Solomon Islands Government

CHRISTIAN CARE CENTRE

Family Support Centre

Royal Solomon Islands Police Force

Solomon Islands: Improving Services for Victims of Gender Based Violence

SAFENET Assessment & National Action Plan 2014-2016

The Solomon Islands Government logo used on the front cover of this report represents the following agencies:

- The Ministry of Health and Medical Services in tripartite (Health Facilities, Integrated Mental Health Services, and Social Welfare Division);
- The Public Solicitor's Office of the Ministry of Justice and Legal Affairs; and
- The Ministry of Women, Youth, Children and Family Affairs (as the agency responsible for hosting the SAFENET National Workshop and producing this report).

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- Ministry of Health and Medical Services in tripartite (Health Facilities, Integrated Mental Health Services, Social Welfare Division);
- Royal Solomon Islands Police Force;
- Christian Care Centre;
- Family Support Centre; and
- Public Solicitor's Office.

Finally, the Ministry would like to thank the participants of the SAFENET National Workshop. As the frontline service providers to victims of gender based violence, their contributions were vital to the development of the *SAFENET Assessment & National Action Plan 2014-2016.*

The Ministry hopes that all those who have contributed to this project will find their confidence justified in the *SAFENET Assessment & National Action Plan 2014-2016*. The Ministry hopes that through the implementation of this National Action Plan, real and tangible change will occur, to the benefit of victims and survivors of gender based violence in the Solomon Islands.

Ethel F. Sigimanu
Permanent Secretary
Ministry of Women, Youth, Children & Family Affairs

Acronyms

CARECOM	Technical Advisory Monitoring Committee
CCC	Christian Care Centre
DHIS	Demographic and Health Survey
DV	Domestic Violence
EVAW	Eliminating Violence Against Women
EVAW Policy	National Policy on Eliminating Violence Against Women
FV	Family Violence
FSC	Family Support Center
GBV	Gender Based Violence
GDI	Gender and Development Index
GEWD Policy	National Policy on Gender Equality and Women's Development
HF	Health Facilities
IMHS	Integrated Mental Health Services
MHMS	Ministry of Health and Medical Services
MOU	Memorandum of Understanding
MP	Member of Parliament
MWYCFA	Ministry of Women, Youth, Children and Family Affairs
PSO	Public Solicitors Office
RBA	Rights Based Approach
RSIPF	Royal Solomon Island Police Force
SI	Solomon Islands
SOP	Standing Operating Procedure
SV	Sexual Violence
SWD	Social Welfare Division
TOR	Terms of Reference
TOT	Training of Trainers
UNFPA	United Nations Population Fund
VAW	Violence Against Women

SAFENET
Results Framework and National Action Plan

'For every prison built we should build a shelter for women and children'

Section One

Summary of Key Findings

The Government of the Solomon Islands recently established a formal referral system called SAFENET made up of both government and non-government organizations/agencies to provide coordinated, frontline services and support to victims/survivors of gender based violence (GBV)/violence against women (VAW). Capacity to respond in a safe, non-judgemental, survivor centered way is weak within SAFENET and the coordinated referral system is not yet functioning.

A 3 day participatory workshop designed to assess capacity, highlighted details to enable the development of a 3 year National Action Plan. Three Programme Areas of Focus have been identified, 16 recommendations and 49 activities.

Programme Area of Focus 1:
Strengthen the Operational Systems for SAFENET

Recommendation: 1) Simplify the Standard Operating Procedure (SOP) information in the MOU and develop a separate SOP for SAFENET.

Critical foundations to implement a coordinated, multi-sector GBV response have been agreed between the 5 signatories to the SAFENET MOU; they include an outline of clear roles and responsibilities and to the use of the Standard Operating Procedures of each party once the referral system is initiated.

The MOU requires simplification of the SOP details, SOP details for all 5 signatories and separate SOP details for SAFENET to strengthen a coordinated and consistent GBV response.

Recommendation: 2) Revise the mandate of the Social Welfare Division to incorporate gender equality, women's empowerment and tackling gender discrimination and enable resourcing for SAFENET OR relocate the coordinating body to the Ministry of Women, Youth, Children and Family Affairs (MWYCFA) to strengthen sustainability.

The Social Welfare Division (SWD) has been identified as the coordinating body for SAFENET, and all SAFENET members have agreed to a standardized, safe, confidential GBV response. The legitimacy of SAFENET is undermined because SWD does not have an institutional mandate for gender equality, women's empowerment and tackling gender discrimination, all critical elements to eradicate violence against women.

Recommendation: 3) *Strengthen the programmatic leadership of SAFENET with a Terms of Reference (TOR) for the coordinating body.*

There are no TORs for the coordinating body, SWD; synchronized with the job description for the coordinator of SAFENET. Funding for the SAFENET coordinator ended in September 2013.

Recommendation: 4) *Institutionalize coordination with standardized forms, minimum standards, a clearly defined SAFENET approach and a 'Glossary of Terms'.*

Referral and coordination are not yet happening in a formalized, consistent way despite important preliminary work. When referral happens it is ad hoc, incomplete, often unsafe, with limited follow-up. Some agencies are not fulfilling the agreed roles and responsibilities.

Recommendation: 5) *Define the SAFENET approach to respond to victims/survivors of GBV/VAW.*

The Memorandum of Understanding (MOU) outlines processes and procedures to respond to reported incidents of GBV/VAW in and between the 5 signatory agencies. A number of guiding principles/values are implied, but not specifically defined to inform SAFENETs response processes and procedures.

The Minimum Standards for SAFENET will be strengthened with clarity on the three interlocking approaches used to implement them: the Rights Based Approach, Survivor Centered Approach and Gender Specific / Equality Approach.

Recommendation: 6) *Develop an evidence base of GBV/VAW response and referral by systematizing data collection, documentation and monitoring for SAFENET.*

There is no clarity on which agency will be responsible for the collection, management and storage of the GBV/VAW data compiled in the various SAFENET organizations, nor is there a simple, standardized form to gather GBV/VAW data.

Recommendation: 7) *Provide orientation/sensitization training to all SAFENET members on minimum standards and the interlocking approaches, SAFENET referral processes and forms, data collection, documentation and forms to achieve a standardized response.*

Programme Area of Focus 2: Train and develop SAFENET service providers

Recommendation: 8) Increase the capacity of SAFENET service providers to assess victims/survivors of GBV/VAW and to provide standardized safe, non-judgemental, survivor lead GBV services across the country.

SAFENET members have a range of capacities and skills to understand and respond to GBV/VAW. Sensitization and capacity has been developed through attendance at workshops facilitated by state and non-state organizations both within and outside of the Solomon Islands.

There is little consistency in the GBV/VAW capacities amongst SAFENET service providers and limited capacities outside Honiara. Many service providers do not know the basic do's and don't of crisis response. The attitudes of some service providers continues to be problematic, blaming women for the violence they experience, placing them at risk and discriminating against them because of internalized gender norms and prejudices. Many women are sent back into unsafe situations.

Recommendation: 9) *Institutionalize annual refresher training to improve GBV/VAW service provision of SAFENET members and respond to new and emerging issues i.e. developing specialized skills such as investigation techniques, sexual assault response, the use of rape kits, help line response, counseling children.*

There is limited expertise in medical reporting in the provinces, a need for training in investigation techniques and the use of rape kits; there are also limited skills to respond to and counsel child sexual abuse survivors, sexual assault and rape cases and to psychological trauma such as suicide threats.

Recommendation: 10) *Develop a standardized counseling manual with a common approach and safe pastoral counseling guidelines for SAFENET members.*

Different kinds of counseling are being offered within and between agencies including therapeutic, psychiatric and pastoral. Much of the counseling is advice giving rather than counseling, and approaches vary with some placing women at increased risk. Two GBV/VAW related training manuals have been developed amongst SAFENET members.

Recommendation: *11) Ensure the SAFENET referral system is sustainable.*

The longevity and sustainability of SAFENET is weakened by the combined effect of high levels of VAW, too few service providers, limited capacity to respond to GBV and a high dependence on outside expertise. SAFENET members are experiencing high burn out rates due to poor self-care and a high demand for urgent services. Even the small percentage of GBV/VAW cases reported to state agencies or non-state actors (an estimated 20%) places great pressure on the service providers. As the Zero Tolerance Campaign takes hold there is an increased likelihood that more GBV/VAW cases will be reported in a system already under strain.

The sustainability of SAFENET will be strengthened by strategically locating the network in a Ministry mandated to coordinate GBV responses and tackle entrenched gender discrimination; and by institutionalizing coordination and training and developing SAFENET members. In addition, Training of Trainers (TOT) methods, community based prevention and sensitization programmes, institutionalizing GBV/VAW curriculum in academies, colleges and universities and increasing the number of graduates with psychology and psychiatry degrees.

Programme Area of Focus 3:
Increase the availability of and access to GBV services across the country

A huge service gap exists between Honiara and the provinces. SAFENET is currently being piloted in Honiara and has yet to expand to any province. Little or no discussion has taken place within and between the provinces to plan for the expansion of SAFENET.

<u>Recommendation:</u> 12) *Gather more detailed, context specific information to expand coordinated GBV/VAW services to the provinces.*

Access issues are different and complex across the 9 different provinces and no formal assessment or situation analysis has been conducted.

<u>Recommendation</u>: 13) *Expand to the provinces in phases, as resources allow.*

Within the provinces there is a further distinction between urban centres and more remote areas where access is to GBV/VAW related services is severely limited and communication systems weak.

<u>Recommendation:</u> 14) *Invest in GBV/VAW response infrastructure.*

There are only 2 shelters in the country, one in Honiara and one in Makira. Many areas of the country do not have direct access to magistrates courts and the Public Solicitors Office (PSO).

<u>Recommendation:</u> 15) *Develop a plan of action to engage religious and traditional leaders in GBV prevention and response at the community level.*

Traditional and church leaders are providing pastoral counseling and reconciliation services in many provinces, including in remote areas. The pastoral counseling and reconciliation services being offered by traditional and church leaders are not consistent in approach; some do not adhere to a safety first approach and increase the risk and danger for women and children victims/survivors who are sent back into an abusive household, others reinforce gender discrimination.

<u>Recommendation:</u> 16) Hold perpetrators accountable for violence against women and children.

Prosecutions for acts of violence against women and children are rare. When prosecutions do occur, they do not often result in convictions.

Section Two

Priorities for Component 2 World Bank Support

Programme Area of Focus 1: Strengthen Operational Systems for SAFENET

Recommendation	Actions/Activities
1) Simplify the Standard Operating Procedure (SOP) information in the MOU and develop a separate SOP for SAFENET	• Develop a core working group of 3-5 individuals, supported by technical assistance to clarify, simplify and finalize the SAFENET SOPs: - edit and summarize the SOP for the Royal Solomon Island Police Force (RSIPF) into a visual, if possible, to make it easier to understand the RSIPF services and process; - include summary details of SOP for the PSO, Family Support Center (FSC) and Christian Care Centre (CCC); - develop a standard SOP for SAFENET to compliment the individual SOPs from signatory agencies • Provide a standard SAFENET SOP flow chart of the referral process • Consult with women victims/survivors to finalize the SOPs
2) Revise the mandate of the Social Welfare Division (SWD) to incorporate gender equality, women's empowerment and tackling gender discrimination and enable resourcing for SAFENET ***OR*** *relocate the coordinating body to the MWYCFA to strengthen sustainability.*	• Convene a SAFENET membership meeting to discuss revision of SWD or relocation of the SAFENET coordinating body to the MWYCFA
3) *Strengthen the programmatic leadership of SAFENET with TORs for the coordinating body and the coordinator*	• Develop a TOR for SWD as the coordinating agency for SAFENET • Review the TOR/Job Description for the SAFENET coordinator
4) *Institutionalize coordination with standardized forms, minimum standards, a clearly defined SAFENET approach and a 'Glossary of Terms'*	• Finalize and approve the coherent set of 10 minimum standards and 3 interlocking approaches, clearly identifying the meaning of each • Develop standardized forms and flow charts for the SAFENET preliminary assessment, consent, referral, data collection, follow-up processes and hotline number information. • Develop a common, simple, risk assessment form for the SAFENET referral process • Streamline the confidentiality processes/protocol and security measures into a checklist for clarity and ease of implementation • Develop a Glossary of Terms and integrate the terms • Develop a vetting checklist for new partners and expansion to ensure new members understand what is expected of them and to assist the SAFENET coordinating body in

	deciding upon new service providers • Formalize the colour coded system and integrate into the referral process • Include in the map of the SAFENET referral system documentation requirements • Institutionalize weekly case management meetings • Institutionalize non-identifying monthly meetings of GBV/VAW service providers • Develop an orientation kit/manual for SAFENET
5) *Define the SAFENET approach to respond to victims/survivors of GBV/VAW*	• Include the 3 approaches in revision discussions and the final draft of the MOU; add them to the Glossary of Terms and include them in the orientation package and sensitization work
6) *Develop an evidence base of GBV/VAW response and referral by systematizing data collection, documentation and monitoring for SAFENET*	• Develop a standard form to document information and collect data on reported GBV incidents • Provide technical assistance to develop a SAFENET database for the management, use and storage of GBV/VAW data collected and shared; • Purchase IT software for a SAFENET database • Train the SAFENET coordinating body and coordinator in use of the database and software

Programme Area of Focus 2: Train and develop SAFENET service providers

Recommendation	**Actions/Activities**
8) Increase the capacity of SAFENET service providers to assess victims/survivors of GBV and to provide standardized safe, non-judgemental, survivor lead GBV/VAW services across the country	• One 5 day orientation and training session: - 2 days to introduce SAFENET systems, processes and forms - 3 days to train in GBV/VAW, standardized crisis counselling and burn out prevention

Section Three

Introduction

In April 2013, the MWYCFA and the World Bank signed a Grant Agreement for $130,000 USD.

The development objective of this project is to support the Solomon Islands to improve access to services for victims/survivors of GBV and in particular Domestic Violence (DV) by bringing together key stakeholders for a National Workshop in order to define key priorities for intervention.

Problem Statement

Solomon Islands (SI) has one of the highest rates of GBV/VAW in the world. The World Bank recognizes that gender based violence undermines economic and social development, affecting women's well-being and the welfare of their children. It affects the health, well-being, social engagement and labor integration of women; and the health, nutrition, well-being and education of their children. A 2009 study showed that 64% of Solomon Islands women, between 15 and 49, have experienced physical or sexual violence, or both, by an intimate partner, highlighting domestic violence as a key issue.

By international standards, the Solomon Islands perform poorly on gender equality, ranking 129 out of 177 countries on the Gender and Development Index (GDI). Until very recently, the Solomon Islands had no women in Parliament. The first woman Member of Parliament (MP) (1 of 50 members) was voted in in 1980. In 2013 the number of women MPs remains the same. Currently, only 7% of senior positions in the public service are occupied by women. Gender disparities are very serious in the Solomon Islands and gender discrimination entrenched.

There is a strong commitment to improve gender equality and eradicate GBV/VAW in Solomon Islands. In 2007, the Government created the MWYCFA to elevate gender issues in the country. Although small and new, MWYCFA has embarked on an ambitious policy agenda for women's empowerment and gender equality. In 2010 the SI Government passed the National Policy on Eliminating Violence Against Women (EVAW Policy).

This policy addresses seven key strategic areas. These include: developing national commitments to eliminate GBV/VAW; strengthening legal frameworks, law enforcement and justice systems; eliminating and preventing GBV/VAW through public awareness and advocacy; improving protective, social and support services; treating perpetrators; working with men to end GBV/VAW; and improving policy coordination across the spectrum.

Efforts are underway in several of these key areas, including the strengthening of legal frameworks. However, one of the most pressing needs is to improve the delivery and coordination of protective and support services for women. It is widely reported that support services and referral systems for women are inadequate to meet the enormous needs of victims of GBV/VAW and DV. Ensuring improved support and rehabilitation services will increase the options for women to free themselves from violent relationships, so enabling them to

become more productive, economically and socially. It will also improve nutrition, education and health conditions for children and youth.

SAFENET Achievements

A signed Memorandum of Understanding (MOU) (March 2013) between five key frontline GBV service providers:

  - Ministry of Health and Medical Services (MHMS) in tripartite (Health Facilities (HF), Integrated Mental Health Services (IMHS), SWD);
  - Royal Solomon Islands Police Force
  - Christian Care Centre
  - Family Support Centre
  - Public Solicitor's Office
- Clarification of the roles and responsibilities of the signatory organizations.
- Clearly defined aims to assist victims/survivors of GBV incidents by:
  - improving access to appropriate support services for victims/survivors and affected family members
  - Support for prevention
- All party agreement to provide services according to the Standard Operating Procedures
- All party agreement to report on a set of 4 indicators including:
  - Assessment form for quality of services from victims/survivors
  - Incidence of individual using the SAFENET by each partner
  - New client incidence or new incidence for existing client
  - Outside assessment of services delivered by country or regional expert

Section Four

Capacity Diagnostics Methodology

The capacity diagnostics was conducted in two parts. In the first part a detailed Document Review was undertaken including: the 2009 '*Solomon Islands Family Health and Safety Study: A study on Violence against Women and Children'*; Solomon Islands 2010 National Policy on *Gender Equality and Women's Development (GEWD Policy)*; Solomon Islands 2010 National Policy on *Eliminating Violence Against Women (EVAW Policy)*; Gender Based Violence (GBV) Referral SAFENET Memorandum of Understanding (MOU) March 2013; Minutes from SAFENET members July 29, 2103 Meeting; and the Draft Family Protection Bill (2013).

Drawing information from these reports, and focus group and key informant interviews with:

Name	Title	Agency
Pionie Boso	EVAW Policy Officer	MWYCFA
Ethel Sigimanu	Permanent Secretary	MWYCFA
Jennie Chainey	Project Officer (EVAW)	MWYCFA
Alison Ofotalau	Communications Associate	World Bank
Valerie Stanley	Consultant	RSIPF Clinic Project
Aaron Olofia	Director	SWD
Valyn Barrett	PPF Family Violence Advisor	RSIPF
Sophie Munamua-Choniey	Principal Legal Officer	PSO
Nairy Alamu	Interim Centre Manager	FSC
Sister Doreen Awaiasi	Coordinator	CCC
Nashley Vozoto	SAFENET GBV Coordinator	SWD

From the first set of discussions/interviews the facilitator prepared the first draft of the workshop agenda for input from various stakeholders. In particular, the discussions noted the need for workshop time to examine: the various policy instruments guiding SAFENET, some of which oblige government agencies to provide GBV/VAW services; the need to identify overarching minimum standards to inform SAFENET processes and procedures outlined in the MOU; available GBV/VAW services and service gaps in Honiara and the provinces; the SAFENET referral process and the key gaps and constraints to implement a coordinated multi-sector response; and, prioritized actions for SAFENET for the next three years.

In the second phase 9 participatory exercises were purposely selected and designed for the three day workshop. The exercises aimed to identify issues and gaps whilst building consensus on the priority actions to move SAFENET forward. The schedule was flexible and changed according to the daily needs and pace of the participants.

Schedule

Day	Date	Activities
1	November 13, 2013	- Review of documents - Discussions with MWYCFA and World Bank
2	November 14, 2013	- Review of documents - Draft Workshop Agenda - Meetings with SWD Director - workshop assessment
3	November 15, 2013	- Meetings with SAFENET MOU signatories CCC, FSC, PSO at FSC and PSO for workshop assessment - Supplies for Workshop - Final workshop agenda - Documentation review
4	November 16, 2013	- Workshop preparation - Preparation of participant kits - Photocopying
5	November 17, 2013	- Workshop preparation - Flip chart preparation - Revised Agenda
6	November 18, 2013	- Workshop facilitation - Flip chart preparation - Revised Agenda - Summary of Findings Day One
7	November 19, 2013	- Workshop facilitation - Flip chart preparation - Revised Agenda - Summary of Findings Day Two
8	November 20, 2013	- Workshop Facilitation - Flip chart preparation - Revised Agenda - Summary of Findings Day One
9	November 22, 2013	- Workshop Report
10	November 23, 2013	- First Draft Results Framework and National Action Plan - Meeting with MWYCFA re: results framework and Action Plan
11	November 24, 2013	- Key Findings - National Action Plan
12	November 25, 2013	- Meeting with SWD and SAFENET Coordinator - Finalize Results Framework
13	November 26, 2013	- Key Findings - Recommendations - Annexes
14	November 27, 2013	- Key Findings - Recommendations - Annexes
15	November 28, 2013	- Key Findings - Recommendations - Annexes
16	November 29, 2013	- Meeting with Permanent Secretary (presentation of Key Findings) - Key Findings - Recommendations - Annexes
17	November 30, 2013	- Site visit to GBV Crisis and Referral Centre - Discussion with consultant Valerie Stanley re: SAFENET - Key Findings - Recommendations - Annexes

Section Five

SAFENET CAPACITY DIAGNOSTICS Findings, Recommendations and Actions

'We want victims to be afforded the best professional services we can provide'.

Programme Area of Focus 1:
Strengthen the Operational Systems for SAFENET

Critical foundations to implement a coordinated, multi-sector GBV/VAW response have been agreed between the 5 signatories to the SAFENET MOU. They include an outline of clear roles and responsibilities and to the use of the SOPs of each party once the referral system is initiated.

Gaps

The MOU requires simplification of the signatory SOP details, SOP details for all 5 signatories and separate SOP details for SAFENET to strengthen a coordinated and consistent GBV response. It is essential that SAFENET SOPs are developed as quickly as possible so that basic victim/survivor care services and essential prevention activities are put into place rapidly. Over time, the SOPs can be expanded and revised as more actors enter the setting and more services become available.

Standard Operating Procedures:

Recommendation: 1) Simplify the SOP information in the MOU and develop a separate SOP for SAFENET.

SOP details are provided for two of the five individual signatories: in lengthy detail for RSIPF and in a useful summarized flow chart for MHMS; they are not provided for PSO, FSC or CCC.

The MOU requires SOPs for the SAFENET referral system. The Guidecard clearly outlines the range of services available within SAFENET but lacks clarity on the referral procedure. The SAFENET SOP would provide the framework for cooperation with all parties by identifying the SAFENET approach and minimum standards for issues relating to confidentiality, respecting the wishes of the survivor, and acting in the best interests of a child. It will also clearly outline the standardized referral process.

Actions:

1. Develop a core working group of 3-5 individuals, supported by technical assistance to clarify, simplify and finalize the SAFENET SOPs and the associated information package
    i. edit and summarize the SOP for the RSIPF into a visual, if possible, to make it easier to understand the RSIPF services and process;
    ii. include summary details of SOP for the PSO, FSC and CCC;
    iii. develop a SOP for SAFENET to compliment the individual SOPs from signatory agencies and the current Guidecard (see Annex 1).

2. Provide a SAFENET SOP flow chart of the referral process from entry point through follow-up including initial assessment; safety and protection planning; a mechanism for obtaining victim/survivor consent, confidentiality and permission for information sharing; incident documentation and data analysis; coordination and monitoring procedures. In other words, a flow chart that reflects agreements among organisations that reflect the plan of action to implement minimum standards (see Annex 2).

3. Consult with women victims/survivor to finalize the SOPs. The working group will keep the finalization process moving forward at a realistic but rapid pace to be completed within 4 months. It is important that SOPs are finalized as quickly as possible so that basic victim/survivor care services and essential prevention activities are put into place rapidly. Over time, the SOPs can be expanded and revised as more actors enter the setting and more services become available

Programmatic Leadership:

Recommendation 2) Revise the mandate of the SWD to incorporate gender equality, women's empowerment and tackling gender discrimination and enable resourcing for SAFENET OR relocate the coordinating body to MWYCFA to strengthen sustainability.

The SWD has been identified as one of two coordinating bodies for the GBV Referral SAFENET; the second coordinating body FSC. The role is to be rotated annually. The SAFENET coordinating body has been supported with external funding to finance the SAFENET Coordinator, 1 computer, 1 printer, 1 landline and 1 national helpline.

Gap

The legitimacy of SAFENET is undermined because SWD does not have an institutional mandate for gender equality, women's empowerment and tackling gender discrimination, all critical elements to eradicate violence against women.

Action:

4. Convene a SAFENET membership meeting to discuss revision of SWD or relocation of the SAFENET coordinating body to the MWYCFA.

Recommendation 3) *Strengthen the programmatic leadership of SAFENET with TORs for the coordinating body and the SAFENET Coordinator.*

There is no TOR for SWD/FSC as the SAFENET coordinating body, once developed it should be synchronized with the job description for the SAFENET Coordinator. Funding for the SAFENET coordinator ended in September 2013. This position is currently being financed from the SWD budget.

Actions:

5. Develop a TOR for the coordinating agency/secretariat for SAFENET (SWD FSC) (see Annex 3).

6. Review the job description for the SAFENET Coordinator and synchronize with the TOR for the coordinating body (see Annex 4).

Institutionalize Coordination:
Recommendation 4) *Institutionalize coordination with standardized forms, minimum standards, a clearly defined SAFENET approach and a 'Glossary of Terms'.*

All SAFENET members have agreed to a standardized, safe, confidential GBV/VAW response that: assesses the victim/survivor for safety, protection and treatment; uses a standard referral form within SAFENET; keeps records using a common form for data collection; escorts the victim/survivor and provides follow-up services to the victim/survivor.

An anonymous telephone hotline, ideally available 24/7, provides a good starting point for victims/survivors of gender-based violence to receive information about legal options, available services and psychosocial counseling.

10 guiding principles/minimum standards were identified during the 3 day workshop: All actors agree to adhere to ZERO TOLERANCE FOR VIOLENCE and the following minimum standards:

- Work to make SAFENET a **National** network of service providers that has a **formal referral system with simplified processes and procedures** to avoid duplication and repetition, (i.e. asking questions more than once) and to focus procedures on relevant information gathering;
- Carefully **coordinate 10 key** GBV/VAW services (medical, legal, police intervention, court, psycho-social, counseling, shelter, child protection, societal reintegration) across multiple sectors in government and non-government organizations;
- Adopt a **safety first approach** for all victims/survivors, their families and practitioners. Each survivor/victim will be assessed, at the first point of entry, for danger and risks associated with their case.
- Practices **total confidentiality** as critical to safety and protection: information is shared on a 'Need to Know Basis'; general GBV incident data shared between agencies and used for monitoring will be non-identifying; All written information about victims/survivors must be maintained in secure, locked files (see Annex 11).
- Agree to a victim/survivor centred approach in which the **victims/survivors needs, desires and choices guide** the response process**;**
- Offers **timely and non-judgemental support** to victims/survivors of GBV/VAW that does not discriminate on the basis of sex, gender, religion, age or ethnicity (see Annex 13 and 14).
- Strives to **fast track or prioritize response** services for GBV victims/survivors.
- **Follow-up** on all victims/survivors who use SAFENET services;
- Use a **Rights Based Approach (RBA)/Empowerment Approach/Gender Equality Approach** to respond to all incidents of GBV/VAW (see Annex 6).
- Ensure **accountability** at all levels.

Gaps

Referral and coordination are not yet happening in a formalized, consistent way despite important preliminary work. When referral happens it is ad hoc, incomplete, often unsafe, with limited follow-up. Some agencies are not fulfilling the agreed roles and responsibilities. Police services have been identified as slow, non-responsive to security issues for victims/survivors and practitioners and as weak on follow-up in individual cases. CCC, the only agency providing short term shelter services, is a non-state organization with limited resources. They often have to house victims/survivors longer than the 'maximum stay period' because other SAFENET partners are not following up on individual cases. The current referral and response system disempowers survivor/victims that choose to report GBV/VAW.

Standard forms for the SAFENET referral process and data collection have not yet been finalized or approved. At least 3 different referral forms are in circulation, one for each of: the RSIPF, FSC and a DRAFT standard SAFENET referral form. The DRAFT referral SAFENET form needs simplification, and fewer open-ended questions to make data entry easier. A common set of minimum standards have not been agreed to inform the referral process and/or approach to a multi-sector coordinated response (see next section). There is no 'glossary' of terms in the MOU outlining the SAFENET meaning of terms. Accordingly, the meaning of follow-up, safety assessment, protection, fast track/prioritized response are not clear.

Contradictions and regulation obstacles exist within the partnership of organizations. For instance, police regulations (standard procedures) do not enable collaboration with agencies other than the courts. Hence, the lack of follow-up. A 'No Drop Policy' is said to be in operation in the RSIPF since 2006, so too is the practice of reconciliation between parties, both within the RSIPF and the court system.

The MOU outlines processes and procedures to respond to reported incidents of GBV/VAW in and between the 5 signatory agencies. A number of guiding principles/values are implied, but not specifically defined to inform SAFENETs response processes and procedures.

<u>Actions:</u>

7. Finalize and approve the coherent set of 10 minimum standards and 3 interlocking approaches, clearly identifying the meaning of each (see Annex 5 and 6)
8. Develop standardized forms and flow charts for the SAFENET preliminary assessment, consent, data collection, follow-up processes and hotline number information. Finalize and simplify the DRAFT referral SAFENET form (see Annex 2 and 12)
9. Develop a common, simple, risk assessment form for the SAFENET referral process
10. Streamline the confidentiality processes/protocol and security measures into a checklist for clarity and ease of implementation and to protect confidential information provided by victims/survivors and shared by parties to this agreement (see Annex 11)

11. Develop a Glossary of Terms and integrate the terms consent, confidentiality, accountability, non-judgemental approach, fast track/ prioritized response, time bound cases or timely response, expedite pertinent issues, without delay (Annex 10)
12. Develop a vetting checklist for new partners and expansion to ensure new members understand what is expected of them and to assist the SAFENET coordinating body in deciding upon new service providers
13. Formalize the colour coded system and integrate into the referral process
14. Include in the map of the SAFENET referral system documentation requirements
15. Undertake a structural review of each SAFENET member to assess the degree to which member organization understand and implement standardized SAFENET services and referral
16. A minimum requirement for referring victims/survivors to GBV/VAW services is the telephone hotline, provide technical assistance to get the SAFENET telephone helpline functioning and staffed 24/7. Advertise the telephone number nationally and ensure calls to the line from landlines and mobiles are free. Include the help line numbers for different service providers in the Guidecard. Coordinate with the FSC 24 hour helpline.
17. Institutionalize weekly case management meetings (see Annex 7)
18. Institutionalize non-identifying monthly meetings of GBV/VAW service providers (see Annex 8)
19. Request a small high level working group within RSIPF to review and resolve safety and enforcement issues identified by SAFENET service providers. Mandate the working group to discuss ways in which to speed up the response time to calls that involve safety of victims/survivors and practitioners being harassed by perpetrators
20. Develop an orientation kit /manual for SAFENET (see Annex 9).

<u>Recommendation</u> 5) *Define the SAFENET approach to respond to victims/survivors of GBV/VAW*

The Minimum Standards/guiding principles for SAFENET will be strengthened with clarity on the three interlocking approaches used to implement them: the RBA, Survivor Centered Approach and Gender Specific/Equality Approach.

Gaps
Male-dominated service providers, particularly police and medical agencies, create obstacles for women and children reporting. This is a noted problem specifically with rape, sexual assault and child abuse cases. There is a shortage of female doctors and police officers. Non state actors, in contrast to police and medical services, have more female front line workers, a key mechanism of support for GBV victims/survivors.

Gender neutral language was adopted as a strategy to reduce the levels of resistance to gender specific violence against women and domestic violence legislation. For instance, the term GBV was less confrontational and incorporated the requirement to recognize that men can also be victims. RSIPF specifically require that the gender based violence one stop service centre enable men,

women and children to use the services, including housing, as such the shelter services provided will be shared by men and women.

One result is that various terms are used with little clarity of meaning and focus i.e. Family Violence (FV), Violence Against Women, Domestic Violence, Sexual Violence (SV), gender based violence. A gender neutral approach has resulted in the loss of focus on women as the primary victims of intimate partner violence and the absence of analysis which acknowledges VAW and GBV as a reflection of gender inequality and entrenched gender discrimination at all levels of SI society. A gender specific approach requires that violence against women be named and acknowledged and that strategies to respond to VAW tackle root causes of gender inequality and discrimination i.e. the low numbers of women in public office and decision making.

Action:

21. Include the 3 approaches in revision discussions and the final draft of the MOU; add them to the Glossary of Terms and include them in the orientation package and sensitization work with SAFENET service providers.
    a. The rights based approach (RBA) focuses on the promotion and protection of human rights;
    b. The survivor-centered/empowerment approach prioritizes the rights, needs and wishes of the survivor; and
    c. The gender-specific/equality approach recognizes the gender dynamics, impacts and consequences of violence against women and their children (see Annex 6).

Documentation, data collection and monitoring systems for SAFENET:
Recommendation 6) *Develop an evidence base of GBV/VAW response and referral by systematizing data collection, documentation and monitoring for SAFENET*

All 5 SAFENET members have agreed to compile and report on GBV/VAW incident data. The MOU outlines Personal Information Protection and Confidentiality requirements highlighting that consent must be obtained from the victim/survivor in order to disclose information.

The Collaborating Partners have agreed to produce individual quarterly reports on a set of measurable indicators of input, output, and impact and submit them to the Technical Advisory Monitoring Committee (CARECOM). Each indicator should have a specified baseline and target values (annual), and be disaggregated wherever possible by province and other relevant categories such as age, gender etc. The four indicators are:

- Assessment form for quality of services from survivors
- Incidence of individual using the SAFENET by each partner
- New Client incidence (this is a check box on the shared form) or new incidence for existing client
- Outside assessment of services delivered by country or regional expert

Gaps
There is no clarity on which agency will be responsible for the collection, management and storage of the GBV/VAW data compiled in the various

SAFENET organizations, nor is there a simple, standardized form to gather GBV data. As a result, there is no clarity about what information will be recorded. It is not clear if victims/survivors need to visit the coordinating agency, currently SWD, during the referral process, or if not, how the information will be shared.

SWD, as the current coordinating agency, has no specific software for data collection and storage. It may not be realistic or appropriate for one organization to be responsible for all GBV data compilation in either Honiara or the country.

Data is not being collected, shared or managed within SAFENET, although some of the signatories (FSC and CCC) are gathering GBV/VAW incident information.

Confidentiality is clothed in legalese in the MOU and does not clearly or simply state the obligation of and process for confidentiality of all SAFENET members. Non-identifying information is a basic criteria to develop trust and protect the victim/survivor, the process for obtaining consent to disclose and use information is not clear.

Critical information from the performance monitoring framework is missing including clearly worded outcome and output result statements, indicators, baselines and target values.

Actions:

22. Develop a standard form to document information and collect data on reported GBV/VAW incidents. The data collected and reported on from the various sites should be simple and similar to enable provincial and national data comparisons.
23. Provide technical assistance to develop a SAFENET database for the management, use and storage of GBV/VAW data collected and shared; purchase IT software for a SAFENET database and train the SAFENET coordinating body and coordinator in use of the database and software.
24. In the longer term integrate GBV data collection into ongoing, regular sector specific data collection instrument i.e. census, Demographic and Health Survey (DHIS), MHMS data collection from clinics, hospitals and health centre to obtain regular information on GBV/VAW incidents.
25. Monitoring and evaluating GBV/VAW interventions involves more than compiling and monitoring reported incident data. Reported incidents of GBV represent only a small proportion of the actual GBV/VAW incidents in the SI. In the longer term it is essential that SAFENET also compile, and monitor qualitative information about GBV/VAW.
26. Distinguish between identifying and non-identifying data being collected in the referral process to reinforce confidentiality. In keeping with the need for confidentiality, any and all potentially identifying information of the victim/survivor, her family, and the perpetuator must not be included in any data report.
27. Develop an agreed results and performance measurement framework for SAFENET and an agreed monitoring and reporting schedule.

Orientation to standardized SAFENET approach, response and referral:

Recommendation 7) *Provide orientation/sensitization training to all SAFENET members on minimum standards and the interlocking approaches, SAFENET*

referral processes and forms, data collection, documentation and forms to achieve a standardized response.

Action:

28. Train and orient all SAFENET members and collaborating partners in the standardized response and referral system using the orientation kit/manual including the mimimum standards and interlocking approaches, SAFENET referral processes and forms, data collection, documentation and forms

Programme Area of Focus 2: Train and Develop SAFENET Service Providers

Recommendation 8) Increase the capacity of SAFENET service providers to assess victims/survivors of GBV/VAW and to provide standardized safe, non-judgemental, survivor lead GBV services across the country

SAFENET members have a range of capacities and skills to understand and respond to GBV/VAW. Sensitization and capacity has been developed through attendance at workshops facilitated by state and non-state organizations both within and outside of the Solomon Islands.

Within Honiara there are personnel of state and non-state agencies who have skills in medical assessment, safety planning, male advocacy, reconciliation, mediation and crisis counseling, prevention intervention, facilitation and repatriation.

The non-state SAFENET members, FSC and CCC, have staff with extensive skills in GBV/VAW response including safety planning, non-judgemental and survivor centered approaches.

Gaps

There is little consistency in the GBV/VAW capacities amongst SAFENET service providers and limited capacities outside Honiara. Many service providers do not know the basic Do's and Don't of crisis response. The attitudes of some service providers continues to be problematic, blaming women for the violence they experience, placing them at risk and discriminating against them because of internalized gender norms and prejudices. Many women are sent back into unsafe situations.

Actions:

29. Train all SAFENET members in GBV/VAW, crisis counseling, assessment interviews, safety planning, mediation and telephone response
30. Ensure key provincial service providers are included in the SAFENET training and refresher courses

Recommendation 9) *Institutionalize annual refresher training to improve GBV/VAW service provision of SAFENET members and respond to new and emerging issues i.e. developing specialized skills such as investigation techniques, sexual assault response, the use of rape kits, help line response, counseling children*

Gaps
There is limited expertise in medical reporting in the provinces, a need for training in investigation techniques and the use of rape kits; there are also limited skills to respond to and counsel child sexual abuse survivors, sexual assault and rape cases and to psychological trauma such as suicide threats.

Actions:

31. Institutionalize annual refresher (ongoing) training for good GBV/VAW service provision for SAFENET members tackling key specialized skills needed in amongst SAFENET members i.e. Investigation techniques, Sexual assault response, how to use of rape kits, Help line response, counseling children
32. Train SAFENET members in gender analysis and gender mainstreaming techniques

Recommendation 10) *Develop a standardized counseling manual with a common approach and safe pastoral counseling guidelines for SAFENET members*

Two GBV/VAW related training manuals have been developed by SAFENET members for their specific organizations: 1) curriculum and a manual to train nurses in GBV/VAW at MHMS, and 2) a pastoral counseling skills manual at CCC.

Gaps
Different kinds of counseling are being offered within and between agencies including therapeutic, psychiatric and pastoral. Much of the counseling is advise giving rather than counseling and approaches vary, some place women at increased risk.

Actions:

33. Streamline and build upon curriculum and training manuals developed by SAFENET members (CCC, FSC and MHMS) towards a consistent approach to crisis counseling

Recommendation 11*) Ensure the SAFENET referral system is sustainable*

RSIPF have introduced a basic GBV curriculum into the new recruits program.

The MHMS provided gender and human rights training, GBV/VAW sensitization and orientation to the SOPs for responding to and referring GBV, basic communication skills to 35 male and female nurses. 1 doctor and 1 nurse were supported with United Nations Population Fund (UNFPA) funding for GBV training in New Zealand.

Gaps
The longevity and sustainability of SAFENET is weakened by the combined effect of high levels of VAW, too few service providers, limited capacity to respond to GBV and a high dependence on outside expertise. SAFENET members are experiencing high burn out rates due to poor self-care and a high demand for urgent services. Even the small percentage of GBV cases reported to state agencies or non-state actors (an estimated 20%) places great pressure on the service providers. As the Zero Tolerance Campaign takes hold there is an

increased likelihood that more GBV/VAW cases will be reported in a system already under strain.

The sustainability of SAFENET will be strengthened by strategically locating the network in a Ministry mandated to coordinate GBV/VAW responses and tackle entrenched gender discrimination; and by institutionalizing coordination and training and developing SAFENET members. In addition, TOT methods, community based prevention and sensitization programmes, institutionalizing GBV/VAW curriculum in academies, colleges and universities and increasing the number of graduates with psychology and psychiatry degrees.

Actions:

34. Develop self care/occupational health tools and curriculum to train SAFENET members and collaborators
35. Advocate for gender-based violence curriculum in academies and academic programs for the RSIPF, medical school, nursing colleges, journalism programs, social workers
36. Develop TOT methods and skills to increase the pool of SAFENET members to facilitate GBV awareness raising/prevention and capacity building across sectors and the country
37. Offer scholarships at universities and colleges to increase the number of students entering and graduating with psychology and psychiatry degrees
38. Target churches, religious leaders, Christian orders and traditional to increase capacity for safe, sensitive, women friendly and supportive reconciliation and advise giving

Programme Area of Focus 3:
Increase the availability of and access to GBV services across the country

SAFENET was preceded by REFNET, an informal integrated multi-sectoral referral network of preventive and curative measures to address VAW in the Solomon Islands. It continues to exist in different capacities in some, but not all provinces. The current contact list, attached to the MOU, is out of date. Some provinces, such as Isabel, have developed a strong community-based approach to VAW/GBV through the community grown Isabel United Alliance.

All state and non-state GBV services are available in Honiara, albeit in short supply: police intervention by the RSIPF, legal services by PSO and courts services; psycho-social support, medial treatment and child protection by MHMS; shelter, pastoral counseling, child counseling, reconciliation, mediation by CCC; counseling, accompaniment, pre-legal by FSC.

In Honiara, the Gender Based Violence Crisis and Referral Centre, a one stop location providing medical care, crisis counseling, referral to the police and legal services, for recent survivors of GBV is being finalized with the RSIPF. It is expected that the building will house the SAFENET Coordinator, database and SAFENET equipment.

Gaps

A huge service gap exists between Honiara and the provinces. SAFENET is currently being piloted in Honiara and has yet to expand to any province. Little or no discussion has taken place within and between the provinces to plan for the expansion of SAFENET.

There is consensus amongst SAFENET service providers that GBV/VAW is a national problem and that coordinated multi-sector GBV/VAW response services and a formal referral system are needed across the country in all 9 provinces. Since the majority of the population lives outside Honiara, provincial access to GBV/VAW services is a priority.

Two DRAFT pieces of legislation: '*the Family Protection Bill 2013'* and 'the *Child and Family Welfare Bill*' implicate government service providers within SAFENET because they identify 'duties' of government service providers, namely health care providers, police, public prosecutors and courts.

Access issues are different and complex across the 9 different provinces and no formal assessment or situation analysis has been conducted. The workshop, due to time constraints, was able to examine broad, rather than province specific, access issues. It is assumed that there are GBV/VAW services being provided in the provinces that SAFENET is not aware of, and recognized that some provinces will not have easy access to state services.

The SAFENET model may not be the most appropriate model for replication in the provinces given the diversity of access issues. Alternatives, such as that in Isabel United Alliance, may be more suitable.

<u>*Recommendation:*</u> 12) *Gather more detailed, context specific, information to expand coordinated GBV/VAW services to the provinces*

<u>Actions:</u>

39. Undertake a quick rapid assessment of GBV/VAW response services and access issues in the 9 provinces to inform a staged expansion of GBV services; including consulting on alternative GBV/VAW response options

Within the provinces there is a further distinction between urban centres and more remote areas where access is to GBV/VAW related services is severely limited and communication systems weak.

<u>*Recommendation*</u>: 13) *Expand to the provinces in phases, as resources allow*

<u>Actions:</u>

40. Develop a phased plan to establish GBV/VAW focal points in the 9 provinces and equip them with the necessary communication equipment (2 way radios, computer, internet etc)
41. Implement phased plan for provincial focal points

RSIPF and MHMS are the most likely government agencies to have outposts in the provinces: there are 27 police posts across the country with 24 hours holding authority and the capability for quick response; and medical clinics in most parts of the country.

There are only 2 shelters in the country, one in Honiara and one in Makira. Many areas of the country do not have direct access to magistrates courts or PSO services. A lack of alternatives, even in better resourced areas such as Honiara, puts added pressure on the GBV response system. There are no rape kits in the country, including in Honiara.

Resource constraints have meant that the SAFENET offers short term crisis support or emergency interventions. The EVAW policy goal to eliminate VAW and take positive measures to address inequalities, VAW risk factors and gender discrimination suggests that services should not end after emergency interventions. Victims/survivors of violence need services that provide advocacy and support on a long-term basis, accompanying them through all the processes and coordinating the interventions. Both short and long term support to victims/survivors should be standard procedure.

There are both short and long term human resource constraints amongst all of the SAFENET service providers and very limited resources to expand SAFENET to the 9 provinces. Transport is a key access issue for GBV/VAW services, both within and outside Honiara, and requires immediate investment and support.

<u>*Recommendation:*</u> 14) *Invest in GBV/VAW response infrastructure*

<u>Actions:</u>

42. Develop a prioritized GBV/VAW response infrastructure investment plan
43. Discuss transport support with the RSIPF in Honiara, a vehicle has been allocated to the GBV/VAW crisis and referral centre
44. Build 1 shelter in each province. In the short term, negotiate with MHMS to use beds in medical clinics for emergency shelter in more remote areas
45. Budget for supply of rape kits for SAFENET

<u>*Recommendation:*</u> 15) *Develop a plan of action to engage religious and traditional leaders in GBV/VAW prevention and response at the community level*

Traditional and church leaders are providing pastoral counseling and reconciliation services in many provinces, including in remote areas. The pastoral counseling and reconciliation services being offered by traditional and church leaders are not consistent in approach; some do not adhere to a safety first approach and increase the risk and danger for women and children victims/survivors who are sent back into an abusive household, others reinforce gender discrimination.

<u>Actions:</u>

46. Mandate CCC to set up a national working group, made up of leaders of different faith based organizations to review the pastoral counseling approach, identify issues and develop a plan of action to sensitize church leaders across the country and negotiate a gender sensitive, survivor centered, safe, non-judgemental approach.
47. Mandate the SAFENET coordinating body to set up a second working group to examine the traditional system and identify both issues and

opportunities for a gender sensitive, safe and survivor centered GBV response across the country

Recommendation: 16) Hold perpetrators accountable for violence against women and children

Prosecutions for acts of violence against women and children are rare. When prosecutions occur, there do not often result in convictions.

Action:

48. Integrate the message that the perpetrator is always responsible for abusive behavior/VAW and should be held accountable.

'…we will combine forces to develop a collaborative and effective response to gender based and domestic violence'.

SECTION SIX

Results Framework and National Action Plan 2014-2016

Goal	
A safe, coordinated, survivor centred multi-sectoral response to gender based violence functioning across the Solomon Islands.	
Outcome 1.0 Improved victim/survivor centered GBV/VAW response services implemented at all SAFENET focal points across the SI.	
Outputs	*Actions/Activities*
Output 1.1 Increased capacity of SAFENET members and collaborators to offer safe, non-judgmental, supportive victim/survivor centered GBV/VAW response services.	**SHORT TERM (YEAR ONE - 2014)** Train all SAFENET members (Honiara and Provinces) in GBV/VAW, crisis counseling, assessment interviews, safety planning, mediation and telephone response. Develop self care/occupational health tools and curriculum to train SAFENET members and collaborators. **MEDIUM TERM (YEAR TWO - 2015)** Institutionalize annual refresher (ongoing) training tackling key specialized skills needed in amongst SAFENET members i.e. investigation techniques, sexual assault response, how to use rape kits, help line response, counseling children. Train SAFENET members in gender analysis and gender mainstreaming techniques. CCC to set up a national working group, made up of leaders of different faith based organizations to review the pastoral counseling approach, identify issues and develop a plan of action to sensitize church leaders across the country and negotiate a gender sensitive, survivor centered, safe, non-judgemental approach. SAFENET coordinating body to set up a second working group to examine the traditional system and identify both issues and opportunities for a gender sensitive, safe and survivor centered GBV response across the country. Streamline and build upon curriculum and training manuals developed by SAFENET members (CCC, FSC and MHMS) toward a consistent approach to crisis counseling. **LONG TERM (YEAR THREE - 2016)** Advocate for gender-based violence curriculum in academies and academic programs for the RSIPF, medical school, nursing colleges, journalism programs, social workers. Develop TOT methods and skills to increase the pool of SAFENET members to facilitate GBV awareness raising/prevention and capacity building across SI. Offer scholarships at universities and colleges to increase the number of students entering and graduating with psychology and psychiatry

	degrees. Target churches, religious leaders, Christian orders and traditional to increase capacity for safe, sensitive, women friendly and supportive reconciliation and advise giving.
Output 1.2 Increased number of provincial focal points offering coordinated, safe, survivor centered, gender based violence response services	**SHORT TERM (YEAR ONE - 2014)** Training of focal point staff (noted above). Integrate the message that the perpetrator is always responsible for abusive behavior/violence against women and should be held accountable. Undertake a quick rapid assessment of GBV/VAW response services and access issues in the 9 provinces to inform a staged expansion of GBV/VAW services; including consulting on alternative GBV/VAW response options. **MEDIUM TERM (YEAR TWO - 2015)** Develop a phased plan to establish GBV/VAW focal points in the 9 provinces and equip them with the necessary communication equipment (2 way radios, computer, internet etc). Implement phased plan for SAFENET focal points in all 9 provinces. **LONG TERM (YEAR THREE - 2016)** Implement phased plan for SAFENET focal points in all 9 provinces.
Output 1.3 Increased number of qualified psychologists, psychiatrists and trained GBV/VAW counselors	**MEDIUM TERM (YEAR TWO - 2015)** Develop a prioritized GBV/VAW response infrastructure investment plan. Discuss transport support with the RSIPF in Honiara, a vehicle has been allocated to the GBV/VAW crisis and referral center. Budget for supply of rape kits for SAFENET. **LONG TERM (YEAR THREE - 2016)** Build 1 shelter in each province. In the short term, negotiate with MHMS to use beds in medical clinics for emergency shelter in more remote areas.
Outcome 2.0 Strengthened, formal, multi-sectoral coordination of standardized GBV/VAW response services within the SAFENET referral system.	
Output	*Actions/Activities*
Output 2.1 Increased standardized, safe referrals of victims/survivors within SAFENET system	**SHORT TERM (YEAR ONE - 2014)** Set up a core working group of 3-5 individuals, supported by technical assistance to clarify, simplify and finalize the SAFENET SOPs and the associated information package. Edit and summarize the SOP for the RSIPF into a visual. Add summary details of SOP for the PSO, FSC and CCC into MOU. Develop a standard SOP for SAFENET.

	Create a standard SAFENET SOP flow chart of the referral. Consult with women survivor/victims to finalize the SOPs. Convene a SAFENET membership meeting to discuss revision of SWD or relocation of the SAFENET coordinating body to the MWYCFA. Finalize and approve the coherent set of 10 minimum standards and 3 interlocking approaches. Develop standardized forms and flow charts for the SAFENET preliminary assessment, consent, referral, data collection, follow-up processes and hotline number information. Develop a common, simple, risk assessment form for the SAFENET referral process. Streamline the confidentiality processes/protocol and security measures into a checklist. Develop a Glossary of Terms. Develop a vetting checklist for new partners and expansion. Formalize the colour coded system and integrate into the referral process. Develop a map of the SAFENET referral system documentation requirements. Ensure SAFENET telephone helpline is functioning and staffed 24/7. Advertise the telephone number nationally and ensure calls to the line from landlines and mobiles are free. Advertise the FSC 24 hour helpline. Institutionalize weekly case management meetings. Institutionalize non-identifying monthly/quarterly meetings of GBV/VAW service. Develop an orientation kit/manual for SAFENET. Approval of all protocols and guidelines for inclusion in MOU. Train and orient all SAFENET members and collaborating partners in the standardized response and referral system using the orientation kit/manual including the minimum standards and interlocking approaches, SAFENET referral processes and forms, data collection, documentation and forms . **MEDIUM TERM (YEAR TWO - 2015)** Set up a small high level working group within RSIPF to review and resolve safety and enforcement issues. Mandate the working group to discuss ways in which to speed up the response time to calls that involve safety of victims/survivors and practitioners being harassed by male perpetrators. **LONG TERM (YEAR THREE - 2016)** Undertake a structural review of each SAFENET member to assess the degree to which member organizations understand and implement standardized SAFENET services and referral.

Output 2.2 Improved quality of GBV/VAW information collected, shared and stored by SAFENET	**SHORT TERM (YEAR ONE - 2014)** Develop a standard form to document information and collect data on reported GBV/VAW incidents. Distinguish between identifying and non-identifying data being collected in the referral process to reinforce confidentiality. Train and orient all SAFENET members and collaborating partners (as above in 2.1). Develop performance measurement framework for SAFENET and an agreed monitoring and reporting schedule. **MEDIUM TERM (YEAR TWO - 2015)** Procure technical assistance to develop a SAFENET database for the management, use and storage of GBV/VAW data collected and shared. Purchase IT software for a SAFENET database. Train the SAFENET coordinating body and coordinator in use of the database and software. Train SAFENET members in use of data collection forms and data collection. Collect and share GBV data being collected by SAFENET members in regular monthly/quarterly meetings. **LONG TERM (YEAR THREE - 2016)** Identify ongoing, regular sector specific data collection instruments and negotiate with sector to integrate GBV data collection into other instruments. Compile, and monitor qualitative information about GBV.
Output 2.3 Enhanced GBV/VAW communication system within and between provinces	**LONG TERM (YEAR THREE - 2016)** Procure and install communication equipment into provincial focal points sites (i.e. 2 way radios, solar panels, phones, computer, internet). Training of SAFENET members and collaborators in use and maintenance of SAFENET equipment.

** **5 Priority Actions Identified for 2014:**

1. Revise and finalise MOU (including all SOPs and forms)
2. Develop orientation kit/manual for all SAFENET members
3. Develop data collection system
4. Orientation training to all SAFENET members
5. Undertake a quick rapid assessment of GBV/VAW response services and access issues in the 9 provinces

Annex 1

FLOW CHART SAFENET REFERRAL SYSTEM

PRESENTATION OF CLIENT TO REFERRAL SAFENET

ASSESSMENT FOR SAFETY, PROTECTION, TREATMENT, COUNSELLING AND SUPPORT

SERVICE PROVIDERS	TYPES OF SERVICES
POLICE Call Tel: 999 or RSIPF Family Violence Mob: 7478758	**PROTECTION**
Ministry of Health NRH Emergency dept, call Tel: 23600 Honiara City Council Clinics	**TREATMENT** **MEDICAL REPORT**
Family Support Center Call Tel: 26999	**COUNSELLING** **PRE- LEGAL SERVICES**
Public Solicitor Office Call Tel: 28406	**LEGAL ASSISTANCE**
Social Welfare Division Call Tel: 20686 / 20569	**CHILD WELFARE** **PROTECTION NEEDS**
Christian Care Centre Call Tel: 7479326	**SAFETY / SHELTER**

Annex 2

DRAFT SAFENET REFERRAL PATHWAY

TELLING SOMEONE AND SEEKING HELP (REPORTING)	
Victim/Survivor tells family, friend, community member; that person accompanies survivor to the SAFENET entry point	Survivor/victim self-reports to any SAFENET service provider

IMMEDIATE RESPONSE **Crisis support, Risk and needs assessment, safety plan, immediate medical care, determine victim/survivor decisions/needs for next steps, obtain consent**	

VICTIM/SURVIVOR CHOICES COULD INCLUDE POLICE/LEGAL ACTION, ADDRESSING IMMEDIATE SAFETY AND SECURITY RISKS, MEDICAL TREATMENT, SHELTER, COUNSELLING, SAFETY PLAN. Refer and accompany victim/survivor to service of choice i.e. police/security or to legal assistance/protection officers for information and assistance with referral			

AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES Over time and based on survivor's/victims choices **can** include any of the following:			

Annex 3

DRAFT Terms of Reference for SAFENET Coordinating Body

- Provide leadership
- Strategic planning
- Orchestrating a functional division of labour
- Mobilising resources and ensuring accountability
- Monitoring effectiveness; identifying and resolving challenges
- Gathering data and managing information
- Coordination of activities

- Specific coordination activities include:
  - Sharing information about resources, guidelines, and other materials;
  - Sharing non-identifying data about GBV incidents;
  - Discussion and problem-solving about prevention and response activities, including planning these activities and engaging with other relevant coordinating and leadership bodies;
  - Collaborative monitoring and evaluation;
  - Identifying programme planning and advocacy needs, and sharing those among other actors, coordinating bodies, and leadership structure

The coordinating agency is responsible for encouraging participation in the GBV monthly meetings and weekly case management meetings. Specifically for

- Convene the meetings. Specifically,
  - develop the agenda,
  - schedule and chair the meetings, and
  - distribute minutes to all participants of the GBV/VAW service providers group (Honiara and Provinces).
- Know who is doing what and where;
- Communicate and following up with a wide range of actors;
- Link with other clusters/sectors; and
- Promote other methods for coordination and information sharing among all actors, e.g. by representing SAFENET at relevant cluster/sector meetings and/or with government authorities to inform and advocate for GBV/VAW issues and concerns.

- Coordinate SAFENET working groups
  - follow up with the local and/or national GBV/VAW working groups as needed for issues and action points.

Annex 4

JOB DESCRIPTION SAFENET COORDINATOR

Schedule 4

PS FORM 6 – JOB

MINISTRY OF HEALTH &MEDICAL SERVICES
SOCIAL WELFARE DIVISION

Post Number:	HSSP – 0001
Post Title:	Gender Based Violence Program Coordinator
Level:	8/9
Accountable to:	Director of Social Welfare
Direct reports:	Nil

Scope and purpose
The Referral SAFENET is a new clearing house being formed in the social Welfare Division of the Ministry of Health and medical Services to coordinate the activities of the five agencies most involved in providing services to victims of violence in the Solomon Islands. These agencies, which are Referral SAFENET members, are:

- Ministry of Health & Medical Services
- Royal Solomon Islands Police Force
- Family Support Centre
- Public Solicitor
- Christian Care Centre (COM)

The role of the program Coordinator is to support the gender – based violence operations of each of these Referral SAFENET members in accordance with the Referral SAFENET Memorandum of Understanding (MoU), to monitor the SAFENET effectiveness and resolve any problems that might arise. Although the post receives supervision and day-to-day support from social welfare Division and the Ministry, SAFENET members also support the position holder by providing expertise, information and advice where necessary.

Gender –Based Violence (GBV) and Child Abuse (CA) are serious socio-cultural and public health concerns in the Pacific Island countries and significant forms of human rights abuse.

The Solomon Islands Family Health and Safety Study prepared by the Secretariat of the Pacific Community (SPC) for the Ministry of Women, Youth, Children and Family Affairs (MWYCFA) "shows a high prevalence of violence against women in Solomon Islands. The data indicate that nearly 2 in 3 (64%) ever- partner women, aged 15 – 49, reported experiencing physical or sexual violence, or both, by an intimate partner;…"

"Women in Solomon Islands are more likely to experience severe forms of physical partner violence, such as punching, kicking, or having a weapon used

against them, rather than just moderate violence". It is envisaged that the position will be incorporated into the government establishment in 2013.

Liaisons

The GBV Program Coordinator liaises on the regular basis with the following agents.

Internal – MHMS officers involved in delivery of social welfare and gender- based programs in all provinces

External – Program officers and managers at the Referral SAFENET members' agencies, journalist and media representatives. Community group members and organisers.

Responsibilities and performance indicators
The GBV Program Coordinator contributes to the success of the Ministry as a highly professional, ethical, cost-effective organisation meeting the health needs of the people of the Solomon Islands, in particular in the key results areas listed below.

Effective performance in each area will be assessed according to the indicators relating to each key result area. The duties and responsibilities listed below show some ways of achieving the level of performance required.

Key results area	*Duties and responsibilities to include*	*Performance indicators*
1. Support the development of GBV services by Referral SAFENET agencies	• Produce a consolidated guide to the GBV policies and standard operating procedures of all SAFENET members. • In consultation with the SAFENET members, review the implementation of each member's policies and the services that each delivers • Analyse any gaps and overlap in the GBV services across all provinces for consideration by all SAFENET members.	1.1 Annual overview of all GBV services in all provinces produced for SAFENET members
2. Monitor the delivery of GBV services	• In consultation with SAFENET members, developed performance indicators for GBV service delivery e.g. incident rates, referral numbers and response times • Develop forms and procedures for collecting GBV service performance data • Consolidate and analyse GBV service data • Report service delivery levels, trends and anomalies on a quarterly basis to SAFENET	2.1 Quarterly reports to SAFENET present an accurate overview of GBV service delivery in the Solomon Islands

	management meeting	
3. Establish and maintain an effective GBV network	• Through independent research, consultation and regular liaison with experts, SAFENET members and community groups involved in GBV, compile information about GBV strategies and activities throughout the region • Serve as a GBV reference point and resource person for SAFENET members • Provide information and advice to volunteer and community groups interested in contributing to GBV program	3.1 Updates of all GBV activities are circulated among SAFENET agencies monthly 3.2 Request information on GBV issues and activities are met within one week
4. Assist in GBV service provision by SAFENET members and community groups	• Organise, and assist in presenting, training for SAFENET members officers dealing with GBV related and related matters • Organise, and assist in presenting training for individual volunteers and community groups interested in taking action on GBV • Work with telecommunication providers to establish a reliable 24 hour national hotline for victims of GBV and their supporters • Liaise with SAFENET members, community group and volunteers to develop a 24 hour roster of people who are trained and committed to providing hotline services	4.1 At least two training sessions delivered for SAFENET members each year 4.2 At least one community level GBV training session offered in each province each year
5. Promote public awareness of GBV and SAFENET activities	• Build effective working relationships with print, radio and television journalist to raise their awareness of GBV and encourage appropriate reporting • Write press releases for publication in newspapers, promoting GBV strategies and SAFENET activities • Plan GBV activities and events to include radio and television opportunities, e.g. speakers available for radio interviews and displays suitable for	5.1 At least one report of GBV strategies and activities by SAFENET members appears in a SI newspaper every month 5.2 GBV strategies and activities by SAFENET members are covered by radio and television at least every two months 5.3 At least one GBV public event in every province

	television coverage • In consultation with SAFENET members and community leaders, prepare presentations and hand-out materials for use by SAFENET members at community forums and public events • Organise community awareness events, including visits and presentation by SAFENET members, for all provinces • Represent the Ministry at GBV related public forums	every year
6. Apply Ministry standards and procedures to the coordination of SAFENET	• Produce GBV and SAFENET action plans, evaluations and reports as required for inclusion in the Ministry planning procedures • Keep financial records of expenditure in accordance with MHMS Accounts Division requirements • Apply very high standards of personal conduct and integrity as a model for other officers and community members involved in SAFENET • Refer any apparently inappropriate conduct by any person involved in SAFENET activities for investigation by relevant authorities	6.1 GBV strategies are included in Ministry plans 6.2 Random inspections show that all financial records are accurate and up to date

In addition, the Gender – Based Violence Program Coordinator will perform other duties as directed by their immediate supervisor.

Annex 5

SAFENET Minimum Standards

All SAFENET members agree to adhere to *ZERO TOLERANCE FOR VIOLENCE* and the following minimum standards:

- Work to make SAFENET a **National** network of service providers that has a **formal referral system with simplified processes and procedures** to avoid duplication and repetition, (i.e. asking questions more than once) and to focus procedures on relevant information gathering;

- Carefully **coordinate 8 key** GBV/VAW services (medical, legal, police intervention, court, psycho-social, (counseling, shelter) child protection, societal reintegration) across multiple sectors in government and non-government organizations;

- Adopt a **safety first approach** for all victims/survivors, their families and practitioners. Each survivor/victim will be assessed, at the first point of entry, for danger and risks associated with their case.

- Practices **total confidentiality** as critical to safety and protection: information is shared on a 'Need to Know Basis'; general GBV incident data shared between agencies and used for monitoring will be non-identifying; All written information about victims/survivors must be maintained in secure, locked files.

- Agree to a survivor/victim centred approach in which the **victims/survivors needs, desires and choices guide** the response process**;**

- Offers **timely and non-judgemental support** to victims/survivors of GBV that does not discriminate on the basis of sex, gender, religion, age or ethnicity.

- Strives to **fast track or prioritize response** services for GBV/VAW victims/survivors .

- **Follow-up** on all victims/survivors who use SAFENET services;

- Use a **Rights Based Approach (RBA)/ Empowerment Approach / Gender Equality Approach** to respond to all incidents of GBV/VAW.

- Ensure **accountability** at all levels.

Annex 6

SAFENET 3 Interlocking Approaches

A) Rights Based Approach

In the human rights based approach, human rights determine the relationship between individuals and groups with valid claims (rights holders) and State and non-state actors with correlative obligations (duty-bearers). It identifies rights-holders and their entitlements and corresponding duty-bearers and their obligations, and works towards strengthening the capacities of rights-holders to make their claims, and of duty-bearers to meet their obligations (UNICEF 2004; p.92).

Justice is doing and giving what is rightfully due to the survivor according to international and national health and human rights standards and laws. Providers of care for women survivors of violence should:

1. Assess the capacity of rights-holders to claim their rights and identify the immediate, underlying, and structural causes for non-realization of rights.
2. Identify the barriers to women and girls' access to health services and address those barriers through improved legislation on health sector response to violence against women and girls, integrated and comprehensive health programming, and community outreach to women and girls.
3. Assess the capacities and limitations of the duty-bearers (health care personnel, police, prosecutors) to fulfill their obligations according to national and international standards, laws and agreements.
4. Develop strategies to build capacities and overcome limitations of duty-bearers, such as thorough staff training and supervision.
5. Monitor and evaluate both outcomes and processes guided by human rights standards and principles, and ensure national accountability.
6. Ensure programming is informed by the recommendations of international human rights bodies and mechanisms.

Source: Virtual Knowledge Centre 2011

B) Survivor-centered approach

There is no excuse for violence. Addressing gender-based violence means adopting a clear stance and condemning violence against women in all its forms. Keeping a neutral stance on an act of violence means running the risk of tolerating violence. It is always the perpetrator who is responsible for the violence (WAVE 2006). Especially when many agencies and services are involved, it is always important to keep the survivor in control of all actions undertaken and also accept, when she doesn´t want to separate from a violent partner.

A survivor-centered approach means that all those who are engaged in violence against women programming prioritize the rights, needs, and wishes of the survivor. The survivor-centered approach is based on a set of principles and skills designed to guide professionals - regardless of their role - in their engagement with women and girls who have experienced sexual or other forms of violence. The survivor-centered approach aims to create a supportive environment in which the survivor's rights are respected and in which she is treated with dignity and respect. The approach helps to promote the survivor's recovery and her ability to identify and express needs and wishes, as well as to reinforce her capacity to make decisions about possible interventions (UNICEF, 2010). Providers must have the resources and tools they need to ensure that such an approach is implemented (Virtual Knowledge Centre 2011).

Empowerment The main aim of all services should be to empower women survivors of violence and their children by, inter alia, making sure they know their rights and entitlements and can make decisions freely in a supportive environment that treats them with dignity, respect and sensitivity. Services should always aim at supporting survivors to choose the course of action in dealing with the violence instead of feeling powerless in order for the survivors to re-gain control of their lives and to promote their right to autonomy and self-determination (WAVE 2010/Virtual Knowledge Centre 2011).

C) Gender-specific approach

Services need to demonstrate an approach which recognizes the gender dynamics, impacts and consequences of violence against women and their children within an equalities and human rights framework, including the need for women only services (WAVE 2010). Service providers should be skilled, gender-sensitive, have ongoing training and conduct their work in accordance with clear guidelines, protocols and ethics codes (United Nations, 2006 quoted in Virtual Knowledge Centre 2011). A gender-specific (or gendered) approach means to recognize the gendered nature of violence against women as violence that is "directed against a women because she is a women or that affects women disproportionately" (CEDAW General Recommendation, 11th session, 1992, No. 19, para 6). It also means to recognize the root causes of violence against women "a manifestation of historically unequal power relations between women and men, which have led to domination over, and discrimination against, women by men and to the prevention of the full advancement of women" (Council of Europe 2011). Finally it means to aim for the empowerment of women, for equality between women and men and for the rights of women to fully enjoy their human rights. It means to recognize "that the realisation of de jure and de facto equality between women and men is a key element in the prevention of violence against women" (Council of Europe 2011). A "gender-neutral" approach is not able to tackle the root causes of violence. The support must be appropriate and tailored to the specific needs of service users. Special attention should be given to address the needs of specific groups of women, such as young women, older women, migrant women, asylum seeking and refugee women, women from minority ethnic groups, women with disabilities and others (WAVE 2010).

Source:
http://www.health-genderviolence.org/category/category/creating-referral-pathways-integrated-into-health-care

Annex 7

TOR Weekly Case Management Meetings

Case management meetings are small, closed meetings where highly sensitive information is discussed.

The survivor must authorize/consent to information sharing with all participants in case management meetings. Therefore, participants in these meetings must be invited; it is not a regular open meeting for "key actors".

Case management meetings might involve the key GBV/VAW/psychosocial actors and health, representation from the non-state actors involved in psychosocial or health response.

It is often necessary and appropriate to invite individuals from security, protection, education, justice, or others as required

Annex 8

Monthly SAFENET Meeting TORs

The purpose is to institutionalize non-identifying monthly meetings of GBV/VAW service providers for:

- support to and problem-solving with the SWD and the SAFENET coordinator;
- Review and discussion of GBV monitoring reports prepared for CARECOM (see page 5 MOU agencies, provinces, other GBV/VAW working groups). These are reports that do NOT contain any identifying information about individuals or incidents
- Identify information, needs, issues, successes
- Provides policymaking, advocacy, technical, administrative, and logistical assistance to SWD and SAFENET coordinator
- Analyse GBV data/information, including qualitative information and quantitative and non-identifying GBV/VAW incident data
- Develop targeted prevention strategies
- Identify, discuss and resolve specific issues and gaps in GBV/VAW response and prevention (including training and awareness-raising needs and wider policy issues)
- Discuss and plan ways to work with other sectors and groups to plan, share information, and solve problems with other sectors and groups
- Share information about activities and coordinate interventions.

Annex 9

SAFENET ORIENTATION KIT CHECKLIST

- Revised MOU
- Simple SOP for each signatory to MOU
- SOP for SAFENET
- Guidecard
- Referral Process Map
- SAFENET Standardized Referral Form
- Assessment (Risk/Safety) Questionnaire
- Checklist for Confidentiality
- Consent Form
- SAFENET Data Collection Form
- SAFENET Reporting Format and Schedule
- SAFENET Minimum Standards
- 3 Interlocking SAFENET Response Approaches
- Glossary of Terms
- Help line numbers
- Terms of Reference SAFENET Coordinating Body
- Terms of Reference SAFENET Coordinator
- Vetting checklist for new partners and expansion
- Details of the colour coded system
- Documentation map for the SAFENET documentation requirements
- TORs Case Management Meeting
- TORs Monthly SAFENET Meeting
- SAFENET Results Framework

Annex 10

GLOSSARY OF TERMS

Attempted rape
Involves a sexual assault in which there was an attempt at rape, but no penetration. The assault may have involved forcing the woman to perform sexual acts that she did not want to do or that she did not like.

Child Sexual Abuse
There are many different definitions of child sexual abuse. Most commonly child sexual abuse takes place when an adult or someone bigger or older than a child involves a child in sexual activity. This includes a wide range of sexual activity – sexual touching (breasts, genitals, anus), oral sex, sexual intercourse, vaginal penetration with fingers, penis or any other object, child prostitution, child pornography, child sex rings (where adults regularly involve a group of children in sexual activity).

Consent
Agreement which is given voluntarily and willingly i.e. without threat or force.

Domestic Violence
Domestic violence is an act directed at the claimant or a person at risk, or a threat of such an act, that harms or is likely to harm their safety, health or wellbeing. It may consist of a single act or a number of acts that form part of a pattern of behaviour, even though some or all of those acts when viewed in isolation appear to be minor or trivial.

A domestic relationship exists between a claimant and a respondent if : a) they are or were married to each other in accordance to law, custom or religion; b) they live or lived together in a relationship in the nature of marriage, although they are not, or were not, married to each other; c) they are the parents of a child or are persons who have or had parental responsibility together for a child; d) they are family members; e) they are or were in an engagement, courtship or customary relationship, including an actual or perceived intimate or sexual relationship of any duration; f) they share or recently shared the same residence; g) the claimant is wholly or partially dependent upon any form of care in the same household as the respondent; or h) the claimant is a domestic worker in the respondent's household.

Empowerment
The main aim of all services should be to empower women survivors of violence and their children by, inter alia, making sure they know their rights and entitlements and can make decisions freely in a supportive environment that treats them with dignity, respect and sensitivityempowerment

Family Violence
Family violence and domestic violence are used inter-changeably in RSIPF documents. Family violence defined as abusive or controlling behaviour by a family member or several family members (not confined to a legal relationship) over another. Primarily violence is directed towards women and children. Violence and abusive behaviour include: physical, psychological, sexual, economic and social.

Fondling
Unwanted sexual touching of certain parts of the body such as the buttocks, breasts and genital area

Gang rape

Involves more than one person forcing another person to have sex. Most often gang rapes involve more than one male forcing a female to have sex, however gang rape can occur between the same sex and opposite sex.

Gender-based Violence
Gender-based violence (GBV) is the term used to describe unequal power relations between women and men and its contribution to gender violence. Gender-based violence is used to maintain gender inequalities and/or reinforce traditional gender roles, such as the subordinate and undervalued status of women in society and relationships. It results in physical, sexual and psychological harm to both women and men and includes any form of violence or abuse that targets women or men on the basis of their sex.

Gender-specific approach
Services need to demonstrate an approach which recognizes the gender dynamics, impacts and consequences of violence against women and their children within an equalities and human rights framework, including the need for women only services (WAVE 2010).

Incest
An incestuous relationship involves sexual activity between a child and her/his adult family members. Most often an incestuous relationship involves a male adult (father, uncle, adult brother) and a female child.

Rape
Is sex with any person without their consent. Rape means penetration. Penetration can be oral (in the mouth), anal or vaginal. It can happen to both females and males. The vast majority of rape is inflicted on women by men. It is rape even if there is no physical force, no weapons, no cuts or bruises. Rape can occur between the same sex and opposite sex.

Sexual Assault
Sexual assault is a crime involving any unwanted act of sexual nature that is imposed on another person. This includes sexual assault in a marriage or dating relationship. The range of behaviours considered as sexual assault range from rape (i.e. unwanted sexual intercourse) to unwanted fondling or touching.

Sexual Harassment
Any unwanted sexual attention in the workplace. It can involve unwanted comments, suggestions, sexualised talk, looks, repeated propositions for dates / dinner, demands for sexual intercourse, touching, sexual insults, threats of demotion and job loss for not having sex, promised favours of promotion for sex. Harassment can also take place in non-working situations where a person in 'authority' and respect exploits their position of trust and power. Examples of this include teachers, lecturers or principles who sexually harass students and religious leaders who target members of their congregation.

Survivor-centered approach
A survivor-centered approach means that all those who are engaged in violence against women programming prioritize the rights, needs, and wishes of the survivor. The survivor-centered approach is based on a set of principles and skills designed to guide professionals - regardless of their role - in their engagement with women and girls who have experienced sexual or other forms of violence. The survivor-centered approach aims to create a supportive environment in which the survivor's rights are respected and in which she is treated with dignity and respect.

Violence Against Women

Violence against women (VAW) is a technical (and political) term used to collectively refer to violent acts that are primarily or exclusively committed against women. Violence against women is a form of Gender Based Violence3 (GBV). Most GBV is upon women. VAW is any form of violence against women that does, or is likely to, result in physical, sexual or psychological harm or suffering, including threats of violence and arbitrary deprivation of liberty, whether occurring in public or private life (UN Declaration on Violence Against Women 1993).

It includes, but is not limited to:

- Domestic violence
- Early forced marriage
- Commercial sexual exploitation of women, including forced prostitution
- Sexual violence, including:
- intimate partner violence
- rape
- incest
- child sexual abuse
- knowing transmission of STIs and HIV
- Sexual harassment
- Other forms of violence:
- violence against women during/after armed conflict or emergency
- trafficking of women,
- acts of violence intended to reinforce gender hierarchies and/or perpetuate gender inequalities (such as harmful “traditional” practices),
- homophobic violence and other hate crimes.

Annex 11

CHECKLIST FOR CONFIDENTIALITY

- Distinguish between identifying and non-identifying data being collected;
- Remove all identifying information about individuals or incidents from reports for monthly meetings and submitted on quarterly basis;
- Interviews should be conducted privately.
- Do not share files/data with others in office/outside office;
- Keep records in locked, safe, secure space/ filing cabinets;
- Be aware of who you talk to, where you talk, who else is around, how will the information will be perceived.
- Discussing details of the case should be on a 'need to know basis' only.
- Do not release the name of the survivor/victim;
- Ensure survivor/victim permission is secured to share file information by tick box on SAFENET standard referral form
- Identifying data will be used in case management meetings, consent of survivor/victim needed;
- participants in case management meetings must be invited; it is <u>not</u> a regular open meeting for "key actors
- Non-identifying data will be used in monthly SAFENET meetings
- Don't distort details when venting your feelings about the story to your spouse
- Be aware: You may be duty bound to talk about a case when there are threats of harm.

Why is there a need for confidentiality?

The survivor/victim trusts you to keep whatever information you have received safe. It is important that there is confidentiality in this work to avoid a survivor/victim being ridiculed, to avoid misinterpretation of facts, distortion or malicious use of the information. People do not hear things in the same way and interpret things differently. Non-confidentiality can destroy your chances of intervention. Confidentiality protects the image and integrity of those who give information.

It is important to maintain confidentiality for the safety of both the survivor/victim and the person receiving the information. Even if the information you receive as a practitioner is fabricated, remember to keep it confidential in order not to damage someone's life.

Annex 12

DRAFT REFERRAL SAFENET GBV/VAW/DV FORM

STANDARD REFERRAL FORM Date: _____ Case #:_____

To: _____

From: _____

Reason for referral (please tick appropriate box)

Social Welfare

☐ Child Welfare Protection ☐ Family In Destitute

Family Support Centre

☐ Therapeutic Counseling ☐ Legal Clinic

Christian Care Centre

☐ Temporary Shelter ☐ Pastoral Counseling

RSIPF

☐ Safety condition ☐ Criminal Investigation ☐ Bail

Public Solicitor

☐ Protection/ Restraining order ☐ Other

NRH / Health Clinic

☐ Medical care ☐ Wound care ☐ EC ☐ PEP ☐ STI/HIV treatment

☐ Tetanus ☐ Hepatitis B vaccine

Client's Details

Name: _____ Address: _____

Age: _____ Alternative Address: _____

Sex: _____ Occupation: _____

Marital status: _____Religion: _____ Province:_____

Type of incident: _____ Place of incident: _____

Date of incident: _____ Time of incident: _____

☐

Phone : _____ No. of visit:
Name of care giver (if survivor is a child): _____

Does the survivor have a safe place to go? [[Yes] No]

Does the survivor plan to report to the police? [Yes] [No] [Already]

Details of Children, if they will also be affected or unsafe

NAME	**SEX**	**AGE**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name and function of staff present during treatment/interview by referring service provider:

_____
_____
_____

What has been done by referring service provider**?**[Attach documentation if relevant]

Date of treatment / interview: _____

Description:_____
_____
_____
_____
_____Intended follow up:
_____

Other service providers attended to survivor:

_____
_____
_____

Perpetrator details:

Can the survivor identify the perpetrator(s)? [Yes] [No]

Name: _____ Address: _____
Sex: _____ Age: _____Occupation: _____ Phone: _____
Relationship to victim: _____Province/Nationality: _____
Description (if perpetrator unknown): _____

_____**Brief history or nature of the incident**

_____
_____
_____
_____
_____
_____
_____
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_____
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_____
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_____

Referring officer sign: _____ Date: _____Time: _____

Annex 13

Towards a non-judgemental approach

What you need to be aware of as a practitioner

As a person working with abused women:

- Be aware of your own attitudes, experiences and reactions to violence.
- Be non-judgemental, and objective.
- Know your own limitations – you are there to help her define her problems, not to solve them.
- Be aware of your own needs to be a powerful expert or rescuer. Remember that there are many different ways of helping. You can help by listening, by just being there, by referring a victim to resources. Most importantly, let the victim know that you care.
- Keep in mind that there are many barriers to leaving a relationship. Encourage the victim to find her own strength and make her own decisions. Do not be surprised if she is not able to break free of the relationship this time.
- Respect the victim/survivor as an individual. Respect her problems, concerns and feelings and respect individual differences in handling and dealing with domestic violence.

Source:
Gender Studies and Human Rights Documentation Centre VAW Training Manual

Annex 14

WHAT YOU CAN DO TO HELP AN ABUSED WOMAN

The objective of any intervention is to help the abused woman make her own decision. As a resource person working with victims therefore, your main duty is to put all the options before her and allow her to make her choice. Below is a list of things you should or should not do.

DO

Believe her: Accept what the woman is telling you. Do not dismiss her remarks as those of a "hysterical woman". Tell her you believe her. Affirmation of the woman is of primary importance. Identify the ways she has developed coping strategies, solved problems and exhibited courage and determination. Affirming her strengths, the efforts she has taken and will take to end the abuse are very important. Believe her and give her credit for being in the best position to evaluate the risks of separation from the abuser. Reiterate, whenever possible that she is not responsible for the abuser's behaviour.

Listen and let her talk about her feelings: Sensitive listening is very important. This may be the first time the abused woman has told her story. The usual experience of abused women is that no one listens to them or takes them seriously. Either as a professional or as a friend, the most effective help you can provide is an open ear. Do not tell an abused woman what she should or should not be thinking. This is all part of being non-judgemental.

Give clear messages:

- ✓ violence is never okay or justifiable
- ✓ the safety of the woman and her children is always the most important issue
- ✓ wife assault is a crime
- ✓ she did not cause the abuse
- ✓ she is not to blame for her partner's behaviour
- ✓ she cannot change her partner's behaviour
- ✓ apologies and promises will not end the violence
- ✓ she is not alone
- ✓ she is not crazy
- ✓ abuse is not loss of control, it is a way of controlling another person

- Talk with her about what she can do to plan for her and her children's safety. Allow her to make her own decisions.
- Help her find the good things about herself and her children
- Know the key resources in the community and how to contact them
- Respect her confidentiality
- Establish trust and build confidence. Let her know that she can rely on you to keep her secrets safe
- Deal with her injuries
- **Use her knowledge** – when exploring an abused woman's options, remember to use her knowledge of the situation. For example, if she leaves her partner for a few days, what does she think he will do? What does she see

happening if she stays with him? Even though she may be emotionally upset, an abused woman still understands her partner and her life better than you do as an outsider.

- **Ask questions** – Help her explore her feelings and options by asking her questions. For example, if she is going to stay in the relationship because she feels her partner will stop beating her, gently ask her why she feels this way? What makes her believe he will change? Elicit information about the abuse in a sensitive and supportive manner.

An abused woman needs our support and encouragement in order to make choices that are right for her. However, there are some forms of advice that are not useful and even dangerous for her to hear.

Don't

- Don't tell her what to do, when to leave or when not to leave
- Don't tell her to go back to the situation and try a little harder
- Don't rescue her by trying to find quick solutions
- Don't suggest you try and talk to her husband and try to straighten things out
- Don't tell her she should stay for the sake of the children

Source:
Gender Studies and Human Rights Documentation Centre VAW Training Manual