Responding to GBV in countries with limited capacity

Experiences from Central African Republic, Libya, Pakistan, Myanmar, and Papua New Guinea

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What is Capacity?

- Lots of discussion on “building capacity” in humanitarian contexts
- Buzzword
- Is it an actual priority in humanitarian setting?
- What do we actually mean when we talk about capacity?
Why these 5 countries?

- Central African Republic
- Libya
- Pakistan
- Myanmar
- Papua New Guinea
Central African Republic

- **Type of Emergency:** Conflict/Neglect
- **Primary GBV Type:** Sexual Violence
- **Prevention?** Climate of insecurity so no activities
- **Response?** Inadequate resources in the capital. Where most survivors are? Almost nothing
Libya

- Type of Emergency: Conflict/Dictatorship
- Primary GBV Type: Sexual Violence/ IPV
- Prevention? Climate of insecurity restricts women’s movements
- Response? Ad hoc non-professional,
Pakistan

- Type of Emergency: Conflict/Natural Disaster

- Primary GBV Type: IPV, Sexual Violence, Honor Killings

- Prevention? Mainstream GBV through other sectors, engage CBOs and women’s rights organizations

- Response? GBV coordination, Weak health response, engage through child protection, overstretched – can’t cover the needs
Myanmar

- Type of Emergency: Conflict/Neglect
- Primary GBV Type: Sexual Violence, IPV, Trafficking
- Prevention? Some anti-trafficking, proposed new VAW laws
- Response? GBV Coordination, Humanitarian response weak – ignored GBV, antiquated laws (1860s British Colonial)
Papua New Guinea

- **Type of Emergency:** Neglect, “Humanitarian Like”, Society of violence

- **Primary GBV Type:** Sexual Violence, IPV

- **Prevention?** A lot of police programming but still low trust in police, perpetrators

- **Response?** Ad hoc psychosocial, health sector leads due to MSF
### GBV Capacity as seen from “above”

<table>
<thead>
<tr>
<th></th>
<th>CAR</th>
<th>Libya</th>
<th>Pakistan</th>
<th>Myanmar</th>
<th>PNG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Capacity</td>
<td>LOW</td>
<td>LOW</td>
<td>MIDDLE</td>
<td>LOW</td>
<td>LOW</td>
</tr>
<tr>
<td>Financial resources</td>
<td>LOW</td>
<td>HIGH</td>
<td>LOW</td>
<td>MIDDLE</td>
<td>MIDDLE</td>
</tr>
<tr>
<td>Human Resources</td>
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<td>MIDDLE</td>
<td>MIDDLE</td>
<td>LOW</td>
<td>LOW</td>
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<tr>
<td>Coordination</td>
<td>LOW</td>
<td>LOW</td>
<td>MIDDLE</td>
<td>LOW/MIDDLE</td>
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</tr>
<tr>
<td>Political Will</td>
<td>(HOL)LOW</td>
<td>(HOL)LOW</td>
<td>(HOL)LOW</td>
<td>(HOL)LOW</td>
<td>(HOL)LOW</td>
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<tr>
<td>That Certain Something</td>
<td>LOW</td>
<td>LOW</td>
<td>LOW</td>
<td>MIDDLE</td>
<td>LOW</td>
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</tbody>
</table>
## GBV Capacity to care for survivors

<table>
<thead>
<tr>
<th>Category</th>
<th>CAR</th>
<th>LIBYA</th>
<th>PAKISTAN</th>
<th>MYANMAR</th>
<th>PNG</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH</td>
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<td>MIDDLE</td>
<td>LOW</td>
<td>LOW</td>
<td>LOW/HIGH</td>
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<tr>
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<td>LOW</td>
<td>LOW</td>
<td>LOW</td>
<td>NONE/HIGH</td>
</tr>
<tr>
<td>SECURITY</td>
<td>NONE</td>
<td>NONE</td>
<td>NONE</td>
<td>NONE</td>
<td>LOW</td>
</tr>
<tr>
<td>LEGAL/JUSTICE</td>
<td>NONE</td>
<td>NONE</td>
<td>LOW</td>
<td>NONE</td>
<td>LOW</td>
</tr>
<tr>
<td>SOCIO-ECONOMIC</td>
<td>NONE</td>
<td>NONE</td>
<td>LOW</td>
<td>NONE/LOW</td>
<td>NONE</td>
</tr>
</tbody>
</table>
Despite limitations on capacity – in some places, a minimum multi-sectoral response to GBV survivors can be put in place.
What has worked?

- CAR – Engaging youth in community protection teams to provide referral information

- Libya – address lack of technical supervision through skype calls from European diaspora, support and train volunteer women’s services, engage with former prisoners

- Pakistan – entry via child protection, build capacity of women’s orgs on GBViE, advocacy to government for GBV work acceptance.

- Myanmar – focus on sectoral response, donors on board before IOs, protection monitoring lead to healthcare

- PNG – screen for IPV in prenatal clinics in VCT clinics due to HIV/AIDS work and refer to MSF – focus on health sector
Recommendations

- Response must be more appropriate - what is needed on the ground? Start there.

- Can we enforce minimum standards like the MISP to improve response?

- Response must be timely - IASC Guidelines out for 8 years yet still hear GBV not life-saving

- Must have “champion” agency. One active agency can push enough to make it happen – ex. MSF in PNG.
Recommendations

- Build pool of available trained and qualified GBV staff for all stages of the humanitarian response

- Analyse existing capacity for GBV response in each context to meet the gaps ex. Pakistan

- In the absence of GBV programming, start coordination and promote response through other sectors ex. Myanmar

- Good response requires short, medium and long term interventions. 6 months won’t bring change!
Recommendations

- Community sensitivity around GBV should not be a reason to not engage - should be indicator for greater interventions and for innovative approaches.

- Ensure available support to national staff, including self care (see food for thought)

- Work to gain political will and commitment from senior management and key stakeholders immediately and constantly.

- For forgotten emergencies, need more advocacy at national, regional and global level simultaneously?
Food for Thought

- Why don’t we have better support and guidance for GBV responders? Particularly those “national staff” who bear the brunt of the work?

- Must always fight for GBV – GBV staff get shorter contracts, lower grades – is it the “feminization” of this sector?

- Can we build capacity when our own capacity is reduced due to burn out rates?