affects comparability of resolution rates.
  Mitigation: We analysed resolution rates mainly within provider types and within districts; we used resolution as a proxy for "follow-through" rather than strict legal closure, and we documented these definitional issues clearly so users interpret the metrics appropriately.
- **Absence of survivor-level perspectives**
  Limitation: The study captures provider and system perspectives only; it does not include direct interviews with survivors, so it cannot fully explain reasons for drop-out or perceptions of quality.
  Mitigation: We used narrative inputs from frontline workers and district actors to interpret quantitative patterns and clearly recommend a follow-up qualitative study focused on survivor journeys and lived experiences.
- **Fieldwork logistics and fuel constraints**
  Limitation: Fuel shortages, high fuel prices (on black market) and difficult terrain in some areas limited field mobility; a few very remote or low-volume sites were contacted by phone rather than visited in person.
  Mitigation: We prioritised in-person visits to high-caseload and strategically critical facilities, used trained child protection workers to collect GPS coordinates.
- **Justice data and jurisdictional limits**
  Limitation: TA-level magistrate courts are mostly 2nd/3rd grade without criminal jurisdiction; criminal GBV cases should be referred to district-level 1st grade magistrates, which complicates interpretation of "court" caseload and resolution rates.
  Mitigation: We treated TA courts primarily as referral and mediation points, interpreted their numbers cautiously, and explicitly linked low court caseloads and resolution rates to structural jurisdictional limits and distance from district courts, rather than only to performance.
- **Overall constraints on precision and generalisation**
  Limitation: Combined, these issues mean the dataset cannot provide precise prevalence or conviction rates and is not nationally representative.
  Mitigation: We framed all findings as **operational evidence for planning** in the five study districts, not as national statistics. We used multiple triangulation (across provider types, TAs, and tools), emphasised patterns and inequities rather than exact counts, and converted data system weaknesses directly into a structured set of recommendations on harmonised datasets, unique IDs, digitalisation, data quality audits, and routine geospatial use.

4.0 Key Findings and Spatial Patterns

4.1 Profile of mapped GBV service providers at TA levels

The 98 mapped facilities show a system dominated by health services and community-based structures, with a relatively narrow layer of statutory, specialised actors.

Table 1: Distribution of mapped GBV service providers by type (n = 98)

Service provider type	Number	% of all providers
Community Victim Unit (CVU)	21	21.4%
Health clinic / health centre	20	20.4%
Police Victim Support Unit (PVSU)	19	19.4%
"Other" facilities (NGOs, FBOs, etc.)	15	15.3%

Community gatekeepers	5	5.1%
Courts	5	5.1%
Community-based organisations (CBOs)	5	5.1%
One Stop Centres	4	4.1%
Women's forums	3	3.1%
Social Welfare Offices	1	1.0%
Total	**98**	**100%**

The **98 mapped facilities** confirm a system dominated by **frontline health and community structures**, with a relatively narrow layer of statutory and specialised actors. **Health facilities and CVUs account for 41.8%** of all mapped providers, and when **PVSUs** are added, **over three in five service points (61.2%)** fall within these three categories. By contrast, the specialised statutory layer remains thin: **courts (5), One Stop Centres (4) and Social Welfare (1)** together account for only **10.2%** of mapped providers. This "front-loaded" architecture explains why most survivors' pathways begin and often end at community, clinic and police levels, while justice and integrated survivor-centred care remain structurally harder to reach.

4.2 Availability and depth of GBV services

Most facilities report providing core psychosocial and advisory services. Fewer offer the more specialised interventions required for full survivor-centred care.

Table 2: Self-reported GBV-related services provided (n = 98)

Service provided	Facilities	% of mapped providers
Counselling	88	89.8%
GBV case support	79	80.6%
Child protection services	71	72.4%
Child neglect case handling	60	61.2%
Follow-up visits to victims	40	40.8%
Safe spaces for survivors	35	35.7%
Legal divorces (proxy for legal support availability)	16	16.3%

Core psychosocial and advisory support remains widely available, most providers report **counselling (89.8%)** and **GBV case support (80.6%)**, and nearly three-quarters offer **child protection**. However, the system thins out for services that require sustained resourcing and specialist capacity: fewer than half report **follow-up visits**, only about a third report **safe spaces**, and formal/legal support functions remain limited in routine service points. This reinforces a pattern where survivors can often access *initial support and mediation*, but face greater difficulty securing *protected accommodation, specialised medico-legal support, or sustained justice accompaniment*, especially outside district centres. The system is strong in **psychosocial entry points**, yet thin in the specialised services that determine whether a case translates into **protection, justice and long-term safety**.

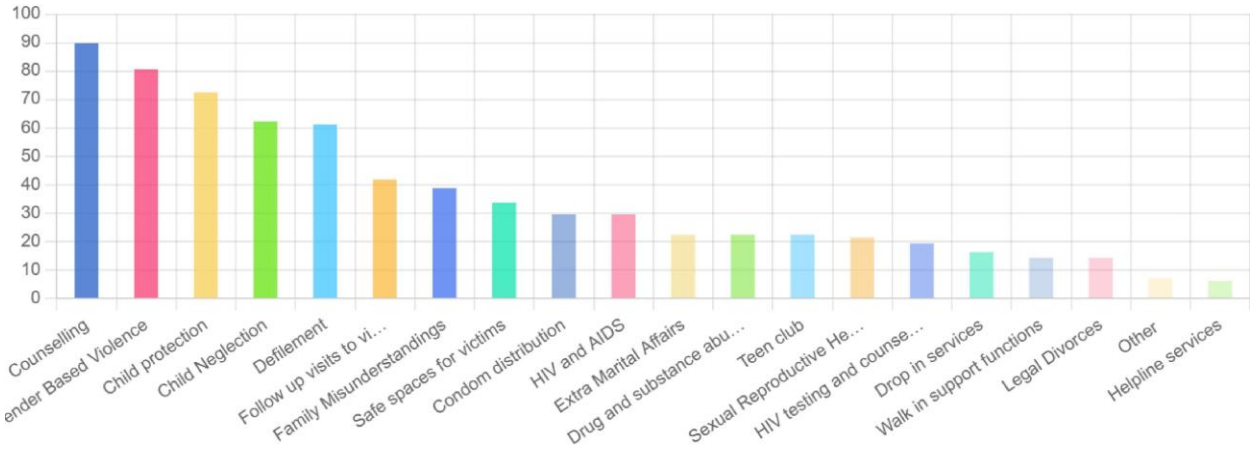

FIGURE 1: SERVICES OFFERED BY GBV PROVIDERS

4.3 Regional and district distribution (Study Districts Only)

The overall supply of GBV services is skewed towards the southern part of the country and a subset of districts.

Table 3: Distribution of mapped facilities by region (n = 98)

Region	Number	% of facilities
Southern (Balaka, Phalombe, Nsanje)	55	56.1%
Northern (Mzimba)	22	22.5%
Central (Mchinji)	21	21.4%
Total	**98**	**100%**

Table 4: Distribution of mapped facilities by district (n = 98)

District	Number	% of facilities
Nsanje	31	31.6%
Mzimba	22	22.4%
Mchinji	21	21.4%
Phalombe	13	13.3%
Balaka	11	11.2%
Total	**98**	**100%**

Although all five districts host GBV services, mapped supply remains uneven: **Nsanje, Mzimba and Mchinji together account for 75%** of mapped providers (74/98), while **Balaka and Phalombe together account for 25%** (24/98). This creates asymmetric dependency and risk: districts with fewer mapped providers are more exposed to **single-point failure**, staffing gaps, interruptions and long referral chains.

4.4 TA-level concentration and hard-to-reach catchments

At TA level, service concentration becomes even more pronounced.

Table 5: Top 10 Traditional Authorities by number of mapped GBV facilities

Traditional Authority (TA)	District	Number	% of all facilities
Ndamela	Nsanje	18	18.4%
Mkanda	Mchinji	14	14.3%
M'Mbelwa	Mzimba	13	13.3%
Mlolo	Nsanje	13	13.3%
Chindi	Mzimba	9	9.2%
Nazombe	Phalombe	7	7.1%
Mduwa	Mchinji	7	7.1%
Nkhulambe	Phalombe	6	6.1%
Phalula	Balaka	6	6.1%
Chanthunya	Balaka	5	5.1%
Total		**98**	**100%**

At TA level, concentration becomes even more pronounced. A small group of TAs (**Ndamela, Mkanda, M'Mbelwa and Mlolo**) contains a disproportionate share of providers, functioning as de facto GBV service hubs for surrounding catchments. Meanwhile, **Nazombe, Nkhulambe, Chanthunya and Phalula** have fewer mapped providers despite high access constraints, meaning survivors in these areas rely more heavily on long-distance travel, corridor-based facilities, or lightly resourced community structures.

In parallel, approximately **80% of facilities** report that their catchment includes at least one hard-to-reach area (river crossings, floodplains, hills, long walking distances, poor roads), meaning that even in "facility-dense" TAs, service access remains unequal within the TA. Services are therefore **double-concentrated**: geographically (in a shortlist of TAs) and functionally (in a limited number of facilities serving complex and

difficult catchments). This creates pressure on hub facilities and raises the risk that survivors in peripheral settlements disengage early due to distance, cost, disability barriers and transport unreliability.

4.5 District-level service density by population and land area

To move beyond simple facility counts, we examined **GBV service density** relative to both **population** and **land area** in the five districts using 2023 population projections and district areas.

The national TA-level population-density map highlights **pronounced spatial variation** in settlement patterns across the five study districts, with direct implications for GBV service demand, accessibility, and resource allocation. Population clusters and sparsely populated uplands align strongly with observed GBV caseloads, travel-time barriers, and facility placement gaps.

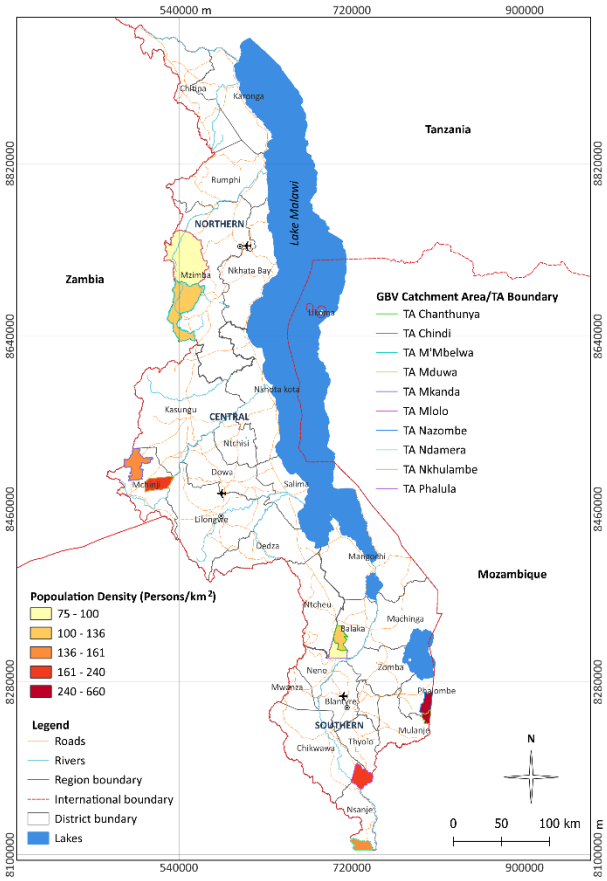

Figure 2: Population Density in the Catchment Areas

Clear North–South Population Gradient

The map shows a **north–south corridor of medium-density populations (100–161 persons/km²)**, intersected by higher-density pockets in specific TAs. This corridor broadly aligns with Malawi's major transport spine (Mzuzu–Lilongwe–Blantyre), which is also where most GBV service points are located. As a result, communities along this axis typically have **better physical access** to CVUs, clinics, PVSUs and OSCs. In contrast, **eastern escarpments and western upland plateaus,** particularly in Phalombe, Balaka and upland parts of Nsanje show low density and poor connectivity, aligning with the highest travel-time barriers.

TAs With Highest Population Density (161–240+ persons/km²)

A small number of TAs appear in the **highest-density category (161–240 or 240–660 persons/km²)**:

- **TA Mkanda (Mchinji)**
- **TA Mduwa (Mchinji)**
- **TA Nkhulambe (Phalombe)**
- **Parts of TA Nazombe (Phalombe)**

These high-density TAs correspond with **high GBV caseloads**, strong CVU activity, and substantial demand for PVSU and health-facility services. However, in TAs like **Nkhulambe and Nazombe**, high density collides with **mountainous terrain and long travel times**, producing severe access inequities despite high population concentration.

Population Density Bands

- **High density (161–240+ persons/km²):** Mkanda, Mduwa, Nkhulambe, parts of Nazombe.
- **Moderate density (100–161 persons/km²):** M'Mbelwa, Chindi, Chanthunya, Phalula, Mlolo, Ndamera.
- **Low–moderate density (75–100 persons/km²):** Scattered uplands in Balaka, Phalombe, Nsanje.

Moderately Dense TAs (100–161 persons/km²) – The Service Corridors

Moderately dense TAs include:

- **M'Mbelwa and Chindi (Mzimba)**
- **Chanthunya and Phalula (Balaka)**

- **Mlolo and Ndamera (Nsanje)**

These TAs form the **functional GBV service hubs** of their districts. The population density in these areasand their proximity to major roads explains why:

- Most facilities (CVUs, clinics, PVSUs) cluster here.
- Most recorded GBV cases originate from these TAs.
- Travel times fall into the **20–45 minutes** range for most households.

However, the map shows that density falls sharply as one moves away from valley or road corridors, meaning **upland and off-corridor communities** even within these TAs remain underserved.

Low-Density, High-Vulnerability Zones

Less populated areas, especially:

- **Upland Phalombe (Nazombe/Nkhulambe escarpments)**
- **Peripheral Balaka (Chanthunya outskirts)**
- **Flood-prone Nsanje river margins (Ndamera and Mlolo outer zones)**

present a unique combination of **low population density and extreme access barriers**. These zones consistently show:

- **Travel times >60–90 minutes**
- **Transport costs in the MWK 10,000–15,000 range**
- **Very low reported case volumes**, linked to access-driven underreporting

The map visually reinforces how **distance and terrain**, not GBV incidence, drive low engagement with services.

District-Level Spatial Patterns

The map confirms distinct spatial accessibility profiles:

- **Mzimba**: moderate density with two strong service corridors (Chindi, M'Mbelwa), but underserved uplands.
- **Mchinji**: corridor-dense along Mkanda/Mduwa, sparse towards the border.
- **Balaka**: limited facilities over moderate density, vulnerable to service gaps.
- **Phalombe**: high-density foothills contrast with isolated mountainous settlements.
- **Nsanje**: dense valley corridor but flood-isolated communities in surrounding floodplains.

These structural patterns explain district variance in reporting rates, caseload distribution, and facility strain.

4.6 Intra-district clustering at TA level

At intra-district level, service points are not evenly spread; they cluster in specific **Traditional Authorities aligned with trading centres, major roads and administrative hubs**.

Using the TA-level counts above and the mapped point distribution, intra-district clustering is clear: **a handful of TAs account for most providers**, aligning strongly with trading centres, major roads, and administrative corridors. **Ndamela (18)** is the most concentrated TA in the study, followed by **Mkanda (14)** and the paired corridor hubs **M'Mbelwa (13)** and **Mlolo (13)**. By contrast, service availability thins rapidly in **Nazombe (7)**, **Nkhulambe (6)** and the Balaka TAs (**Chanthunya 5; Phalula 6**), which also face high travel times and cost barriers.

Because around **80%** of facilities report hard-to-reach areas in their catchments, **district averages are misleading**: even in TAs with multiple service points, off-corridor settlements may remain effectively unserved during rainy seasons or when transport is unavailable. TA-level analysis therefore confirms that programming should prioritise **sub-district targeting**, focusing on TAs that combine **low facility density, weak terrain/road accessibility and low recorded referral volumes**—the classic signature of **under-served and under-reported GBV risk**.

4.7 Facility-level caseload distribution

Table 6: Facility-reported GBV case loads (n = 98)

Indicator	Cases received	Cases referred onward
Mean	129.4	81.7
Median	25	17
Maximum	940	817
Standard deviation	369	337

Median case counts (25 received, 17 referred onward) tell a different story from the means. The large gap between median and maximum values and the high standard deviations show a **heavy-tailed distribution**: a few facilities primarily district hospitals, One Stop Centres and central VSUs carry a **disproportionate share of the caseload**, while many community structures remain lightly burdened. From a systems perspective, this suggests opportunities to **redistribute and rationalise caseloads** through stronger community-level triage, outreach and remote counselling, backed by robust referral and support.

4.8 Spatial equity: combining density, caseload and access

Bringing the density analysis, caseload data and accessibility metrics together:

- **Nsanje** emerges as a paradox: it has high facility density per population and area, yet remains one of the most vulnerable districts due to **flood risk, poverty, and cross-border movement**. The high density likely reflects an intentional response to these risks, but travel distances from some TAs still exceed 30 km.
- **Mzimba** has many facilities in absolute terms but low density per km², and large TAs with sparse services. High caseloads in TAs like **M'Mbelwa and Chindi** suggest **overstretched hubs** serving vast catchments.
- **Balaka and Phalombe** have relatively **few facilities per capita**, with some TAs (Nazombe, Nkhulambe, parts of Chanthunya/Phalula) showing both **low facility density and low referral counts** classic indicators of **hidden demand** and/or access barriers.

5.0 District-Level Referral Insights

5.1 Respondent profile

Table 7: Respondents by region and provider type (n = 20)

Category	Number	% of respondents
Region		
– Northern	3	15%
– Central	6	30%
– Southern	11	55%
Provider type		
– Police Victim Support Unit	6	30%
– Court / Magistrate	6	30%
– One Stop Centre	4	20%
– Health clinic / facility	2	10%
– Social Welfare Office	1	5%
– Other	2	10%

The sample cuts across **police, justice, health and social welfare**, ensuring that perspectives on referral flows are not sector-biased. Over half of respondents are based in the **Southern Region**, which is consistent with the higher facility density there.

5.2 TA-to-district referral flows and case burden

Table 8: TAs most commonly cited as referral origins (n = 20)

TA of origin	Respondents citing TA	% of respondents
Ndamera	4	20%
M'Mbelwa	3	15%
Phalula	3	15%
Nazombe	3	15%
Mduwa	3	15%
Mkanda	3	15%
Chanthunya	1	5%

Over a three-year reference period, the **mean total number of GBV cases received from TAs per provider is 193**, with a median of 86 and a very high standard deviation (264), again indicating a **few high-volume facilities**.

Table 9: Mean number of referred cases from selected TAs (3-year period)

TA	Mean cases	Interpretation
M'Mbelwa	319.0	High-volume TA; substantial burden
Chanthunya	225.0	High-volume TA
Chindi	212.7	High-volume TA
Phalula	188.5	High-volume TA
Mlolo	55.0	Moderate-volume TA
Ndamera	51.0	Moderate-volume TA
Nazombe	2.5	Very low – likely under-reporting
Nkhulambe	1.0	Very low – likely access barriers

The referral data show a **dual picture**: some TAs (M'Mbelwa, Chindi, Chanthunya, Phalula) send large numbers of cases to district service providers, reflecting either higher incidence, better detection/reporting, or both. Others (Nazombe, Nkhulambe) appear almost invisible in referral statistics, a strong **red flag for hidden demand** and geographic or socio-cultural barriers.

5.3 Accessibility: Distance, travel time and cost of access

5.3.1 Distance, travel time and cost of access to district-level GBV services

Table 10 shows that **access to GBV services varies sharply between TAs**, even within the same district. On distance and travel time (Table 10), **around 80% of the TAs of concern (8 out of 10)** fall into the **20–40 km** and **40–75 minute** bands to reach district-level GBV service providers. This includes **M'Mbelwa, Chindi, Mkanda, Mduwa, Phalula, Chanthunya, Ndamera and Mlolo**. For survivors in these areas, especially women and girls who may be injured, traumatised or responsible for childcare, a one-way trip of this length is already a significant barrier, particularly if they are expected to return multiple times for health, police and court processes. Within this group, TAs such as **M'Mbelwa and Chindi** (Mzimba) and **Ndamera and Mlolo** (Nsanje) illustrate how "better-served" areas in terms of facility presence can still contain **pockets of isolation**: services are clustered around trading centres and main roads, while outlying villages remain distant from any functioning GBV entry point.

At the extreme end of the spectrum**, Nazombe and Nkhulambe** (Phalombe) fall squarely into the **30–50 km** and **60–90+ minute** distance/time bands. For survivors in these TAs, a single trip to access a police VSU, health facility, court or Social Welfare Office can consume most of a day and may require complex, multi-stage travel (walking, bicycle, minibus). When combined with household responsibilities, fear of stigma and safety concerns, these distances make GBV help-seeking **exceptional rather than routine**. The fact that these TAs simultaneously show **very low recorded referral caseloads** strongly suggests that distance and time are not simply inconveniences; they are **binding constraints** that suppress demand and keep many cases entirely off the formal radar.

Table 10: Approximate distance and travel time to district-level GBV services by TA of origin

TA of origin	Proximity to district service providers*	Distance band (km)**	One-way travel time band**	Spatial interpretation
M'Mbelwa	Moderate to far	25–40 km	45–75 minutes	Large TA in Mzimba with significant caseload; survivors often travel long distances to reach district services.
Chindi	Moderate to far	25–40 km	45–75 minutes	High caseload and multiple facilities; still includes remote villages far from the district centre.
Mkanda	Moderate	20–30 km	40–60 minutes	Relatively better road links, but not all villages are close to the district level service providers; mixed access.
Mduwa	Moderate	20–30 km	40–60 minutes	Mid-range TA; access depends on specific village location and transport availability.
Phalula	Moderate	20–30 km	40–60 minutes	Balaka TA with some facilities; still requires significant travel for specialised services.
Chanthunya	Moderate	20–30 km	40–60 minutes	High referral caseload with moderate distance; cost and repeated travel still significant.
Ndamera	Moderate to far	25–35 km	45–70 minutes	Nsanje TA with relatively good facility density but long distances from some villages to the district level service providers.
Mlolo	Moderate to far	25–35 km	45–70 minutes	Nsanje TA with mixed terrain and flood risk; travel times can spike in rainy season.
Nazombe	Far / remote	30–50 km	60–90+ minutes	Hilly, remote TA in Phalombe with very low referral counts; high probability of under-reporting due to distance.
Nkhulambe	Far / remote	30–50 km	60–90+ minutes	Remote TA with very low recorded cases; distance and terrain likely suppress help-seeking.

*Based on referral patterns, narrative descriptions and known geography.
**Bands are consistent with survey means/medians (overall mean 31–34 km; median 24–30 km; mean travel time 54 minutes; median 45 minutes).

Table 11 translates these spatial burdens into **financial terms**, showing that distance bands map directly onto **transport cost bands**. TAs in the "moderate" distance group; **Mkanda, Mduwa, Phalula, Chanthunya, Ndamera and Mlolo** fall mostly into the **MWK 5,000–10,000** cost range per trip, already at or above the overall median of roughly **MWK 7,000**. For poor rural households, this level of expenditure is significant, particularly where income is seasonal and irregular. In practice, it pushes survivors to **ration their engagement** with the system: they may prioritise an initial health or police visit but be unable to afford repeated travel for court dates or follow-up counselling. For high-burden TAs such as **Phalula and Chanthunya**, which already show high three-year caseloads, these cost bands imply that current utilisation may reflect only a **subset of those who would seek help if transport were affordable**.

For **Nazombe and Nkhulambe**, Table 11 shows the cost profile is even more stark: typical transport costs lie in the **MWK 10,000–15,000** band per visit, well above both the median and mean reported across TAs. When these costs are combined with the longest distance and travel-time bands in Table 10, formal GBV services become **de facto inaccessible** for many survivors. Under these conditions, it is rational though deeply problematic for households to rely on informal mechanisms, traditional leaders or do nothing at all. The very low mean referral counts reported from these TAs should therefore be interpreted as **evidence of structural exclusion**, not of low GBV risk.

Table 11: Approximate transport cost burden to reach district-level GBV services, by TA of origin

TA of origin	Typical transport cost band (one trip)*	Relative level vs overall median (MWK 7,000)	Likely affordability and access implications
M'Mbelwa	MWK 8,000–12,000	Above median	High-cost journeys; survivors from poorer households may delay or forego repeated visits (e.g., court follow-up).
Chindi	MWK 8,000–12,000	Above median	Cost compounding with distance; multiple trips (health, police, court) become financially prohibitive.
Mkanda	MWK 5,000–8,000	Around median	Still significant for low-income households; more manageable for once-off visits than for repeated appearances.
Mduwa	MWK 5,000–8,000	Around median	Cost remains a barrier, but less extreme than more remote TAs.
Phalula	MWK 6,000–9,000	Slightly above median	Survivors likely to prioritise the most urgent service (e.g., health) and skip others (e.g., court) due to cost.
Chanthunya	MWK 7,000–10,000	Above median	High caseload TA; cost constraints risk partial or incomplete case follow-through.
Ndamera	MWK 6,000–9,000	Slightly above median	Repeated travel for case follow-up is a tangible financial burden.
Mlolo	MWK 6,000–9,000	Slightly above median	Seasonal flooding can spike costs further (detours, slower routes).
Nazombe	MWK 10,000–15,000	Well above median	Very high relative cost; helps explain extremely low referral numbers despite GBV risk.
Nkhulambe	MWK 10,000–15,000	Well above median	Transport costs act as a hard barrier; survivors may instead rely entirely on informal or local mechanisms.

* Cost bands aligned with overall survey mean (MWK 11,615) and median (MWK 7,000).

Even before factoring in terrain, survivors typically travel **30–34 km** and **45–60 minutes** to reach a district-level GBV actor. With a **median travel cost of MWK 7,000** and mean of MWK 11,600, the cost burden is significant in a context where many households operate close to subsistence level. For repeat visits (e.g. medical follow-up, court hearings), these costs quickly become prohibitive, effectively **pricing survivors out of justice and long-term care**.

Table 12: Estimated distance, travel time and transport cost from TA to district facility

Metric	Mean (Set 1, n=7)	Median (Set 1)	Mean (Set 2, n=9)	Median (Set 2)
Distance (km)	31.46	24	33.91	30
Travel time (minutes)	54	45	similar	~
Transport cost (MWK)	11,615	7,000	–	–

Taken together, Tables 10 and 11 show that at TA level, **GBV access is stratified along spatial and economic lines**. TAs closer to district hubs with lower cost bands have at least a feasible pathway into the system, even if burdensome. TAs in the mid-bands face chronic but potentially addressable barriers, where **targeted transport support, strengthened local entry points and better outreach** could substantially improve uptake. TAs at the far/high-cost end especially Nazombe and Nkhulambe represent **priority access gaps** where traditional "facility strengthening" alone will not be sufficient. For these areas, MICGBV and partners will need to combine **mobile GBV services, localised GBV focal points and transport subsidies** if they are to bring survivors within meaningful reach of the protection and justice system.

5.3.2 Distance, Travel Time and Cost of Access to GBV Services – Intra-District TA-Level Patterns

The TA-level maps show a clear and systematic bias in the location of GBV service providers towards **main road corridors, trading centres and lower-lying valley floors**, with far fewer services in upland or river-isolated zones. Health clinics, police VSUs and One Stop Centres tend to sit on or near district and main roads, while community structures (CVUs, women's forums, community gatekeepers and CBOs) are more dispersed but still clustered around better-connected settlements. Combined with the elevation and road-class layers, this pattern confirms that **physical geography and road infrastructure are major determinants of service accessibility** in all five districts.

Where travel-time rasters are available, these spatial biases translate into large differences in **average time to the nearest GBV service point (GBV-SP)**:

- TA **Mduwa** – around **21 minutes** on average.
- TA **Chindi** – around **38 minutes**.
- TAs **Chanthunya and Phalula** – around **73 minutes**.
- TA **Nkhulambe** – around **91 minutes**.

These gradients align with the earlier survey-based estimates of 20–50 km travel distances and highlight which TAs face the most severe access deficits even before cost, stigma or service quality are considered.

Mzimba: M'Mbelwa and Chindi

In **Mzimba**, both **M'Mbelwa** and **Chindi** fall in the **25–40 km** and **45–75 minute** bands to district-level GBV services, with transport costs typically around **MWK 8,000–12,000 per trip**. These TAs host a relatively high number of GBV service points and show high three-year referral caseloads, which indicates that the system is actively used. However, the distance and cost bands confirm that this use comes at a **substantial access cost**: survivors and their families are absorbing long journeys and high out-of-pocket expenses, particularly for repeated court or health visits. Intra-district spatial inequality here is less about "served vs unserved" TAs and more about **served but stretched hubs**; M'Mbelwa and Chindi functioning as catchment centres for large, partly remote hinterlands. Within these TAs, villages closer to the main road and Boma have markedly easier access than those in more peripheral zones, creating **pockets of relative exclusion inside otherwise "well-covered" TAs**.

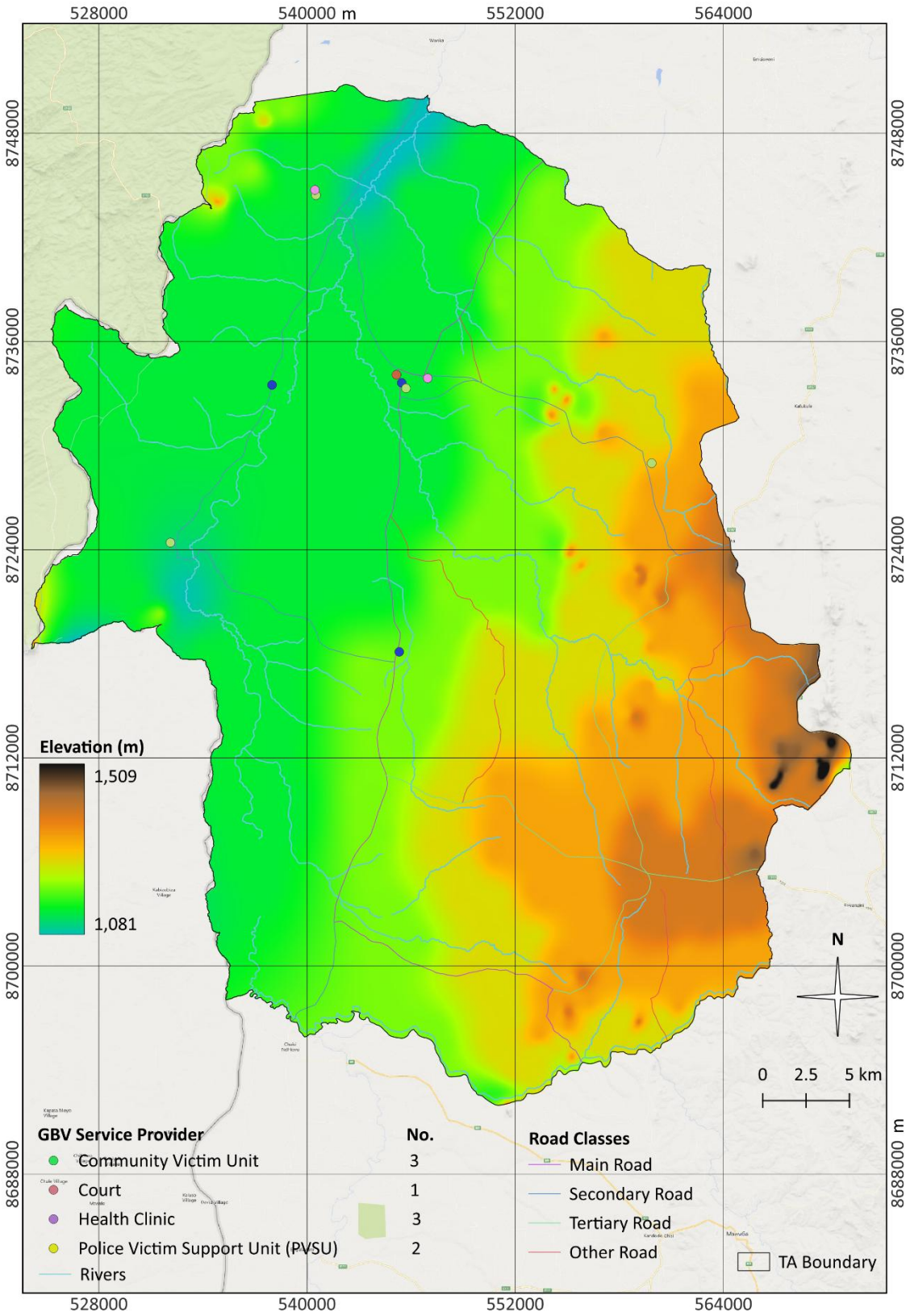

Figure 3: Distribution of GBV Service Providers in Traditional Authority Chindi

In **Chindi**, the map shows a **dense cluster of GBV service providers**; health clinics, PVSUs, CVUs and possibly an OSC located along the main east–west and north–south road axes and close to key trading centres (Figure 3). The road network is relatively well-developed, with multiple district and secondary roads connecting settlements across moderate elevation gradients. The travel-time analysis yields an **average**

of 38 minutes to the nearest GBV-SP, making Chindi one of the **better-connected TAs** in the sample. However, the raster still shows pockets of longer travel times in the more remote northern and western peripheries, where the combination of hills, rivers and weaker road infrastructure slows access. This spatial pattern is coherent with the quantitative data: **Chindi contributes a high number of referrals and has strong CVU and PVSU resolution rates**, it has 86**% recorded resolution**.

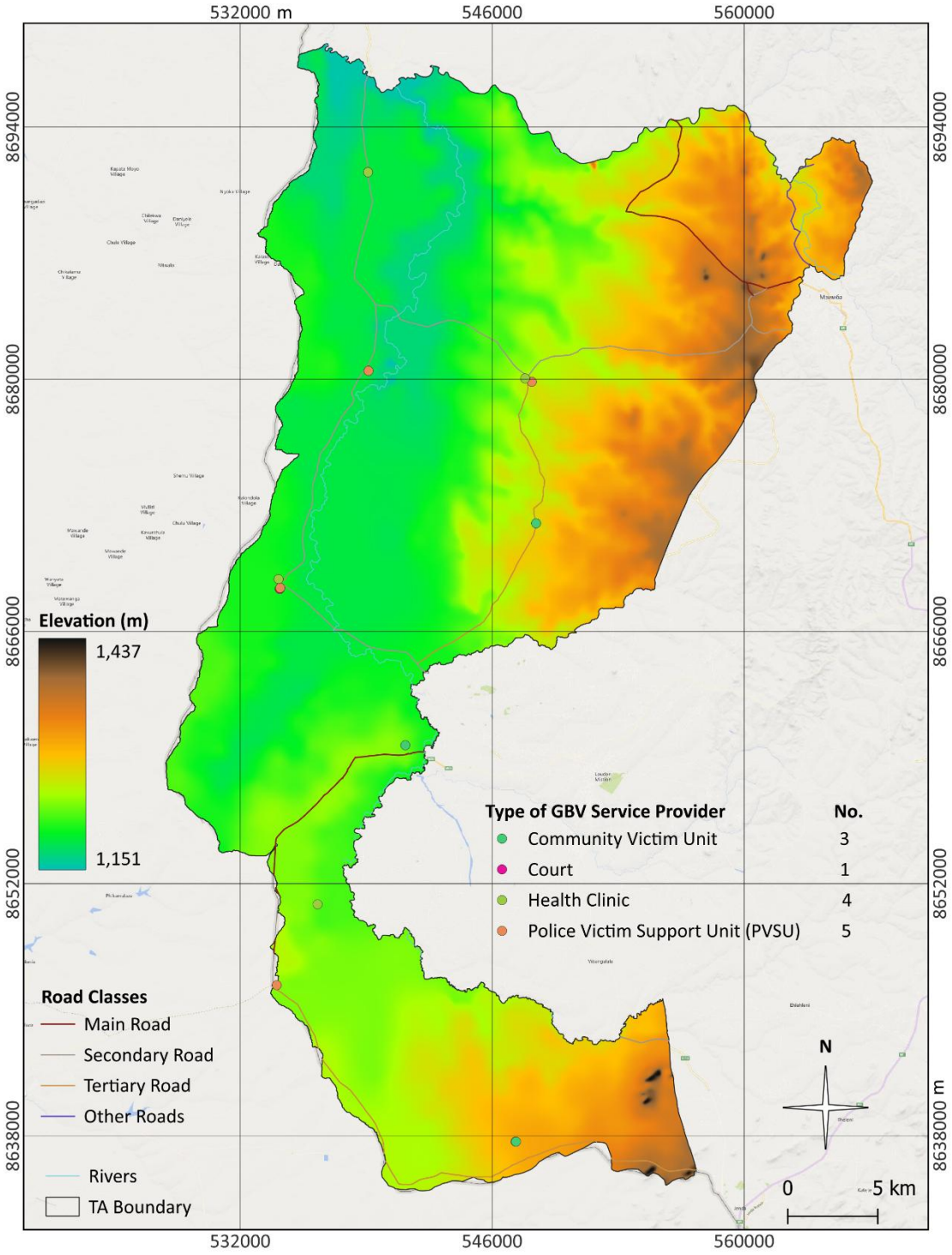

Figure 4: Distribution of GBV Service Providers in Traditional Authority M'Mbelwa

The M'Mbelwa map showed a **dense but highly linear GBV service corridor** running along the main north–south road and adjacent river. Within this strip there were **3 Community Victim Units, 4 health clinics, 5 PVSU and 1 court**, giving the TA one of the richest service mixes in the study. However, the surrounding hills and side valleys contained **very few or no service points**, meaning many upland villages remained spatially peripheral to this corridor. Quantitative data confirmed **high caseloads and strong**

resolution rates at CVU and health-clinic level, while court performance lagged behind. Taken together, the map and case statistics indicated that M'Mbelwa functioned as a **high-capacity GBV hub**, but one that primarily served communities located along the road–river axis; households in more remote terrain still faced substantial travel time and cost to access the same level of support. Figure 4 shows the distribution of GBV service providers in Traditional Authority M'Mbelwa

Mchinji: Mkanda and Mduwa

In **Mchinji**, **Mkanda** and **Mduwa** are both classified in the **20–30 km** and **40–60 minute** distance/time bands, with transport costs in the **MWK 5,000–8,000** range. Mkanda has more facilities and slightly higher caseloads, and benefits from better road connections, making access more predictable and somewhat less costly per kilometre. Mduwa, while in the same distance band, is more sensitive to local variations in infrastructure and transport availability. For poor households, these cost and time profiles still pose a significant barrier, but not an absolute one: survivors can and do reach services, yet often **ration their engagement**, for example, prioritising an initial health or police contact but dropping off when repeated travel for court or follow-up counselling is required. Within Mchinji, therefore, intra-district access inequalities are **moderate but meaningful**: TAs are not dramatically different in distance, but small differences in roads, transport and caseload translate into **real differences in who completes the full referral pathway**.

The TA-level maps for **Mduwa** and **Mkanda** show a similar pattern: services are **numerous and varied** but heavily concentrated along primary road corridors.

- In **Mduwa**, the travel-time layer indicates an **average of about 21 minutes**, the shortest among the TAs analysed. The points show a mix of **health clinics, PVSUs, CVUs and possibly a court** clustered near the main north–south road and close to the TA headquarters. Peripheral villages west and east of this corridor still face noticeably longer travel times, but the overall accessibility is relatively good. Figure 5 shows the distribution of GBV service providers in Traditional Authority Mduwa.

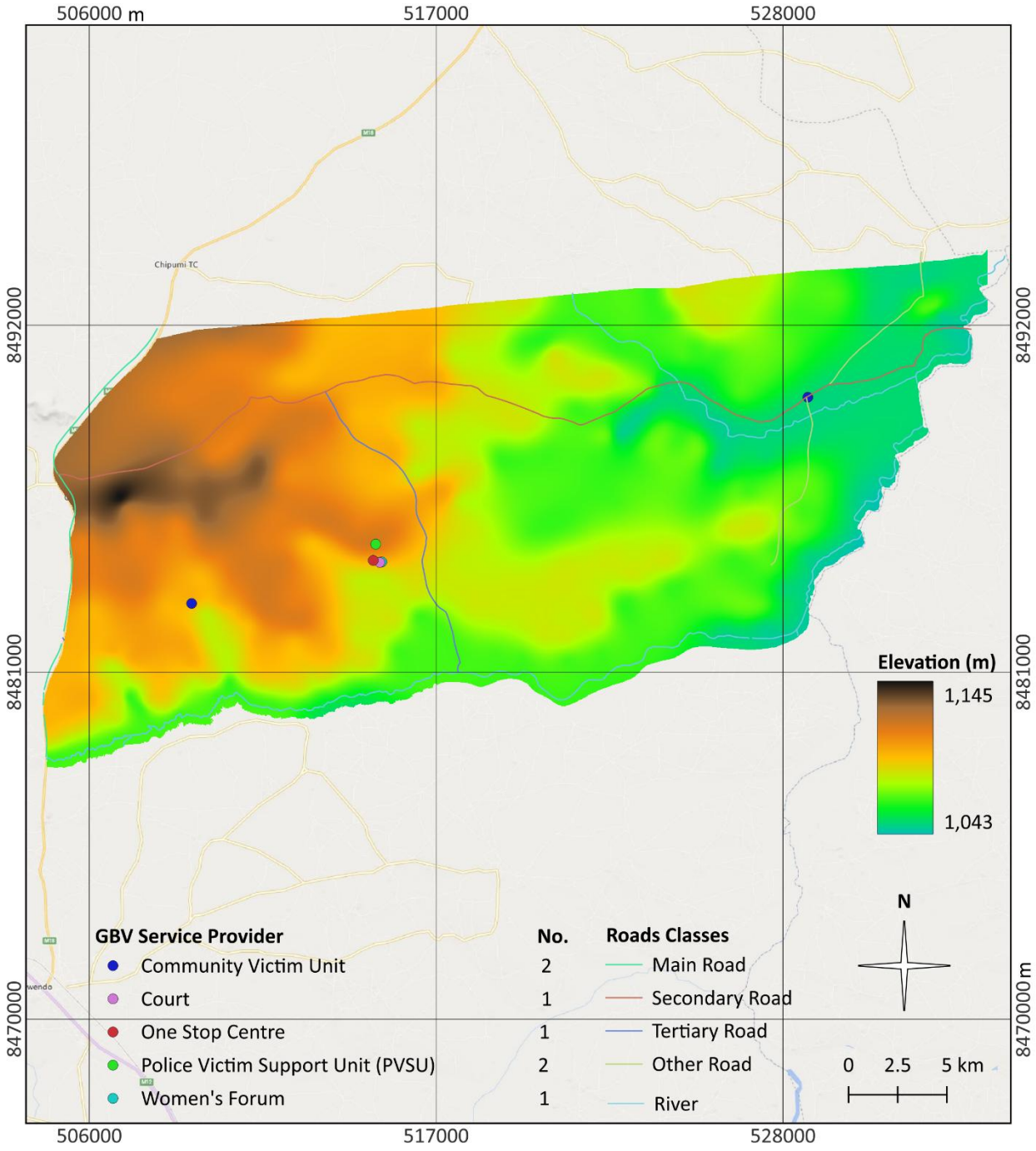

Figure 5: Distribution of GBV Service Providers in Traditional Authority Mduwa

- In **Mkanda**, the map depicts **1 CVU, 8 health clinics, 3 PVSUs, 1 Women's Forum and 1 court**, again primarily aligned along major roads and river crossings. Terrain is mixed but less extreme than in Nkhulambe or Nazombe, and there appears to be a fairly dense network of secondary and tertiary roads. This spatial pattern, combined with the quantitative data showing **moderate to high resolution rates for CVUs and PVSUs**, suggests that Mkanda functions as a **secondary GBV hub** for its district. Figure 6 shows the distribution of GBV service providers in Traditional Authority Mkanda.

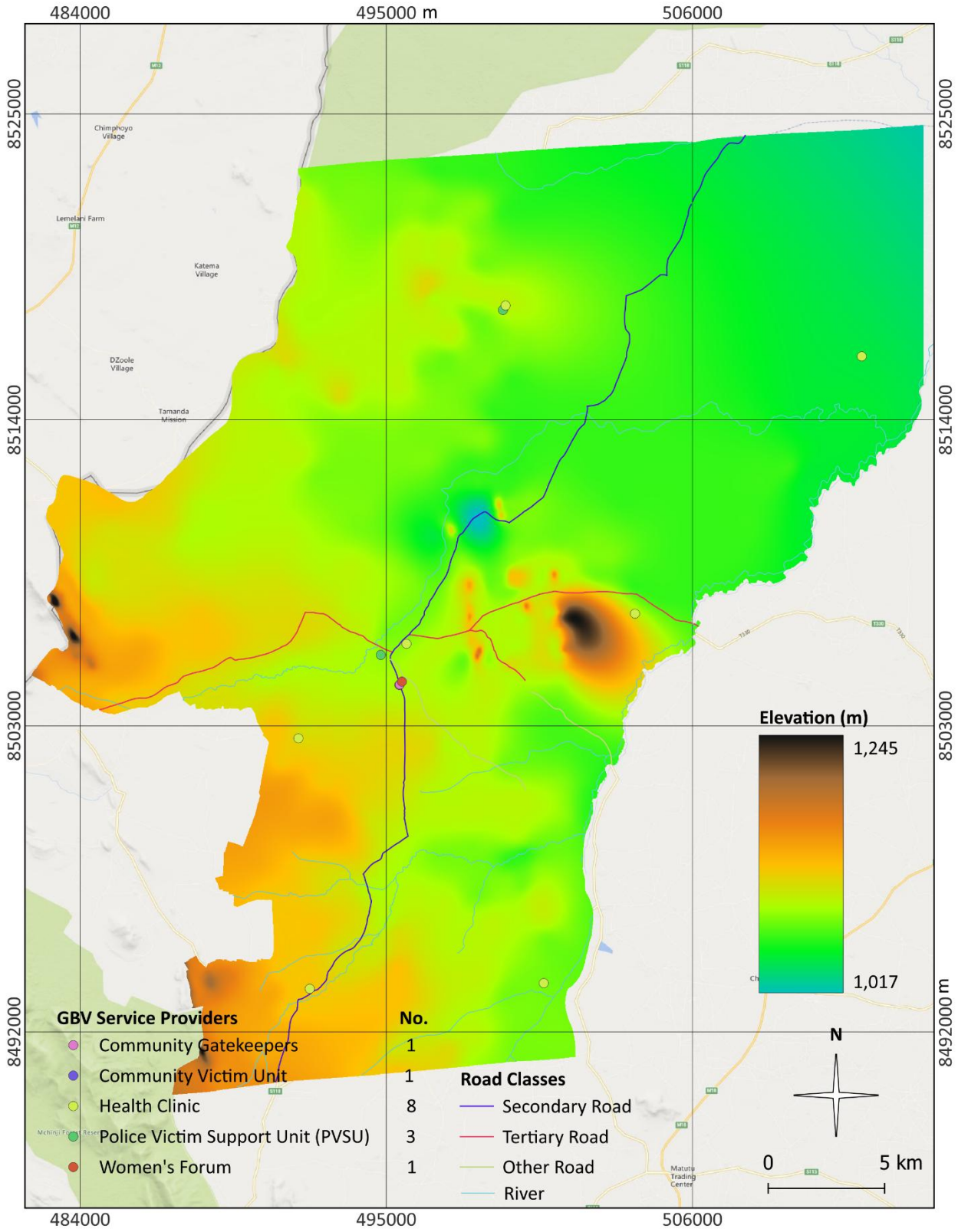

Figure 6: Distribution of GBV Service Providers in Traditional Authority Mkanda

Despite good average travel times, both TAs still show **pockets of relative isolation** away from main roads and in areas where bridges or culverts are lacking. These areas are likely under-represented in referral data and warrant targeted outreach.

Balaka: Phalula and Chanthunya

The joint map for **Chanthunya and Phalula** shows a somewhat better mix of GBV providers but still considerable distance between them and outlying villages. Chanthu nya hosts **one community gatekeeper, one CVU, one health clinic, one PVSU and one Social Welfare Office**, while Phalula has **two community gatekeepers, one health clinic, one PVSU and one court**. Most of these facilities are located along main and tertiary roads running north–south through relatively flatter terrain in the southern and central parts of the two TAs.

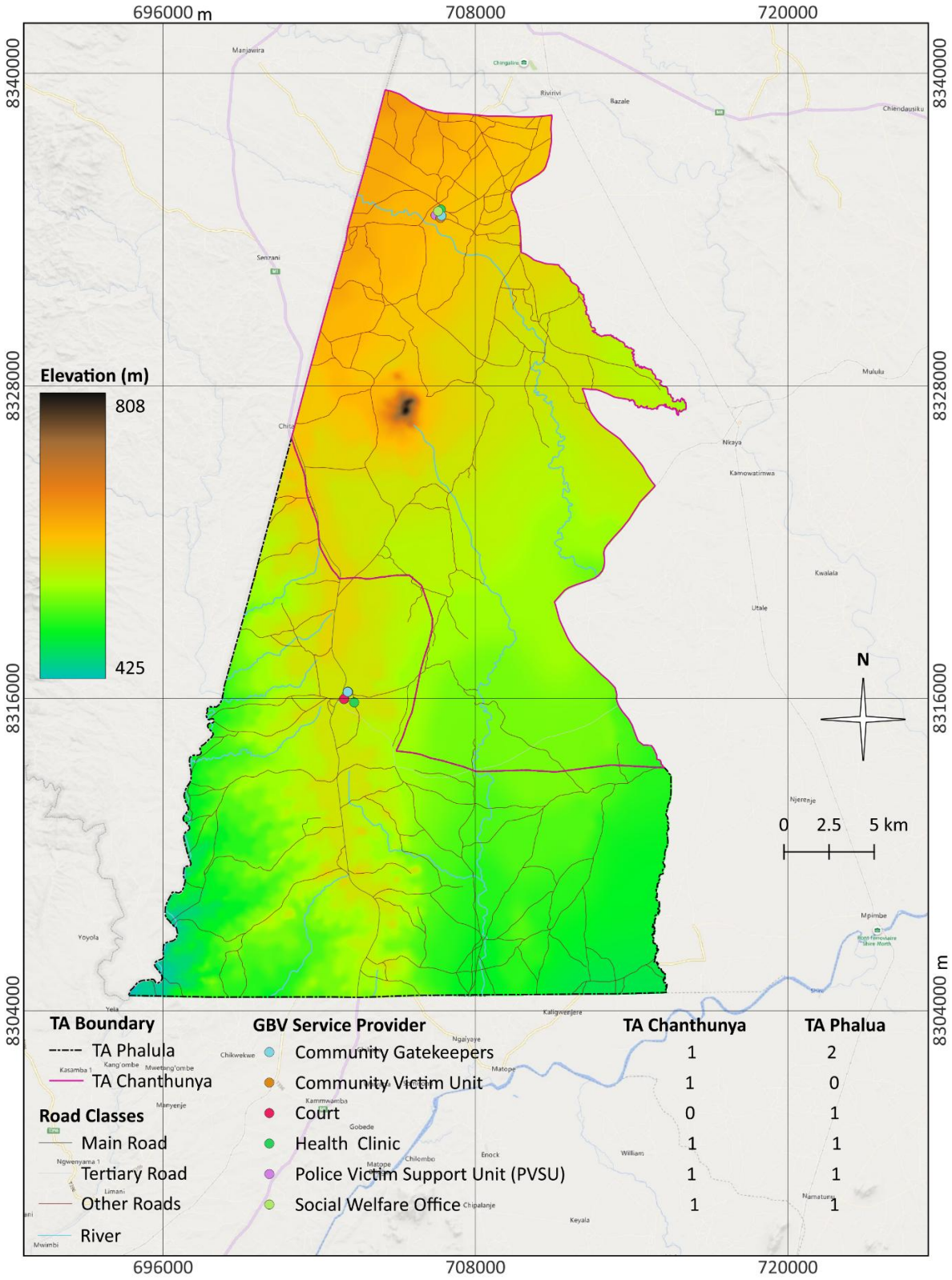

Figure 7: Distribution of GBV Service Providers in Traditional Authorities Phalula and Chanthunya

The elevation raster shows higher ground and more fragmented terrain towards the north-western edges, where very few or no providers are present. The travel-time model estimates an **average of around 73 minutes** to reach the nearest GBV-SP. This confirms that even though the **service mix is relatively balanced**, **spatial dispersion and road conditions still impose long journeys** for many householdsparticularly those in upland settlements away from the main road. When combined with mid-range transport costs (roughly MWK 6,000–10,000), this helps explain why Balaka district, despite high resolution rates among the cases that reach services, still shows **substantial TA-level access barriers**.

Both **Phalula** and **Chanthunya** lie in the **20–30 km** and **40–60 minute** bands, yet they are characterised by **high GBV caseloads** and **above-median transport costs**. This means that survivors in both TAs must not only travel but also navigate **capacity constraints at destination facilities**, particularly for specialised services clustered at the district centre. Within Balaka, the combination of moderate distances, high per-trip costs and high caseloads creates a **double pressure**: survivors are pushed towards **partial engagement** (one or two sectors only), and frontline providers operate under **high case pressure** with limited room to absorb additional demand. Compared to other districts, Balaka's intra-district pattern highlights how **even moderate geographic barriers can translate into severe access challenges when layered onto high caseloads and low overall facility density**. Figure 7 shows the distribution of GBV service providers in Traditional Authorities Phalula and Chanthunya.

Nsanje: Ndamera and Mlolo

In **Nsanje**, **Ndamera** and **Mlolo** are situated in the **25–35 km** and **45–70 minute** bands, with transport costs typically in the **MWK 6,000–9,000** range. Both TAs have relatively high numbers of mapped facilities, yet providers consistently describe **mixed terrain, poor roads and flood-prone areas**. This means that while nominal distances are comparable to some Mchinji and Balaka TAs, **effective travel times and costs can spike significantly during the rainy season**, when detours and disruptions are common. Intra-district differences in Nsanje are therefore strongly **seasonal**: villages that are reasonably accessible in the dry season can become effectively cut off at certain times of year, especially in Mlolo. As a result, Nsanje's TA-level pattern is less about static distance and more about **climate-sensitive accessibility**, underscoring the need to treat GBV access as part of broader disaster-risk and resilience planning.

In **Mlolo**, the spatial pattern also followed a **road-and-river corridor**, but with less overall density than M'Mbelwa. The map displayed **severa health clinics, multiple CVUs, a PVSU and at least one court**, mostly clustered near the primary valley road and river crossings. Elevation data highlighted **significant upland terrain to the east and west**, with few mapped providers in those higher areas. This geography aligned closely with the referral findings: survivors from Mlolo frequently travelled **25–35 km** to reach GBV services and incurred **medium–high transport costs**, especially when descending from upland villages to the valley floor. Resolution rates at community and police level were reasonably strong, but the map made clear that these outcomes were **unevenly distributed**, favouring settlements near the corridor while upland communities bore disproportionate access penalties. Figure 8 shows the distribution of GBV service providers in Traditional Authority Mlolo.

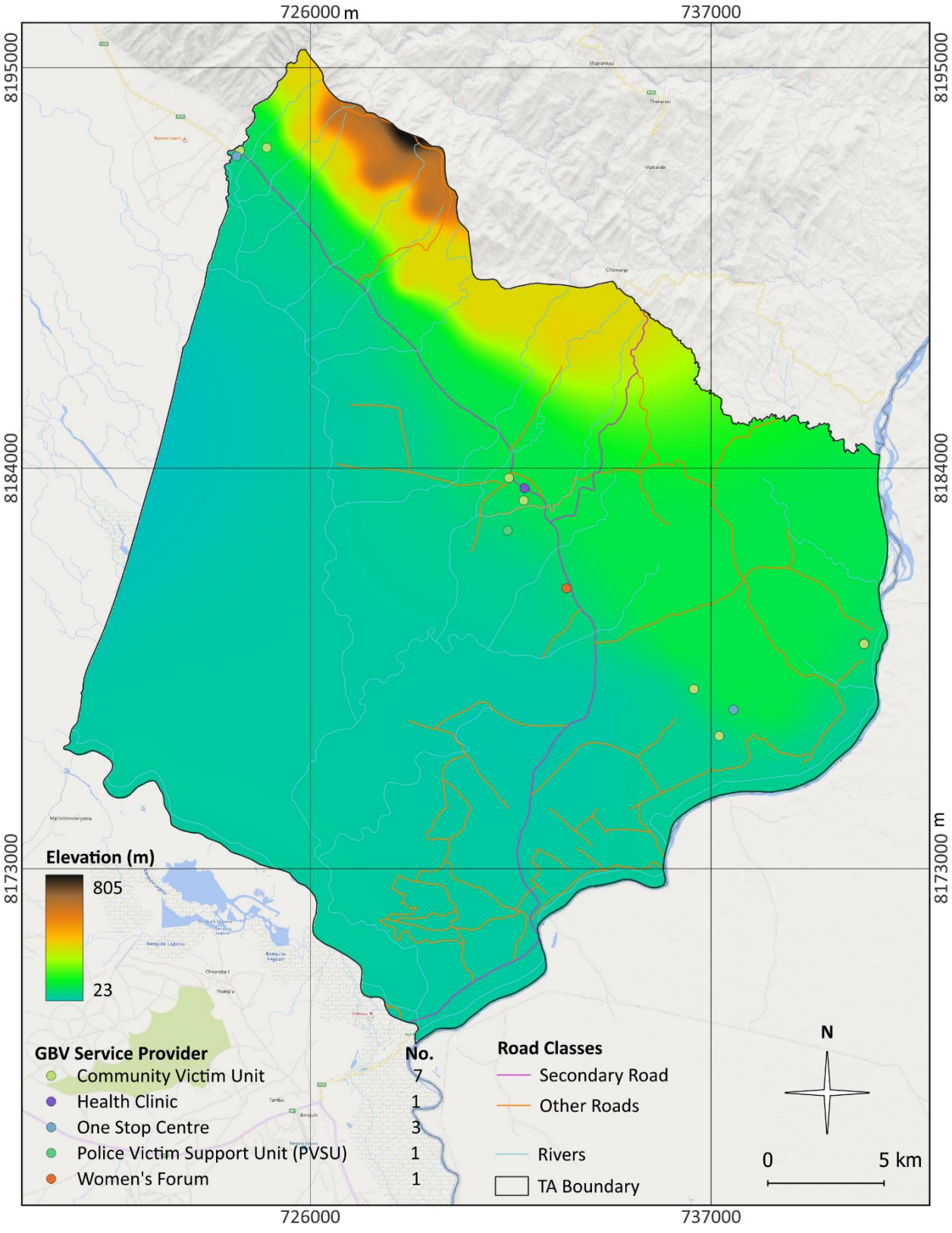

Figure 8: Distribution of GBV Service Providers in Traditional Authority Mlolo

The **Ndamera** map showed a **concentrated band of GBV services** along the main floodplain road: roughly **12 gatekeepers, 3 health clinics, 2 CVU and 1 PVSU**. This created a relatively continuous chain of access points for villages located on or near the road, and the quantitative data reflected this, with the Ndamera PVSU achieving an **exceptionally high-resolution rate (99%)** and the CVU also performing well. However, the elevation and hydrology layers highlighted Ndamera's **flood-prone setting**, with

multiple river channels intersecting the corridor. Villages located behind these rivers or away from the main road were likely to experience **seasonal isolation**, as bridges and low-lying road segments became impassable during peak floods. Thus, while Ndamera appeared well served on paper, the maps underscored that **effective accessibility was highly seasonal**, and that remote or river-cut-off communities probably faced long detours or complete temporary exclusion from otherwise strong GBV services. Figure 9 shows the distribution of GBV service providers in Traditional Authority Ndamera.

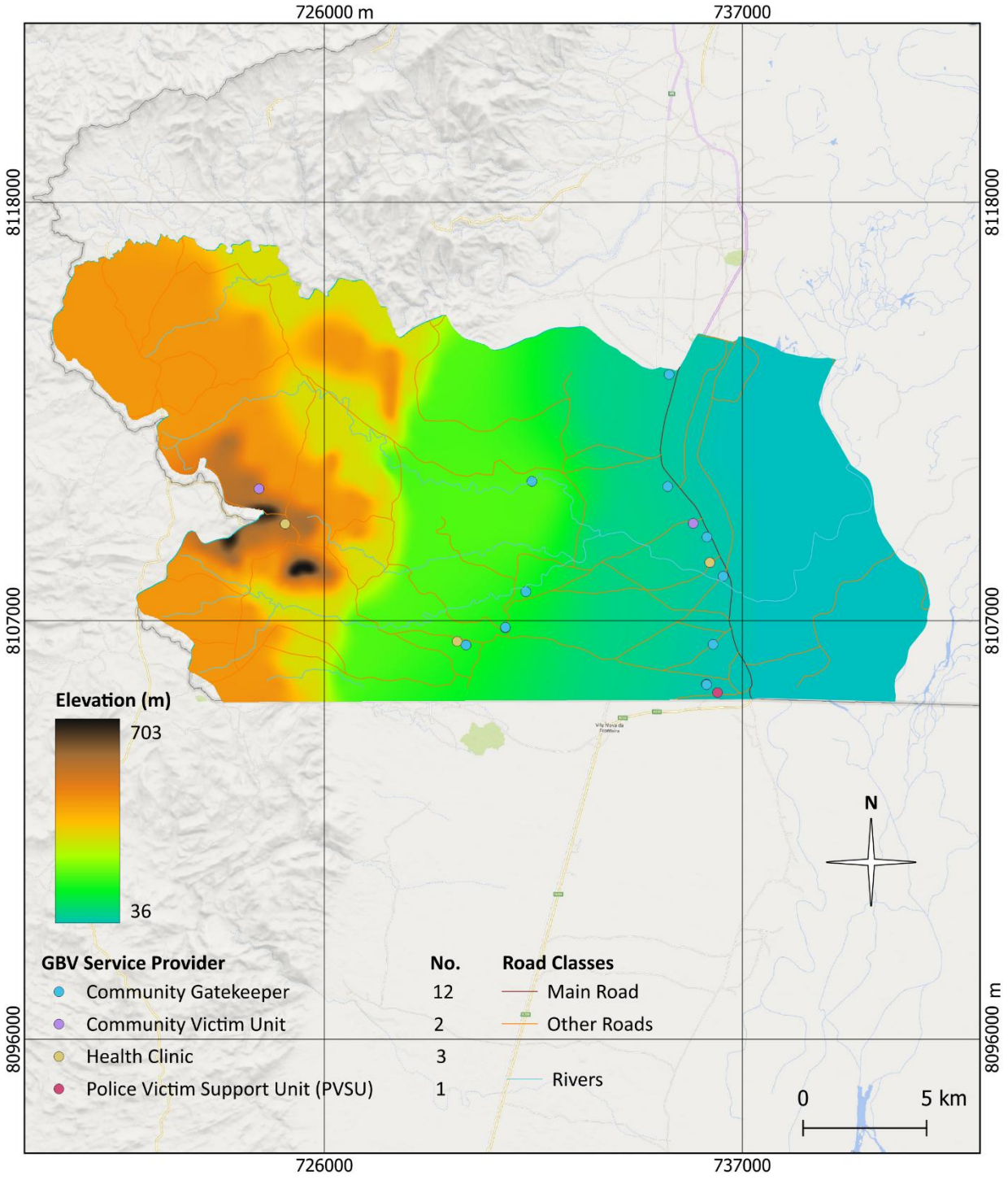

Figure 9: Distribution of GBV Service Providers in Traditional Authority Ndamera

Phalombe: Nazombe and Nkhulambe

In **Phalombe**, **Nazombe** and **Nkhulambe** occupy the most extreme bands in both tables: **30–50 km**, **60–90+ minutes** and **MWK 10,000–15,000** per trip. Both TAs have low-to-moderate numbers of mapped GBV service points but **very low recorded referral caseloads**. This combination—long distances, long travel times, high costs and low caseload—is a textbook signature of **structural exclusion**: survivors are unlikely to engage with the formal system except in the most acute cases, and even then only if a household can mobilise significant resources. Within Phalombe, there is effectively **no "better" TA in access terms**: both Nazombe and Nkhulambe sit at the top of the risk spectrum, and the intra-district story is one of **uniformly poor access** rather than gradients. This makes Phalombe, and these two TAs in particular, a clear candidate for **mobile GBV services, localised entry points and dedicated transport support** rather than incremental facility strengthening alone.

The Nkhulambe map shows a **sparse GBV service network** in a physically challenging environment. Only a **single health clinic**, **one police VSU**, **one community gatekeeper** and around **three CBOs** are mapped, with all of them located along the main north–south road and near the valley floor. The western part of the TA is dominated by rugged, high-elevation terrain; large areas lie far from tertiary roads and are drained by small rivers, which likely become barriers during the rainy season. The travel-time surface indicates an **average of 91 minutes** to reach the nearest GBV-SP, with extensive zones exceeding one hour. When this is overlaid with earlier cost estimates (transport in the MWK 10,000–15,000 band), Nkhulambe emerges as one of the **most structurally disadvantaged TAs in the study**: long distances, steep terrain, low service density and high cost. This spatial configuration is fully consistent with the referral data showing **very low case volumes reaching formal services** and **weak PVSU resolution performance**, suggesting that geography is actively suppressing help-seeking and case follow-through. Figure 10 shows the distribution of GBV service providers in Traditional Authority Nkhulambe.

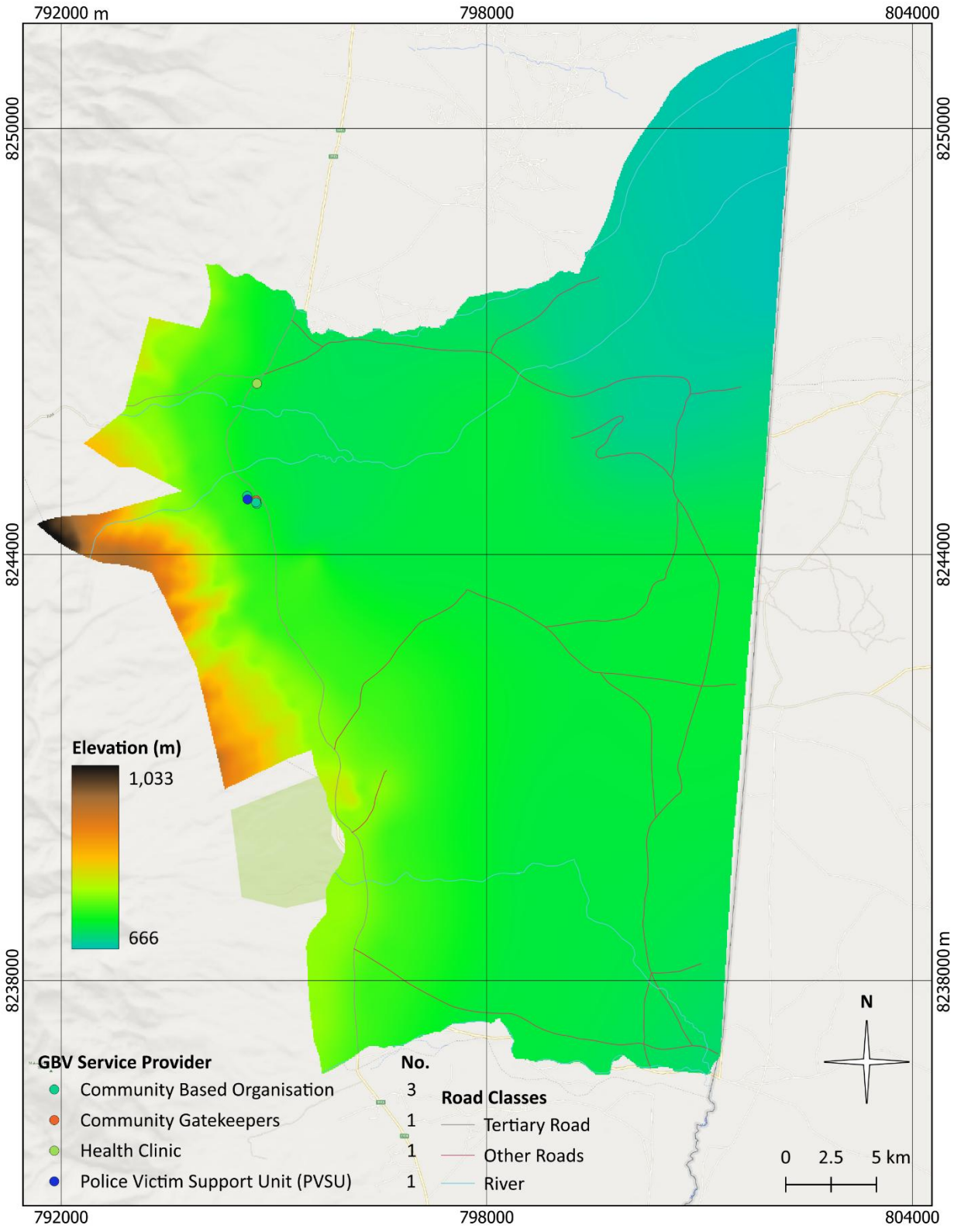

Figure 10: Distribution of GBV Service Providers in Traditional Authority Nkhulambe

The map for **Nazombe** is striking for its **very low service density**: only about two CBOs, two CVUs, one health clinic, one PVSU and one court are mapped. The elevation raster shows a mix of hilly and mid-elevation terrain, with roads mainly of tertiary or lower classification. Many settlements appear distant from these few service points, and travel times (from the wider modelling) fall into the **far/remote band (30–50 km; 60–90+ minutes)** for a large **proportion** of households. This spatial configuration matches the quantitative evidence of **extremely low referral volumes, high transport costs and poor PVSU**

performance. Nazombe is therefore best understood as a **classic GBV service blind spot**: limited infrastructure, no nearby statutory services, and heavy reliance on a tiny number of community structures that lack the authority or resources to manage more serious cases. Figure 11 shows the distribution of GBV service providers in Traditional Authority Nazombe.

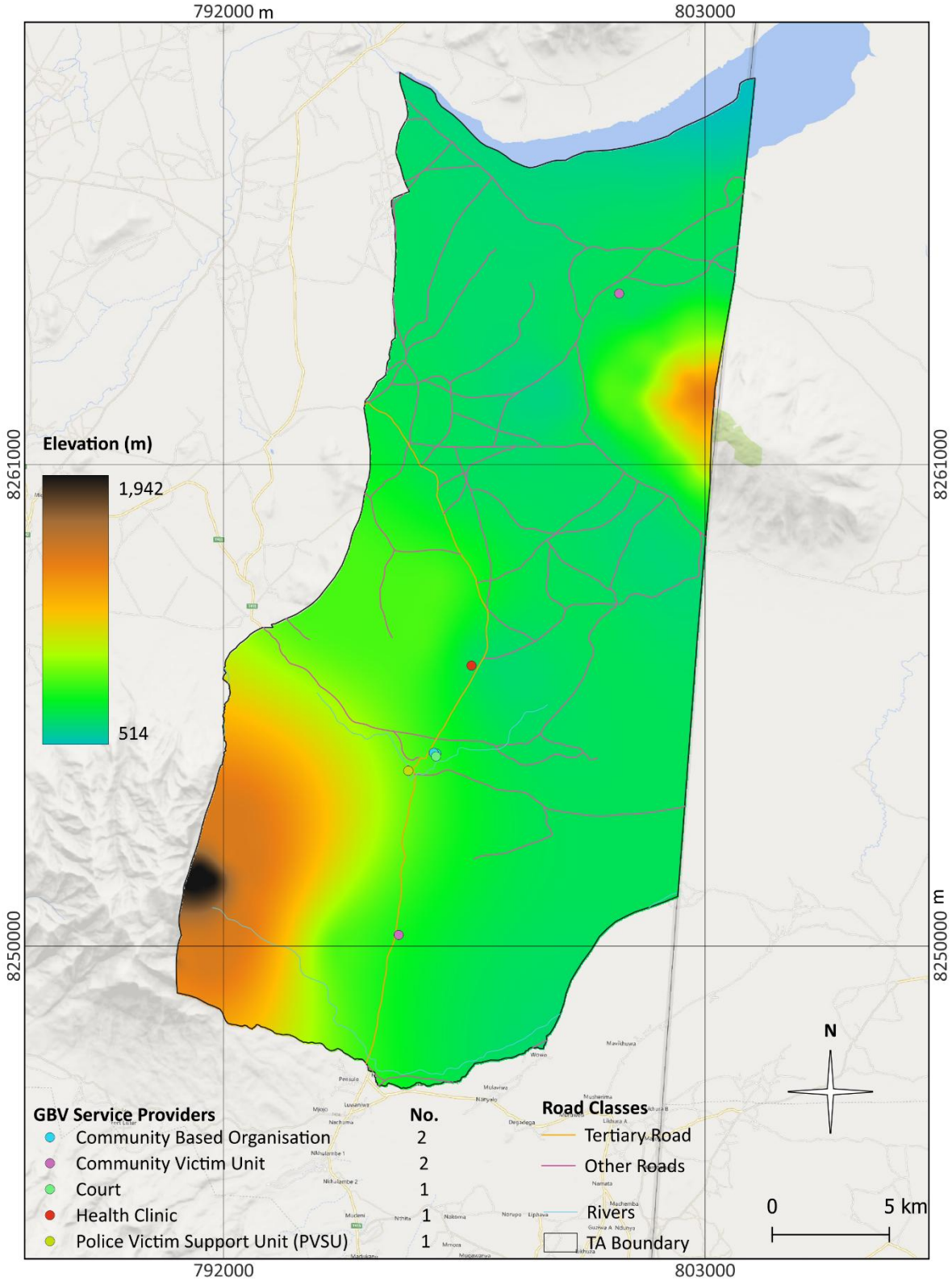

Figure 11: Distribution of GBV Service Providers in Traditional Authority Nazombe

Smaller low-density pockets are also visible in other TAs—for example, parts of Nkhulambe's uplands, the north-western corner of Chindi and peripheral zones in Chanthunya and Phalula—where no GBV service symbols are present within several kilometres of scattered settlements. These micro-gaps are likely to correspond to **hard-to-reach villages that seldom appear in referral data**.

Cross-district view of TA-level access

Looking across all five districts, the TA-level analysis shows that **no TA in the sample sits in an "easy access" category**: even the relatively better-off TAs are in the 20–30 km and 40–60 minute bands, with costs that are high relative to rural income profiles. **Average travel times vary sharply**: from about **21 minutes in Mduwa** and **38 minutes in Chindi** to **73 minutes in Chanthunya/Phalula** and **91 minutes in Nkhulambe**, mirroring the earlier distance and cost estimates and reinforcing the idea of **TA-level inequities**. The key differences lie in **how extreme the distance and cost burdens are, how many facilities exist to absorb demand, and how much GBV is currently being reported**. **Service concentration along main roads and valley floors** means that **communities located off these corridors face much longer travel times**, especially in TAs with rugged terrain (Nkhulambe, Nazombe) or flood-prone rivers (Mlolo, Ndamera). TAs with a richer combination of **health clinics, PVSUs, CVUs and at least one OSC or court** (e.g., M'Mbelwa, Mkanda, Mlolo) not only show better spatial coverage along roads but also have stronger resolution rates in the quantitative data.

Mzimba and Balaka have high-burden TAs where survivors are clearly making significant efforts to access services but are limited by cost and capacity; Nsanje has TA-level access that is highly sensitive to flooding and road disruptions; Phalombe has TAs where distance and cost effectively push survivors out of the formal system altogether. Furthermore, **elevation and hydrology act as structural barriers:** steep slopes and rivers separate many villages from the main service corridors, adding seasonal variability to travel times that is not fully captured in average figures. For MICGBV and partners, these patterns underline that **district-wide GBV strategies must be differentiated at TA level** with high-burden service providers prioritised for service deepening and transport support, mid-band TAs for strengthened outreach and referral management, and far/high-cost TAs for foundational access interventions such as mobile services and subsidised transport.

5.3.3 Distance, Travel Time and Cost of Access to TA-Level GBV Services, by Service Type

The TA-level analysis shows that **distance, travel time and transport cost are experienced very differently depending on which service survivors are trying to reach**. While average figures for each TA sit in the 20–50 km and 40–90+ minute bands, these are essentially **"blended" distances** across several service types. When we unpack police, health, community victim support structures (CVSUs), magistrate courts and women's forums, a clear access hierarchy emerges: **community structures are closest, health services are mid-range, and statutory services (police/courts) are the furthest and most expensive to reach**, especially for survivors in hard-to-reach areas.

1. Magistrate Courts: centralised jurisdiction and compounded access barriers

Magistrate courts sit at the very end of the GBV response chain and, in practice, are the **least accessible service type** for survivors in all TAs. This is not only because courts are physically centralised at district level, but also because **TA-level magistrate courts are typically 2nd or 3rd grade and lack jurisdiction over criminal cases**. All criminal GBV cases, including rape, defilement and aggravated assault, must ultimately be referred to **district magistrate courts presided over by 1st grade magistrates**, which are located at the district headquarters.

This jurisdictional arrangement effectively means that, regardless of whether a TA has a local lower-grade court, **any survivor pursuing a criminal GBV case will need to engage with the district court**, not just the nearest TA court. For TAs in the mid-distance bands such as **Mkanda, Mduwa, Phalula, Chanthunya, Ndamera and Mlolo**, where typical distances to district centres are **20–35 km** and transport costs **MWK 5,000–10,000 per trip**, this already imposes a heavy burden, especially because criminal cases require **multiple appearances** (initial filing, mention, hearings, adjournments, sentencing). For survivors from the

furthest TAs, **Nazombe and Nkhulambe**, the requirement to reach a 1st grade magistrate court at district level implies repeated journeys of **30–50 km**, **60–90+ minutes** one way, and **MWK 10,000–15,000** per trip.

In hard-to-reach areas within these TAs, where road conditions, river crossings and seasonal flooding further extend travel time and raise transport costs, the combined effect is that **criminal GBV justice becomes practically out of reach** for most survivors. A survivor might manage a single journey to report to police or seek medical care, but the cumulative cost and time required to sustain a case through a district magistrate court process is prohibitive. This helps explain why, even where incidents are reported locally to CVSUs, women's forums or lower-grade TA courts, **very few cases are seen all the way through to conviction at district level**.

From an access and equity standpoint, the lack of criminal jurisdiction at TA-level magistrate courts effectively **adds another layer of distance, travel time and cost** to the justice pathway. Survivors living in TAs with only 2nd/3rd grade courts face a double barrier: they must first navigate local-level reporting and then find the resources to keep appearing at a distant district court that has the actual decision-making authority. In practice, this leads to **case attrition**, particularly for the poorest and most remote households, and reinforces a pattern where **geography and income determine who can afford to seek justice for GBV-related crimes**.

2. Police Victim Support Units (VSUs): central but distant for many TAs

Police VSUs are **fewer and more centralised** than health or community providers. They are typically located at **district headquarters, police stations and a small number of TA centres**, which means that for many survivors, the VSU is **not the first physically accessible point of help**. In TAs such as **M'Mbelwa and Chindi (Mzimba), Mkanda and Mduwa (Mchinji), Phalula and Chanthunya (Balaka), Ndamera and Mlolo (Nsanje)**, police VSUs may be located within or near the TA centre, but **villages in the outer parts of these TAs still fall in the 20–40 km / 40–75 minute bands** to reach them. In hard-to-reach sections of these Tas where roads are poor, river crossings are unreliable or flood-prone, travel time for a VSU visit can easily spill beyond the upper bound of these bands, even if the straight-line distance looks moderate.

For **Nazombe and Nkhulambe (Phalombe)**, the situation is more severe. With these TAs classified in the **30–50 km and 60–90+ minute** distance bands, access to a police VSU usually implies a full-day round trip and transport costs in the **MWK 10,000–15,000** range. For most rural households, that is effectively unaffordable. As a result, police become a **late-stage or exceptional recourse**, rather than a routine part of the GBV response. This goes a long way towards explaining why TAs with the highest distance and cost bands also show **very low recorded police referrals**: it is not that violence is absent, but that the **threshold to engage with the police system is very high** in both time and money, particularly from hard-to-reach villages.

3. Health facilities: more distributed, but still costly for remote TA communities

Health facilities (health centres, hospitals) are **more widely distributed** than police or courts and, in many TAs, represent the **closest formal entry point** for GBV survivors, particularly for post-rape care, PEP and physical treatment. In TAs such as **Mkanda, Mduwa, Phalula and Chanthunya**, health facilities often fall at the **lower end of the 20–30 km bands** for at least part of the TA, which is still a substantial walk but more manageable than travelling all the way to the district centre. For these TAs, it is common for survivors to **reach health services first**, and only later or not at all engage with police or courts, largely because the additional travel and cost required to reach those statutory services is prohibitive.

However, for hard-to-reach zones within the same TAs (e.g., scattered settlements off the main roads, or across rivers), even health facilities are far. Providers report that **catchments frequently include areas where survivors must walk for several hours** before finding transport or reaching the nearest clinic. In **Nazombe and Nkhulambe**, the nearest health facility offering GBV-relevant services can still lie within the 20–30 km or higher range from some villages. Thus, while health facilities reduce the distance compared to courts or police, they are **not "nearby" in an absolute sense** for many rural survivors, particularly in hilly or flood-affected terrain.

4. Community Victim Support Units (CVSUs) and women's forums: closest but least resourced

CVSUs and women's forums are typically the **closest formal or semi-formal GBV structures** to communities. They are often located at village or group village level and therefore **sit well below the 20 km band** for many households, including in hard-to-reach areas where neither police nor health facilities are easily accessible. In TAs with high facility counts, such as **Chindi, Ndamera and Mlolo**, CVSUs and women's forums are spread across village clusters and are the **most physically reachable option** for survivors living in remote hamlets.

However, these structures usually offer **limited service packages**; basic psychosocial first aid, listening, safety planning and informal mediation without the authority or capacity to provide clinical care, forensic evidence collection, or legal protection. For survivors in hard-to-reach parts of **Nazombe and Nkhulambe**, this means that while a women's forum or CVSU may be close, the **full GBV response pathway remains distant, time-consuming and expensive**. The immediate support can be local, but **justice and comprehensive care are geographically remote**. This is why these TAs show "very low" formal case referrals despite the presence of some community structures: the **first mile is served; the rest of the pathway is effectively out of reach**.

Across all service types, the presence of **hard-to-reach areas in almost 80% of facility catchments** acts as a **multiplier of distance, time and cost**. In TAs that are already in higher distance/cost bands (Nazombe, Nkhulambe), hard-to-reach status effectively **locks entire sub-areas out of formal GBV services**. In mid-band TAs (Mkanda, Mduwa, Phalula, Chanthunya, Ndamera, Mlolo), it creates **internal inequities**: villages closer to main roads and TA centres have meaningful access to police and health services, while more remote villages may only realistically reach a CVSU or women's forum, if that.

For programming, the interaction between **service type, TA-level distance/cost, and hard-to-reach geography** leads to three key conclusions:

1. **Police and courts** are the **least accessible** services in every district and for every TA, with the steepest distance, time and cost gradients, especially for hard-to-reach communities.

2. **Health services** are more spatially available but still at distances and costs that are substantial for many survivors, particularly where terrain and seasonality extend travel times.

3. **CVSUs and women's forums** are the most physically accessible but the least endowed with resources and formal authority, leaving hard-to-reach communities with local support but **no realistic pathway to comprehensive care and justice**.

This evidence suggests that, to make GBV services genuinely accessible at TA level, MICGBV and partners need **differentiated, service-specific strategies**:

- bring elements of police and court functions closer to high-risk TAs (e.g., mobile court sessions, police outreach);

- upgrade selected CVSUs and women's forums in remote TAs into **enhanced GBV entry points** linked to health and police; and

- explicitly design **transport and accompaniment support** for survivors who must still travel long distances from hard-to-reach communities to statutory services.

5.4 Referral pathways and coordination quality

This section examines **how GBV cases move across providers** from community and health entry points, through police, to magistrate courts, and how coordination quality shapes final case outcomes in the five study districts **over the last three years**.

Across all mapped facilities, **131,800 GBV-related cases were recorded**, of which **84,976 (64.5%)** were reported as resolved. The combined evidence from regional/district case outcomes, provider-type caseloads, TA-level performance, and qualitative responses shows a **multi-layered but weakly coordinated referral system**, with a clear pattern of **attrition** as cases move upward along the formal pathway.

5.4.1 Entry points and dominant referral pathways

The district referral survey confirms that survivors primarily **enter the system through community and police structures** rather than courts:

- Around **40%** of district-level service providers identify **police** as their main referral source.
- About **30%** cite **Community Victim Support Units (CVSUs)**.
- **Self-referrals** account for roughly **10%**, with the remaining **20%** coming from other actors (health facilities, NGOs, leaders, etc.).
- **Magistrate courts** are mentioned as a primary referral source by only **one in ten** providers.

This means that **approximately seven in ten cases that reach district-level actors originate from police or CVSUs**, underscoring their role as **critical gatekeepers and coordinators** of GBV response. Courts, by contrast, sit at the very end of the pathway and are rarely the starting point.

Referral instruments are also heavily weighted toward **paper and informal mechanisms**:

- **Written referral letters** are used by about **57%** of providers.
- **Verbal referrals** account for roughly **29%**.
- **Phone-based communication** and **physical accompaniment** each occur in about **19%** of referrals.

This pattern points to a system where coordination relies largely on **individual relationships, paper letters and ad-hoc phone calls**, rather than standardised, trackable referral tools or integrated information systems—an arrangement that is particularly fragile where distances are long and transport is unreliable.

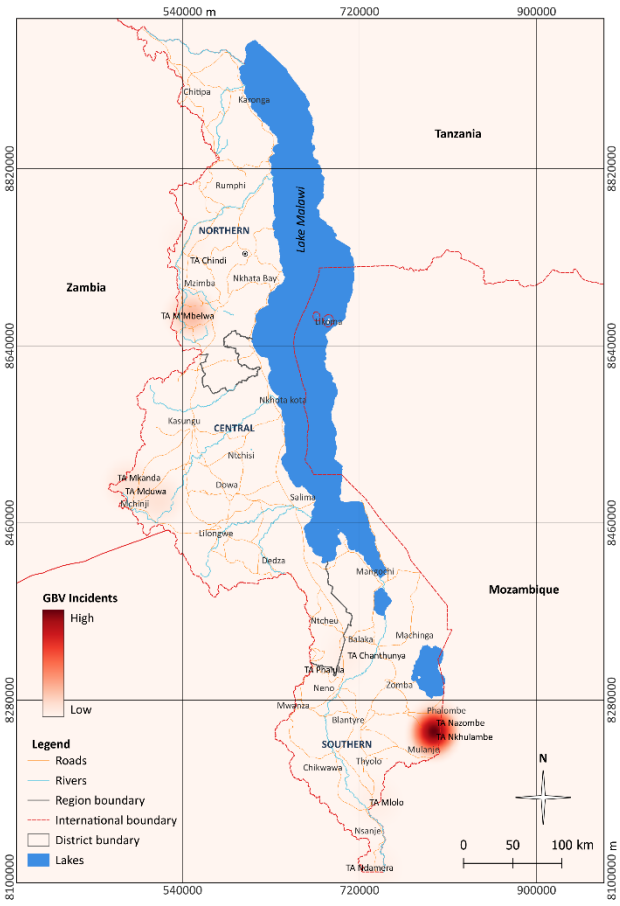

Figure 12: GBV Incidents in the Catchment Area

5.4.2 Regional and district case outcomes (study districts only)

At an aggregate level, the **regional** and **district** breakdowns highlight where GBV caseloads are concentrated and how many cases are successfully brought to closure. Within the five-district sample, the **Southern region (Balaka, Nsanje, Phalombe)** carries **68.9% of all recorded cases** with a **64.2%** resolution rate, meaning roughly **one in three cases remains unresolved** at reporting point. The **Northern region (Mzimba)** handles **17.9%** of cases but achieves the **highest resolution rate (69.0%)**, suggesting stronger follow-through once cases enter the system. The **Central sample district (Mchinji)** accounts for **13.2%** of cases and has the **lowest resolution rate (59.8%)**, pointing to district-specific coordination and capacity issues rather than national-level differences in policy.

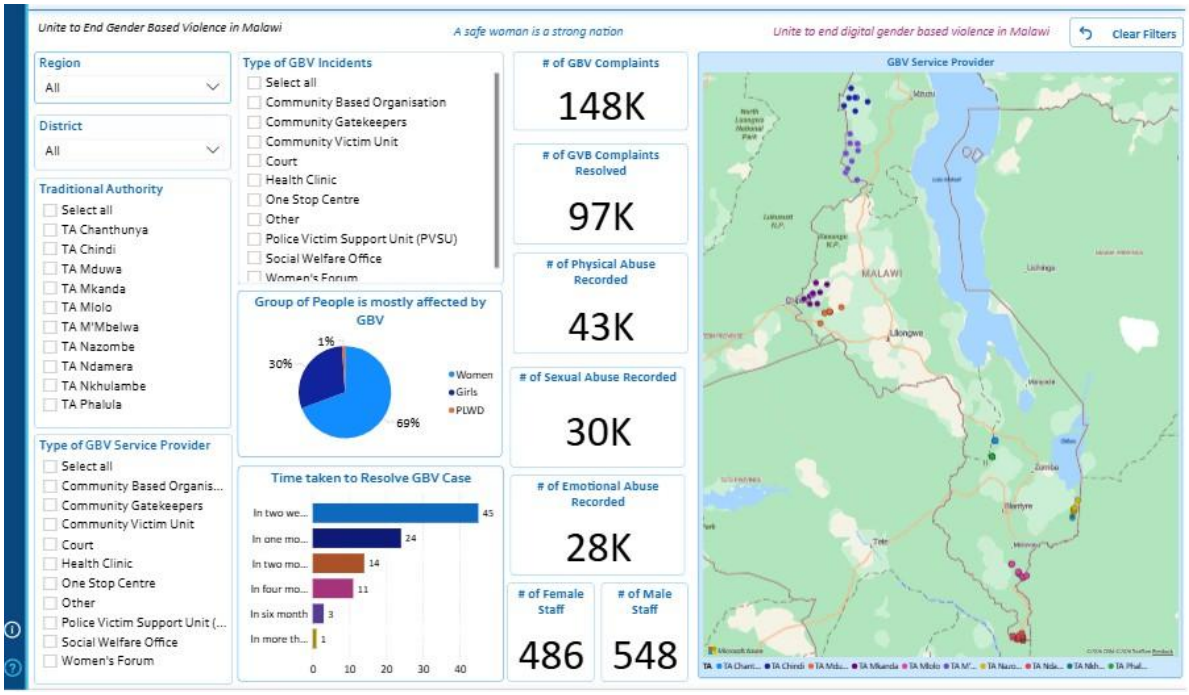

Figure 13: Number of GBV Cases Recorded and Resolved for the period of 3 years (2023-26)

Within the study area, **Nsanje and Mzimba together account for 69.3% of all recorded cases (42.7% + 26.6%)**, functioning as major GBV hubs with relatively strong resolution rates (80% and 69%). **Balaka** handles only **9.9%** of recorded cases but has the **highest resolution rate (80.9%)**, indicating efficient case closure once survivors reach services. By contrast, **Mchinji and Phalombe** combine **sizeable caseloads** with **lower resolution rates (60–63%)**, signalling a need for targeted strengthening of case management, follow-up, and inter-agency coordination in those districts.

Table 13: District GBV case outcomes, last 3 years (study districts only)

District	Cases received	Cases resolved	Resolution rate (%)	Share of all received cases (%)
Phalombe	98,496	64,830	65.8	66.6
Mzimba	17,649	14,576	82.6	11.9
Mchinji	16,400	10,879	66.3	11.1
Nsanje	15,445	10,251	66.4	10.4
Balaka	9,915	6,329	63.8	6.7
Total	**147,905**	**96,865**	**65.5**	**100.0**

5.4.3 Where cases are actually managed: workload and outcomes by provider type

Across the mapped providers, 147,905 GBV-related cases were recorded as received and 96,865 as resolved (overall resolution rate 65.5%). Disaggregating by provider type shows a clear division of labour across 10 provider categories, with health facilities still carrying the largest share, but substantial case volumes also concentrated in CBOs and “Other” provider types.

Table 14: Cases received vs Resolved for the period of 3 years (2023-26)

Provider type	Cases received	Cases resolved	Resolution rate (%)	Share of all cases (%)
Health Clinic	55,512	31,967	57.6	37.5

Community Based Organisation (CBO)	32,831	24,033	73.2	22.2
Police Victim Support Unit (PVSU)	16,383	11,410	69.6	11.1
Other	14,415	10,203	70.8	9.7
Community Victim Unit (CVU)	13,752	9,734	70.8	9.3
Court	10,908	7,116	65.2	7.4
Community Gatekeepers	1,658	947	57.1	1.1
One Stop Centre (OSC)	1,296	612	47.2	0.9
Women's Forum	1,080	792	73.3	0.7
Social Welfare Office	70	51	72.9	0.0

Three key points stand out:

- **Health clinics remain the core workload bearer**, receiving **55,512 cases (37.5%)**, but with a moderate resolution rate (**57.6%**), consistent with heavy caseload pressure and the fact that many cases require onward referral for legal/protection outcomes.
- **CBOs and "Other" providers together manage nearly one-third of all recorded cases** (**47,246 cases; 31.9%**) and show comparatively higher closure rates (**71–73%**), indicating that a large volume of GBV-related disputes are being handled outside the statutory justice pathway and often resolved through community-led or programme-supported mechanisms.
- **Courts and police do not dominate volume**, but they remain critical for escalation: **PVSUs handle 11.1%** of cases with relatively strong reported closure (**69.6%**), while **courts account for 7.4%** of recorded cases (**10,908**); meaning justice-system performance must be interpreted alongside referral attrition, jurisdictional limits, and travel/cost barriers rather than volume alone.

Taken together, the data indicate that **most GBV-related disputes, especially civil/family matters such as marital conflict, extra-marital affairs and child neglect are handled and resolved outside the court system**, primarily by **CVUs, health clinics and PVSUs**.

5.4.4 TA-level performance: community, health, police and courts

To understand how referral pathways operate in practice, it is useful to zoom in on high-volume Traditional Authorities (TAs) and compare performance across Community Victim Units (CVUs), health clinics, Police Victim Support Units (PVSUs) and magistrate courts. Importantly, this TA-level analysis focuses on these four core frontline and statutory provider types. While they do not capture the full system caseload (which also includes CBOs, safe spaces and other providers), they represent the formal referral spine through which cases are expected to escalate from disclosure to justice.

5.4.4.1 Community Victim Units (CVUs)

Across all TAs, CVUs handle **13,752 cases** with an aggregate **resolution rate of 70.6%**. High-volume CVUs in **M'Mbelwa, Mduwa and Ndamera** demonstrate that community-based structures can combine **substantial caseloads with strong resolution performance**. Lower resolution ratios in **Chindi and Mkanda** are notable, given their significant client volumes and distance bands, and point to specific opportunities to reinforce CVU capacity, supervision and linkages to police and health services.

Table 15: CVU caseload and outcomes by TA (high-volume sites)

TA	No. of CVU providers	Cases received	Cases resolved	Resolution rate
TA M'Mbelwa	3	4,676	3,610	77.2%
TA Mduwa	2	3,996	2,736	68.5%
TA Mlolo	7	1,872	1,260	67.3%
TA Mkanda	1	900	504	56.0%
TA Chindi	3	911	551	60.5%
TA Ndamera	2	908	744	81.9%

TA Nazombe	2	474	315	66.5%
TOTAL (CVU only)	**20**	**13,752**	**9,734**	**70.8%**

5.4.4.2 Health clinics

Health facilities remain a central entry point for survivors, but they account for a smaller share of total caseload. Across **20 mapped health clinics**, a total of **55,512 GBV cases were received and 31,967 resolved**, yielding an overall **resolution rate of 57.6%** and representing **37.5% of all recorded cases**.

Caseload is highly concentrated. **TA Nkhulambe's health clinic alone accounts for 47,040 cases received (31.8% of all cases across the five districts)** with **27,020 resolved** (**57.4%**), indicating extreme workload pressure on a single facility. The next highest-volume health TAs; **Mkanda** and **Nazombe** are far smaller in absolute volume but show comparable or higher closure rates.

Table 16: Health-clinic caseload and outcomes by TA (selected sites)

TA	Cases received	Cases resolved	Resolution rate (%)	Share of all received cases (%)
TA Nkhulambe	47,040	27,020	57.4	31.80
TA Mkanda	4,392	2,304	52.5	2.97
TA Nazombe	2,423	1,265	52.2	1.64
TA M'Mbelwa	1,208	1,186	98.2	0.82
TA Ndamera	504	340	67.5	0.34
TA Mlolo	180	180	100.0	0.12
TA Chanthunya	48	48	100.0	0.03
TA Chindi	14	12	85.7	0.01
TA Phalula	15	10	66.7	0.01

5.4.4.3 Police Victim Support Units (PVSUs)

Across **20 mapped PVSUs**, providers recorded **16,383 cases received and 11,410 resolved**, giving an overall **resolution rate of 69.6%** and accounting for **11.1% of all GBV cases**. Performance varies sharply by TA. **TA Nazombe** and **TA Nkhulambe** together account for the largest police volumes, but with **much weaker closure in Nkhulambe (30.3%)**, reinforcing the pattern of a major bottleneck in that TA's police response relative to its extremely high health-clinic caseload. PVSUs generally perform well once survivors reach police services. **TA Nkhulambe shows a clear police-level bottleneck**, mirroring pressure seen at the health-clinic level. High resolution rates in smaller-volume TAs suggest that **distance and access**, rather than police effectiveness per se, limit outcomes.

Table 17: PVSU caseload and outcomes by TA

TA	Cases received	Cases resolved	Resolution rate (%)	Share of all received cases (%)
TA Nazombe	6,210	4,856	78.2	4.20
TA Nkhulambe	2,310	700	30.3	1.56
TA Mduwa	2,844	2,268	79.7	1.92
TA Mkanda	2,740	1,868	68.2	1.85
TA M'Mbelwa	1,872	1,182	63.1	1.27
TA Phalula	1,000	800	80.0	0.68
TA Mlolo	540	432	80.0	0.37
TA Ndamera	430	425	98.8	0.29
TA Chanthunya	140	140	100.0	0.09
TA Chindi	351	326	92.9	0.24
Total (PVSUs)	**16,383**	**11,410**	**69.6**	**11.10**

5.4.4.4 Magistrate courts

Courts represent a relatively small share of service points but handle a non-trivial volume of cases in a few high-burden TAs. Across the mapped magistrate courts, **10,908 cases were recorded as received and 7,116 as resolved**, giving an overall **resolution rate of 65.2%** and accounting for **7.4% of all recorded cases**. Caseload is **highly concentrated**. **TA Nazombe dominates court activity**, with **8,550 cases received and 6,525 resolved (76.3%)**, accounting for the large majority of all court-level cases. This suggests that Nazombe functions as a major justice hub for GBV-related matters, absorbing cases that may originate beyond its immediate catchment.

By contrast, **TA Mduwa records 1,728 cases but resolves only 468 (27.1%)**, indicating substantial backlog or prolonged processing at court level. **TA Chindi shows a comparatively strong court outcome**, with **360 cases received and 312 resolved (86.7%)**, although on a much smaller absolute caseload. **TA M'Mbelwa (252 cases; 108 resolved)** and **TA Phalula (18 cases; 15 resolved)** contribute very small volumes, limiting the interpretive weight of their resolution percentages.

These findings must be interpreted in light of the justice system's structure. All TA-level courts in the study are staffed by second- or third-grade magistrates without criminal jurisdiction, requiring **referral of criminal GBV cases to first-grade magistrates at district level**. Each referral adds distance, cost, and delay for survivors. Given travel burdens, often **20–40 km per trip and up to 50 km and MWK 10,000–15,000** per trip for **remote TAs such as Nazombe and Nkhulambe**, attrition remains likely even where recorded resolution rates appear high. Overall, court performance is therefore **uneven and highly dependent on a small number of high-capacity locations**, reinforcing the importance of strong upstream resolution through community, police, and health providers.

Table 18: Magistrate court caseload and outcomes by TA

Traditional Authority (TA)	Cases received	Cases resolved	Resolution rate (%)	Share of all received cases (%)
TA Nazombe	8,550	6,525	76.3	5.78
TA Mduwa	1,728	468	27.1	1.17
TA Chindi	360	312	86.7	0.24
TA M'Mbelwa	252	108	42.9	0.17
TA Phalula	18	15	83.3	0.01
Total (Courts)	**10,908**	**7,116**	**65.2**	**7.38**

5.4.5 Structural drivers of attrition along the referral chain

Putting the tables above (**under section 5.4.4**) together with the earlier spatial and cost analysis, a **cascade of attrition** becomes visible:

1. **High intake at community and health level**
    - **Community Victim Units (CVUs) and health clinics in high-burden TAs—most notably Nkhulambe, Nazombe, M'Mbelwa, Mduwa, Mkanda and Mlolo—absorb the majority of GBV case intake**, together accounting for over **46% of all recorded cases** across the five districts.
    - These providers handle **large absolute volumes** (for example, the Nkhulambe health clinic alone manages over **47,000 cases**, while CVUs in M'Mbelwa and Mduwa each manage several thousand) and still achieve **moderate-to-strong resolution rates (57–71%)**, indicating both **high community trust** and a **preference for closest-to-home, non-judicial resolution pathways**.
    - Even in more remote TAs such as **Chanthunya and Phalula**, where absolute caseloads are smaller, **local CVUs, clinics and PVSUs resolve a high proportion of cases**, reinforcing the role of proximity, familiarity and lower travel costs in shaping survivor help-seeking behaviour.
2. **Moderate thinning at police level**

- PVSUs handle fewer cases than clinics but still significant numbers; in several TAs they achieve **very high resolution rates**, suggesting that where survivors overcome the additional distance and cost to reach police, many cases are taken seriously and progressed.

3. **Sharp drop at magistrate courts**

   - Only **7.38% of all cases** reach courts, and only **one quarter of those are resolved**. The requirement to escalate criminal matters from TA-level to district-level magistracy, combined with **distance, travel time, transport cost and court scheduling**, filters out most cases, especially for survivors in **far/remote, hard-to-reach TAs**.

4. **Weak coordination and feedback**

   - Across the chain, referrals rely heavily on **written letters, verbal messages and sporadic phone calls**, with patchy feedback. Originating providers often do not know whether the survivor accessed the next service, whether charges were filed or dropped, or whether protective measures were enacted. This makes it difficult to **track survivors end-to-end or to manage backlogs systematically**.

In practice, this means that **most GBV cases are resolved or stall at the lowest tier at which survivors can still cope with the distance and cost burden**. Community and health providers thus carry the dual role of first responder and de facto final arbiter for many civil and even quasi-criminal matters, while **the formal justice system remains largely peripheral** to survivor trajectories in the five districts.

5.4.6 Operational Functioning, Accessibility and Referral Dynamics

5.4.6.1 Case resolution timelines

The distribution of reported GBV case resolution times shows that most providers **close cases relatively quickly**, at least in their own registers:

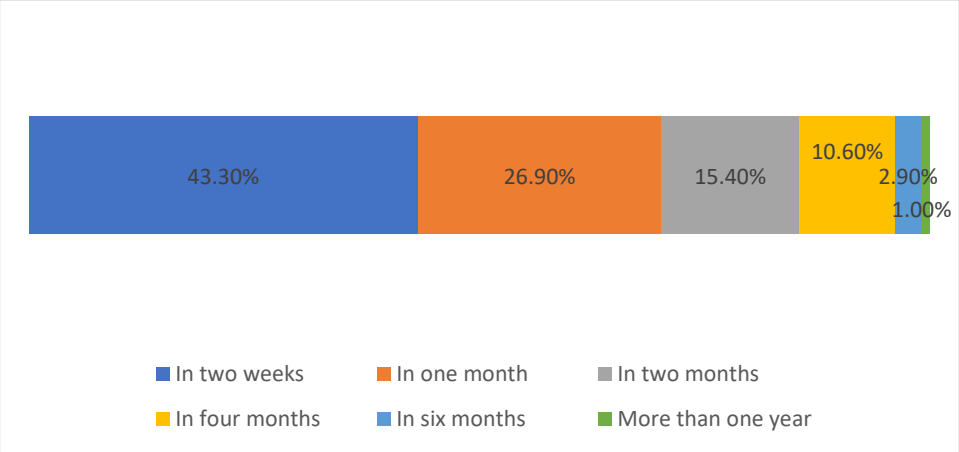

Figure 14: GBV Case Resolution Time

Cumulatively, about **70% of providers** report that "typical" cases are resolved **within one month**, and **over 85% within two months**. Only a very small minority indicate that cases commonly remain open beyond four to six months, and **less than 1%** report typical durations of more than a year.

- **High closure at community and police level vs low closure at court level.** Community-based and police providers demonstrate consistently strong case-closure performance, with Community Victim Units (CVUs) resolving approximately **70.8%** of cases **(9,734 of 13,752) and Police Victim Support Units (PVSUs) resolving about 69.6% (11,410 of 16,383)**. These rates reflect effective first- and second-line handling of GBV-related disputes, particularly at TA level.

- **Courts** resolve cases at a comparatively weaker rate, with **65.2% closure overall (7,116 of 10,908 cases)**. However, this aggregate figure masks strong concentration and uneven performance, with high closure driven largely by Nazombe, and much lowe or delayed resolution in other TAs.
- The pattern strongly suggests that a substantial share of cases recorded as resolved within **short timeframes (e.g. two weeks to one month)** are being concluded **at community or police level**, often through **mediation, reconciliation, withdrawal or informal settlement**, rather than through full judicial adjudication.
- Taken together, these findings reinforce that **the GBV response system is functionally weighted toward community, health and police mechanisms**, with courts playing a **later-stage, more selective role** that is constrained by jurisdiction, distance, cost and survivor attrition along the referral pathway.
- **Distance and cost as drivers of early closure.** Given average travel distances of **31–34 km**, travel times of **45–54 minutes**, and typical transport costs in the **MWK 7,000–11,600** range, survivors and families are under strong pressure to minimise repeated trips. The fact that a large proportion of cases are recorded as resolved within one month may therefore reflect **attrition and pragmatic settlement** rather than timely completion of the ideal medical–psychosocial–legal pathway. The time-to-resolution profile indicates an **operational system that closes cases quickly on paper**, but where the **quality and depth of resolution** especially for criminal GBV are likely uneven and often truncated before court-level outcomes are reached.

5.4.6.2 Financial and material environment of service providers

Income-generating activities (IGAs)

Only about **one in six** GBV service providers reported having any form of **Income Generating Activity (IGA)** to support operations. The overwhelming majority (**84.6%**) depend entirely on external funding (government budgets, donor grants, ad-hoc community contributions). CVUs, women's forums and safe spaces, many of which are central to referral initiation and local mediation, are structurally fragile. Without IGAs, even small expenses (transport for follow-up, stationery, phone credit) are difficult to sustain, which directly affects the ability to **track cases over time** and maintain consistent follow-up. In better-resourced TAs (e.g. M'Mbelwa, Chindi, parts of Mkanda), some community structures may benefit from NGO projects or linkages to stronger institutions, but in under-served or remote TAs (Nazombe, Nkhulambe, parts of Mlolo and Ndamera), **lack of IGAs, long distances and high transport costs** create a triple vulnerability: few services, fragile financing, and expensive access.

- **Time-to-resolution data** suggest **quick closure in frontline registers**, but not necessarily holistic or just outcomes—especially for criminal cases.
- **Financial and material constraints** (very low prevalence of IGAs, limited food provision) undermine the ability of community and facility-based services to **sustain engagement** with survivors over time.
- **Disability accessibility gaps** mean that a large subset of survivors face **additional, often invisible barriers**, even where services are geographically "nearby".
- **Referral pathway patterns** show that **health, CVUs and PVSUs do most of the work**, while courts and Legal Aid remain weakly integrated, contributing to the justice bottleneck identified throughout your analysis.

Provision of food during prolonged stay

Only **14.4%** of facilities reported being able to provide **food for survivors during prolonged stays** (e.g. overnight observation, multiple-day safety stays, or prolonged court processes). Services are effectively configured for **short, outpatient interactions**. For survivors who need to remain in a facility for safety, medical reasons, or to attend sequential appointments, lack of food provision shifts the burden back onto families who may already be financially stretched and paying for transport.

In remote TAs, where travel is costly and dangerous (especially at night), the inability to provide basic sustenance increases the likelihood that survivors **return home prematurely** or skip follow-up visits altogether, compounding the attrition documented in your referral analysis.

5.4.6.3 Physical accessibility for persons with disabilities

Just over **half** of responding facilities (**51.9%**) reported that their buildings were accessible to persons with disabilities, while **one-third (33.7%)** explicitly indicated that they were **not accessible**. For the balance, accessibility status is unknown. This means that for roughly **one in three GBV service points**, survivors with mobility, visual or other physical impairments would face structural barriers at the point of entry; steps without ramps, narrow doors, inaccessible toilets, or lack of seating and privacy.

Given that these **98 mapped facilities** are distributed across **Nsanje (31), Mzimba (22), Mchinji (21), Phalombe (13) and Balaka (11)**, this aggregate pattern implies that a **substantial share of facilities in every district remains physically inaccessible to persons with disabilities**, even before accounting for **distance, terrain, flood risk and unreliable transport**. In practical terms, this means that for many survivors with disabilities, **access barriers are layered**: long travel distances and high transport costs are compounded by **non-accessible infrastructure at the point of service**, sharply reducing the likelihood of timely, safe and sustained engagement with GBV support services.

In a context where many survivors with disabilities already face heightened risks of GBV and greater dependence on caregivers, the combination of long travel distances and non-accessible infrastructure sharply reduces the likelihood of timely and safe help-seeking. If we apply the overall accessibility proportion (52%) as a rough benchmark, **only around half of the GBV service points in each district are likely to meet basic accessibility criteria**, and **around a third are likely to be structurally excluding** for people with disabilities. The current pattern is sufficient to conclude that disability-friendly provision is **the exception, not the norm**, across the five districts.

While this study did not conduct a full facility-by-facility accessibility audit (e.g. ramps, handrails, tactile markers, accessible toilets), the yes/no self-report already provides a strong signal that **structural discrimination is embedded in the physical footprint of GBV services**. Without targeted upgrades, even the best-designed referral protocols and outreach strategies will leave a significant group of survivors behind.

5.4.6 Justice system bottlenecks and the role of magistrate courts

The court data need to be interpreted in light of the **structural constraints of the magistracy in the study area**. In all TAs assessed, local magistrate courts are staffed by **second or third-grade magistrates who do not have criminal jurisdiction**. Under Malawi's legal framework, **all criminal GBV cases (e.g. defilement, rape, grievous bodily harm)** must be **referred to first-grade magistrates at the district headquarters** for trial and sentencing.

This has three important implications:

1. **Every criminal case requires an additional referral "jump"** from the TA-level magistrate to the district court. This automatically adds **extra distance, travel time and cost** to the justice pathway, on top of the earlier journeys to CVUs, clinics and police.

2. The statistics show that, even before cases reach district court, **substantial attrition has already occurred along the referral pathway**. Courts collectively account for **10,908 cases**, representing **only 7.4% of all GBV-related cases recorded across providers**, confirming that the vast majority of cases are handled and concluded outside the formal justice system. Within this subset, **7,116 cases (65.2%) are recorded as resolved**, but this aggregate masks **pronounced TA-level variation**: resolution rates range from **76.3% in Nazombe** and **86.7% in Chindi**, to much lower levels in **Mduwa (29.5%)** and **M'Mbelwa (42.9%)**. These disparities reflect differences in court capacity, jurisdictional constraints, backlog, and survivor drop-off due to distance, cost and prolonged case timelines.

3. Because survivors from many TAs must travel **25–40 km or more**, often at a cost of **MWK 7,000–15,000 per trip**, repeated court appearances are **logistically and financially unsustainable** for most households. The probability that a criminal case reported at community or police level will survive all the way through to district-court judgment is therefore extremely low, especially for survivors in **far/remote TAs such as Nazombe and Nkhulambe**.

In effect, the **centralisation of criminal jurisdiction at district level turns distance, travel time and transport cost into de-facto screening mechanisms**, filtering out all but the most severe, high-profile or externally supported cases from the formal justice system.

5.4.4 Spatial and economic drivers of attrition along the pathway

When the referral patterns are read together with the **TA-level accessibility profiles**, a geographic gradient of attrition becomes clear:

- **Most TAs of concern fall within the 20–40 km, 40–75 minute bands**, already a substantial burden for survivors who may be injured, traumatised, caring for children or lacking independent mobility.
- **Nazombe and Nkhulambe** fall into **30–50 km and 60–90+ minute bands**, with typical transport costs in the **MWK 10,000–15,000 range**, well above the overall median of MWK 7,000.
- Even in mid-distance TAs such as **M'Mbelwa, Chindi, Mduwa, Mkanda and Phalula**, the combination of **multiple service points (clinic, CVU , police, court)** and repeated trips quickly multiplies cost and time.

The quantitative picture of case flow mirrors this geography:

- Community and health providers in high-burden TAs (e.g. **M'Mbelwa, Chindi, Phalula, Chanthunya**) report **thousands of cases received** and **reasonable resolution ratios**, indicating that they are absorbing large volumes of demand.
- Police VSUs in these same TAs typically report **hundreds to low thousands of cases** with high closure rates, but the **volume drops sharply again at court level**, where only a small fraction of cases ever appear.
- In far/remote TAs (especially **Nazombe and Nkhulambe**) both case intake and resolution figures for police and courts are **very low**, despite high facility caseloads in health and community settings. This strongly suggests **suppressed reporting and early drop-out**, driven by the cumulative burden of travel and cost.

In short, **distance and cost are not just background constraints; they actively shape where and how cases are managed**. They encourage resolution at the **lowest possible tier** often CVU, health facility or police—because every additional referral step requires another expensive journey.

5.4.5 Coordination, feedback and information systems

Table 19: Referral pathways and coordination profile

Main referral pathways (multiple responses)	Frequency	% of facilities
Hospitals / health facilities	71	**68.3%**
Social welfare	70	**67.3%**
Police Victim Support Unit (PVSU)	70	**67.3%**
Courts	62	**59.6%**
One Stop Centre	41	**39.4%**
Legal Aid	14	**13.5%**
Other	10	**9.6%**

These figures confirm a **multi-sectoral but uneven referral architecture**:

- **Hospitals, Social Welfare, and PVSUs** sit at the core of the referral network, each cited by roughly **two-thirds of facilities** as key referral destinations. This aligns with the case statistics showing that health clinics, CVUs and PVSUs handle **around 97%** of all recorded GBV cases across the four main provider types.
- **Courts are referenced by 60% of facilities**, but the earlier case analysis showed that they handle only **7.4% of all recorded cases** and resolve just **25.1%** of those. This mismatch indicates that

while courts are nominally part of the referral pathway, **few referrals actually translate into filed, heard and concluded cases**, especially where 2nd/3rd grade magistrates lack criminal jurisdiction and must forward cases to distant district courts.

- **One Stop Centres (OSCs)** are part of the referral pattern for only **39.4%** of facilities, reflecting their **limited geographic coverage**. Survivors in TAs without an OSC in reasonable reach (e.g. Nazombe, Nkhulambe, outlying parts of Mlolo and Ndamera) are therefore unlikely to benefit from **integrated, survivor-centred care** in one location.
- **Legal Aid** is cited by just **13.5%** of facilities, highlighting a significant gap in **legal accompaniment and representation**. For many survivors, particularly those facing complex criminal or family-law issues, this means navigating the justice system **without specialised legal support**, increasing the odds of withdrawal or unfavourable outcomes.

When combined with the qualitative findings on referral modes (dominance of **written referral letters**, limited use of structured phone-based coordination, and weak feedback loops), this pattern reinforces the view that:

- The **bones of a multi-sectoral system exist**, most facilities know they *should* refer to health, police, social welfare and courts;
- But the **"ligaments" of coordination**, standardised tools, feedback mechanisms, shared case IDs, and joint review processes remain weak. As cases move "up" the chain from community to health to police to court, **distance, cost, disability barriers and coordination gaps** progressively erode the number that reach a meaningful, documented resolution.

Qualitative responses and categorical data from the referral survey highlight a **referral architecture that exists on paper but is weakly stitched together in practice**:

- **Inbound referrals** to district-level services are dominated by **police and CVSUs**, with occasional self-referrals and NGO/community referrals.
- **Outbound referrals** run in multiple directions: from CVUs to clinics and police; from clinics to police and social welfare; from PVSUs to courts and One Stop Centres. However, these flows are often **unidirectional**.
- **Referral instruments** are largely analogue: standard referral letters are common, but **shared, standardised forms across sectors are rare**, and many referrals rely on verbal guidance or personal phone calls.
- **Feedback loops are weak.** Originating facilities frequently do not receive systematic updates on whether a referral led to medical treatment, protection measures, prosecution, or dismissal. This undermines case tracking and survivor follow-up.

From a systems perspective, this means the GBV response in the study districts has **strong "bones" but weak "ligaments"**: the right actors exist and are generally performing well within their own mandates, but the **connective tissue shared protocols, routine feedback, integrated data is underdeveloped**. As a result, survivors are highly exposed to falling through the cracks between providers, particularly when referrals involve long-distance travel or multiple institutions.

5.4.6 What the referral analysis means for MICGBV

Taken together, the referral and coordination analysis shows a **cascading pattern of attrition**:

1. **Many cases are received and partially addressed at community and health level**, where resolution rates are respectable but resources and mandates are limited.
2. **Fewer cases progress to police**, though those that do often receive meaningful follow-up, particularly in high-performing PVSUs.

3. **Only a very small subset reaches magistrate courts**, where structural jurisdictional limits and the centralisation of criminal cases at district level combine with distance and cost to further thin down the caseload and depress resolution rates.

For MICGBV and its partners, improving GBV case outcomes in these five districts will therefore require **more than strengthening individual institutions**. It will demand:

- **Closer-to-community justice and police presence** (including mobile services and circuit courts) to reduce the need for long, repeated trips.
- **Standardised, multi-sectoral referral tools and feedback mechanisms**, so that each step in the chain is documented and survivors are actively followed up.
- **Targeted transport and accompaniment support** for survivors from high-distance, high-cost TAs, particularly Nazombe, Nkhulambe and parts of Mduwa, Mkanda and Nsanje's flood-prone TAs.
- **Use of the new geospatial and dashboard tools** to routinely monitor where in the pathway cases are stalling and to adjust coordination strategies accordingly.

6.0 Accessibility Gaps and Systems-Level Challenges

The combined spatial, referral and case-management data point to a GBV system that is present and active across the five districts, but structurally uneven, costly to access, and weakest where survivors need it most at the level of justice and long-term protection. Five interlinked systems challenges stand out.

6.1 Spatial inequity between and within districts

The geospatial analysis confirms clear **inequalities in where services are located and who they are realistically reachable for**.

At **district level**, Mzimba and Nsanje have relatively dense networks of mapped GBV service providers, while Balaka and Phalombe have far fewer facilities per TA. This makes Balaka and Phalombe structurally vulnerable to **single-point failures** (e.g. if one health centre, PVSU or CVSU becomes non-functional, large areas are left with no nearby formal entry point).

At **TA level**, facilities are heavily clustered in a limited set of jurisdictions; Chindi, Ndamera, Mkanda, M'Mbelwa, Mlolo and Mduwa together host a disproportionate share of the 98 mapped providers. Other TAs in the same districts, including Nazombe and parts of Chanthunya and Nkhulambe, have fewer or weaker service points and rely on distant service providers in neighbouring TAs or at the district centre. This pattern is reinforced by the TA-level caseload data: high-burden TAs such as M'Mbelwa, Chindi, Phalula and Chanthunya send substantial numbers of cases to district-level providers, while remote TAs such as Nazombe and Nkhulambe record very low case volumes despite known GBV risk factors strongly suggesting **access-driven under-reporting** rather than low incidence.

In effect, spatial inequity operates on two levels: some districts are better endowed than others, and within districts, a small cluster of TAs acts as de facto GBV "hubs" while peripheral TAs remain poorly served.

6.2 Distance, travel time and cost: access rationed by geography and poverty

The TA-level accessibility analysis shows that **distance, travel time and transport cost are not marginal inconveniences; they are core determinants of who can use the system at all.**

Across the TAs of concern, most survivors are in **20–40 km distance bands** and **40–75 minute travel-time bands** to reach district-level GBV services. The mean distances reported in the referral survey sit around **31–34 km**, with median travel times of roughly **45 minutes**. Estimated **transport costs** cluster around **MWK 7,000–11,600 per one-way trip**, with far-remote TAs such as Nazombe and Nkhulambe likely facing costs in the MWK 10,000–15,000 range.

- TAs such as **M'Mbelwa, Chindi, Ndamera and Mlolo** have reasonably strong service presence but still include extensive hard-to-reach zones. Survivors from outlying villages must cross rivers, traverse poor roads, or navigate flood-prone terrain to access district services.
- In **Nazombe and Nkhulambe**, distance and cost bands are at the top of the range. For households in these TAs, a single trip to a police VSU or district court can consume most of a day and a significant share of monthly income.

Almost **80% of facilities** report having hard-to-reach areas in their catchments. These structural barriers disproportionately affect **survivors who are poor, rural, caring for children, living with disabilities, or lacking independent control over money and mobility**. In practice, this means that the right to access GBV services is **de facto rationed by geography and poverty**: those who live closest and can afford transport are able to progress through the system, while many others are effectively locked out.

6.3 Service package gaps and justice bottlenecks

The mapping shows that **service presence does not automatically equate to comprehensive, survivor-centred care**.

On the positive side, the vast majority of providers offer **counselling and basic GBV support**, with many also providing child protection, family counselling and follow-up visits. Health facilities frequently add HIV testing, contraception and sexual and reproductive health services.

However, the system thins out sharply when it comes to **specialised services**:

- **Forensic examination, legal aid, safe shelter and comprehensive psychosocial care** are offered by a small subset of providers, typically located in district centres.
- **One Stop Centres, social welfare offices and magistrate courts** are few and geographically concentrated, creating long and complex referral chains for survivors in outlying TAs.

The justice sector stands out as the **weakest link in the chain**:

- Courts are involved in only **7.4% of all tracked cases** (10,908 out of 147,905 cases in the four main provider types), and their overall **resolution rate is only 25.1%**.
- By contrast, **CVUs and PVSUs resolve between 65% and 71%** of the cases they handle, and even health clinics under pressure from large caseloads resolve about **58%** of their cases.

The structural configuration of courts further amplifies this bottleneck. **Most TA-level courts in the study area are 2nd or 3rd grade magistrate courts without criminal jurisdiction.** All criminal GBV matters must therefore be referred to **1st grade magistrate courts located at district headquarters**, which are already distant and costly to reach. Every step from statement taking, to hearings, to judgement adds additional journeys, time off work, and transport cost. The result is that **very few GBV cases actually traverse the full path from first disclosure through to formal justice outcomes**, especially for survivors in remote TAs.

6.4 Referral pathways and a cascade of attrition

The referral and case outcome data reveal a **layered but leaky** referral architecture, where many cases enter the system but progressively drop out as they move "up" the chain.

Entry points. Most survivors enter the GBV system through **community and police structures**. Around **70%** of district-level providers identify **police VSUs and Community Victim Support Units** as their primary referral sources, with a smaller share from self-referrals and other institutions. This confirms that the **frontline of the GBV response is local and community-anchored**, not court-led.

The structural result is a **cascade of attrition**:

1. Many cases are reported and partially addressed at community and health level where resolution rates are relatively strong but mandates and resources are limited.

2. Fewer cases reach or stay engaged with police; distance, cost, fear of reprisal and family pressure all contribute to drop-out between first disclosure and formal complaint.

3. Only a **small subset** of cases ever reaches the magistrate courts, and even fewer progress through repeated hearings to a final judgement.

The fact that **TA-level magistrate courts cannot hear criminal cases** and must refer them to district 1st-grade magistrates adds an extra layer of attrition: in remote TAs, survivors are asked to repeatedly cross long distances and pay high transport costs for multiple court appearances. For many, especially in **Nazombe, Nkhulambe and parts of Mduwa and Mkanda**, this is simply not feasible, regardless of the merits of the case.

6.5 Data and information system weaknesses as a systems constraint

The above patterns are not only the product of geography and service configuration; they are also shaped by **weak, fragmented data systems** that obscure survivor trajectories and hinder accountability. While the analysis above provides valuable insight into GBV caseloads and resolution patterns, the data also reveal **significant weaknesses in existing information systems**. These weaknesses affect how confidently the figures can be interpreted and point to clear priorities for system strengthening.

6.5.1 Fragmented and parallel data systems

Across the five districts, GBV data are captured in a mixture of **paper registers, ad-hoc Excel files, Kobo forms and sector-specific systems** (e.g. police registers, health HMIS, social welfare case books). There is **no single integrated case management system** and no common unique case identifier that follows a survivor across providers. As a result:

- The totals reported in this study are best understood as **"episodes of service contact"**, not unique survivors; the same case may appear multiple times (e.g. at CVU → PVSU → clinic → court).
- Double-counting is likely, especially in high-volume TAs such as Nkhulambe, M'Mbelwa and Ndamera where referral chains are more active.
- Facility-level and district-level totals cannot be reconciled into a clean "one survivor = one record" dataset, limiting the precision of incidence and prevalence estimates.

5.5.2 Inconsistent definitions of "case" and "resolved"

The Kobo tools asked for "GBV-related cases received to date" and "cases resolved", but field consultations and the pattern of figures suggest that **definitions vary by provider type**:

- Some community structures appear to count **any family dispute, child protection concern or marital conflict** as a GBV "case", even where no violence is alleged.
- In several facilities, "resolved" seems to mean **"no longer active in our register"** (e.g. because the case was referred on, the survivor stopped coming, or informal mediation occurred), whereas others only record a case as resolved when **formal procedures are completed** (e.g. court judgement or documented reconciliation).
- The very high resolution rates in some PVSUs and CVUs (90–100%) and the very low rate in courts (25.1%) likely reflect **different thresholds for closure**, not only differences in quality.

These definitional inconsistencies mean that **resolution rates are comparable within a provider type in a given district**, but **less reliable across types and districts**. They should therefore be interpreted as indicators of **system performance and follow-through**, rather than precise justice or survivor-satisfaction outcomes.

5.5.3 Outliers and plausibility concerns

Several facilities report **extremely large cumulative caseloads** (e.g. >20,000 or >40,000 cases "to date"), compared with much smaller figures for almost all other sites. While this may partly reflect large catchments, it also suggests possible:

- **Misclassification** (e.g. counting all outpatient visits or all child protection contacts as GBV);
- **Data entry errors** (extra zeroes, swapped received/resolved columns); or
- **Aggregation of multiple years without a clear reference period**.

Similarly, some courts show **zero resolved cases** despite non-trivial numbers received, which may indicate a real backlog but could also reflect **incomplete registers or poor retrospective record-keeping**. These outliers do not invalidate the overall patterns, but they do highlight the need for **routine data-quality checks (range checks, outlier review, reconciliation with paper registers)** before figures are used for high-stakes decision-making.

5.5.4 Missingness and uneven disaggregation

The facility survey reveals **gaps in key fields**:

- Not all providers completed both "cases received" and "cases resolved"; some left one or both fields blank, forcing the analysis to treat them as zero or exclude them.
- Disaggregation by **sex, age, disability, type of GBV and relationship to perpetrator** is not consistently captured across providers, making it impossible to examine who benefits most or least from services.
- TA names and GPS coordinates are complete for almost all sites, but **linkage between GBV registers and geospatial layers is not yet standard practice** in routine systems; this integration currently relies on the project's one-off mapping exercise.

These gaps limit the study's ability to explore important equity questions (e.g. adolescent girls vs adult women; persons with disabilities vs others) and to monitor intersectional vulnerabilities.

5.5.5 Limited longitudinal tracking and feedback

Data flows in the current system are **largely one-directional**:

- When a CVU refers a case to a PVSU or clinic, or when police refer to court, the originating provider **rarely receives structured feedback** on whether the case progressed, stalled, or was closed.
- Registers are structured around **provider-level caseloads**, not survivor trajectories; there is no mechanism to reconstruct, from routine data alone, the complete path of a case from first disclosure to final outcome.
- District coordination meetings rarely use **merged or linked datasets**; instead, each sector reports its own figures, which may not be comparable or mutually consistent.

This weak feedback architecture contributes directly to the **attrition observed along the pathway**: once a case is referred out, it often disappears from the originating register, and no-one is explicitly mandated to track whether it ever reaches a meaningful resolution.

5.5.6 Implications for interpretation and for system strengthening

In light of these data-management gaps, the figures presented in this report should be viewed as **best-available operational estimates**, not as a fully harmonised GBV surveillance system. They are **robust enough to identify patterns**, for example:

- the dominance of health, CVUs and PVSUs in managing cases;
- the very small and weakly resolved caseload at magistrate courts;
- the spatial inequities between districts and TAs; and
- the progressive attrition as cases move up the referral chain.

However, they are **not yet robust enough** to answer questions such as "What proportion of all GBV incidents in TA X reach court?" or "What is the true conviction rate for GBV cases originating from TA Y?".

6.6 Integrated systems implications

Taken together, the spatial, financial, service-package and information-system gaps describe a GBV response that is **busy, committed and locally active**, but structurally constrained:

- **Where** a survivor lives (district, TA, village) largely determines which services are even theoretically accessible.
- **How far** they must travel and **how much** they must pay determines whether they can realistically remain engaged beyond the first contact.
- **What type of provider** they reach first shapes whether their case is likely to be handled informally at community level, managed clinically, or escalated to police and court.
- **How data are captured and shared** determines whether the system learns from these pathways or allows survivors to fall through invisible cracks.

6.0 Data-Informed, Actionable Recommendations

The recommendations below are deliberately **geographically targeted**, **system-level** and **data-anchored**. They are structured along five strategic axes: **(i) spatial rebalancing, (ii) reducing distance and cost, (iii) strengthening the referral architecture, (iv) institutionalising GIS and data systems, and (v) deepening analysis on vulnerability and quality of response.**

6.1 Rebalance the spatial distribution of GBV services

6.1.1 Prioritise under-served districts and TAs

The spatial analysis shows that **Mzimba and Nsanje** host the majority of mapped facilities and caseload, while **Balaka and Phalombe** have fewer service points and rely heavily on a small number of service providers. Within districts, service density is high in TAs such as **Chindi, Ndamera, Mkanda, M'Mbelwa, Mlolo and Mduwa**, while TAs such as **Nazombe and Nkhulambe** are clear "cold spots": they have few facilities, high distance and cost bands, and extremely low recorded referrals.

Data-informed actions

- **At district level (Balaka, Phalombe):**
  - Formally treat **Balaka and Phalombe** as **under-served districts** based on their lower facility density and smaller share of the overall caseload.
  - Prioritise them in MICGBV and government planning cycles for:
    - new or upgraded **CVSUs, safe spaces and women's forums**;
    - at least **one additional One Stop Centre–type node** per district (or upgraded high-volume health facility) to provide integrated medical, psychosocial and basic legal support.
- **At TA level ("cold spots"):**
  - Use the TA-level profiles (service density, caseload and referral volumes) to identify areas with:
    - no mapped facility within a reasonable catchment (e.g. 10–15 km); and/or
    - very low referral counts despite known GBV risk (for example **Nazombe and Nkhulambe**).
  - Establish or strengthen **GBV entry points** in these TAs (CVUs, community gatekeepers, CBOs) that are formally linked to health, police and district-level services through a standard referral protocol.

This ensures that new investments respond to **mapped geographic and caseload gaps**, not only to administrative boundaries, and that cold-spot TAs move from "blind zones" to having at least one functional, connected entry point.

6.1.2 Introduce mobile and satellite GBV services

The distance and travel-time analysis demonstrates that survivors in several Tas, particularly **Nazombe, Nkhulambe, and some parts of Mlolo and Ndamera** fall into the **30–50 km / 60–90+ minute** bands for reaching district services. For these communities, well-equipped service providers at district level alone are insufficient.

Data-informed actions

- **Mobile GBV outreach:**
    - In TAs where mean distances exceed **30 km** and typical transport costs fall in the **MWK 10,000–15,000** band, pilot **mobile GBV teams** providing:
        - basic clinical care (PEP, STI prophylaxis, emergency contraception where feasible);
        - psychosocial first aid and safety planning;
        - legal information, referrals and remote liaison with PVSUs and courts (e.g. phone-based follow-up and scheduled days for statement taking).
    - Use TA-level case volumes and access indicators (distance, time, cost, hard-to-reach status) to set **outreach frequency**, with more frequent visits to high-burden, poorly served TAs.
- **Satellite "mini-hubs":**
    - In high-burden but peripheral TAs (e.g. **M'Mbelwa, Chindi, Phalula, Chanthunya**) where clinics and CVUs are already managing significant caseloads, invest in **satellite specialised services** (periodic visits by social welfare officers and paralegals, enhanced psychosocial support, medico-legal documentation) rather than expecting all survivors to travel to district HQ.

6.2 Reduce financial and temporal barriers to access

The referral survey indicates that typical journeys from the TAs of concern cost **MWK 7,000–11,600** (and up to 15,000 in the most remote TAs), with travel times of around **45–54 minutes** each way. Given prevailing poverty levels, these costs are prohibitive, especially when survivors are expected to make repeated trips between health, police and courts.

6.2.1 Establish sustainable survivor support fund (SSF) and accompaniment mechanisms

Data-informed actions

- **Survivor Support Fund:**
    - A district-level Survivor Support Fund (SSF) should be established as a core mechanism for reducing distance- and cost-related exclusion from GBV services, especially for survivors in hard-to-reach TAs.
    - The SSF should provide **targeted, time-bound support** covering (1) emergency transport to clinics, PVSUs, OSCs, shelters or courts; (2) short-term food and accommodation in acute cases (typically one–three nights); and (3) safe accompaniment by trained community focal persons, paralegals or women's forum members.
    - The fund should prioritise survivors who face compounded barriers those living in remote or terrain-isolated villages, survivors with disabilities, minors, and households with limited income or high-risk safety concerns. Eligibility criteria and cost ceilings should be

standardized and transparent, ensuring the fund remains both equitable and financially sustainable.

- To strengthen long-term viability, the SSF should adopt a **hybrid financing model**. The funding model should consist of a small annual district budget allocation (e.g., Gender/Social Welfare) and a predictable contribution from MICGBV and partners that anchors 50–60% of projected expenditure in the early years. This should be complemented by locally mobilised **corporate social responsibility (CSR)** contributions from estates, agro-industrial employers, trading companies, transport associations and faith institutions, framed as a modest but recurring investment in community safety. A further revenue stream should come from **community-managed income-generating activities (IGAs)** operated by selected CVUs or women's forums such as solar charging kiosks, grain mills, agro-dealer outlets or rental assets (tents/chairs/PA systems).
- To protect survivors, IGAs should be structurally separated from survivor payments and run under transparent financial rules, with 30–50% of net income automatically channelled into the SSF. Where legally appropriate, a small share of GBV-related fines or restitution ordered by courts may be earmarked through government systems to top up district GBV support lines, without interfering with survivors' personal compensation rights.
- Operational efficiency will be maintained through a **simple and predictable benefits package**. TA-specific ceilings will be set for transport reimbursement (based on distance and travel-time bands), maximum funded trips per case (e.g., emergency treatment plus two–three justice-related visits), and capped daily rates for short-term accommodation and meals.
- To reduce cash handling, the SSF should rely on **voucher-based transport partnerships**: districts should sign memoranda of understanding with minibus associations, motorcycle taxis, or where applicable boat operators, allowing survivors or accompaniment persons to travel without paying upfront. Pre-agreed fares, routes and redemption rules may reduce financial risk and ensure that survivors are not asked to advance money they do not have.
- Accompaniment should be integrated into existing community structures through designated CVSU members, women's forum leaders or paralegals receiving a small, standardised allowance per escorted trip, rather than establishing a new cadre.
- Governance should be anchored in a **District-level SSF Committee**, chaired by the District Gender or Social Welfare Officer and involving health, police/PVSU representatives, courts, WROs and selected CVSU members. This committee should (1) approve annual SSF plans and budgets, (2) set and revise eligibility rules and distance-based ceilings, (3) review quarterly expenditure and usage dashboards, (4) identify misuse risks and correct them, and (5) ensure that SSF use informs district GBV planning.

- **Survivor accompaniment:**
  - Encourage CVUs, community volunteers and paralegals to provide **physical accompaniment** for survivors, particularly children, persons with disabilities and those at high risk recognising that accompaniment is often as important as fare subsidies in enabling survivors to navigate complex institutional pathways.

6.2.2 Enhance local service capacity to reduce unnecessary referrals

The analysis shows that **health clinics, CVUs and PVSUs already resolve a high share of cases**, but the quality and depth of their service packages vary. Strengthening these frontline providers can reduce the need for long-distance travel for issues that can safely be managed locally.

Data-informed actions

- **Upgrade high-volume local providers:**
  - Identify **high-volume, high-resolution facilities** (for example CVUs in M'Mbelwa, Mduwa and Ndamera; clinics in M'Mbelwa, Chindi, Ndamera and Mlolo; PVSUs in Ndamera, Chindi and Phalula) as priority sites for capacity upgrading.

- Provide these sites with:
    - advanced psychosocial and trauma-informed counselling training;
    - standardised medico-legal documentation tools and guidance (even if forensic analysis remains centralised);
    - stronger linkages with social welfare, child protection and safe housing options.

- **Clarify which cases require escalation:**
    - Use the unified referral protocol (see below) to spell out which cases **must** be referred to district level (e.g. sexual violence requiring forensic examination, complex child custody or trafficking cases) and which can be **safely managed locally** with remote oversight.
    - This will reduce **unnecessary referrals**, lower survivor cost and time burdens, and allow district service providers to focus on the most severe and complex cases.

6.3 Strengthen and standardise the GBV referral architecture

The data point to a **multi-entry system with weak connective tissue**: survivors typically enter through CVUs, health facilities or police, referrals are transmitted largely through paper letters and verbal communication, feedback is irregular, and courts sit at the thin end of the funnel with the lowest resolution rates.

6.3.1 Develop and roll out a unified multi-sectoral referral protocol

Data-informed actions

- **Standard referral form and minimum dataset:**
    - Bring together police, health, social welfare, courts and key NGOs to agree on a **single GBV referral form** with a clear minimum dataset, including:
        - TA of origin and approximate distance to the receiving facility;
        - survivor characteristics (age, sex, disability status);
        - type of violence;
        - services requested and services provided;
        - referral destination and planned next step;
        - whether transport/accompaniment was required and provided.
    - Design the form so it can be used **on paper and in digital form** (e.g. Kobo, ODK, web forms) and can be easily linked to the geospatial database via TA codes and, where feasible, GPS coordinates.

- **Clear role definitions and pathway steps:**
    - In the protocol, define minimum expectations for each provider type, for example:
        - what CVUs should do before referring to PVSUs or clinics;
        - what PVSUs should complete before referring to court;
        - how clinics should engage police and social welfare in cases of sexual violence or high risk.

This will reduce arbitrary variation in referral practice and make it easier to follow and support case journeys across providers.

6.3.2 Build robust feedback loops and joint case review mechanisms

One of the strongest themes from the data is that referrals are often **one-way**, with little structured feedback to the originating provider, contributing to case attrition and incomplete records.

Data-informed actions

- **Quarterly multi-sectoral case review meetings:**
    - Institutionalise **district-level GBV case review meetings** where police, health, CVUs, social welfare and courts jointly review:
        - aggregated referral flows between TAs and providers;
        - resolution rates by provider type and TA;
        - selected anonymised cases illustrating bottlenecks and good practice.
- **Feedback obligations and metrics:**
    - Include a **feedback section** on the referral form to be completed by the receiving facility and returned (physically or digitally) to the referring provider.
    - Track the **percentage of referrals for which feedback was received** as a routine performance indicator and discuss this in coordination meetings.

Over time, this can transform the system from fragmented provider silos into a **network of mutually accountable actors**, each responsible for both their own actions and the communication of outcomes.

6.4 Institutionalise GIS, dashboards and data systems in GBV planning

The project has proved the value of **GPS-tagged facility data, TA-level profiles, Kobo dashboards, GIS maps and Power BI visualisations**. However, these tools are not yet embedded in routine planning or monitoring processes.

6.4.1 Adopt the web-based GIS and dashboards as official planning tools

Data-informed actions

- **Formal adoption and use in planning:**
    - Host the geospatial database, web maps and dashboards within MICGBV or relevant government infrastructure.
    - Require districts to use these tools when developing GBV workplans and funding proposals, for example, by including at least one map and a short narrative on TA-level service gaps and access barriers in each plan.
- **Spatial performance indicators:**
    - Develop a limited set of **spatial equity indicators**, such as:
        - number of GBV service points per 10,000 people by district or TA;
        - proportion of TAs with at least one mapped GBV entry point;
        - median distance from populated areas to the nearest full-service facility.
    - Track these indicators annually to assess whether inequities are narrowing.

6.4.2 Build local capacity for geospatial decision-making

The impact of GIS and dashboards depends on whether district teams can interpret and use them.

Data-informed actions

- Provide **practical training** to District Gender Officers, DSWOs, district planning units and key NGOs on:
    - interpreting GBV service density maps and referral flow diagrams;
    - using dashboard filters to compare TAs by caseload, distance, travel time and resolution rate;
    - converting these insights into concrete activities (e.g. where to place new CVUs, when to send mobile teams, which TAs should receive transport vouchers).
- Develop **simple user guides and presentation templates** so district officers can confidently generate and present their own analytical products at coordination meetings and stakeholder forums.

6.4.3 Strengthen routine data capture and quality

The current reliance on scattered paper registers and ad-hoc spreadsheets undermines the ability to track cases and compare performance over time.

Data-informed actions

- **Harmonised minimum dataset and data dictionary:**
    - Agree a cross-sector **minimum dataset** for GBV (case type, TA of origin, survivor profile, provider type, referrals made and received, outcome) and a shared data dictionary to reduce inconsistent interpretation.
- **Unique case identifiers:**
    - Introduce a **simple unique case identifier** format that all providers (CVUs, PVSUs, clinics, courts) can apply to their registers, enabling future linkage of survivor trajectories while protecting confidentiality.
- **From paper to digital with validation:**
    - Gradually transition from ad-hoc paper and Excel files to **standardised digital tools** (e.g. Kobo, ODK or GBV modules within existing health or social welfare information systems) with built-in data validation checks.
- **Routine data quality audits:**
    - Incorporate basic **data quality audits** into district GBV coordination responsibilities (e.g. reviewing extreme values, reconciling paper and digital records, checking for obvious double counting).
- **Geospatial tagging in routine systems:**
    - Ensure that routine registers always capture, at minimum, **TA of origin**, and progressively add GPS where feasible, so future spatial analysis becomes part of standard monitoring rather than a one-off project exercise.

These steps will gradually transform GBV data from isolated snapshots into a **coherent, longitudinal evidence base** for programming and advocacy.

6.5 Deepen analysis on vulnerability and quality of response

The current work has mapped **where** services are and **how** cases move. The next step is to sharpen the focus on **who is most at risk** and **how good the response actually is**.

6.5.1 Overlay GBV services with socio-economic and climate risk

GBV risk intersects with **poverty, gender inequality and climate vulnerability**, particularly in flood-prone districts and remote agrarian TAs.

Data-informed actions

- Enrich the geodatabase by adding layers on:
    - household poverty and vulnerability,
    - population density and age/sex structure,
    - flood and drought risk, especially in low-lying and riverine areas.
- Generate **"double- and triple-burden" maps** showing communities that:
    - are far from services,
    - have high poverty, and
    - face recurrent climate shocks.

These maps can support **integrated programme design** (e.g. GBV + climate resilience + livelihoods) and strengthen funding proposals for the most structurally disadvantaged communities.

6.5.2 Move from presence of services to quality of response

Simply knowing that a facility exists does not tell us whether survivors receive **timely, respectful, survivor-centred care.**

Data-informed actions

- Conduct **quality audits** in a purposive sample of high-caseload facilities (e.g. busy clinics, CVUs and PVSUs identified through the caseload analysis), examining:
    - clinical management of rape and sexual violence (availability and correct use of PEP, emergency contraception, STI management);
    - adherence to survivor-centred principles (confidentiality, informed consent, non-discrimination, privacy);
    - child-friendly and disability-inclusive procedures;
    - quality of documentation, including use of the unified referral form.
- Use audit findings to develop **facility-specific improvement plans** that combine training, mentoring, supervision and targeted resource mobilisation (e.g. basic infrastructure such as private counselling rooms, lockable filing cabinets, ramps).

6.6 Further Important Considerations

Several cross-cutting issues emerged from the spatial, referral and case-management analysis that were not fully captured in maps, tables or resolution statistics, but were highly relevant for the design and sustainability of GBV system-strengthening in the five districts.

1. Seasonality, climate risk and infrastructure fragility

Flooding, washed-out bridges and degraded earth roads were not just background conditions; they periodically reconfigured the accessibility landscape, especially in Nsanje, Phalombe and low-lying parts of Mzimba. During the rainy season, average travel times and costs could spike well beyond the modelled values, and entire groups of villages were effectively cut off from clinics, PVSUs and courts for weeks at a time. Any intervention based on this assignment such as mobile outreach, circuit courts or survivor transport

support needed to be explicitly timed around these seasonal access windows and aligned with district disaster risk management plans.

2. Transition from project data to routine information systems

Much of the analytical power in this assignment came from one-off, GIS-enabled data collection using Kobo and spatial overlays. Routine GBV data systems, however, remained heavily paper-based, fragmented across sectors and inconsistent in definitions. There was a real risk that, without deliberate follow-up, the maps and dashboards produced by this study would become static "project outputs" rather than living planning tools. Further work would be required to embed key elements—TA of origin, basic referral pathways, GPS/TA coding, unique case identifiers into HMIS, police registers, social welfare case books and any emerging GBV modules in DHIS2 or other MIS platforms.

3. Equity and disability inclusion beyond simple physical access

While just over half of mapped facilities reported being physically accessible to persons with disabilities, around one-third explicitly reported that their buildings were **not** accessible, and many more did not meet minimum standards in practice (ramps, handrails, accessible toilets, firm paths). The analysis also did not capture communication barriers (e.g. sign language, accessible information formats) or staff capacity to engage with survivors with intellectual or psychosocial disabilities. Future investments should therefore go beyond infrastructure retrofits to include co-design with Organisations of Persons with Disabilities (OPDs), disability-sensitive protocols, and monitoring of who is actually using services not only whether a ramp exists.

4. Community dynamics, norms and informal dispute resolution

The data showed that a large proportion of "GBV-related" cases were resolved at CVU and community level, often involving family misunderstandings, extra-marital affairs and child neglect. While this confirmed the central role of community structures, it also raised important questions about **norms, power and safeguards** in informal resolution: whose interests are being protected, to what extent women and girls can decline mediation, and whether serious violence is being inappropriately channelled away from formal justice. Further qualitative work and training would be needed to ensure that community-level settlement remains survivor-centred and does not reinforce harmful gender norms.

5. Financial and institutional sustainability of key innovations

Several recommendations including mobile courts, mobile GBV outreach and the Survivor Support Fund (SSF) offered strong potential to reduce distance and cost barriers, but their sustainability depended on broader institutional arrangements. For the SSF in particular, long-term viability required a **hybrid financing model** (district budget lines, MICGBV/partner seed capital, modest CSR contributions, and earnings from community-run IGAs earmarked for survivor support), combined with tight eligibility criteria, standard benefit packages, voucher-based transport, and district-level oversight. Without these design elements, there was a risk that well-intentioned financial support mechanisms would either collapse when project funding ended or become vulnerable to misuse.

6. Monitoring, learning and iterative adjustment

Because of data-quality limitations (inconsistent definitions, outliers, missing values), the figures in this study were best treated as **operational estimates** rather than precise surveillance statistics. This implied that the rollout of recommendations should be coupled with an explicit monitoring and learning agenda: annual updates to GIS layers and dashboards, routine data-quality checks, and periodic sense-making sessions at district level to review patterns (e.g. travel times, referral completion, court progression) and adjust interventions accordingly. Over time, this iterative use of data could be more transformative than any single investment in infrastructure or training.

7. Ethical, safeguarding and "do no harm" considerations

Finally, any expansion of GBV services or referral pathways needed to be carefully designed to avoid unintended harm. Enhancing access without parallel investment in confidentiality, survivor-centred practices, and staff supervision could increase disclosure but also risk breaches of privacy, retaliation, or secondary victimisation. Likewise, strengthening data systems without robust safeguards could expose

sensitive survivor information. The next phase of work should therefore embed safeguarding standards into all technical support whether on GIS, referral protocols, transport funds or mobile services and ensure that survivors' safety and agency remain at the centre of system reforms.

6.7 Conclusion

Overall, the evidence shows that **GBV services in the five districts are active but uneven**. They are spatially clustered, expensive and time-consuming to reach from certain TAs, and only weakly connected to the formal justice system. Community and frontline providers resolve a large share of cases, while courts remain a narrow, structurally constrained bottleneck. Data systems are too fragmented to reliably reconstruct survivor journeys or to hold the system to account.

At the same time, the new **geospatial database, web maps and dashboards** offer a practical foundation for **evidence-based planning**. The recommendations above therefore constitute a **coherent systems-strengthening agenda**, rather than a list of isolated interventions. If the recommendations above are implemented, particularly spatial rebalancing, transport support, referral standardisation and data institutionalisation the GBV system in the five districts can move from a **reactive, facility-centric model** to a more **proactive, survivor-centred and spatially equitable network**.

By **rebalancing where services sit**, **reducing the cost and time required to reach them**, **standardising and digitising referral and data systems**, and **deepening the equity and quality lens**, MICGBV and its partners can shift from a reactive, facility-centred response to a **strategic, location-aware GBV system**. Such a system would be better able to reach survivors in the hardest-to-serve TAs, sustain their engagement across the full referral chain, and deliver outcomes that are both more equitable and more accountable.