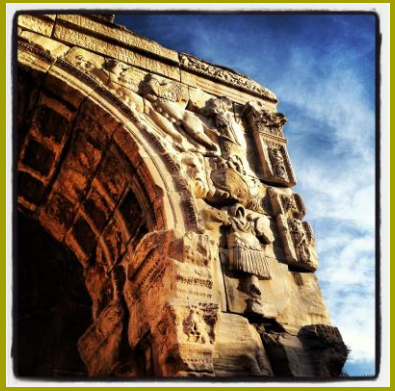

Responding to GBV in countries with limited capacity

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

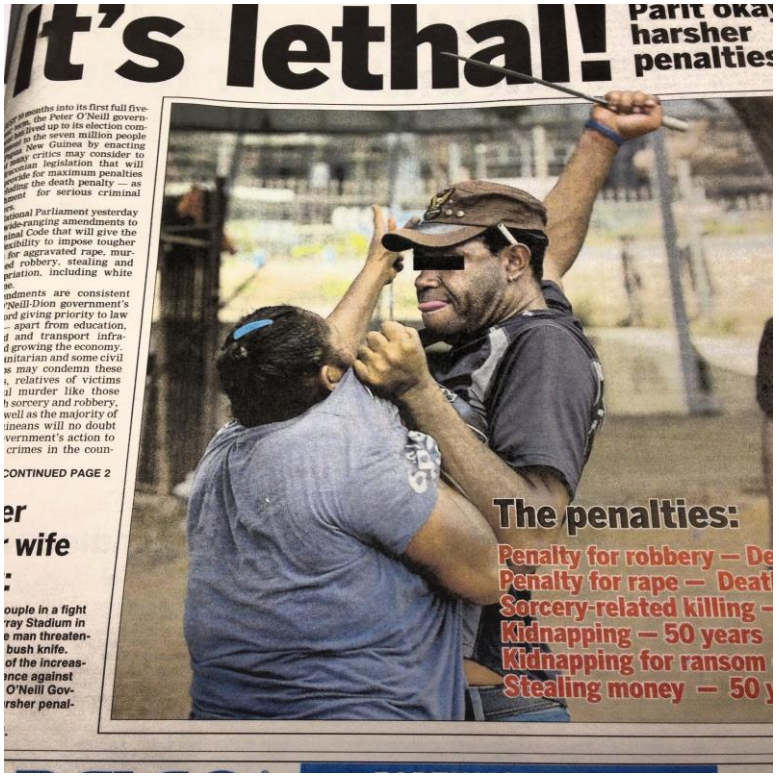
- Type of Emergency: Conflict/Natural Disaster
- Primary GBV Type: IPV, Sexual Violence, Honor Killings
- Prevention? Mainstream GBV through other sectors, engage CBOs and women's rights organizations
- Response? GBV coordination, Weak health response, engage through child protection, overstretched – 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"

	CAR	Libya	Pakistan	Myanmar	PNG
Technical Capacity	LOW	LOW	MIDDLE	LOW	LOW
Financial resources	LOW	HIGH	LOW	MIDDLE	MIDDLE
Human Resources	LOW	MIDDLE	MIDDLE	LOW	LOW
Coordination	LOW	LOW	MIDDLE	LOW/MIDDLE	LOW
Political Will	(HOL)LOW	(HOL)LOW	(HOL)LOW	(HOL)LOW	(HOL)LOW
That Certain Something	LOW	LOW	LOW	MIDDLE	LOW

GBV Capacity to care for survivors

	CAR	LIBYA	PAKISTAN	MYANMAR	PNG
HEALTH	LOW	MIDDLE	LOW	LOW	LOW/HIGH
PSYCHO-SOCIAL	NONE	LOW	LOW	LOW	NONE/HIGH
SECURITY	NONE	NONE	NONE	NONE	LOW
LEGAL/ JUSTICE	NONE	NONE	LOW	NONE	LOW
SOCIO-ECONOMIC	NONE	NONE	LOW	NONE/LOW	NONE

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?

Thank you!