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Elimination and prevention of all forms of violence against women and girls

PROVISION OF SUPPORT SERVICES TO WOMEN AND GIRLS VICTIMS/SURVIVORS OF VIOLENCE

by

NDUKU KILONZO
Executive Director
Liverpool VCT, ***an indigenous Kenyan organization***
Kenya

Background:

Data that as many as seven in ten women in the world report experiencing physical and/or sexual violence at some point in their lifetime[1]. The impact of violence against women on health, productivity, economy and therefore a country's ability to achieve its goals is documented. However, services are few and of limited scope, coverage and quality in many countries around the world[2]. A range of sectors are required to deliver protection, support and rehabilitation services to survivors of gender-based violence including health, law/order/justice and social services[3, 4].

Expanding services to reach all women implies bringing sector-specific and cross-sectoral services to scale. However, there currently exist limited data, few models and operational research that provide evidence for the 'how-to' develop and deliver cross-sectoral services. At country level, many VAW services have been implemented by civil society as projects that run parallel to government services. It is essential to recognize the role of civil society in taking up the roles that governments have abdicated. Civil society also provides for generation and piloting of new models of services, setting quality of care models and in extending reach to marginalized and underserved populations. **However, where projects cannot be replicated within the national infrastructure, scale up and sustained service delivery is not possible.**

This paper draws on the limited available evidence[3, 5-7] and more widely on my experience in implementing services for sexual violence in Kenya through a research-policy-practice cycle [8, 9][10] developed by LVCT and is embedded in working within national frameworks (annex 1). It attempts to answer the question, *"What needs to be done to have a holistic and multi-sectoral response to the needs of survivors of gender based violence?"* It thus focuses on gaps, challenges and considerations for national systems that would facilitate scale up of services. It also is limited to response services for survivors of VAW. It a) explores the context of VAW services, b) draws on literature from the scale up of health care services to outline gaps and challenges existing in VAW responses and c) makes recommendations.

Setting the context

Violence against women is experienced in diverse manifestation, severity and chronicity by different categorizations of women based on their age, socio-economic status, marital status, geographic location and occupations. Different forms of VAW is often perpetuated within the family. The community justifies and supports harmful traditional practices. Institutional violence against women in education and health services and workplaces has been documented and VAW is often seen as a 'private' issue, and responses appear to be informed by this perspective.

States have a responsibility to enact and enforce laws that protect human dignity. Where protection fails, there is a responsibility to avail the requisite services to address the physiological, psychological consequences and ensure positive justice outcomes for survivors. However, states appear to have abdicated this responsibility. Few countries have the policy and legal environments and service infrastructure to respond or influence uptake of health, social and justice related services by survivors. Support services are of limited scope, coverage and quality in many countries around the world.

Separation of sexual violence from other forms of VAW is increasing. Service delivery and legislation in both conflict and non-conflict settings is focussed on sexual

violence and does not always include other forms of violence. The challenge is partly in the resistance to legislating broader gender-based violence such as seen in the example of Kenya. Prior to the Sexual Offences Act 2006, Kenya had a weak legal framework for addressing sexual violence, with various clauses in the Penal Code, Criminal Code and Evidence Act. In September 2004, a motion on sexual offences was tabled through a Private Members Bill[8]. The Parliament, predominantly male (93%), rejected the inclusion of three elements that were originally included in the bill: marital rape, arguing for implied consent for sex in marital relationships and female genital mutilation, arguing for its acceptability as a cultural traditional practice. Different forms of gender-based violence are interconnected. Evidence suggests that survivors of sexual violence are likely to experience other forms of violence, which exacerbates the psychological, reproductive health and other physiological consequences. **The false dichotomy created by these legal and health driven separations has the potential to compromise the development of holistic services and the response to the needs of survivors.**

Gaps and challenges in VAW services:

Lack of responsibility, accountability and strong leadership at country levels: Data suggests that for scale up of services to be achieved, strong leadership and political commitment is a requirement. Strong leadership is accompanied by authority for decision making, responsibility for coordination of implementers, a clear reporting framework[12]. Many countries do not have a responsible authority or an agency for VAW. Thus, there is **no accountability** for coordination of the different sectors, setting cross-sectoral standards and advocacy for a resource envelope. The mandate for responding to VAW is often with Ministries (Health, Police, Justice, Social services) which develop sector specific responses in line with their Ministry responsibilities. These ministries do not speak with each other, do not undertake joint planning and have no common referral pathways. The result is the lack of common frameworks that outline common points of reference, processes, roles, referral pathways, evidence requirements and training.

Buy-in is compromised by multiple, diverse and uncoordinated stakeholders: In addition to lack of an 'institutional home' and therefore government leadership, **there is often multiple and complex range of private and civil society organizations within countries that are un-coordinated and in competition**. They range the spectrum of prevention, care and treatment; service delivery, capacity building and advocacy; legal, health and social services; policy, research and programming. **Parallel and uncoordinated funding streams and efforts by development partners reduce opportunities for leveraging on resources, technical and human capacities to effectively respond to the needs of survivors of VAW**.

The drive for single rather than combinations of approaches is problematic: It is increasingly recognized that a multiplicity of approaches that is dependent on needs of the end user are necessary to expand services that are acceptable [3, 5]. Colombini and colleagues[3] outline advantages and challenges of a spectrum of services ranging from one-stop to integrated in various forms. Increasingly there seems to be debate between one-stop and integrated services with different funding agencies promoting specific models without due consideration for how best to combine their strengths and minimize their differences to develop enhanced models. For instance, one-stop services are often found at secondary and tertiary levels of care which are feasibly in high population, high density, high resource facilities/urban centres. They thus have limited ability for increased coverage [13, 14] particularly in rural set-ups and in settings where health systems are weak and resources limited. Integrated models offer opportunities for decentralized service delivery points, but are constrained by weak provider competencies, poor infrastructure and documentation and attrition through the

referral pathway [14]. **Decisions should not be 'either/or', rather focus on the optimal combination to serve in-country purposes.** Debates that posit different models against each other need to be cognizant of local realities and of cross-sector considerations. For instance, law, order and justice sector services are embedded in public systems with limited maneuverability for parallel projects. Thus, VAW models (health service, community follow up or legal pro-bono services to survivors) need to be able to link with and work within police systems as prosecution and defence in court are the duty of the state.

Programme development elements:

There is a need to define what scale up of VAW services means: **Currently there exist no agreed on description of the types of services required for different manifestations and severity of VAW.** Outcomes of VAW responses are not defined or agreed upon thus programmes are not guided. There also lack generally agreed on targets towards which in-country planning and responses is geared. For instance, coverage as a defined indicator used in health programmes provides a premise for advocacy, implementation planning and evaluation. **There exist no targets and service packages that take into consideration of variations in definitions of VAW, measuring chronicity and the differences across different points of service delivery in the health, law, order and justice sectors.** However, this lack of guidance on service targets, means that programmatic interventions may not be focused on the goals of sustained expansion.

Planning VAW services is challenging without strong leadership: **The lack of an institutional home for VAW, the multiplicity of civil society stakeholders and limited coordination of service providers mean that joint planning (between health, law/order/justice and social services) is unlikely to be achieved.** The potential impact at service levels is often inadequate and compromised management of evidence and of the survivor, who both have to pass through different systems to end up in the justice system. There has been increasing advancement of sector specific development of services for different forms of GBV in many resource limited settings such as health sector services, few legal or pro-bono support services. This is essential. However, in the long-term it is not sustainable, if only one sector is implementing service delivery and other sectors to which survivors and evidence is referred are non-functional.

Implementing VAW services is possible, but faces a number of challenges:

The current VAW responses include a complex combination of both the lack of, and availability of sector specific and cross-sectoral policy guidance and standards. This varies by country. The law, order and justice sectors have standardized operating procedures to govern crime scene investigations, evidence collection, storage and management. However, few of these procedures are tailor made for VAW in its unique requirements such as handling evidence health sector evidence and the need for privacy by survivors. Some countries also have rules and regulations to operationalize sexual offences legislation, which do not necessarily apply to other forms of GBV, thus increasing the separation of services. Where legislation exists, enforcement is poor. Health worker attitudes (discussed further below) towards VAW as a 'private' issue also impact negatively on the ability of survivors to present and get quality care in facilities.

While VAW policy action and where applicable legislation has been passed, a primary challenge to implementation of services is the lack of cognizance of the local in-country realities. For instance, forensic evidence collection and DNA testing are increasingly embedded in sexual offences and broader GBV legislation. They are seen as

important for securing positive justice outcomes. However, most resource limited settings lack requisite facilities for a functional evidence chain, a criminal data bank, decentralised DNA capacity and follow-up mechanisms. Offenders' registers do not exist, and thus any DNA matching would be problematic [15], compromising the purpose for which they are promoted. Further evidence suggests that proper documentation is more likely to result in a positive justice outcome than DNA[16]. Additionally procedures for maintaining a secure chain of evidence (documentation, management, handover and accountability of evidence) across the different sectors are lacking, providing legal challenges to attaining positive justice outcomes for survivors.

Expansion of services requires availability of commodities and supplies. Health sector services require supplies for examination and treatment of injuries, drugs for prevention of sexually transmitted infections including HIV, pregnancy in the context of sexual violence, availability of nationally recognized data collection tools at the point of care. Within the legal, order and justice and social services, availability of secure crime scene investigation commodities, logistics for maintaining the integrity of the evidence chain (collection, management, documentation) and tools for data collection are required, but often are not part of sector resource envelopes**. In most countries commodities and supplies for VAW are not built into the essential packages of health nor in supply chain management systems. There is limited investment and funding in ensuring GBV commodities and supplies as part of national systems.** Thus, even where standards are available, the lack of commodities and supplies necessary for coordinated implementation and actual service delivery translates to inability to expand services.

Provider competencies are a key aspect to the quality of care. Currently few countries have national sector specific training curricula and fewer still have standardized cross-sectoral training curricular. Such cross-sectoral training would include management of evidence, legal provisions, evidentiary requirements, management of evidence, standardized referral pathways and referral tools. These are elements common to all sectors that provide VAW services. Providers' training is also not institutionalized as part of primary provider training for instance, in police training schools, in social worker training or in medical training school. **The popular and well-resourced and fragmented in-service provider training is expensive, does not institutionalize GBV knowledge and skills and cannot be sustained in the long run, hence compromising the ability to expand quality services.** Further, training for VAW services does not often explore values and deconstruct values of providers that perpetuate stigma and discrimination in service delivery points.

Measuring the success of expansion of VAW services remains problematic: Developed countries that have legislation they also have sector specific data, data collection tools and mechanisms. **Many resource-limited settings do not have common indicators within sectors and across sectors to guide the development of data tools and mechanisms for reporting back to the national level.** For instance, health sector management information systems may collate data on numbers of survivors seen and disaggregated by age and service offered. VAW requirements for additional legal documentation by health providers in contexts where they are few and far stretched has implications for the quality of reporting. Health and social provider training often lacks training on data tools. Police provide national reports on numbers reported and the Justice system will provide its own data. Collation of these different data does not exist, as there is often no responsible authority for VAW.

Considerations/Recommendations

1. VAW responses require well-resourced institutional homes with mandate and authority for sector and stakeholder coordination, harmonized service delivery and

national reporting frameworks. Lobby for agencies in-country to be responsible for VAW is necessary.

2. In-country coordination mechanisms for the different stakeholders are urgently required.
3. Opportunities for different stakeholders to meet and define and create consensus on outcomes, coverage of the different types of services (to meet the often very diverse needs of survivors), and on multi-sectoral indicators for GBV services, should be harnessed.

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ANNEX 1: The LVCT research-policy-practice cyclic model

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