Data that as many as seven in ten women in the world report experiencing physical and/or sexual violence at some point in their lifetime[1]. The impact of violence against women on health, productivity, economy and therefore a country’s ability to achieve its goals is violence and does not always include other forms of violence. The challenge is partly in the resistance to legislating broader gender-referral pathway [14].

important for securing positive justice outcomes. However, most resource limited settings lack requisite facilities for a functional evidence chain, a criminal data bank, decentralised DNA capacity and follow-up mechanisms. Offenders' registers do not exist, and thus any DNA matching would be problematic [15], compromising the purpose for which they are promoted. Further evidence suggests that proper documentation is more likely to result in a positive justice outcome than DNA[16]. Additionally procedures for maintaining a secure chain of evidence (documentation, management, handover and accountability of evidence) across the different sectors are lacking, providing legal challenges to attaining positive justice outcomes for survivors.

Expansion of services requires availability of commodities and supplies. Health sector services require supplies for examination and treatment of injuries, drugs for prevention of sexually transmitted infections including HIV, pregnancy in the context of sexual violence, availability of nationally recognized data collection tools at the point of care. Within the legal, order and justice and social services, availability of secure crime scene investigation commodities, logistics for maintaining the integrity of the evidence chain (collection, management, documentation) and tools for data collection are required, but often are not part of sector resource envelopes

Thus, even where standards are available, the lack of commodities and supplies necessary for coordinated implementation and actual service delivery translates to inability to expand services.

Provider competencies are a key aspect to the quality of care. Currently few countries have national sector specific training curricula and fewer still have standardized cross-sectoral training curricular. Such cross-sectoral training would include management of evidence, legal provisions, evidentiary requirements, management of evidence, standardized referral pathways and referral tools. These are elements common to all sectors that provide VAW services. Providers' training is also not institutionalized as part of primary provider training for instance, in police training schools, in social worker training or in medical training school.

Further, training for VAW services does not often explore values and deconstruct values of providers that perpetuate stigma and discrimination in service delivery points.

<u>Measuring the success of expansion of VAW services remains problematic</u>: Developed countries that have legislation they al2 (80.2 (y) 55.4 (V) -( ) -20 Tm /F2 (ha) A) -0.2 5.4 (V24 143.527

national reporting frameworks. Lobby for agencies in-country to be responsible for VAW is necessary.

2. In-country coordination mechanisms for the different stakeholders are urgently required.
3. Opportunities for different stakeholders to meet and define and create consensus on outcomes, coverage of the different types of services (to meet the often very diverse needs of survivors), and on multi-sectoral indicators for GBV services, should be harnessed.

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ANNEX 1: The LVCT research-policy-practice cyclic model

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