*Building Partnerships,*
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# WHAT NEEDS TO BE DONE TO HAVE A HOLISTIC AND MULTI-SECTORAL RESPONSE TO THE NEEDS OF SURVIVORS OF GBV?

**Panel discussion on "Elimination and prevention of all forms of violence against women and girls" at the Commission on the Status of Women - Fifty-sixth session – 29th February 2012**

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# Situating current responses

- Data on VAW and its impact on health, productivity, economy are well known

- Services are few
  - Limited in scope, range and quality
  - Most models – NGO projects
  - Few models provide the 'how to' of developing cross-sector services or of bringing to scale

So, what is needed? - *this presentation*

  - Focus on gaps and challenges
  - Focus on national systems - the primary foundation for sustained scale up of services

# The context?

- VAW – different manifestations, severity and chronicity by different women
  - Need for different types of services
  - State responsibility to avail these services
  - States have abdicated this responsibility

- Different forms of GBV inter-connected,
  - Survivors tend to experience multiple forms of GBV
  - Current services and legislation focus on SV
  - Responding to only one form of SV will not respond to the needs of women

*The false dichotomy created between different forms of GBV will compromise development of holistic services and the response to needs of survivors*

*Gaps and challenges?*

# Responsibility and accountability?

- Lack of responsibility, accountability and strong leadership
  - No institutional home for GBV
  - Ministry specific mandate (health, law/order/justice, social services) is not cross-sectoral
  - No joint planning at government level

- Multiple, diverse and un-coordinated stakeholders
  - Multiple private and civil society organizations (prevention, care treatment; service delivery, capacity-building and advocacy; legal, health, social services; policy, research, programming)
  - Stakeholders in competition
  - Parallel and uncoordinated funding and efforts by DPs reduce opportunities for leveraging on resources, technical and human capacities

# Service delivery approaches?

- Is it, 'either/or' for different approaches? Or is it a the most suitable combination?
  - 'one-stop' vs 'integrated' models or both for different settings?
  - Consideration for models that are compatible with all sectors

*One-stop services*: Feasible for high population, high density, high resource programmes BUT challenging for scale up in limited resources setting, rural set-ups

*Integrated services:* Allow for scale up as part of integrated health care systems (personnel, commodities, drugs, follow up) and can be brought to national scale with accountability indicators

- Purposes of the different models
  - Funding agency preferences? Or in-country needs, resources and ability to sustain post external financing?

# Scale up and standards?

- Defining scale up of VAW
  - Different VAW manifestations require different service packages and targets e.g. Chronic SV in the homestead cannot be treated the same as a SV event; Severe IPV requires different services
  - GBV programme outcomes are not agreed on
  - There exist no coverage indicators across different sectors

- Joint planning (sectors/stakeholders)-currently challenging

- Lack of policy guidelines and standards
  - Some sector guidance available in some countries
  - No cross-sector guidance for evidence and for survivor management across sectors

# Local realities?

Limited cognizance of local realities in service devt' as primary to sustained service delivery

- Legislation/services rely on forensic evidence - possible?
  - e.g. FORENSICS - DNA infrastructure, functional evidence chain, criminal data bank, follow-up mechanisms
  - Proper documentation more likely to result in justice vs forensic evidence – *Jewkes et al, 2009*
- Commodities and supplies at desired service points?
  - Drugs e.g EC, PEP; secure crime scene investigation tools, data tools at point of care
  - Consideration for: costs of addition into supply management chain, potential for stockouts when developing service models
- Limited funding investment into availability of supplies

# Providers?

- Standards for building human resource capacities
  - No national training curricular
  - No cross-sectoral training requirements
  - Training fragmented and focused on in-service (expensive, does not institutionalize GBV knowledge and skills, not sustainable)

# Measuring success?

- No common indicators that are sector specific, and that are cross sectoral
  - Lack of data collection tools, mechanisms and responsibility
  - Data collation to national level reporting is lacking as there is no responsibility
  - Data for medical/legal purposes not highly valued

# Recommendations

- Well resourced institutional homes with RESPONSIBILITY, AUTHORITY and ACCOUNTABILITY for GBV
  - Stakeholder coordination
  - Harmonized service delivery
  - National reporting framework

- In-country coordination mechanisms urgently needed
  - Stakeholder coordination meetings
  - Joint planning
  - Information exchange and sharing

- Common consensus on outcomes, coverage for different service packages and multi-sectoral indicators


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