Briefing paper

Policy and practice requirements for bringing to scale sexual violence services in low resource settings

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Background

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 sexual violence on health, productivity, economy and a country's ability to achieve its development goals is well documented [2]. States have a responsibility to enact and enforce laws that protect their citizens from sexual violence. Where protection fails, there is a responsibility to provide survivors with the requisite services to address the physiological, psychological consequences and ensure they receive positive justice outcomes. However, few countries have the policy, legal environments and service infrastructure to respond or influence uptake of health, social and justice related services by survivors of sexual violence [3]. For example, 127 countries still do not have effective laws on marital rape even though it is a crime under international law [4]. Cultural beliefs and societal responses can be major barriers to victims seeking help post assault. A range of sectors are required to deliver services to survivors of sexual violence including health, criminal justice and social services [5, 6]. In many countries around the world, post rape care is often fragmented, of limited scope, coverage and quality, focusing mainly on immediate clinical care with poor medico-legal linkages [3], with limited attention given to mental health needs of survivors and service providers [7, 8]. Follow up and long-term management of sexual and reproductive health including HIV outcomes of survivors is severely lacking.

Good quality sexual violence care involves the integration of multiple services and sectors, including health, social welfare, education, and justice sectors. Each of these sectors has different responsibilities, standards, mechanisms for service delivery and reporting requirements. Increasing coverage of sexual violence services requires expansion and scale-up of all required services to all survivors, in accordance to set (international) standards across all the sectors [9-11]. Often the first point of entry for a survivor for sexual violence care and support is via the health sector. Sexual violence is often not prioritized by the health sector or any government sector, and few, if any, of the most basic sexual violence services are institutionalized within sector plans, budgets and management information systems, particularly in low and middle income countries. Often sexual violence services are delivered as projects by non-government providers [12], potentially constraining the services access to national supply systems, budgets and other resources that could make scale up a reality. Limited evidence exists for the 'how-to' deliver and expand both sector specific and cross-sectoral service for post rape care.

Scaling up health care, has for the most part focussed on replicating specific cost effective interventions and achieving high coverage rates of services. A different emphasis is emerging in the literature [13] which focuses on 'the how to scale up' [14-16]. Various authors review the political, social, and environmental contexts in which scaling up occurs to identify some policy and practice considerations for successful scale up of health programmes. Strong leadership and governance, understanding of local realities, applying a multiplicity of strategies, and incorporating research into implementation through a 'learning by doing' approach are some key elements necessary for sustaining expanded services [15, 17]. Hanson et al, [13] summarise the following as key critical issues in scaling up health policies and interventions: the cost of scaling up and resources required to expand service delivery, including the trade-offs that may arise between equity and efficiency; the constraints to scaling up that operate at different levels, from the household and community level through to the service delivery, strategic and national policy, and cross-sectoral levels; the potential synergies and deleterious health system effects of global health initiatives; and the opportunities afforded by novel approaches to service delivery, including making use of private sector delivery channels. Savitha et al, [14] suggest some key dimensions for expanding health services. These include: defining scale up in terms of results, timelines and strategies; identifying the types, amounts of resources required and existing absorptive capacities; planning and implementation; and monitoring and evaluation.

Integration and sexual violence services

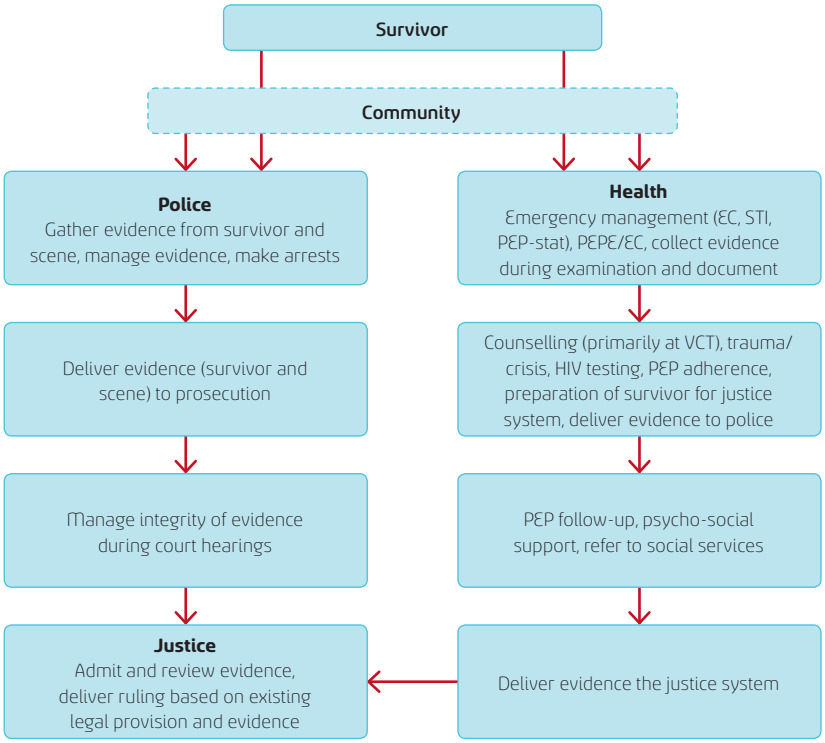
A survivor of sexual violence requires the health sector, criminal justice sector and the community for the range of services necessary to achieve optimum health and justice outcomes. Resource poor settings are characterised by limited services and inadequate legal support for survivors of all forms of gender based violence [18]. Sexual and gender based violence and HIV are linked. Research from around the globe, and in particular from low and middle income countries where the burden of HIV is the greatest, shows that sexual and gender based violence place women and girls at increased risk for HIV. This risk occurs both through direct infection as a result of rape, but also indirectly as a result of women's unwillingness to subordinate themselves to men, increasing both their HIV risk and risk of violence. Inter-sectoral collaboration lies at the core of a comprehensive response to the management of SGBV survivors. Ideally the relationship between the different sectors that would provide services for sexual violence and gender based violence should be overlapping and complementary [19]. In reality, services in most settings are designed and delivered primarily for sexual violence, and as sector specific without necessary consideration of cross-sectoral requirements for a comprehensive response.

This briefing paper draws on this body of work to explore the policy and practice requirements for delivering and expanding comprehensive multi-sectoral care for survivors of sexual violence. Whilst its focus is on sexual violence, it hopes to provide the impetus for development and expansion of a multi-sectoral response for broader gender based violence as well. In drawing on health sector data, the paper suggests that health sector considerations are also relevant to the scaling up of legal, justice and social welfare sector services. The paper draws on the experience of LVCT, a local Kenyan organization that has supported expansion of service delivery in Kenya.

The paper first outlines services required for care and support for SGBV survivors. (Figure 1). It then discusses how to develop the necessary pillars needed to provide and scale up comprehensive post rape care, and how to measure the extent to which expansion has been successful.

Comprehensive post-sexual violence care: what is needed?

Figure 1: What is required to deliver comprehensive post-sexual violence care



(Source: LVCT)

A short summary of the roles and responsibilities of each sector detailed in Figure 1 are provided below:

The health sector: is at the nexus of prevention, treatment and rehabilitation following sexual violence. It should provide clinical treatment, preventive therapy, psychological support, and information and advice [20-22]. It should also collect, store and analyse evidence of the effects of the violence and deliver that evidence to the criminal justice system for purposes of its investigations and use in any trial [2]. In many countries health services are few, models diverse and quality of care unregulated. The health system is organized into both vertical and horizontal management approaches premised on health sector reforms. Often HIV and STI services are delivered through vertical approaches that are managed centrally with specialized machinery for human resource development, logistics, facilities and training. Other reproductive health, physical and mental trauma and follow up care are delivered through horizontal approaches that focus on public health, decentralized management and shared infrastructure [20]. Mental health services are generally under-developed and few in number, with limited focus on sexual violence trauma and care [8]. Even in these cases, mental health management solely applies to initial point of contact diagnoses, overlooking follow up care and management of longer term effects. Similarly, child protection services are scarce, with health sector responses to sexual violence generally geared towards adult women survivors [23]. The health sector also has a fundamental role in the prevention of sexual violence through appropriate primary health care responses and early screening for child abuse and neglect, and intimate partner violence.

The legal, police and justice sector(s): There has been an increase in sexual violence legislation, especially sub-Saharan Africa in recent years [3]. The aim of sexual violence legislation is to protect the fundamental rights of persons to bodily integrity through punishing and prosecuting perpetrators as an approach to preventing sexual violence and meting out justice. The separations of the roles of the legal, police and justice sectors are country specific. However, overall sector specific responsibilities include:

- Police conduct investigations to collect and document evidence from the geographic scene of the crime and the statements from the survivors; managing and conveying this evidence and that from the health sector to the justice sector; and to make arrests.
- The judiciary draws on all these forms of evidence and legal provisions to make rulings.

The justice sector needs to, as much as is possible, truncate or hasten the lengthy legal proceedings which are often a deterrent to health providers' commitment to documentation and forensic management, in avoidance to being tied down and following through the legal process.

Community responses: Community driven responses including rehabilitative services, advocacy and programming for prevention of sexual violence, uptake of services and zero tolerance are largely undertaken by civil society. Some community based responses are situated within line ministries such as social services or have direct links to health, legal, police and justice services. Few models have been tested nor their potential for scale up explored, particularly interventions for the prevention of sexual violence [23, 24]. Countries often lack a coherent national approach to advocacy, limiting the ability of advocacy programmes to influence national mechanisms such as planning and prioritization processes, programme implementation, financing, reporting mechanisms for sexual violence responses across and within sectors.

Developing necessary pillars for a multi-sectoral response

The essentials in brief: A multi-sectoral approach guided by the following principles is essential.

- *National policy* and a guiding framework that mandates a multi-sectoral response for sexual violence;
- *Strong leadership* includes authority for stakeholder coordination and mandate for reporting by a government agency;
- Investment into building a body of ***evidence for service models*** and policy action;
- Decision on service delivery approaches, data collection and management systems and provider capacities need to be informed by l***ocal realities***.

Strong leadership and governance

Strong leadership is accompanied by authority for decision making, responsibility for coordination of implementers, and a clear reporting framework [15]. In many countries different Ministries have responsibility for sexual violence in relation to their specific mandates (health, police, justice, social services). These Ministries often do not interact with each other regarding this mandate, do not undertake joint planning, do not commit to financing responsibility and have no common referral pathways. Thus, there is no accountability for coordination of the different sectors (including civil society actors), no mandate for monitoring adherence to cross-sectoral standards for management of the survivor and the evidence, and no responsibility within government for advocacy for a resource envelope for sexual violence services. In addition to the lack of an 'institutional home', a multiple and complex range of private and civil society organizations often exist within countries that are mostly un-coordinated and in competition. The services they provide range across 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 sexual violence [42].

In this regard, making decisions regarding resources required to expand service delivery may require trade-offs by national government leadership. This will need to be guided by clear policy and guidelines, which are currently lacking. Thus, vested responsibility for GBV should be specific. The unit, office or agency responsible, requires authority to coordinate the response within Ministries without being engaged in the sector specific mandates of service delivery. The authority to follow up on aggregated reports from sector sub-systems in order to provide the overarching picture for sexual violence and mitigate potential constraints of scaling up in the different sectors is necessary. The leadership level needs to be able to influence strategic and national policy decisions within sectors (health, police, justice, social services) responsible for sexual violence.

Building evidence for effective prevention and response approaches

Although research and training on responses to sexual violence have moved forward, evidence being presented at research meetings demonstrate that much is still needed in the different sectors in dealing with cases of sexual violence [25]. There exists limited investment in rigorous evaluation or implementation research on models for service delivery particularly in low resource settings. Although different models of health services for survivors are being tested, they are few [26]. These include models that offer health and legal services at one service point with providers 'coming' to the survivor, while others include delivery of the required range of services across different service points and/or by different providers in a facility [20, 21]. Innovative models to strengthen the often weak, but necessary multi-site linkages with external referrals to other specialized or non-health sector services[3] are being tested. For example, in Zambia, data demonstrated the safety and effectiveness of training police to deliver emergency contraception and showed improved referrals to health facilities for on-going care [27]. While HIV provides the dominant framework and financing for scaling up post rape care, particularly in sub-Saharan Africa, few studies provide strategies for delivering models of care that integrate sexual violence services into HIV programming [21].

Understanding local realities

It is increasingly recognized, that a quality service must incorporate a multiplicity of approaches that are based on the needs of the end user and guided by local realities [5, 28]. Colombini and colleagues [5] outline the advantages and challenges of different forms of service delivery. For example, they highlight that one-stop services are often located at secondary and tertiary levels of care in urban centres where there is a high population, high density living and facilities have relatively more resources. They note however such models' scope for increased coverage is limited [12, 29] particularly in rural setings and those where health systems are weak and resources limited [19]. Integrated models on the other hand offer opportunities for decentralized services, but are constrained by weak provider competencies, poor infrastructure and documentation and attrition through the referral pathway [12]. Debates that posit different models against each fail to recognize opportunities to harness different strengths of different models to develop an optimal combination of services that are cognizant of local realities and serve in-country purposes. The private sector in the form of private for profit and civil society organizations provides most services in resource limited settings. These channels require to be recognized within the national infrastructure and report in alignment to national requirements to synergize on expanded coverage.

Expanding service delivery

The essentials in brief

- Expanding service delivery needs to start with a clear and well communicated ***definition*** of the outcomes of the expansion and ***setting standards*** for all implementers to ensure uniformity;
- ***Implementing*** these expanded services needs to take into consideration service delivery mechanisms and entry points within the health, legal, police and justice sectors and how they can be linked;
- Implementation also needs to be premised on existing logistics and supply chain management systems for sustainable commodity availability;
- The presence of capable, well supported and mentored providers at service points is essential.

Defining scale up

The package of post rape care health services has been defined internationally and in-countries [9] with outcomes related to the health of survivors and positive justice. Drawing on existing guidance, these can be summarized into:

- Short, medium and long-term physiological health outcomes;
- Short, medium and long-term mental health outcomes;
- Positive justice outcomes within the shortest possible timeframe.

'Coverage' of services has been used in health programmes to set service delivery targets, either by population or geographic expansion [14]. Setting coverage targets for sexual violence health services would potentially provide guidance on service targets, and a platform for advocacy, implementation, monitoring and evaluation [30]. However, the concept of 'universal coverage' does not apply within the law, order and justice sector in the way it does for health. This presents challenges for setting and reconciling cross-sectoral targets for reaching and serving survivors of sexual violence.

Planning service expansion and setting standards

Service delivery by each sector to the survivor and effective linkages to the next service point require both sector specific and cross-sector standards. Sector specific standards include definition of standard operating procedures and tools for management of the survivor and the evidence. The health sector requires clinical management guidelines for physical and psychological trauma, STI/HIV and pregnancy prevention, evidence collection and management, as well as, mental health management guidelines outlining counselling and psycho-social support. The law, order and justice sector requires standardized operating procedures to govern crime scene investigations, evidence collection, storage and management of evidence in accordance to legal requirements. Social services require procedures for child protection and support. Some countries have some of these sector-specific standards existing in different forms [31, 32]. However, cross-sectoral standards are often lacking.

The development of standards for service delivery does not always take cognizance of local realities. For instance, sexual violence legislation and evidentiary requirements increasingly rely on forensic evidence and deoxyribonucleic acid (DNA) testing. They are seen as important for securing positive justice outcomes. Moreover, 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 [3], compromising the purpose for which they are promoted. Research also shows that securing a positive legal outcome is a complex process. A review of the literature on the impact of medico-legal evidence on legal outcomes found no significant relationship between legal outcome and detection of DNA, but that the documentation of injury was the strongest predictor of a positive legal outcome [33, 39, 40].

Implementing expanded services

- *Service delivery points and mechanisms:* Responsibility for delivery of services to survivors of sexual violence is often unassigned to any specific unit within the different sectors. For instance, in most sectors, no Division or Department of Government is responsible for reporting on sexual violence. There is inadequacy of statistics on the incidence and prevalence of sexual violence, given the long term mental and other health consequences of such violence. Thus, determining the level of unmet needs for services is compromised leaving policy makers and program developers rely on grossly under-reported cases of rape to plan the service response.

  There is often no assigned responsible unit for implementation of standards, investment in provider capacity development and functionality of sector specific and cross-sectoral systems. Referral pathways across sectors are often not clearly articulated and are not functional with no common tools, registers and follow up to ensure linkage of those referred to different sectors. 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. Each of the service units at decentralized (district or sub-national levels) in each of these sectors and among civil society provide different and disconnected services to the same survivor compromising optimal management. This fragmentation, is exacerbated by the development of sector specific services for different forms of GBV such as services for sexual violence, being separate from those of intimate partner violence in many resource limited settings). Further, different sectors appear to each develop services with no reference to other sectors to whom referral happens such as between health and legal services. While sector specific service development is essential, all sectors need to develop in parallel for system wide integration to be successful.
- *National logistics and commodities supply infrastructure:* Expansion of services requires availability of commodities and supplies [15]. Sustained and timely availability of products at the point of service delivery influences quality of care. Health sector services require supplies for treatment of injuries, drugs for prevention of sexually transmitted infections including HIV, pregnancy, post rape care kits for examination and documentation and availability of nationally recognized data collection tools at the point of care. Within the legal and justice sector, 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 not part of sector resource envelopes. For the social sector, provision of places of safety and commodities for the sustenance of these safe spaces for children and survivors is lacking. Lack of mechanisms for protection of survivors mean that they often go back to the environment in which the sexual violence occurred, thus increasing their risk of revictimisation. Most services in low and middle income countries do not have post rape care supplies in their government approved essential packages of health, in supply chain management systems, nor the cost of safe houses built into sector budgets. Overall, there is limited investment and funding in ensuring sexual violence commodities and supplies are part of national systems [34]. 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 at service delivery:* Currently few countries have national sector specific training curricula for management of sexual violence. Where curricula for provider (health, police, judicial and social services) training exist few comprehensively address:
  a) service provider attitudes [35] through designing value, and evidenced based curricular;
  b) deliverability of services through reporting mechanisms (data collection tools, structures and frequency) and supervision;
  c) training for all providers who are key to the service chain. For instance, health curricula will train clinical providers who undertake examination and documentation, but not include laboratory staff who analyze evidence, pharmacy staff and health records information officers; and
  d) addressing vicarious trauma in service providers.

Fewer countries have determined common competencies required by all providers across sectors and standardized cross-sectoral training curricular that include aspects of management of both the survivor and the evidence that would be common across all sections. These would include legal provisions regarding sexual violence, collection, management and delivery of evidence, appropriate use of common referral pathways and referral tools.

A key challenge to implementation is that 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 schools. The 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.

Measuring the success of expansion of sexual violence services

Data is essential for policy decision making, resource mobilization and allocation in government and advocacy. Sexual violence data in country is limited and often unavailable with no data collection tools or information management systems. Much of the existing research has limitations which impact on cross-study comparability, these are due to differences in definitions, research tools, methods and sampling used [36]. In some cases, sector specific data may exist. For instance, the health sector management information systems may collect and aggregate data on numbers of survivors seen. This may be disaggregated by age and service offered and where this is done ends as part of health systems data. Police may have number of reports made to them which end up as part of national police reports, and police statistics often present data on more than one crime in the same section, therefore making it difficult to get a clear picture on individual types of crime (e.g. rape/sexual violence/stalking). Where such systems exist, there are no common indicators from which sector sub-systems draw their data requirements, there exist no mechanisms to aggregate and no coordinating authority through which to channel the collated data. Another key gap is data on children, and perpetration.

The lack of a common country monitoring and evaluation framework that outlines indicators, data requirements from each sub-systems, frequency and reporting mechanisms has implications, including an absence of a national coherent data base that can be used to strengthen effective linkages across services; and national planning data against which policy decisions and national financing can be influenced. In addition, the requirements for legal documentation by health providers in contexts where they are few and far stretched often means poor quality of documentation and therefore reporting. Community services often have weaker data collection systems in resource limited settings and this applies to sexual violence services.

Resources and financing the sexual violence response

Little published research exists on aspects of costing and cost effectiveness of sexual violence services [37, 38]. Data required by sectors in negotiating resource envelopes such as the costs of implementing and delivering a multi-sectoral response to sexual violence, particularly in low income countries is lacking, thus sectors cannot effectively budget and make demands through national financing mechanisms. Advocacy data necessary to demonstrate the costs of sexual violence to the economy and different sectors, or added value of preventing sexual violence is absent. This poses a challenge to advocating for the inclusion of sexual violence services into national and local government budgets. The potential to establish and accelerate scale up of sexual violence services is hampered by the inability to make informed trade-offs regarding equity and efficiency of services due to limited knowledge of costs and few evaluated approaches.

Contextual issues, challenges and opportunities

High levels of poverty, stigma, diversity of culture, religious beliefs and language and use of alternative services, including traditional healers, are all potential challenges to the scaling up of sexual violence services in developing countries. All require attention when thinking through models, and how to adapt, test and implement them in different contexts [42].

What is needed to bring sexual violence services to scale in low resource limited settings?

What is needed to build the key pillars for a multi-sectoral response

1. A government agency/unit in a Ministry or semi-autonomous agency with the authority to coordinate other Ministries should be identified and have the responsibility for a multi-sectoral response for sexual violence. The mandate for national level aggregate reporting of sexual violence and responsibility for monitoring sector and civil society adherence to set guidelines for a multi-sectoral response should be vested in this unit. Resources for stakeholder coordination and standard setting are needed.
2. Long-term commitment and investment in research through existing research mechanisms to build the body of evidence required for a comprehensive long-term response. An implementation research agenda, with a focus on evaluation of existing and new interventions for sexual violence responses are urgently required. In addition to under researched service delivery areas, research on vulnerable groups such as children, costing and cost effectiveness, long-term support and care models in resource limited settings is needed.
3. Learning from existing approaches to scale up in resource limited settings, cross-country interactions and evaluation of successes, challenges and opportunities within other responses such as the HIV response will provide valuable learning.

What is needed to plan and implement expanded services

1. In-country consensus on the expected outcomes for scale up across different sectors is required. A range of packages of services whose delivery will attain the desired outcomes should be defined, documented and shared across the different sectors. Clear targets for service delivery coverage and uptake of services should be set and institutionalized within national frameworks across the different sectors that are involved in service delivery. These form the common goals for expanding services.
2. Both cross sector, and sector specific standards are essential.
   a) Cross-sectoral standards should be jointly developed, agreed and available on master reference document outlining: a) referral pathways and tools; b) management of survivors; c) minimum standards of evidence, collection and storage procedures that

guarantee admissibility in court as aspects of evidence management; d) maintaining a secure chain of evidence (auditability, handover and accountability of evidence across the sectors).

b) Sector specific standards should be developed. They however need to be harmonized with cross-sector standards.

3. Implementing expanded services requires a range of approaches:

a) Service delivery points require clarity of standards and reporting to effectively deliver services. Therefore each sector requires assigned responsibility with clear reporting lines for service delivery outcomes. To ensure effective linkages at decentralized service delivery level, a multi-sectoral coordination team drawing from each sector including health, police, justice to undertake joint planning, monitoring of services and evaluation against agreed on outcomes should be established. These teams should also form referral networks to facilitate survivor access to services. The functionality of such teams should be the responsibility of the agency responsible for coordination.

b) Models for service delivery need to be linked into the national commodities and supply chain management systems. Considerations for drugs and commercial post rape care kits during service expansion should include the costs, their level of priority in the country's supply chain management system and the continuity of sexual violence service delivery in the event of stock-outs. Procedures for meeting requirements for a secure chain of evidence should be institutionalized where locally assembled kits are recommended.

c) The development of a curriculum and subsequent training needs to be two-fold: first, sector specific national training curricula that prepare providers in each sector. For instance health sector would include clinical evaluation and management; legal documentation; mental health care training for counselors and psychologists; scene management for police etc. Second, cross sectoral training modules that address common elements of service delivery should provide standardized information and skill in evidence collection and management; survivor referral and linkages; legal requirements; and justice processes. Both forms of training should take into consideration the type/complexity of technical skills necessary in comparison to skills required in each sector, duration required to train providers, data collection and ongoing mentoring and supervision systems needed.

d) Investment in delivery of training for providers should aim to provide a minimum information and skill level for all providers to be trained, and address vicarious trauma in service providers. Approaches based on a cascading rather than classroom based training have been identified as less costly, with the potential to deliver transferable skills to large groups of providers on a continuous basis. This serves to avail a pool of trained resource persons and forms a realistic platform upon which to continuously equip providers with competencies and reduce attrition of the trained frontline providers, thus enhancing programme sustainability. Where applicable, joint training of different providers should be offered. Country planning for integration of sexual violence training into pre-service rather than in-service curricular should be a concomitant approach.

What is needed for measuring success of expansion of sexual violence services

1. Development of an agreed upon monitoring and evaluation framework guided by in-country realities. Such a system would primarily feed off the existing sector systems that are already in place and are responsible for capturing service delivery data. This requires two approaches:
   a) Ensure indicators for sexual violence with necessary data collection requirements, tools, reporting mechanisms embedded within sector specific systems. For instance, the health sector needs to have sexual violence related indicators within national reporting forms that are reported from each service delivery point and aggregated to the national level as part of routine service data; police data that is reported to the national level should include sexual violence related figures and information; data reported within the prosecution and justice sub-systems should include sexual violence indicators as negotiated in each country. Each sector should establish data collection requirements from civil society who support service delivery ensuring all data is captured.
   b) A national sexual violence surveillance system should draw from the agreed on sector indicators. Mechanisms for delivery of specific collated data with reporting tools and frequency from the different sectors into the national framework should be established. These would provide for overarching data necessary national level planning and advocacy.

Summary of key factors for fostering sustained scale up of sexual violence services in low resource settings

Policy considerations	Key issues for sexual violence services scale up	Opportunities for sexual violence services scale up
Strong leadership and governance	• Accountability for targets and resources • Authority for multi-sectoral coordination • Responsibility for reporting	• Identify clear leadership from a government unit responsible for sexual violence with authority and mandate • In-country stakeholder and information coordination mechanism • Consensus for reporting
Building the evidence	• Investment in research • Sharing of definitions, research tools, methods and sampling for research on sexual violence • Resource mobilization for research	• Investment in documentation and evaluation of existing practices • Develop and resource a deliberate implementation science agenda • 'Learning by doing' approach
Cognizance of local realities	• Multiplicity of strategies and approaches • Adapting models to fit into national infrastructure	• Use of different models • Integration is a process not an event • Focus decision making on existing strengths in practice, infrastructure and resources and build on these

Service expansion considerations	Key issues for sexual violence services scale up	Opportunities for sexual violence services scale up
Defining scaling up	• Sexual violence outcomes • Coverage targets	• Consensus on the service packages required in-country • Consensus on service coverage targets and regular benchmarks • Consensus on quality indicators by health, law/order/justice and social welfare sectors
Planning perspectives	• Sector specific standards • Cross sector standards • Multi-sector joint planning	• Develop sexual violence guidelines/standard operating procedures for clinical, mental health, investigation and prosecution, justice services and processes • Implement a cross-sectoral Quality Assurance Framework (sector specific and cross-sectoral) • Reference document for referral pathways for survivor and for evidence • Establish sub-national level sexual violence teams to strengthen service delivery and provide informal peer to peer supervision
Implementation perspectives	• Service delivery points and mechanisms • Logistics and commodities • Provider competencies	• Establish clear management and supervision responsibility for sexual violence in the sectors • Routinely review multi-sectoral plans with clear targets, timeframes, budget and outcomes • Advocate for sexual violence services as part of essential packages of services for health • Ensure sexual violence commodities and supplies are a part of national supply systems in all sectors, with dedicated data collection tools • Develop common training module across sectors • Provide joint provider training where applicable • Implement cascaded training/content delivery models
Monitoring and evaluation	• sexual violence national indicators • Sector specific data collection • sexual violence national data	• Cross-sectoral and M & E framework agreed on • Sector indicators drawn from national indicators, data collection as part of routine, with reporting requirements to national level • Proper and all inclusive dissemination of M&E framework and indicators across GBV service sectors for clarity on inter- linkages • Aggregated data from sectors sent regularly to sexual violence M & E system with follow up
Resources for scaling up	• Sector sexual violence budget lines • sexual violence budgets	• Costing and cost effectiveness data • Piggy back on other funds such as HIV

Conclusion

In many low income settings, models of sexual violence services are still in pilot phase with few examples of promising practices having been incorporated into mainstream government policy and services [20]. This paper outlines the issues in current programmes, highlights roles and responsibilities of different sectors, and identifies what is needed to bring existing services to scale. Cognizant that no single best practice is applicable to all contexts, it draws on considerations that are needed in developing comprehensive models that can support expanded service delivery, guided by local realities. Promising practices and models need to be developed/adapted and tested. Finally, integration and scale up of services is a process, not a one off event, and at the core of any successful scale-up effort must lie a well-functioning health system. There exists a range of opportunities that can be harnessed in the current context of increasing attention towards sexual violence, with learning from other sectors to deliver on sustainable multi-sectoral services for sexual violence.

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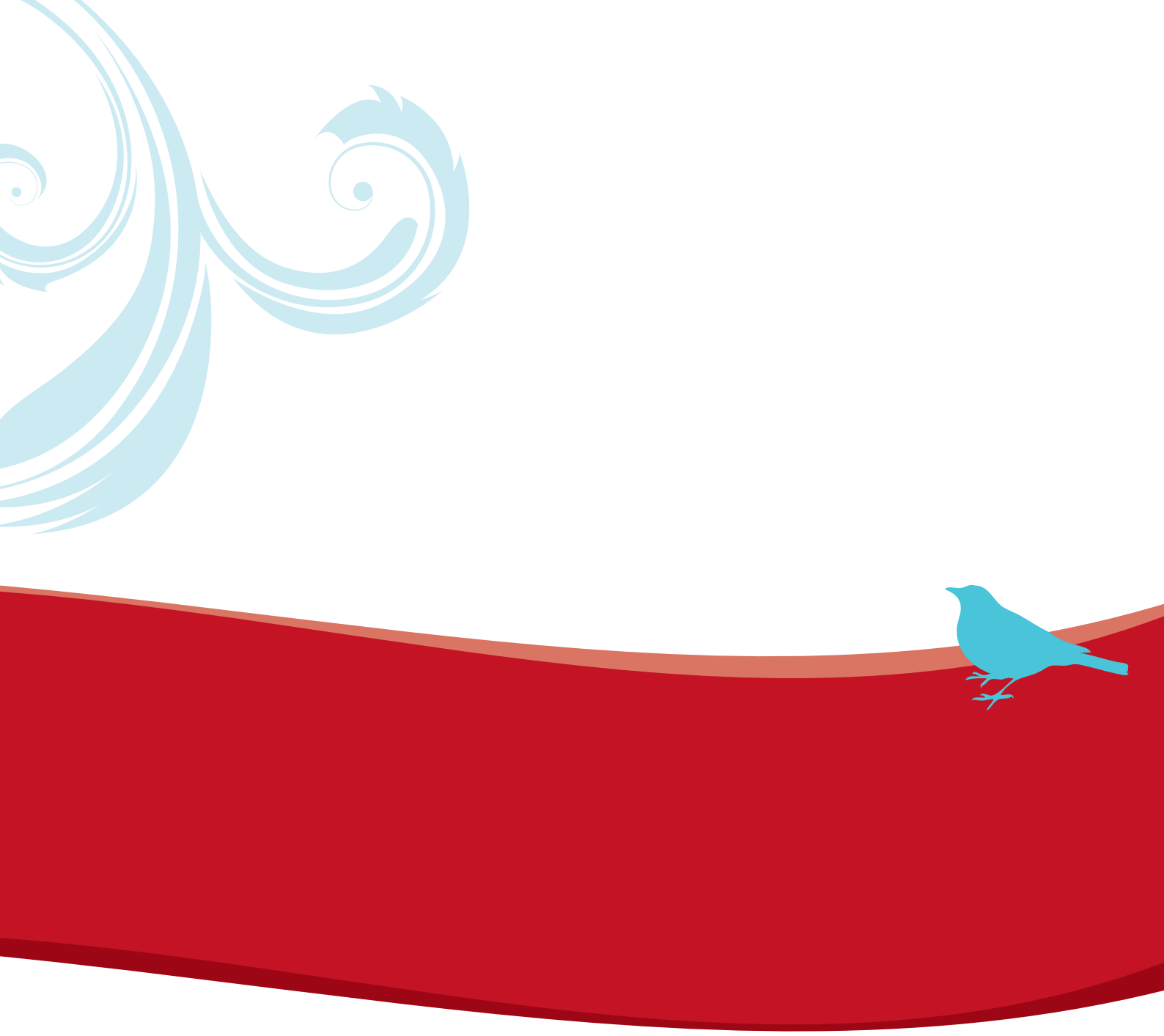

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