Building a Sustainable Legal-Health Social Service Referral System in the Palestinian Occupied Territory

progress, challenges and lessons learned

Juzoor for Health and Social Development

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- **Overall objective was:**

  Contribute to improving overall delivery of legal, health, and social services for women victims of gender based violence and those at risk of violence.

Target group(s)

- Government sector: National policy makers and key individuals in the Ministry of Health, Ministry of Justice, Ministry of Interior, Ministry of Women's Affairs, Ministry of Education, Ministry of Social Affairs and the President's Office;
- Civil Society Sector: NGOs, networks, coalitions
- Health and Social Sectors: doctors, nurses, midwives, social workers
- Law enforcement: police
- Decision Makers in Academic Institutions: heads of police academy, medical schools, midwifery schools and nursing schools.

Main Activities :

- Form a Steering Committee , Sectoral Technical Committee
- Network with SALMA partners and Euro-Mediterranean organizations to learn from their experiences
- Carry out Site visits to selected country (ies)
- Needs Assessment on existed curricula for the medical, nursing, midwifery and police academy.
- Needs Assessment on existing services (social, legal and health services).

- Drafting the referral system and operational protocols , local consultants were hired to build the referral system
- The project developed "a service providers' directory" which has organizations' names, addresses and description for around 300 organizations that provide services to women victims of violence.
- Piloting in Ramallah district, and Evaluation of the pilot experience.

- Update the curricula of the medical, midwifery and nursing schools, the police academy, social and legal curricula.

- Campaign to Formalize the Referral System at National Level
  - Workshops, Meetings with government ministries, President's Office to *advocate for the new system*, Media campaign targeting decision makers and general public

Achievements and main strengths of the project :

- The development of the referral system is an important step towards institutionalizing the service beyond the personal and individual dealing with the cases.
- It was fully developed by Palestinian experts to fit the Palestinian context.
- The protocols were adopted by the national committee to combat violence against women, a national committee chaired by the MoWA.
- The MoWA and MoSA have the responsibility present the systems to the Palestinian cabinet for endorsement and follow up.

- A national Palestinian referral system has been developed for cases of GBV as well as new standard operating procedures for police, health and social service sectors on how to work with survivors for all participating organizations.

- Screening procedures for organizations that do not focus on GBV but are traditional entry points for survivors have also been developed.

- A unified intake, referral and confidentiality forms, centralized through MoSA, has been developed so that a survivor does not have to repeat her story to different providers.

Challenges

- Mapping of the quality of service providers has not yet been undertaken.
- However, the project is experiencing roll out issues stemming from attitudes among non-GBV organizations, particularly healthcare providers.
- In addition, some of the major service providers are reluctant to replace their own customized intake and referral forms in support of a unified system where all information is centralized.

Challenges

- Coordination of work of referral system, follow up on cases, and ensuring monitoring and reporting can be complicated and time consuming.

- Having to deal with gender-based violence places additional pressure on already over-worked health care providers. It may result in their resistance to engaging with VAW issues.

- Referral systems are highly dependent on the capacity and competency of a professional staff. Thus, there is always a strong need for on-going monitoring of standards and quality of services (internally and externally) and capacity building.

- It is challenging to overcome culturally specific barriers.
  - social structure rests on principles of family honor, formal relations between families. Women are afraid that if their situation becomes public they will lose their privacy or hurt the family honor and reputation. Obligatory reporting can reduce the willingness of victims to seek help.
  - Security is always an issue. Some women that attend health clinics can be accompanied by perpetrators or family members, which raises issues of privacy and confidentiality.

"if I protest I'll be marked in the society and then my daughter wouldn't be able to get married…

If I voice my protest the community will blame me for not bearing it in silence. This helplessness is a torture in itself."

- the approaches and intervention mechanisms used in both public and private institutions still not providing women with complete protection from violence. A number of factors contribute to this, including:
  - the failure of the legal frameworks applicable in the oPt to provide women with adequate legal protection, especially in the case of the Palestinian penal code, personal status law, and civil status law.
  - Additionally, the work of institutions on cases of VAW in the oPt is in most cases unsystematic in terms of follow-up, coordination with other relevant institutions, and approach in service provision.

Some significant achievements have been made towards combating VAW by both ,the PA and civil society organizations in the last 10 years

- In 2005, a ministerial decision to combat VAW was issued by the Palestinian Council of Ministers.
- The first safe shelter for women victims of violence was opened in coordination with MoSA in 2007 .
- The PA formally recognized VAW as a collective problem in Palestinian society through the formation of a National Committee to Combat VAW in 2008.
- In the same year Family protection units were created in 2008 in police departments in different districts in West Bank and a ministerial decision was issued by the Palestinian cabinet to adopt gender-responsive budgeting.

More progress….

- CEDAW was endorsed in 2009 and the UN Security Council Resolution 1325 was adopted by the PA in 2006.

- NGOs have created coalitions and lobbying campaigns for combating VAW, which in turn, have contributed to the spreading awareness of and work on the issue from the private to the public sphere.

- Women's organizations have established income generating projects for women's economic and social empowerment.

And more …

- Many service providers (health, education, counseling) received training on GBV and gender equality.
- the PA in collaboration with civil society stakeholders has developed a *National Strategy for Combating Violence against Women (VAW) 2011-2019* which provides a blueprint for building the institutional infrastructure needed to holistically prevent and address VAW across six targeted Ministries.
- And in 2013 the Palestinian cabinet endorsed the national referral system.

But …

- These achievements are tempered by deeply rooted socio-cultural attitudes that continue to approve the right of males to exert their control over women.

- Income generating projects have failed to produce a viable income for women and are limited to economic roles which are socially acceptable for women.

- The national strategy awaits implementation.
- GBV Services in the public health care system are limited and fragmented.

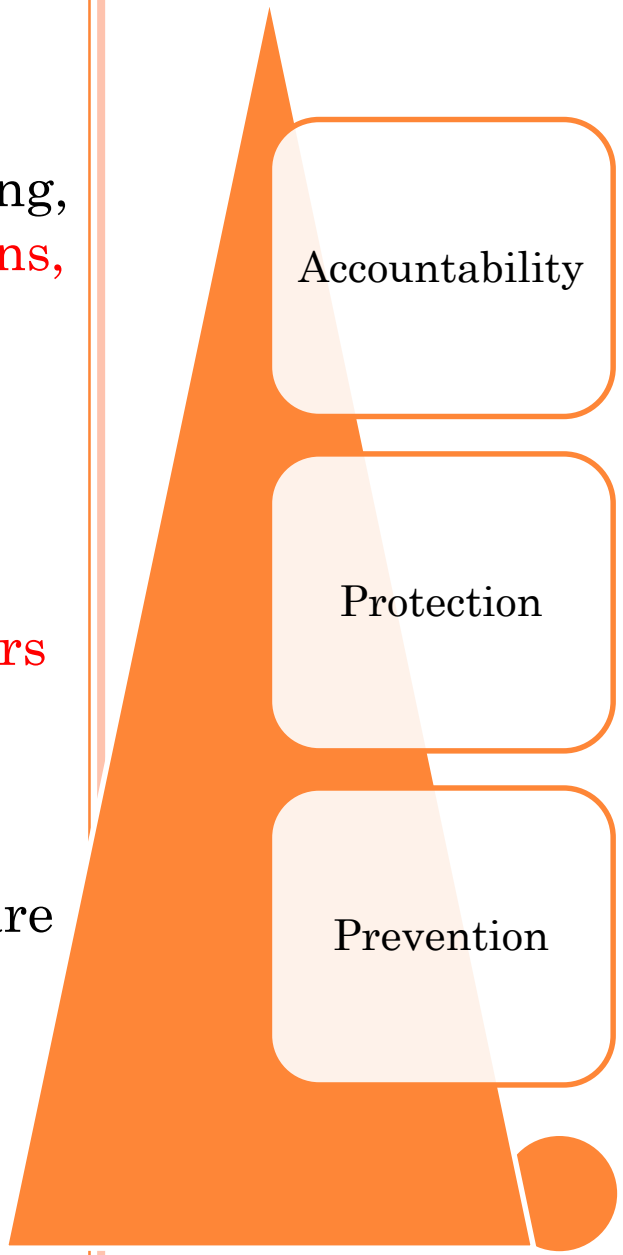
- The results of the violence survey in oPt, 2011 as well as a survey carried out in 2012:
- 57.6% of women ignore the violence and accommodate themselves to live with it.
- 51.3 % discussed the subject with their husbands and demanded to stop the violence .
- 30.2 left the house to the house of one of the parents or relatives.
- 1.6 only sought the advice of community leaders like ‘Mukhtar”.
- 0.7 seeking help at a medical center or police or community foundation .

Our Guiding Principles

- Prevention of gender-based violence from occurring in the first place, and from recurring, by working with local grassroots organizations, civil society, and key stakeholders in the community, including men and boys;

- Protection from gender-based violence by identifying and providing services to survivors once the violence occurs; and

- Accountability to ensure that perpetrators are prosecuted and to end impunity by strengthening legal and judicial systems.



What have we learned from this experience???

- **The multi-sectoral model: health sector, psychosocial sector, legal/justice sector, security sector..has some limitations!!**

- One of the limitations of the multi-sectoral model as it exists to date is that it specifies many of the sectoral responsibilities in terms of response but gives limited attention to prevention. Where it does identify prevention activities, it fails to prioritize them or even provide a conceptual framework for prioritizing them
- It concentrate the efforts at the tertiary, or operational response level.
- However, the most they can hope to achieve at this level is to mitigate the intensity of the problem for individuals who have suffered violence.

The multi-level model

- For effective short- and long-term GBV prevention, interventions must take place across all the key sectors and at three levels, so that structural, systemic and individual protections are institutionalized. These levels are as follows:

  - Primary prevention/structural reform: law reform, policy development within ministries of health, social welfare, justice and security, Human rights education

- Secondary prevention/systems reform, which includes systems and strategies to monitor and respond:
  - Intervention at this level includes developing and building the capacity of legal/justice systems, healthcare systems, social-welfare systems and community mechanisms

- Tertiary prevention/operational response, which includes response at the individual level through direct services to meet the needs of women and girls who have been subjected to GBV:
  - Case management, referral and advocacy, Counseling and support, Medical forensic examination, treatment and follow-up, Linkage with police and courts, Court support through the judicial process

Changing the Norms around GBV

- community-based education efforts
- Programs for men aimed at promoting gender equitable relationships
- Behavior change mass media campaigns and edutainment
- Incorporation of gender equality, human rights and violence prevention into school curricula

- According to the UNFPA mapping of combating GBV projects in Palestine during 2014: “the main area of interventions is training/capacity development, that together with awareness make up for around 37% of interventions both in West Bank and Gaza.
- Prevention appears to be stronger than response at the level of services. 9% of respondents provide services in West Bank and 7% in Gaza.
- Among the services provided the higher percentage covers the provision of psychosocial support for victims of GBV, and the weakest is the health response.

Training outline for the services providers

- Introduction to concept of gender
- The social status of man and women in the local context
- Introduction to Violence and violence against women
- The role of the health care providers
- The ethical values to work with women victims of violence
- Identifying , assessment, documentation and referring cases
- Intervention phase with women

- Safety plan
- Referral pathways with the health sector and with other sectors
- Training of trainers skills

Trainees are….

- Case manger at the clinic level, GBV focal person, trainers to work with health care providers at the targeted clinics.
  - ToT will be for three days
  - Trainees will conduct the clinic training
- Clinical training will be done for two sessions (two hours each session)
- The clinical training will address GBV in term of definition, statistics, health consequences of GBV, role of HCP, ethical consideration, identification and assessmnet of cases, …..

- ToT will be conducted first (February 2018).
- Training materials will be presented for the stakeholder for feedback.
- Follow up visits with the clinics (monthly visit) for any comment or feedback.

Conclusion

- The process of developing a referral system needs time and patience. Visible results may take even a longer time to be appreciated.