

**PUTTING SURVIVORS AT THE CENTER:**  
CREATING NEW PROGRAMMING MODELS FOR NON-GBV  
SPECIALIST ORGANIZATIONS TO SUPPORT GBV SURVIVORS

# Barriers to and Challenges Accessing Specialized Care for Survivors of Gender-based Violence: Formative Research Findings from the Democratic Republic of Congo, Iraq, and South Sudan

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The first part of this baseline report is a literature review of the barriers to GBV service provision in low- and middle-income, and conflict settings. The review also explores existing research on the efficacy and successes of program interventions aiming to challenge these barriers to help survivors seek specialized GBV services. The second part of this baseline report includes primary research on the barriers and challenges to GBV service provision in the DRC, KRI, and South Sudan and the many recommendations that were made to overcome these barriers and challenges by key stakeholders in these three locations. This data was collected during in-country "design" workshops as well as through focus group discussions and key informant interviews with survivors, women and girls, community leaders, and civil society members.

# Acronyms

<b>ADR</b>	Alternative dispute resolution	<b>LGBTQ+</b>	Lesbian, gay, bisexual, trans, queer and other non-cis heterosexual identities
<b>AMHR</b>	Applied Mental Health Research Group	<b>MHPSS</b>	Mental health and psychosocial support
<b>CBT</b>	Cognitive behavioral therapy	<b>MISP</b>	Minimum Initial Service Package for Reproductive Health in Crisis Situations
<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination Against Women	<b>MSF</b>	Médecins Sans Frontières
<b>CHW</b>	Community healthcare workers	<b>NFI</b>	Non-food items
<b>CIJ</b>	Customary and informal justice systems	<b>NGO</b>	Non-governmental organization
<b>CMR</b>	Clinical management of rape	<b>OBA</b>	Output-based aid
<b>CTP</b>	Cash transfer programs	<b>OSC</b>	One-stop centers
<b>DRC</b>	Democratic Republic of Congo	<b>PEP</b>	Post-exposure prophylaxis
<b>EC</b>	Emergency contraception	<b>PFA</b>	Psychosocial first aid
<b>FBO</b>	Faith-based organization	<b>PPE</b>	Personal protective equipment
<b>FGD</b>	Focus group discussions	<b>PSAC</b>	Putting Survivors at the Center: Creating New Programming Models for Non-GBV Specialist Organizations to Support GBV Survivors
<b>FGM/C</b>	Female genital mutilation and/or cutting	<b>PSS</b>	Psychosocial support
<b>FORAL</b>	Foundation RamaLevina	<b>PTSD</b>	Post-traumatic stress disorder
<b>GBV</b>	Gender-based violence	<b>PwD</b>	People with disabilities
<b>GBVIMS</b>	GBV Information Management System	<b>SOP</b>	Standard operating procedures
<b>GWI</b>	Global Women's Institute	<b>SRH</b>	Sexual and reproductive health
<b>HCP</b>	Healthcare providers	<b>TF-CBT</b>	Trauma-focused cognitive behavioral therapy
<b>IASC</b>	Inter-Agency Standing Committee	<b>TOR</b>	Terms of reference
<b>ICT</b>	Information and communication technologies	<b>UN</b>	United Nations
<b>IDLO</b>	International Development Law Organization	<b>UNICEF</b>	United Nations Children's Fund
<b>IDP</b>	Internally displaced persons	<b>VSLA</b>	Voluntary savings and loan associations
<b>INGO</b>	International non-governmental organization	<b>WfWI</b>	Women for Women International
<b>IPV</b>	Intimate partner violence	<b>WRC</b>	Women's Refugee Commission
<b>IRC</b>	International Rescue Committee		
<b>KII</b>	Key informant interviews		
<b>KRI</b>	Iraqi Kurdistan		

# Gaps and Barriers to GBV Service Provision in Low- and Middle-Income Countries and Humanitarian Settings: A Review of Existing Sources

## Barriers to GBV Services

### STIGMA AND HARMFUL SOCIAL NORMS

In humanitarian contexts around the world, GBV survivors face stigma and social norms that often shame survivors and place the blame for sexual violence on survivors.<sup>1</sup> Survivors often fear that knowledge about their experience of GBV will result in societal rejection, by their families and the wider community, and social isolation.<sup>2</sup> Stigma and social norms also contribute to the normalization of GBV, especially intimate-partner violence.<sup>3</sup> This stigma frequently prevents survivors from seeking specialized GBV services, especially when issues of confidentiality are associated with certain care providers.<sup>4,5</sup> As well, fear of rejection by their families and their communities, and fear of retaliation commonly prevent survivors from disclosing an instance of violence. In certain contexts, survivors will forego seeking care services and reporting an instance of GBV for fear that their families will experience “affiliation stigma” because of their experiences.<sup>6</sup> In all cases, actual stigma and perceived stigma contribute to survivors’ “feelings of helplessness and insecurity,” and can consequently prevent survivors from seeking and receiving the support and care that they need in the aftermath of an experience of GBV.<sup>7</sup> Worse, social stigma can make it difficult and in worst cases, prevent survivors from accessing formal justice, as communities and families might prefer to solve GBV cases internally, as GBV is often seen as a “private” issue that should not be publicly discussed.<sup>8</sup> Importantly, social stigma is not reserved for GBV alone, but can equally plague survivors seeking specific types of services or care that are also stigmatized within their communities, such as mental and psychosocial support services.

- 1 GBV AoR, “[Strengthening Access to Justice for GBV Survivors in Emergencies](#),” 2020.
- 2 Nancy Perrin et al., “[Social Norms and Beliefs about Gender Based Violence Scale: A Measure for Use with Gender Based Violence Prevention Programs in Low-Resource and Humanitarian Settings](#),” *Conflict and Health* 13, no. 1 (March 8, 2019): 6.
- 3 Sarah M. Murray et al., “[Measuring Sexual Violence Stigma in Humanitarian Contexts: Assessment of Scale Psychometric Properties and Validity with Female Sexual Violence Survivors from Somalia and Syria](#),” *Conflict and Health* 15, no. 1 (December 24, 2021): 96.
- 4 Sara E. Casey et al., “[Care-Seeking Behavior by Survivors of Sexual Assault in the Democratic Republic of the Congo](#),” *American Journal of Public Health* 101, no. 6 (June 2011): 1054-55.
- 5 Kennedy Amone-P’Olak, Ask Elklit, and Sarah Bøgelund Dokkedahl, “[PTSD, Mental Illness, and Care among Survivors of Sexual Violence in Northern Uganda: Findings from the WAYS Study](#),” *Psychological Trauma: Theory, Research, Practice, and Policy* 10, no. 3 (May 2018): 282-89.
- 6 Murray et al., “[Measuring Sexual Violence Stigma in Humanitarian Contexts](#).”
- 7 Sheru Muuo et al., “[Barriers and Facilitators to Care-Seeking among Survivors of Gender-Based Violence in the Dadaab Refugee Complex](#),” *Sexual and Reproductive Health Matters* 28, no. 1 (2020): 1722404.
- 8 GBV AoR, “[Strengthening Access to Justice for GBV Survivors in Emergencies](#).”

# Barriers to Justice

## FORMAL LEGAL SYSTEM

Broadly, state-level barriers include a variety of factors such as weakened judicial systems<sup>9</sup>; the lack of importance attributed to GBV by state actors and the formal legal system<sup>10</sup>; gender discrimination within the security sector and especially among local police who are often the first-line of responders GBV incidents<sup>11</sup>; limited state-provided funding for GBV services<sup>12</sup>; and lack of awareness on the part of survivors regarding their legal rights<sup>13</sup>. In an IRC assessment of GBV in the Hagadera Refugee Camp (in the Dadaab refugee complex located in Northeast Kenya), a crucial barrier for GBV survivors seeking care is the lack of confidence in the formal judicial system operating within the camp. Survivors identified a lack of police follow-up on reports of GBV, police corruption, and low successful judicial prosecutions of perpetrators as key reasons for not seeking police report.<sup>14</sup> Similarly, in South Sudan, political patronage and the corresponding corruption of the formal legal system is frequently cited as disincentivizing relative to reporting GBV and seeking care following an experience of GBV.<sup>15</sup> For non-host communities, like Syrian refugees in Iraq, trust in the legal system of the host country is minimal and is a major barrier for reporting and seeking GBV specialist services.<sup>16</sup> This is especially true for refugees without proper legal paperwork (e.g., national IDs, birth certificates, etc.).

In many countries, an overall lack of legal protections from GBV serves as a primary barrier to seeking justice.<sup>17</sup> Even in countries with laws protecting against GBV exist, their enforcement may be weak, and the definitions of GBV included in these laws might be minimal or worse, discriminatory.<sup>18</sup> For example, laws that allow perpetrators of rape to escape punishment if they choose to marry their victims (known as “marry your rapist” laws), and laws that acknowledge domestic violence but exclude marital rape as a punishable offense.<sup>19</sup> As well, many discriminatory laws exist that require a female survivor of violence to meet a high burden of proof, whereas male perpetrators are not held to the same standard.<sup>20</sup> In South Sudan, women are required by law to produce four witnesses; only a judge can waive this requirement.

- 9 GBV AoR, “Strengthening Access to Justice for GBV Survivors in Emergencies.”
- 10 South Sudan Women’s Empowerment Network (SSWEN), “Initial Assessment and Mapping: Reducing Inequality and Gender-Based Violence in South Sudan: Case Studies for Wau, Juba, and Renk.”
- 11 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”
- 12 Women for Women International (WfWI), “‘What of Our Unfulfilled Promises?’ Situational Assessment and Policy Brief on Syrian Women Refugees’ Experiences in the Kurdistan Region of Iraq” (Washington, D.C., 2022).
- 13 Sarah B. Barnes, “Accessing Justice for Gender-Based Violence in Humanitarian Settings,” Gender-Based Violence Dispatch (Washington, D.C.: Wilson Center, December 2021).
- 14 Sinead Murray and Anne Achieng, “**Gender Based Violence Assessment: Hagadera Refugee Camp (Dadaab, Kenya)**,” Save the Children’s Resource Centre, May 2011.
- 15 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”
- 16 Emma MacTavish, “Barriers of Reporting Sexual Violence in Syrian Refugee Camps” (MA Thesis, Victoria, British Columbia, Royal Roads University, 2016).
- 17 GBV AoR, “Strengthening Access to Justice for GBV Survivors in Emergencies.”
- 18 High-Level Group on Justice for Women, “Justice for Women: High-Level Group Report,” 2019.
- 19 GBV AoR, “Strengthening Access to Justice for GBV Survivors in Emergencies”; ActionAid, “The Justice Deficit: A Global Overview,” 2018; High-Level Group on Justice for Women, “Justice for Women: High-Level Group Report.”
- 20 Claire Walkey et al., “**The Legislative Frameworks for Victims of Genderbased Violence (Including Children) in the 27 Member States**” (European Parliament’s Committee on Women’s Rights and Gender Equality (FEMM), 2022).

Meanwhile, the testimony of a man is accepted if he swears on the Qur'an.<sup>21</sup> Other discriminatory practices can include forcing a survivor to give testimony or present evidence in front of the perpetrator.<sup>22</sup> In some settings, the requirement of certain legal paperwork to receive any kind of formal care following an experience of GBV can serve as a barrier to aid and justice. For example, in South Sudan the continued use of Form 8—which is a police form that was at one point required from all survivors in order to receive medical assistance—even though this is no longer a legal requirement, prevents survivors from accessing medical and other types of GBV services. Instead, survivors report that police and other state representatives, as well as some hospitals and medical cleanings, continue to ask for Form 8, causing confusion for survivors. As well, some survivors reported that police were selling these forms, rather than distributing them freely, making it even more difficult for survivors to seek support.<sup>23</sup>

The breakdown of formal legal systems because of conflict also serves as a barrier to survivors seeking justice. This breakdown can lead to high levels of impunity for perpetrators, especially if the perpetrators are linked to the military or other political groups<sup>24</sup>, and relatedly, can stall the implementation and enforcement of laws meant to protect survivors.<sup>25</sup>

## COMMUNITY GOVERNANCE AND CUSTOMARY LAW

Around the world, customary and informal justice systems—which can include customary law, religious laws, and indigenous rules and practices<sup>26</sup>—“are central to women’s experiences of accessing justice.”<sup>27</sup> In humanitarian settings in particular, the breakdown of the state systems and institutions makes informal justice systems the primary source of justice, including for survivors of GBV, “even when these systems are not mandated to address GBV or do not prioritize survivors’ safety, well-being, and rights.”<sup>28</sup>

Until recently, under the CEDAW, approaching or working with community and informal justice systems, or other alternative dispute resolution (ADR) processes, was frowned upon as a method of securing justice for survivors of GBV, as CIJ systems “were seen to encourage lenient approaches to gender discrimination, especially [GBV], with customary systems particularly criticized for reinforcing patriarchal values and imposing harmful outcomes for women.”<sup>29</sup> But, in 2017, the CEDAW amended its advice in the Committee’s General Recommendation No. 35, which “allows GBV to be adjudicated through ADR processes in specific circumstances.” According to IDLO, this approach acknowledges that formal systems are just as flawed as customary and informal systems (CIJ) systems; it also recognizes that survivors may not want to pursue formal charges against a perpetrator for fear of further stigmatization

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- 21 South Sudan Women’s Empowerment Network (SSWEN), “Initial Assessment and Mapping: Reducing Inequality and Gender-Based Violence in South Sudan: Case Studies for Wau, Juba, and Renk.”
  - 22 GBV AoR, “Strengthening Access to Justice for GBV Survivors in Emergencies.”
  - 23 South Sudan Women’s Empowerment Network (SSWEN), “Initial Assessment and Mapping: Reducing Inequality and Gender-Based Violence in South Sudan: Case Studies for Wau, Juba, and Renk.”
  - 24 South Sudan Women’s Empowerment Network (SSWEN).
  - 25 The Global Women’s Institute, “No Safe Place: A Lifetime of Violence for Conflict-Affected Women and Girls in South Sudan” (Washington, D.C., 2017).
  - 26 GBV AoR, “Strengthening Access to Justice for GBV Survivors in Emergencies.”
  - 27 **International Development Law Organization (IDLO)**, “Issue Brief: Women and Customary and Informal Justice Systems,” September 10, 2020.
  - 28 GBV AoR, “Strengthening Access to Justice for GBV Survivors in Emergencies,” 16.
  - 29 International Development Law Organization (IDLO), “Issue Brief.”



and even retaliation.<sup>30</sup> In many cases, survivors might find CIJ systems more accessible, in terms of affordability, location, and even language. CIJ systems are also more appealing to survivors because they are perceived to be much faster than formal justice systems, which can take months, sometimes years, to conclude.<sup>31</sup>

However, CIJ systems pose specific problems for survivors. Just like formal legal systems, CIJ systems reflect social norms and values; in patriarchal societies, therefore, CIJ systems are more likely to impose patriarchal rules and norms. Multiple studies on GBV response in humanitarian settings highlight these tensions, noting that in many communities, customary law is enshrined within the formal legal system, as it is in the Transitional Constitution in South Sudan. This makes it nearly impossible to enforce national legislation on GBV where it exists. This is the case in South Sudan: although the Local Government Act of 2009 prevents customary law authorities from prosecuting cases of violence, these courts—known as Boma Courts, in reference to the smallest administrative area in South Sudan—remain “the most common form of conflict resolution” across the country.<sup>32</sup> In particular, Boma Courts and customary law focus on mediation and reconciliation “rather than protection of individuals or punishment of perpetrators,” which in practice leaves women and girl survivors at the mercy of their male family members, the male perpetrator and his kin or family members, and the male chiefs presiding over the Boma Courts.<sup>33, 34</sup> Further, common perceptions of GBV as a “private” or “family” matter put pressure on survivors and their families to “solve” these issues quickly through the Boma Courts, rather than pursuing formal justice.<sup>35, 36</sup> This is exacerbated by the belief that the customary system was “helping to keep families together” while the “national laws were perceived to promote divorce.”<sup>37</sup> The use of CIJ systems can therefore result in further harm to the survivor. CIJ systems can serve as a barrier to survivors exercising their own agency and voice relative to their experience of violence. As the IRC has noted relative to informal and traditional mediation systems, “there are very real concerns for how women and girls are treated [in these systems] and they often contradict international laws especially on the rights of women and children.”<sup>38</sup>

## Barriers to Specialized Healthcare Services

The Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations includes guidance on supporting survivors who have experienced sexual violence (e.g. clinical management for survivors of

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30 Beyond Borders, Center for Domestic Violence Prevention (CEDOVIP), and ICRW, “**Whose Justice, Whose Alternative? Locating Women’s Voice and Agency in Alternative Dispute Resolution Responses to Intimate Partner Violence**,” 2016.

31 GBV AoR, “Strengthening Access to Justice for GBV Survivors in Emergencies.”

32 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”

33 The Global Women’s Institute, “No Safe Place: A Lifetime of Violence for Conflict-Affected Women and Girls in South Sudan,” 13.

34 South Sudan Women’s Empowerment Network (SSWEN), “Initial Assessment and Mapping: Reducing Inequality and Gender-Based Violence in South Sudan: Case Studies for Wau, Juba, and Renk,” 14.

35 Murray and Achieng, “Gender Based Violence Assessment,” 25.

36 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”

37 Murray and Achieng, “Gender Based Violence Assessment.”

38 Murray and Achieng, 25.

rape) The consequences of sexual assault on a survivor's physical and mental health are well documented and may include physical injury, sexually transmitted infections (STIs) including HIV, unwanted pregnancy, unsafe abortion, anxiety, shame, post-traumatic stress, and depression, among others. Timely access to clinical care, delivered by competent and compassionate healthcare providers (HCPs), is essential to prevent adverse consequences and begin a survivor's physical and emotional healing.

However, limited clinical competency and negative attitudes among HCPs serve as a barrier to comprehensive, confidential, and supportive care seeking for survivors. This can lead to poor quality services and contribute to survivors' re-traumatization. A global review of health care-based interventions for survivors of sexual violence revealed that a lack of clinical competency and negative attitudes are prevalent among healthcare providers and often result in poor quality health services.<sup>39</sup> In the DRC, for example, a multi-stage cluster sample survey (n=607) found that of only 42 self-reported survivors, less than half (46.1%) accessed emergency care services within the 72-hour window for post-exposure prophylaxis (PEP) for the prevention of HIV; similarly, only 47.4% of survivors sought care within the 120-hour window for effective emergency contraception. Further, only three of these survivors reported being offered emergency contraception and/or PEP during their visits, while a simultaneous facility assessment conducted by the study team also revealed a lack of PEP and EC supplies at these healthcare facilities.<sup>40</sup> Studies have documented similar findings across humanitarian contexts, such as in the Gulu district of northern Uganda, where researchers have shown that "health facilities lacked sufficiently qualified staff and medical supplies to adequately detect and manage survivors, and confidential treatment and counseling could not be ensured."<sup>41</sup>

## General Barriers to Accessing GBV Services and Providers

Cost is widely identified as a primary barrier to survivors seeking specialized GBV services after an experience of violence.<sup>42</sup> Financial barriers to service provision are further exacerbated during conflict, given the disruption to livelihoods, currency inflation and devaluation, and the general conservation of financial resources by households that occurs during a crisis, which can mean funds are unequally redistributed away from the needs of high-risk household members like women and girl survivors. For displaced communities, these issues are worsened by legal restrictions on their ability to work in the host community, as well as their limited access to other basic needs like housing.<sup>43</sup> Financial barriers go beyond the inability to afford certain specialized services—in particular, studies emphasize that survivors often refuse medical intervention due to the associated costs<sup>44</sup> as well as costs affiliated with pursuing

39 Sandra L. Martin et al., "Health Care-Based Interventions for Women Who Have Experienced Sexual Violence: A Review of the Literature," *Trauma, Violence & Abuse* 8, no. 1 (January 2007): 3-18.

40 Casey et al., "Care-Seeking Behavior by Survivors of Sexual Assault in the Democratic Republic of the Congo."

41 Mirrka Henttonen et al., "Health Services for Survivors of Gender-Based Violence in Northern Uganda: A Qualitative Study," *Reproductive Health Matters* 16, no. 31 (January 1, 2008): 122-3.

42 GBV AoR, "Strengthening Access to Justice for GBV Survivors in Emergencies."

43 WRC, "Integrating Cash Assistance into Gender-Based Violence Case Management to Support GBV Survivors and Individuals at Risk in Jordan," 2022.

44 Jennifer McCleary-Sills et al., "Help-Seeking Pathways and Barriers for Survivors of Gender-Based Violence in Tanzania: Results from a Study in Dar Es Salaam, Mbeya, and Iringa Regions" (Dar es Salaam, Tanzania: EngenderHealth/CHAMPION, 2013).

justice through the formal legal system<sup>45</sup>—and include the threat of a survivor losing their livelihood source as part of retaliatory actions on the part of their families or their husbands, if they are married. Cost barriers also include “hidden costs,” which denote informal fees associated with receiving or accessing services, including transportation costs and childcare costs.<sup>46</sup> The limited availability of high-quality service providers in humanitarian settings is another widely acknowledged barrier preventing survivors from accessing care after experiencing GBV. For many, the limited options for high-quality services and care within their own communities means either spending money to reach services located in other areas or foregoing treatment and services altogether.<sup>47</sup>

Another key barrier to GBV services is the lack of strong, multisectoral collaboration between humanitarian actors.<sup>48</sup> While GBV sub-clusters, working groups, etc. often exist, local coordination groups are not active in all areas affected by humanitarian crisis or able to engage with every relevant stakeholder. These weaknesses in coordination result in service provision gaps, duplicate programming, and a siloed approach to programming and response that prevents an intersectional response to GBV in humanitarian crises.<sup>49</sup> Ideally, humanitarian organizations and agencies should be working together through country or local-level working groups and committees, and should adhere to the standard operating procedures (SOPs) and terms of reference (TORs) set out in The Inter-Agency Standing Committee (IASC) Task Force on Gender and Humanitarian Assistance.<sup>50, 51</sup>

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45 The Gender Equality Network, “Service Provision for Gender-Based Violence Survivors in Myanmar” (Yangon, Myanmar, April 2018).

46 **“Data Collection for Gender-Based Violence Risk Mitigation”** (GBV Guidelines, 2021).

47 Maria Liapi et al., “Final Report: Accessibility and Barriers to Gender-Based Violence Services for Refugee and Migrant Girls, Boys, Women, and Men in Greece” (Centre for Research on Women’s Issues Diotima, December 2019).

48 M. Marsh, S. Purdin, and S. Navani, **“Addressing Sexual Violence in Humanitarian Emergencies,”** *Global Public Health* 1, no. 2 (June 2006): 133–46.

49 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”

50 **“IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings, 2005** | IASC,” accessed July 24, 2023.

51 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”

# Barriers for Survivors from Other Vulnerable Communities: Male Survivors, Adolescent Girls, LGBTQ+ Communities, and People with Disabilities

## BARRIERS FOR MALE SURVIVORS

As the Inter-Agency Gender-Based Violence Case Management Guidelines (2017) note, while men experience many of the same barriers to care as women, they also face specific barriers because of their sex-gender identity. For example, norms and conceptions of masculinity frequently dictate that “men should be strong,” and, therefore, not complain or speak about their emotions. Hegemonic masculinity norms equate seeking help or emotional support with femininity, which can threaten a male survivor’s self-conception of masculinity.<sup>52</sup> Male survivors also face high levels of stigmatization, which can lead to “threats to their perceived notions of masculinity, self-doubt about their sexual orientation, [and] fear of rejection.”<sup>53</sup> Worse, legal frameworks that restrict the sexual activities of non-heteronormative communities can contribute to men’s fears about reporting sexual violence. For example, the existence of anti-sodomy laws across large swathes of the Middle East and in various African countries that make same-sex relations punishable, deter male survivors of sexual assault from reporting the incident, as the act is itself prohibited by law.<sup>54</sup> Further, many legal systems that recognize GBV are based on the assumption that sexual assault involves only male perpetrators and female victims, reinforcing the hegemonic notion that men “cannot” be survivors of GBV.<sup>55</sup>

Stigma surrounding GBV, as well as preconceived notions about who a victim can be (i.e., only women are presumed to be survivors, and men perpetrators) also affects the ability of service providers to properly support male survivors, as many do not recognize that men can equally be victims of sexual assault.<sup>56</sup> In their study of care-seeking behaviors of male refugee GBV survivors in Cox’s Bazar, Bangladesh, Rome and Sicily, Italy, and Nairobi and Mobasa, Kenya, Chynoweth et al. (2020) noted that many male survivors were unable to find safe and secure entry points to the referral system because there was a severe lack of safe spaces for men. Their study participants claimed that this was because “violence against [men and boys] is not recognized—by anyone.”<sup>57</sup> In some cases, studies have collected evidence that service providers frequently turn away men and boys seeking specialized GBV services on the basis that they are unable to provide the necessary care for these survivors.<sup>58</sup>

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52 Eli Teram et al., “**Towards Male-centric Communication: Sensitizing Health Professionals to the Realities of Male Childhood Sexual Abuse Survivors**,” *Issues in Mental Health Nursing* 27, no. 5 (2006): 499-517.

53 Ligia Kiss et al., “**Male and LGBT Survivors of Sexual Violence in Conflict Situations: A Realist Review of Health Interventions in Low-and Middle-Income Countries**,” *Conflict and Health* 14, no. 1 (February 26, 2020): 11.

54 Sarah K. Chynoweth et al., “**A Social Ecological Approach to Understanding Service Utilization Barriers among Male Survivors of Sexual Violence in Three Refugee Settings: A Qualitative Exploratory Study**,” *Conflict and Health* 14, no. 1 (December 2020): 43.

55 Chynoweth et al.

56 R. Charli Carpenter, “**Recognizing Gender-Based Violence Against Civilian Men and Boys in Conflict Situations**,” *Security Dialogue* 37, no. 1 (March 1, 2006): 83-103.

57 Chynoweth et al., “**A Social Ecological Approach to Understanding Service Utilization Barriers among Male Survivors of Sexual Violence in Three Refugee Settings**,” 13.

58 Women’s Refugee Commission (WRC), “**Addressing Sexual Violence against Men, Boys, and LGBTQ+ Refugees: Learnings from Pilot Projects in Bangladesh, Kenya, and Italy/Bulgaria**,” July 2021.

## BARRIERS FOR ADOLESCENT GIRLS

Adolescent girl survivors of GBV face many of the same barriers that women survivors face, including but not limited to stigma and social isolation, lack of familial support, lack of financial resources to access services, limited awareness of their legal rights as survivors, and inadequate service provider capacity across different sectors.<sup>59</sup> However, adolescent girls do face specific barriers to service provision given their dependent status: In many communities, girls are not allowed to seek services on their own without the permission of their parents or other guardians. Therefore, girls' access to services is generally dependent on whether they receive support from their family members in the aftermath of an experience of violence<sup>60</sup> as well as the fact that they are frequently too young to access women's services and too old to access child-friendly programming. Adolescent girls also face specific forms of GBV, including child, early, and forced marriage and female genital mutilation and/or cutting (FGM/C) that requires targeted prevention and response mechanisms.<sup>61</sup> Globally, however, targeted service provision for adolescent girls is weak and falls short of meeting the requirements set out by global guidelines for GBV service provision in humanitarian contexts.<sup>62</sup>

## LGBTQ+ SURVIVORS

Individuals who identify as part of the LGBTQ+ community are at an increased risk of discrimination and violence because of their real or perceived sexual orientation, gender identity, or gender expression.<sup>63</sup> Hate crimes, "corrective" crimes and "conversion" therapy, and other forms of violence are often perpetrated against LGBTQ+ individuals based solely on their perceived or real identities, and is driven by homophobic and transphobic attitudes.<sup>64, 65</sup> While LGBTQ+ survivors face many of the same barriers to GBV care as other survivors, they also face specific barriers, including safety concerns, shame specific to their sexual and gender identity, lack of a support network, discriminatory attitudes of service providers, legal punishment of non-heteronormative sexual relations and activities, a fear of being "outed," and a lack of specialized services, among others.<sup>66</sup> For these reasons, disclosure of GBV by LGBTQ+ survivors is low, making it difficult for humanitarian organizations to collect more data on the scope of the issue, and the specialized needs of survivors.<sup>67</sup> Although evidence points to the heightened risk of GBV facing LGBTQ+ communities and the barriers that prevent them from accessing timely and high-quality care, a lack of evidence exists about the types of practice and programming that responds to these specific needs.<sup>68</sup>

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59 Philomena Raftery et al., "**Gender-Based Violence (GBV) Coordination in Humanitarian and Public Health Emergencies: A Scoping Review**," *Conflict and Health* 16, no. 1 (June 28, 2022): 37.

60 GBV AoR, "Strengthening Access to Justice for GBV Survivors in Emergencies."

61 International Rescue Committee (IRC), "Protecting and Empowering Adolescent Girls from Gender-Based Violence in Emergencies," November 2017.

62 Raftery et al., "Gender-Based Violence (GBV) Coordination in Humanitarian and Public Health Emergencies."

63 ICRC, "**That Never Happens Here': Sexual and Gender-Based Violence against Men, Boys, and/Including LGBTIQ+ Persons in Humanitarian Settings**," 2022.

64 Harri Lee and Veronica Ahlenbeck, "Reaching Women and Girls Most at Risk of VAWG: A Practical Brief" (DFID, July 2020).

65 Kiss et al., "Male and LGBT Survivors of Sexual Violence in Conflict Situations."

66 "Interagency Gender-Based Violence Case Management Guidelines," 2017.

67 Veronica Ahlenbeck and Danielle Cornish-Spencer, "Research Query: Responding to Violence Against Women Based on Their Diverse Sexual Orientations, Gender Identities, and Expressions - An Annotated Bibliography of Resources" (GBV AoR Helpdesk, May 2021).

68 Kiss et al., "Male and LGBT Survivors of Sexual Violence in Conflict Situations."

## SURVIVORS WITH DISABILITIES

Women and girls with disabilities experience higher rates of GBV.<sup>69</sup> They face increased discrimination and stigma as a result of their intersectional identities, which increases their risk for GBV.<sup>70</sup> In research conducted among refugee populations, the WRC identified that women and girls with intellectual and mental disabilities were perceived by their peers and communities to be more at risk for sexual violence.<sup>71</sup> Caregivers of people with disabilities (PwD) are also at an increased risk of GBV: Women and girls, who bear a disproportionate care burden in households—whether a household includes a PwD or not—might find themselves facing higher risks of exploitation, manipulation, and violence when seeking services on behalf of the person they are caring for.<sup>72</sup> As well, people with newly acquired disabilities, for example, as a result of conflict-related injuries, might face increased risks of GBV.<sup>73</sup>

Survivors with disabilities face many of the same barriers to service provision as their able-bodied counterparts, including a lack of accessible and affordable, high-quality services, limited awareness about existing services, discriminatory and gender inequitable attitudes about GBV, fear of retribution and retaliation for reporting, and an overall dismissal of GBV as a serious crime. However, the increased likelihood that people with disabilities (PwD) are dependent on a caretaker or other person to support their everyday needs increases their vulnerability and makes it more difficult to independently seek confidential help after an experience of GBV.<sup>74,75</sup> PwD also face specific forms of GBV, including GBV perpetrated by their healthcare providers, personal caretakers, and others that support their lives every day. PwD are also frequently denied access to proper sexual and reproductive health care, under the discriminatory assumption that this type of care is not needed for PwD.<sup>76</sup> These barriers can be exacerbated and experienced differently by people with different types of disabilities, including intellectual and/or physical disabilities.<sup>77</sup> In a 2015 WRC study of experiences of GBV among refugees

- 69 Ingrid Van der Heijden, Jane Harries, and Naeemah Abrahams, “Barriers to Gender-Based Violence Services and Support for Women with Disabilities in Cape Town, South Africa,” *Disability & Society* 35, no. 9 (October 20, 2020): 1398-1418, <https://doi.org/10.1080/09687599.2019.1690429>; Aimée Josephine Utuza, “**Gender-Based Violence Among Women and Girls with Disabilities in Sub-Saharan African Countries: A Scoping Review of the Literature**” (M.Sc., Canada -- Ontario, CA, The University of Western Ontario (Canada), 2021); Helen Barrett and Julie Marshall, “Understanding Sexual and Gender-Based Violence against Refugees with a Communication Disability,” 2017. *Understanding Sexual and Gender-Based Violence against Refugees with a Communication Disability*, Ingrid Van der Heijden, Jane Harries, and Naeemah Abrahams, “Barriers to Gender-Based Violence Services and Support for Women with Disabilities in Cape Town, South Africa,” *Disability & Society* 35, no. 9 (October 20, 2020)
- 70 UN Women, “**Sexual and Reproductive Health and Rights of Girls and Young Women with Disabilities**” (General Assembly, Item A/72/133, 2017).
- 71 Women’s Refugee Commission (WRC), “**‘I See That It Is Possible’ Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings**” (New York, NY, May 2015).
- 72 Women’s Refugee Commission (WRC), “**Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings**,” Summary Brief (New York, NY, June 2015).
- 73 Women’s Refugee Commission (WRC), “‘I See That It Is Possible’ Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings.”
- 74 Mary Ann Curry et al., “**Development of Measures of Abuse Among Women With Disabilities and the Characteristics of Their Perpetrators**,” *Violence Against Women* 15, no. 9 (September 1, 2009): 1001-25.
- 75 Marsha Saxton et al., “**Bring My Scooter So I Can Leave You’: A Study of Disabled Women Handling Abuse by Personal Assistance Providers**,” *Violence Against Women* 7, no. 4 (April 2001): 393-417.
- 76 Mihoko Tanabe et al., “**Intersecting Sexual and Reproductive Health and Disability in Humanitarian Settings: Risks, Needs, and Capacities of Refugees with Disabilities in Kenya, Nepal, and Uganda**,” *Sexuality and Disability* 33, no. 4 (2015): 411-27.
- 77 Women’s Refugee Commission (WRC), “**Sexual and Reproductive Health and Disability: Examining the Needs, Risks, and Capacities of Refugees with Disabilities in Kenya, Nepal, and Uganda**,” January 2015.



with disabilities in Kenya, Nepal, and Uganda, the most significant barrier to sexual and reproductive health services, including GBV services, was “negative provider attitudes” towards PwD. Other barriers included long wait times at service provider facilities, communication challenges at provider facilities, and limited accessibility.<sup>78</sup>

## COVID-19

Around the world, the onset of COVID-19 increased the incidence rate of GBV, and intimate partner violence (IPV) in particular.<sup>79</sup> At the start of the pandemic, the WHO projected an estimated 15 million additional cases of GBV due to the pandemic.<sup>80</sup> While COVID-19 exacerbated pre-existing gender-based discrimination and uneven power dynamics, the pandemic also produced several new drivers of GBV. These new drivers include government-enforced lockdowns and other quarantine measures, the loss of livelihoods and other economic stressors, the increased presence of security actors (e.g., military and police) to enforce lockdowns and quarantine, and the redirection of SRH and GBV funding to support pandemic-related programming and interventions.<sup>81,82</sup> Collectively, these issues reduced the number of specialized and trained GBV service providers, resulting in disclosures to non-trained staff who might not have been able to provide proper referrals or survivor-centered care to survivors.<sup>83,84</sup> In addition, the high-risk nature of service provision during COVID-19 increased the dangers facing service providers.

Service providers faced many of the same COVID-19 related challenges as survivors, including mobility restrictions resulting from government-enforced lockdowns and quarantine, a lack of financial resources, limited personal protective equipment (PPE), and other issues.<sup>85</sup> Healthcare workers in particular, a sector where women are overrepresented, experienced high rates of emotional and physical burnout during COVID-19, as well as risks of contracting the virus themselves, all adding to the stress of continuing to provide care during the pandemic.<sup>86</sup> The healthcare sector globally was overwhelmed by the pandemic; in an attempt to meet the demands of COVID-19, services considered “non-life saving,” such as gender-focused programming, were cut, leaving many survivors without access to this life-saving care.<sup>87</sup>

Attempts to respond to these issues during COVID-19 led to an increased use of remote technology to connect with survivors and high-risk groups.<sup>88</sup> These included the establishment of additional 24-

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78 Women’s Refugee Commission (WRC).

79 Maureen Murphy and Angela Bourassa, “Gap Analysis of Gender-Based Violence in Humanitarian Settings: A Global Consultation” (ELRHA, 2021).

80 **“CARE International Expresses Alarm over Lack of Funding for GBV in COVID-19 Global Humanitarian Response Plan,”** CARE International, July 16, 2020.

81 WHO, “Barriers to GBV Health Services in Humanitarian Settings during COVID-19” (Global Health Cluster COVID-19 Task Team, November 2021).

82 Anna Mutavati and Maniza Zaman, **“Fighting the ‘Shadow Pandemic’ of Violence against Women & Children during COVID-19,”** Africa Renewal, April 27, 2020.

83 WHO, “Barriers to GBV Health Services in Humanitarian Settings during COVID-19.”

84 GBV AoR, “Strengthening Access to Justice for GBV Survivors in Emergencies.”

85 UN Nigeria, “Gender-Based Violence in Nigeria During the COVID-19 Crisis: The Shadow Pandemic,” Brief, May 4, 2020.

86 WHO, “Barriers to GBV Health Services in Humanitarian Settings during COVID-19.”

87 Mridu Markan et al., **“Gender-Based Violence Programming in Times of COVID-19: Challenges, Strategies and Recommendations,”** *Frontiers in Global Women’s Health* 3 (December 6, 2022): 952688.

88 Dorcas Erskine, “Not Just Hotlines and Mobile Phones: GBV Service Provision During COVID-19” (UNICEF, 2020).

hour GBV hotlines, increased provision of remote GBV services including case management, the use of mobile phone applications to provide survivors with more information about available services, and finally, the use of new “alert systems” and panic button systems to allow survivors to discreetly and quickly call for help when outside intervention is needed.<sup>89</sup> In Bangladesh and Nigeria, COVID-19 GBV efforts including training community volunteers to provide better responses to immediate disclosures. Similarly, in Bangladesh, trainings and capacity building on gender and protection were rolled out among frontline health workers and program managers working on interventions targeting high-risk groups such as women and adolescent girls.<sup>90</sup> However, reports note that these adaptations were underutilized in many instances because survivors were unaware that such services existed.<sup>91</sup>

## Program Models to Strengthen GBV Services

### LEGAL AID AND SUPPORT

Strengthening survivors’ access to justice can take different forms. Generally, programming focuses on strengthening the capacity of justice service providers and law enforcement through trainings on survivor-centered approaches and gender sensitivity. Some programming involves setting up and building the capacity of specialized GBV police or prosecution units, as well as developing local capacity to collect data on GBV in the community.<sup>92, 93</sup> Across Latin America, for example, women’s police stations have been established with the aim of providing a safe space for survivors to disclose their experiences of GBV and to seek justice. However, evidence highlights that survivors still face other barriers that prevent them from accessing women’s police stations when they exist. Relatedly, a lack of funding and political commitment to supporting women’s police stations similarly prevents shortcomings in service delivery.<sup>94</sup> An evaluation of Family and Sexual Violence Units established in Papua New Guinea noted that cases brought to these centers were frequently uninvestigated and therefore went unprosecuted because of a lack of human and financial resources, political commitment to GBV because it is considered a “woman’s issue,” and a withdrawal of formal complaints in lieu of settling through an informal system.<sup>95</sup> Similarly, in South Sudan, Special Protection Units, which function as GBV desks, can be found in some police stations. These units include staff that are trained specifically to deal with GBV cases. However, research shows that these units suffer from many of the same issues cited earlier in relation to the Family and Sexual Violence units in Papua New Guinea, namely, underfunding and a lack of resources and a lack of political will to sole “women’s issues.”<sup>96</sup>

Several other interventions have been utilized to strengthen GBV survivors’ access to justice in

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89 Dorcas Erskine.

90 ISCG Secretariat, “Mid-Term Review Rohingya Humanitarian Crisis,” 2020.

91 Markan et al., “Gender-Based Violence Programming in Times of COVID-19.”

92 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”

93 Murphy and Bourassa, “Gap Analysis of Gender-Based Violence in Humanitarian Settings: A Global Consultation.”

94 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”

95 GHD Pty Ltd., “Evaluation of the RPNGC Family and Sexual Violence Units,” December 2015.

96 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”



humanitarian settings globally, including the use of mobile courts and the creation of specialized GBV courts. For example, in Uganda, War Child Canada implemented mobile clinics to support the provision of legal services to women and child survivors of GBV.<sup>97</sup> Also in Uganda, the introduction of mobile courts in Nakivale was considered successful based on interviews with community members. However, the sustainability of the mobile courts program was jeopardized by the high costs and the lack of qualified staff (e.g., judges) to support the mobile clinics.<sup>98</sup> In Guinea, ARC International ran two legal aid clinics for refugee survivors of GBV from Liberia and Sierra Leone, which provided three services: awareness-raising on legal rights of survivors, providing legal advice to survivors, and providing legal representation to survivors. Importantly, the successes of the two clinics are linked, according to a toolkit for providing GBV legal services, to the fact that the proper GBV prevention and response services “were in place and trust had been gained from the community” prior to the implementation of any legal services.<sup>99</sup>

## HEALTHCARE

The breakdown of the formal police mechanisms and infrastructure, among other issues, during humanitarian crises often means that healthcare institutions become the front lines of service delivery for GBV survivors.<sup>100</sup> Healthcare providers are also strategically placed to identify survivors, as they are among the few institutions that have regular contact with communities, even during humanitarian crises.<sup>101</sup> Training healthcare providers on proper care for and treatment of GBV survivors is therefore key to supporting survivors’ access to high-quality care after an experience of violence.<sup>102</sup> These trainings can include capacity building on the clinical care of survivors (e.g., clinical management of rape), maintaining confidentiality of survivors, and training providers on survivor-centered attitudes and practices.

In their evaluation of the International Rescue Committee’s (IRC) Clinical Care for Sexual Assault Survivors (CCSAS) multimedia training tool, Smith et al. (2013) note that while healthcare provider (HCP) trainings are largely “associated with positive effects on the quality of clinical care delivery and health and psychosocial outcomes for survivors of sexual assault,” their evaluation of the CCSAS program yielded mixed results.<sup>103</sup> Designed to improve the clinical care of GBV survivors, CCSAS included training modules and tools on direct patient care, the responsibilities of non-medical staff (e.g., receptionists, interpreters, cleaning staff, and security personnel), and preparing the clinic to receive and support survivors. Trainings were conducted over the course of a four-day period, and targeted various healthcare institutions (hospitals and community-based clinics) in different sites and countries. Following the trainings, respect for patient rights (the right to non-discrimination and self-determination) increased from 74% at baseline to 81% ( $p < .05$ ). However, mixed findings emerged relative to healthcare providers’ beliefs about sexual assault. Specifically, the evaluation found that prevalent attitudes and

97 War Child Canada, “A Guide to Sexual and Gender-Based Violence Legal Protection in Acute Emergencies,” n.d.

98 Erica Holzaepfel and Shannon Doocy, “Evaluating the Effectiveness of Gender-Based Violence Prevention Programs with Refugees in Chad, Malaysia, and Uganda” (Social Impact, Inc., 2014).

99 ARC International, “Gender-Based Violence Legal Aid: A Participatory Toolkit” (Minneapolis, MN, 2005).

100 UNFPA, “The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming,” 2019; UNFPA, “Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies,” n.d.

101 Sarah Bott et al., “Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Care Professionals in Developing Countries” (IPPF/WHR, 2015).

102 Janel R Smith et al., “**Clinical Care for Sexual Assault Survivors Multimedia Training: A Mixed-Methods Study of Effect on Healthcare Providers’ Attitudes, Knowledge, Confidence, and Practice in Humanitarian Settings**,” *Conflict and Health* 7 (July 3, 2013): 14.

103 Smith et al., 2.

beliefs about sexual assault (e.g., believing survivors, victim-blaming, etc.) did not change significantly. Importantly, Smith et al. (2013) noted a significant increase in HCP knowledge and confidence levels in providing clinical care for survivors. These findings, they note, are indicative that HCP trainings should ideally be accompanied by “community-wide and targeted educational initiatives” as well as “community sensitization efforts” to encourage more extensive uptake of survivor-centered attitudes.<sup>104</sup>

One-stop centers (OSC) have also become an important model for healthcare service provision for GBV survivors.<sup>105</sup> OSC provide a variety of services and programming, including but not limited to medical care and psychosocial support and economic and empowerment programming, all located, as the name implies, at one center. OSC also take different institutional forms: While some might operate as standalone organizations, others operate as part of hospitals and formal healthcare clinics. The OSC at the Panzi General Referral Hospital located in the Ibanda Health Zone in Bukavu, South Kivu, eastern Democratic Republic of Congo (DRC), has had historical success providing holistic and integrative healthcare support to GBV survivors.<sup>106, 107</sup> According to the program description, the Panzi OSC provides “a complete package [of care] through four pillars: medical, psychological, legal, and socio-economic reintegration.”<sup>108</sup> With the survivor’s consent and input, a care plan is developed to support the healing and recovery process. The Panzi OSC model also provides each survivor with a psychosocial assistant, known as a Maman Cherie, “who provides regular and permanent support and follow-up for their clients during the entire care period.”<sup>109</sup> In a recent evaluation of the Panzi OSC, more than 80% of survivors reported satisfaction with the services they received across the four pillars of care. Importantly, more than 75% of respondents reported that the Panzi OSC met their expectations in terms of care quality and available services. While such findings are positive, several barriers to OSC have emerged in recent research from low- and middle-income countries, including “(1) barriers to implementation such as the lack of multisectoral staff, staff time constraints, lack of medical supplies; and (2) barriers to multisectoral coordination due to fragmented services and unclear responsibilities of implementing partners.”<sup>110</sup>

In humanitarian settings, community healthcare workers (CHW) have become key to overcoming many of the barriers to healthcare for survivors, including poor healthcare infrastructure, limited access to

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104 Smith et al., 22.

105 Mary Ellsberg et al., “**Prevention of Violence against Women and Girls: What Does the Evidence Say?**,” *Lancet* (London, England) 385, no. 9977 (April 18, 2015): 1555–66.

106 Gilbert M. Mugisho et al., “**Sexual and Gender-Based Violence Victims’ Satisfaction of the Support Services through the Holistic Model of Care in the Democratic Republic of Congo**,” *Discover Social Science and Health* 2, no. 1 (November 22, 2022): 22.

107 Denis Mukwege and Marie Berg, “**A Holistic, Person-Centred Care Model for Victims of Sexual Violence in Democratic Republic of Congo: The Panzi Hospital One-Stop Centre Model of Care**,” *PLOS Medicine* 13, no. 10 (October 11, 2016): e1002156.

108 Mugisho et al., “Sexual and Gender-Based Violence Victims’ Satisfaction of the Support Services through the Holistic Model of Care in the Democratic Republic of Congo.”

109 Mukwege and Berg, “A Holistic, Person-Centred Care Model for Victims of Sexual Violence in Democratic Republic of Congo.”

110 International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations,” 121.

healthcare services, and costly healthcare services.<sup>111,112</sup> CHW either function as the lowest level of health care, feeding into primary health care units, or can exist in parallel to formal healthcare structures. Levels of training for these workers vary and are not always recognized by the formal healthcare system. However, their embeddedness within the community makes them key points of contact for those seeking services, given the trust that CHW have built with community members.<sup>113</sup> For this reason, CHW can play a key role in supporting survivors' access to specialized healthcare following an experience of GBV.<sup>114</sup>

While there are a variety of models for CHW delivery of GBV services, there is limited evidence as to which models are successful.<sup>115</sup> In their systematic review of CHW and the provision of GBV healthcare, Gatuguta et al. (2017) noted an overall dearth of knowledge on the subject, with even less information from low- and middle-income countries (only three studies in their review contained evidence from low- and middle-income countries, n=7). They concluded that while "positive evidence...does suggest that CHW are a critical entry point for extending GBV care," the lack of rigorous evaluations and assessments of CHW and GBV healthcare provision makes it difficult to extend these findings with certainty.<sup>116</sup> However, several studies reviewed by Gatuguta et al. (2017) identified that CHW can provide GBV healthcare services in areas where comprehensive services are not available, making them a key stopgap in high insecurity areas, rural areas, and areas with damaged healthcare infrastructure.

In their process evaluation of a CHW training program on administering post-rape care to survivors of sexual assault on the Thai-Burmese border, Tanabe et al. (2013) reported similar findings. The training program, implemented by the Women's Refugee Commission (WRC) and its partners in 2009, piloted a community-based approach to survivor care based on the World Health Organization's (WHO) Clinical Management of Rape Survivors (CMR) (2004) protocol. The program was developed in light of the challenges of ensuring high-quality and accessible facility-based healthcare during a humanitarian emergency. The pilot model included a contextualized version of the CMR, which was taught over the course of a five-day training to high-level CHWs. A handful of these CHWs were then responsible for returning to their communities to train other CHWs. In this program, WRC and its partners chose to have CHWs train birth attendants, among others, upon their return. The program also trained CHWs on routine data collection, following global standards including the GBV Information Management System (GBVIMS) guidelines.

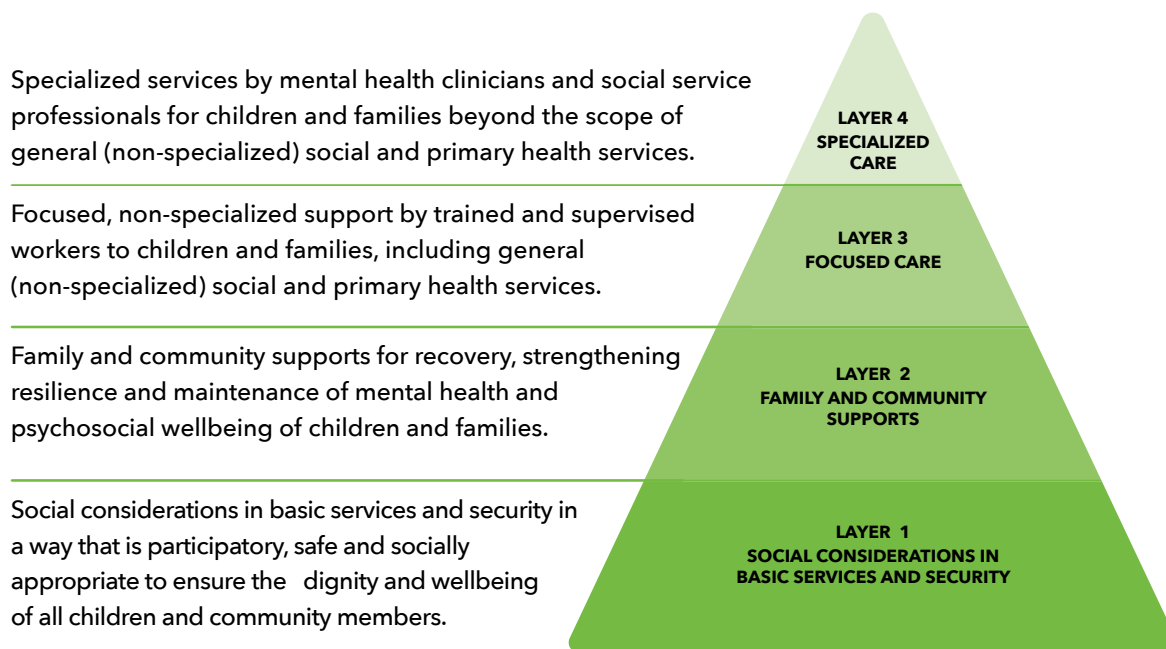
Although the study's authors noted some key limitations to the evaluation, their findings demonstrate positive effects of CHW trainings on GBV, including increased knowledge and confidence in administering clinical care to survivors. Similarly, birth attendants who had been trained by CHW on clinical care for survivors reported feeling "happy" about their ability to "support those that have been

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- 111 Anne Gatuguta et al., "[Should Community Health Workers Offer Support Healthcare Services to Survivors of Sexual Violence? A Systematic Review](#)," *BMC International Health and Human Rights* 17, no. 1 (October 12, 2017): 28.
- 112 Uta Lehmann and David Sanders, "Community Health Workers: What Do We Know About Them?" (World Health Organization, 2007).
- 113 "[Health Workers Can Treat, Empower Survivors of Gender-Based Violence](#)," United Nations Population Fund, accessed July 25, 2023.
- 114 Alexis Mwanza Kabongo, "[What Role Can Community Health Workers \(CHWs\) Play in Addressing Issues Such As Gender-Based Violence \(GBV\)?](#)" Blog, Rotary Peace Center NC, 2023.
- 115 Gatuguta et al., "Should Community Health Workers Offer Support Healthcare Services to Survivors of Sexual Violence?"
- 116 Gatuguta et al., 9.

sexually assaulted” and that they “want[ed] to learn more about GBV” in their work.”<sup>117</sup> However, the evaluation also found that trained CHWs at all levels (both high-cadre and local birth attendants) felt overwhelmed with the amount of new information that they had received. Several CHW who had received the training however gave critical feedback on this point, noting that “community meetings” held over the course of a year—instead of a training packed into five consecutive days—might help to better “prepare” the community to “discuss these issues.”<sup>118</sup>

Zraly et al.’s (2011) study of community-based healthcare services for survivors of conflict-related sexual violence point to similar findings. In their study, survivor healthcare services were administered by women’s genocide survivor associations, who have historically taken on the provision of mental healthcare (e.g., counseling services) for survivors, as well as providing some reproductive healthcare, including testing for HIV.<sup>119</sup> Survivors frequently accessed these services when they were unable to access the formal healthcare system, for various reasons. Based on these insights, the authors suggest that building the capacity of CHWs and these women’s associations can help extend the reach of these crucial care services as long as the formal healthcare system is unable to close this gap.

Other community-based healthcare initiatives providing care to GBV survivors include mobile healthcare clinics.<sup>120</sup> In their study of the Foundation RamaLevina (FORAL), a Congolese NGO that offers a mobile health program that provides an array of healthcare services, including care for GBV survivors,



**FIGURE 1** *The IASC MHPSS Pyramid*

- 117 Mihoko Tanabe et al., “**Piloting Community-Based Medical Care for Survivors of Sexual Assault in Conflict-Affected Karen State of Eastern Burma**,” *Conflict and Health* 7, no. 1 (May 21, 2013): 7.
- 118 Tanabe et al., 7.
- 119 Maggie Zraly, Julia Rubin-Smith, and Theresa Betancourt, “**Primary Mental Health Care for Survivors of Collective Sexual Violence in Rwanda**,” *Global Public Health* 6, no. 3 (April 2011): 257–70.
- 120 Ellsberg et al., “Prevention of Violence against Women and Girls.”

Kohli et al. (2012) found that mobile healthcare options increase the likelihood that medical follow-up and monitoring will take place as well as proper referrals.<sup>121</sup> Study participant feedback indicated that a particularly important feature of the mobile health clinic was its increased availability and schedule hours, which “allowed FORAL HCP to build relationships with village members,” something that was “especially important given the sensitivity of the issues discussed.”<sup>122</sup>

Between 2016-2018, the IRC implemented several mobile health clinic pilots in Myanmar, Burundi, and Iraq, from which a set of guidelines for implementing mobile and remote GBV service delivery programs were developed.<sup>123</sup> Two types of mobile GBV service delivery options were implemented as part of the pilot: short-term rapid GBV response and mobile GBV response for communities during protracted displacement. As the name implies, short-term rapid GBV response mobile delivery targets survivors who are part of a community that has been recently displaced and/or otherwise affected by humanitarian crisis. The goal of short-term mobile GBV service provision is to “provide crisis response, risk reduction activities, and supplies and information” about other GBV response services. For mobile GBV response for communities during protracted displacement, the approach is more contextualized. First, mobile response serves as an entry point for survivors into the referral network. Second, mobile clinics identifies and incorporates community actors and focal points in their work, to ensure that outreach and awareness raising is conducted in the affected community. Evaluations of the separate pilot programs in the three different country sites all documented survivors’ overall satisfaction with mobile services and saw these services as the beginning of what they hoped would become longer-term services in their communities.<sup>124</sup> Thus, while initial findings of mobile service delivery for GBV survivors are positive, the IRC report emphasizes that sustainable long-term plans must be simultaneously put in place to ensure that survivors are not abandoned once program funding for mobile services ends.

## MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Mental health and psychosocial support (MHPSS) is a critical component of survivors’ short- and long-term recovery. MHPSS should include both emergency and long-term support aimed at building survivors’ resilience and strengthening their reintegration within the community.<sup>125</sup> While the MHPSS needs of survivors vary, certain standards exist for specific groups, such as MHPSS for adolescent girls, male survivors, and survivors that are members of the LGBTQ+ group.<sup>126</sup> International guidelines also note that MHPSS services should be integrative and diverse to support the various needs of different communities. This is particularly true for survivors of GBV in humanitarian settings.<sup>127</sup> The complex nature of MHPSS requires a multi-layered approach, which is outlined by the IASC Intervention Pyramid (Figure

121 Anjalee Kohli et al., “**A Congolese Community-Based Health Program for Survivors of Sexual Violence**,” *Conflict and Health* 6, no. 1 (August 29, 2012): 6.

122 Kohli et al., 6.

123 IRC, “**Feasibility and Acceptability of Mobile and Remote Gender-Based Violence (GBV) Service Delivery**,” August 24, 2018.

124 IRC.

125 UNFPA, “Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies”; International Development Law Organization (IDLO) and The Global Women’s Institute (GWI), “Survivor-Centred Justice for Gender-Based Violence in Complex Situations.”

126 IASC, “IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings,” 2007.

127 IASC, “Mental Health and Psychosocial Support in Humanitarian Emergencies What Should Protection Programme Managers Know?,” 2010.

1). Of note, the four layers of MHPSS interventions require different levels of expertise, indicating that both specialist and non-specialist organizations can build programming that is attentive to the MHPSS needs of survivors and others during a humanitarian emergency.

However, limited information exists on the efficacy of different MHPSS intervention strategies in conflict settings. In Tol et al.'s (2013) systematic review of MHPSS interventions in armed conflict (n=7), MHPSS interventions ranged from individual and group counseling activities to specialized MHPSS activities including cognitive behavioral therapy (CBT) and specialized treatment for survivors diagnosed with post-traumatic disorder (PTSD).<sup>128</sup> While the individual studies cited in this review report broadly positive outcomes of MHPSS activities for GBV survivors, Tol et al. note that the lack of rigorous research on MHPSS interventions in conflict settings makes it difficult to produce any generalizable conclusions. In their study on MHPSS activities in Liberia, Lekskes, van Hooren, and De Beus (2007) noted that participants who had received either group or individual counseling as part of the intervention demonstrated slightly more positive outcomes than participants in the control group. While qualitative study findings were overwhelmingly positive, quantitative results did not show a statistically significant difference in the levels of PTSD experienced by participants after completing the MHPSS activities.<sup>129</sup>

Bolton's (2009) evaluation of a multi-year program implemented by the IRC in collaboration with the Applied Mental Health Research Group (AMHR) at Johns Hopkins University (JHU) and Boston University pointed to positive outcomes of MHPSS activities for GBV survivors in the DRC. The evaluation found that women recruited into the program "reported high levels of symptomatology and dysfunction prior to receiving the interventions."<sup>130</sup> However, the lack of a control group as well as a shift in intervention activities mid-way through the project (as a result of donor funding changes) made it difficult to draw any universal conclusions about the effectiveness of the program's MHPSS interventions.

While GBV MHPSS programming exists at each level of the IASC Intervention Pyramid, most GBV programming works at Layers 2 and 3 to strengthen existing supports for survivors (e.g., community and family) supports and providing more survivor-focused supports.<sup>131</sup> This type of programming can include creating and supporting safe spaces for women and girls; guided group discussions with trained facilitators, who lead discussions on various topics; and other forms of individual and group psychosocial support. UNFPA also classifies survivor-centered GBV case management as part of MHPSS interventions at the third level of the pyramid. Community-based MHPSS has also emerged as a key model for providing MHPSS in emergencies when centralized healthcare systems are weakened or when services are out of reach for certain communities. Community-based MHPSS "works with and through a community's natural supports and systems." Strengthening these systems is key to providing emergency care during an emergency but also to "link[ing] MHPSS responses to recovery and regular, non-humanitarian response programming."<sup>132</sup>

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128 Wietse A. Tol et al., "**Sexual and Gender-Based Violence in Areas of Armed Conflict: A Systematic Review of Mental Health and Psychosocial Support Interventions**," *Conflict and Health* 7, no. 1 (August 5, 2013): 16.

129 Jeannette Lekskes, Susan van Hooren, and Jos de Beus, "Appraisal of Psychosocial Interventions in Liberia," *Intervention* 5, no. 1 (January 1, 2007): 18.

130 Paul Bolton, "Assessing the Impact of the IRC Program for Survivors of Gender Based Violence in Eastern Democratic Republic of Congo.," IRC GBV Impact Assessment, 2009.

131 UNFPA, "The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming."

132 United Nations Children's Fund. Operational guidelines on community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version). New York, UNICEF, 2018.



## SAFE SPACES AND WOMEN'S CENTERS

The creation and maintenance of women's centers and safe spaces is a key MHPSS intervention used to meet the needs of GBV survivors (Level 1 & Level 2 of the MHPSS Intervention Pyramid). In Haiti and the DRC, studies have identified the successes of "listening houses" (maison d'ecoute) in supporting survivors. Listening houses provide a safe space where survivors can access psychosocial first aid (PFA) and referrals to specialized GBV services.<sup>133</sup> In Iraq, listening centers are a key point of entry for survivors into the referral network. From these listening centers, safe spaces, and women-only activity spaces in their communities, survivors can access specialized healthcare services, psychosocial support, and in some cases, legal support and advice.<sup>134</sup> As UNFPA (2016) notes that these centers are particularly important among refugee populations because they can provide survivors with all of the services they might need after an experience of violence, without the undue burden of traveling farther than necessary to access specialized support (e.g., having to travel to a hospital outside of the camp boundaries, etc.). For GBV survivors in the Central African Republic (CAR), listening centers provide a holistic approach to GBV response. The centers provide a safe space where survivors can disclose an instance of violence and seek GBV services as well as other non-GBV related interventions, such as livelihoods training, to ensure that GBV service provision remains discreet within the community.<sup>135</sup> As well, these listening centers offer survivors the opportunity to speak to each other, a key aspect of healing and reintegration, according to survivors who had participated in activities at one of these listening centers. The centers also provide survivors with access to specialized psychosocial support (PSS) services.

Women friendly spaces have given rise to women's networks that have taken on added responsibilities relative to survivors in their communities. The Women's Networking Group in Somalia originally started as a set of meetings with community women to discuss "women's issues," an idea that developed as part of a series of community consultations conducted by the International Organization for Migration (IOM) as part of an EU-funded program (Daryeel).<sup>136</sup> First formed in 2021, the group has developed into a large network of groups, all of whom meet to discuss women's issues and, importantly, the steps that communities can take to protect women and girls, including survivors of GBV. In the town of Marka, the Women's Networking Group has developed a working relationship with the Marka District Peace and Safety Committee; every few weeks, the Women's Networking Groups presents their safety recommendations to the town's safety committee with a focus on the needs of survivors. The Women's Networking Group also plays a critical role in settling disputes using the CIJ system in Somalia, known as Xeer.<sup>137</sup>

Plan International has noted the equal importance of safe spaces for adolescent girls. Like adult women, adolescent girl safe spaces can provide a one-stop location where survivors can receive immediate and longer-term GBV care services. Safe spaces for adolescent girls also serve as a critical entry point to the referral network for survivors. In their review of MHPSS services for adolescent girl survivors, Plan International highlighted the IRC's COMPASS (Creating Opportunities through Mentoring, Parental Involvement, and Safe Spaces for Adolescent Girls in Humanitarian Settings) as a key case study for providing integrative MHPSS services to adolescent girl survivors.<sup>138</sup> In COMPASS safe spaces,

133 Kohli et al., "A Congolese Community-Based Health Program for Survivors of Sexual Violence."

134 UNFPA, "The GBV Assessment in Conflict Affected Governorates in Iraq."

135 OCHA, "**Central African Republic: Surviving Gender-Based Violence**," July 28, 2023.

136 IOM, "**Women in Somalia Bring Justice to Gender-Based Violence Survivors**," Storyteller IOM, 2022.

137 IOM.

138 Julie Bodin, "Youth Perceptions of Gender-Based Violence in the Central African Republic," Open Plan 5, no. 1 (2020).

adolescent girls receive support from IRC-trained mentors, who lead participants in a set of “structured, facilitated sessions that focus on topics, tailored for girls, such as self-confidence, building friendships, communication, problem solving, puberty and reproduction as well as gender-based violence and creating healthy relationships.”<sup>139</sup> In several of the pilot programs, mixed-methods evaluations showed increased overall psychosocial well-being, better knowledge of gender support services (including but not limited to GBV service provision), and increased awareness of GBV and a survivor’s rights.<sup>140</sup>

More recently, the use of virtual safe spaces (VSS) has emerged as a promising intervention to support survivors, and primarily women and girls, during periods of limited mobility (e.g., during government-enforced lockdowns due to COVID-19) and to increase the overall accessibility of safe spaces to high-risk communities, such as refugees and IDPs.<sup>141</sup> In Iraq and Lebanon, UNICEF has been piloting VSS for adolescent girls. The platform, called Laaha, provides users with a safe and secure source of information about various aspects of sexual and reproductive health issues, organized thematically by services, relationships and rights, body and health, and safety. Laaha also includes a virtual assistant that can direct the user to specific content based on their inquiries and shows the user how to safely use the platform. The website also features an “Exit” button, which users can click on to leave the platform discreetly and quickly if necessary.<sup>142</sup> The program is still in the piloting phase.

## ECONOMIC AND SOCIAL EMPOWERMENT PROGRAMMING

Interventions that fall into the first level of the MHPSS pyramid include economic and social empowerment programming. Economic and social empowerment programming includes activities that support survivors’ reintegration into their communities and building their resilience after experiencing violence. These activities might include livelihoods trainings, literacy programs, sponsored activities with local women’s groups, and other interventions that support survivors’ socioeconomic well-being. Coupled with targeted GBV support services, empowerment programming can contribute to stronger positive outcomes among survivors.<sup>143</sup>

While strengthened social and economic empowerment of women and girls is widely acknowledged as a protective factor against GBV, the lack of rigorous data collection and evaluations of this type of programming targeted toward GBV survivors makes it difficult to claim universal positive outcomes from such programming. In particular, cash-assistance and cash transfer programs (CTP) have had mixed outcomes relative to the empowerment of GBV survivors.<sup>144</sup> However, the WRC guidelines

139 Kathryn L. Falb et al., “**Creating Opportunities through Mentorship, Parental Involvement, and Safe Spaces (COMPASS) Program: Multi-Country Study Protocol to Protect Girls from Violence in Humanitarian Settings**,” *BMC Public Health* 16 (March 5, 2016): 4.

140 Khudejha Asghar et al., “**Promoting Adolescent Girls’ Well-Being in Pakistan: A Mixed-Methods Study of Change Over Time, Feasibility, and Acceptability, of the COMPASS Program**,” *Prevention Science* 19, no. 8 (November 2018): 1030-42.

141 UNICEF, “Innovative Approaches to GBV Service Provision in Emergencies,” 2021.

142 <https://laaha.org/country-selector>

143 Cudjoe Bennett et al., “**A Comprehensive Approach to Providing Services to Survivors of Sexual and Gender-Based Violence in Democratic Republic of Congo: Addressing More than Physical Trauma**,” *Development in Practice* 27, no. 5 (July 4, 2017): 750-59.

144 Allyson Cross, Tenzin Manell, and Melanie Megevand, “**Humanitarian Cash Transfer Programming and Gender-Based Violence Outcomes: Evidence and Future Research Priorities**” (Women’s Refugee Commission (WRC) & International Rescue Committee (IRC), 2018).



on utilizing cash in GBV response note that “cash can be a key component of survivor-centered GBV case management services in humanitarian contexts,” especially when “GBV response services have associated costs.” As well, cash transfers and support for survivors can help survivors to escape abusive situations. In all instances, however, cash assistance “must be appropriately tailored to meet clients’ protection needs,” and should “minimize further exposure to harm.”<sup>145</sup>

In the DRC, studies have been conducted on two empowerment programs to support survivors of GBV, both implemented by the Panzi Foundation DRC: Dorcas Rurale (DR) and USHINDI.<sup>146</sup> Though the two programs each contain different components, they both aim to support the socioeconomic reintegration of survivors after an experience of violence. DR recruits survivors who have accessed hospital services at Panzi Hospital and offers them two types of support: social support through a women’s network, and financial support. This financial support includes loans (beginning at \$30, then increasing over time with repayment); the provision of livestock (pigs) and seeds (including agricultural trainings for women); the payment of school fees (maximum of two children); literacy training; and income-generating skills trainings (soap- and/or basket-making). Alongside these activities, survivors were also encouraged to participate in financial literacy trainings. Survivors could participate in DR for up to three years after their initial hospital visit.<sup>147</sup> The second program, USHINDI, also focused on financial support, but included both survivors and non-survivors; participants were recruited based on their financial vulnerability. Over the course of 12 months, the USHINDI placed participants into voluntary savings and loan associations (VSLA) and provided them with financial literacy trainings and support. In their study of both DR and USHINDI, Amisi et al. (2018) noted a “general positive significant effect” of programming on both “perceived social inclusion and perceived improved economic well-being.”<sup>148</sup> Importantly, the study noted that “improvements in economic well-being were significantly higher for survivors,” across both programs, indicating the intense need for survivor-centered financial support programming.<sup>149</sup>

In Kenya, an evaluation of an output-based aid (OBA) voucher program targeting survivors showed an overall positive effect on the use of certain reproductive health services, such as an increase in skilled birth attendance and the use of long-term family planning methods.<sup>150</sup> The OBA program allowed clients to access specific healthcare services at a subsidized costs, while reimbursing providers, who are required to provide these services at a “specified standard of quality of care.” The program was implemented across five provinces and in 10 different hospitals, all of which were accredited to provide specific GBV survivor care services such as medical examination and services, STI screening and PEP kits, counseling services, and referrals to other services, including community support groups. While the study verified the success of the OBA voucher program, some findings related to the use of GBV support services were ambiguous. While study participants were largely

145 Women’s Refugee Commission (WRC), “Overview of Toolkit for Optimizing Cash-Based Interventions for Protection from Gender-Based Violence: Mainstreaming GBV Considerations in CBIs and Utilizing Cash in GBV Response,” Updated 2022 2018, 2-3.

146 Christine Amisi et al., “**The Impact of Support Programmes for Survivors of Sexual Violence: Micro-Level Evidence from Eastern Democratic Republic of the Congo**,” *Medicine, Conflict and Survival* 34, no. 3 (July 3, 2018): 201-23.

147 Amisi et al., 208.

148 Amisi et al., 218.

149 Amisi et al., 219.

150 Rebecca Njuki et al., “**Exploring the Effectiveness of the Output-Based Aid Voucher Program to Increase Uptake of Gender-Based Violence Recovery Services in Kenya: A Qualitative Evaluation**,” *BMC Public Health* 12, no. 1 (June 12, 2012): 426.

aware of the voucher relative to reproductive health services, few of them had any knowledge that the voucher offered access to GBV support services. However, the authors noted that this had less to do with the quality of GBV support services available but was tied to the stigma related to GBV in the community and the fear of disclosing an experience of GBV.<sup>151</sup>

Findings from a study conducted by WRC among refugee GBV survivors with disabilities in Kenya, Nepal, and Uganda indicate the critical importance of social and economic empowerment programming for PwD, specifically. This type of programming supports PwD to gain social and economic independence, both of which are key components for empowering survivors to leave an abusive situation and to seek care services after an experience of GBV.<sup>152</sup> Study participants noted the importance and successfulness of “robust peer networks” composed of a variety of activities—including but not limited to, financial literacy programming, safe spaces and facilitated discussion groups, and asset-based programming like VSLAs—in building trust, improved self-esteem, and community-based support for survivors with disabilities.<sup>153</sup> These activities, according to participants, “increased independence and decision-making and [promoted] greater respect and status within the family and community as a result of their newfound access to income-earning opportunities,” all of which serve as protective factors against GBV.<sup>154</sup>

In Jordan, a CARE International-operated cash-assistance program for GBV survivors and those at a higher risk of GBV (e.g., widows, divorcees, female-headed households, people with disabilities, and the elderly) documented the life-saving potential that cash assistance programming has in humanitarian contexts.<sup>155</sup> The program, which included both refugees and non-refugees, empowered GBV case managers to assess their clients’ needs for cash assistance using vulnerability criteria determined collaboratively by UNHCR and the Cash Working Group in Jordan. Based on this initial evaluation, CARE Jordan then developed a care plan for the survivor that included cash assistance. GBV survivors also participated in other social and economic empowerment programming, including skills training and financial literacy programs. An evaluation of the project led by an independent consulting firm noted the overall positive outcomes of this cash assistance based on findings from focus group discussions with participants. Cash assistance “reduced reliance on risky coping strategies,” including the use of survival sex/selling sex, and “enhanced [the] individual agency of women and adolescent girls” who participated in the program.<sup>156</sup>

## SPECIALIZED MENTAL HEALTH SERVICES

Access to specialized mental health services is another critical component of GBV survivor support. Unfortunately, access to specialized mental health services for survivors can be limited in humanitarian settings due to lack of trained medical professionals and issues of accessibility. Further, general stigma surrounding mental healthcare affects survivors’ desire to seek mental healthcare. Research shows that

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151 Njuki et al.

152 Women’s Refugee Commission (WRC), “‘I See That It Is Possible’ Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings.”

153 Women’s Refugee Commission (WRC).

154 Women’s Refugee Commission (WRC), 2.

155 WRC, “Integrating Cash Assistance into Gender-Based Violence Case Management to Support GBV Survivors and Individuals at Risk in Jordan.”

156 WRC.

mental health is “often the least well met” patient need “in low resource or conflict settings.”<sup>157</sup> This reality makes it difficult to implement specialized mental health programming for survivors and, critically, to conduct rigorous evaluations of this programming to learn more about the efficacy of certain types of specialized MHPSS interventions for survivors in low- and middle-income, conflict-affected settings.<sup>158</sup>

In their evaluation of post-rape mental health care administered by Médecins Sans Frontières (MSF) in Brazzaville in the Republic of Congo, Hustache et al. (2009) “found the benefits of post-rape psychological support to be present and lasting.” This psychological support was offered as part of a larger portfolio of care for GBV survivors that MSF provided, including free and anonymous access to emergency contraception, STI testing, and HIV testing and prophylaxis (PEP). Patients who decided to seek MHPSS received an initial psychological intervention; this intervention, conducted by a psychologist, included different types of psychological care that revolved around active listening, resilience and coping strategies, and “working on acceptance and development of future perspectives and plans.”<sup>159</sup> One year after beginning their psychological treatment, patients were recruited for this evaluation (n=70), which used three different scales to measure changes over time: The Trauma Screening Questionnaire (TSQ); “an assessment scale to address medio-psychological care in emergencies (EUMP),” which was contextualized for this evaluation; and the Global Assessment of Functioning (GAF) scale. According to their findings, more than two-thirds of participants showed clear improvement according to the GAF scale. As well, survivors demonstrated a much lower incidence of PTSD at the time of the evaluation (3.1%) versus the time of their admission for psychological treatment (24.2%). Unfortunately, the study is limited due to the small population size (70), which resulted from a high participant drop-out rate (108), who were “lost to follow up, because they had an initial incomplete [home] address [where social workers made initial contact for follow-up] or they had moved.”<sup>160</sup>

Bass et al.’s (2013) controlled trial of psychotherapy among Congolese survivors of GBV demonstrated similarly positive findings, noting that the addition of cognitive processing therapy, along with individual counseling support, “was effective in reducing PTSD symptoms and combined depression and anxiety symptoms and improving functioning in female survivors of sexual violence in eastern [DRC],” as opposed to individual counseling support only.<sup>161</sup> The study evaluated an “adaption of group cognitive processing therapy provided by community-based paraprofessionals (psychosocial assistants)” who had undergone an intensive 5-6 day training session administered by the IRC, on topics specific to GBV case management and psychosocial support.<sup>162</sup> During the trial, 15 villages in the South Kivu province were selected for inclusion; seven received cognitive processing therapy and eight received individual support, all provided by trained psychosocial assistants. Overall, the study found that both the individual-support and cognitive therapy groups experienced “significant improvements during treatment, with effects maintained at six months.” However, participants in the cognitive therapy groups “had significantly greater improvements than those in the individual-support group” with respect to “PTSD symptoms and combined depression and anxiety symptoms.”<sup>163</sup>

157 Sarah Hustache et al., “**Evaluation of Psychological Support for Victims of Sexual Violence in a Conflict Setting: Results from Brazzaville, Congo**,” *International Journal of Mental Health Systems* 3, no. 1 (April 1, 2009): 2.

158 Hustache et al., “Evaluation of Psychological Support for Victims of Sexual Violence in a Conflict Setting.”

159 Hustache et al., 3.

160 Hustache et al., 8.

161 Judith K. Bass et al., “**Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence**,” *New England Journal of Medicine* 368, no. 23 (June 6, 2013): 2187.

162 Bass et al., 2183.

163 Bass et al., “Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence.”

In one of the only randomized controlled trials focused on the mental well-being of adolescent girl survivors of GBV, O’Callaghan et al. (2013) studied the effects of trauma-focused cognitive behavioral therapy (TF-CBT) on 12- to 17-year-old girls “exposed to rape and inappropriate sexual touch” in the DRC. The intervention included 15 group-based, contextualized TF-CBT sessions (n=24), with a waitlist control group (n=28). Given the lack of qualified clinicians, social workers employed by World Vision—which had a strong relationship with the community where the intervention took place and offered courses and training sessions specifically for adolescent girls prior to this intervention—were trained to administer the TF-CBT sessions. Facilitators were supervised by trained staff and participated in pre- and post-training session debriefs with facilitators. Broadly, the TF-CBT treatment group “had a highly significant reduction in trauma symptoms,” a “highly significant reduction in depression and anxiety,” “a highly significant reduction in conduct problems,” and lastly, experienced a “significant increase in prosocial behavior.”<sup>164</sup> These benefits “were either maintained or improved” over the course of a three-month time post-intervention. Importantly, O’Callaghan et al. note that these findings might also be explained by additional factors, including the belief (on the part of the participants) that the program intervention would truly help them. As well, positive findings can be attributed to “the shared experience of group work [that] provided peer support from those with similar experiences,” something that many of the girls—given the stigmatization surrounding GBV survivors—had never experienced prior to the intervention.<sup>165</sup>

## USING TECHNOLOGY TO STRENGTHEN GBV SERVICES

Technology is an increasingly important component of new and innovative interventions for GBV prevention and response.<sup>166</sup> Technology can increase the accessibility of various services and interventions and can provide a discreet form of access for survivors and high-risk populations who otherwise would not be able to reach specialized services. Mobility restrictions enforced during COVID-19 brought focused attention to technological interventions for GBV service provision. In their umbrella review of digital health interventions for adolescents, Huang et al. (2022) conclude that technological interventions are “highly feasible and acceptable,” and provide an innovative modality for integrating GBV and SRH services.<sup>167</sup> Their review also noted that several types of digital interventions have become quite popular for reaching adolescent girls, including smartphone applications and mobile phone text messaging awareness-raising campaigns. More recently, the use of social media has also become important for interventions promoting awareness about available SRH services for women and girls. In their review, Emezue et al. (2022) noted promising findings relative to the effects of digital or technology-based interventions for IPV, with the caveat that these digital interventions must be done in addition to—and not as standalone—the full suite of GBV response services, in line with international

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164 Paul O’Callaghan et al., “**A Randomized Controlled Trial of Trauma-Focused Cognitive Behavioral Therapy for Sexually Exploited, War-Affected Congolese Girls**,” *Journal of the American Academy of Child & Adolescent Psychiatry* 52, no. 4 (April 1, 2013): 364.

165 O’Callaghan et al., 365.

166 GBV AOR Helpdesk, “**Harnessing Technology to Prevent, Mitigate and Respond to Gender-Based Violence in Emergencies Developments, Good Practices and Lessons Learned**,” Guidance Note, 2021.

167 Keng-Yen Huang et al., “**Applying Technology to Promote Sexual and Reproductive Health and Prevent Gender Based Violence for Adolescents in Low and Middle-Income Countries: Digital Health Strategies Synthesis from an Umbrella Review**,” *BMC Health Services Research* 22, no. 1 (November 19, 2022): 1373.

minimum standards and guidelines.<sup>168</sup> Similarly, Philbrick et al. (2022) point out that the use of information and communication technologies (ICT) is “nascent” and more rigorous research on current and future programming is needed to determine the effects of this programming with certainty.<sup>169</sup>

Currently, smartphone applications are a popular mechanism for providing high-risk groups and survivors with information about available services and their rights. Applications like Safetipin and HarassTracker allow users to input instances of GBV, specifically sexual harassment, into the platform, which then maps out the instances for other users to see in real time. The goal of these applications is to create a way for survivors and high-risk groups, specifically women and adolescent girls, to safely navigate the public sphere.<sup>170</sup>

## INTEGRATIVE PROGRAMMING FOR SURVIVORS

Integrative GBV programming, or programming that is “comprised of multiple components, such as community mobilization and engagement combined with survivor care strategies,” have “stronger evidence of positive outcomes” for survivors, especially in humanitarian contexts.<sup>171</sup> The Ushindi program in the DRC is one example of this type of integrative GBV program. The Ushindi program is implemented by a consortium of actors, including Panzi Hospital (discussed above), government organizations, NGOs, and faith-based community actors. This network of actors allows the Ushindi program to offer a comprehensive portfolio of GBV care services to survivors, including medical intervention, psychosocial support, and socioeconomic reintegration services. Importantly, the Ushindi program trains community-based religious leaders and faith-based organizations (FBOs) to serve as the first point of contact for survivors to receive critical life-saving care after an experience of violence. These frontline actors are trained to identify GBV survivors and to administer psychosocial support and referrals to survivors once they are identified. Community leaders are also trained to raise awareness about GBV prevention and response, women’s rights, and family planning, among other key topics, in their communities. Taken together, the integrative program approach coupled with the use of community-based leaders and advocates to identify and refer GBV survivors contributes to the large success of the Ushindi program. As Bennett et al. (2018) note, “the heavy reliance on community and faith-based partners is likely to ensure the longevity and sustainability of this [GBV] service model,” especially because community members are engaged in and committed to the success of this program.<sup>172</sup>

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168 Chuka Emezue et al., “**Technology-Based and Digital Interventions for Intimate Partner Violence: A Systematic Review and Meta-Analysis**,” *Campbell Systematic Reviews* 18, no. 3 (September 2022): e1271.

169 William Philbrick et al., “**Information and Communications Technology Use to Prevent and Respond to Sexual and Gender-based Violence in Low- and Middle-income Countries: An Evidence and Gap Map**,” *Campbell Systematic Reviews* 18, no. 4 (October 25, 2022): e1277.

170 Gerda Binder and Catherine Poulton, “**Six Ways Tech Can Help End Gender-Based Violence | UNICEF East Asia and Pacific**,” February 12, 2021.

171 Bennett et al., “A Comprehensive Approach to Providing Services to Survivors of Sexual and Gender-Based Violence in Democratic Republic of Congo,” 753.

172 Bennett et al., 757.

## Resources

AUTHOR	TITLE	YEAR
ARC International	<i>Gender-Based Violence Legal Aid: A Participatory Toolkit</i>	2005
Gender-Based Violence AoR	<i>Guidance to GBV Coordinators Addressing the Needs of Male Survivors of Sexual Violence in GBV Coordination</i>	n.d.
Gender-Based Violence AoR	<i>Handbook for Coordinating GBV in Interventions in Humanitarian Settings</i>	2019
Gender-Based Violence AoR	<i>The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming</i>	2019
Gender-Based Violence AoR Helpdesk	<i>Harnessing Technology to Prevent, Mitigate and Respond to Gender-Based Violence in Emergencies Developments, Good Practices and Lessons Learned</i>	2021
Global Women's Institute, World Bank, and Inter-American Development Bank	<i>Violence Against Women and Girls (VAWG) Resource Guide: Health Sector Brief</i>	2015
Inter-Agency Standing Committee	<i>Pocket Guide: How to Support Survivors of GBV when a GBV actor is not available in your Area</i>	2015
Inter-Agency Standing Committee	<i>Interagency Gender-Based Violence Case Management Guidelines</i>	2017
Inter-Agency Standing Committee	<i>IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings</i>	2007
Inter-Agency Standing Committee (IASC) Sub-Working Group on Gender in Humanitarian Action	<i>Guidelines for GBV Interventions in Humanitarian Settings</i>	2005
Inter-Agency Standing Committee (IASC) Sub-Working Group on Gender in Humanitarian Action	<i>Establishing Gender-based Violence Standard Operating Procedures (SOPs) for multi-sectoral and inter-organizational prevention and response to gender-based violence in humanitarian settings</i>	2008
Inter-Agency Standing Committee (IASC) Sub-Working Group on Gender in Humanitarian Action	<i>Caring for Survivors of Sexual Violence in Emergencies. Training Guide.</i>	2010
Inter-Agency Standing Committee (IASC) & Women's Refugee Commission (WRC)	<i>IASC Disability Guidelines - GBV</i>	2019
International Rescue Committee (IRC), UNICEF	<i>Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings</i>	2012
International Rescue Committee (IRC), UNICEF	<i>Advancing the Field: Caring for Child Survivors of Sexual Abuse in Humanitarian Settings (A Review of Promising Practices to Improve Case Management, Psychosocial &amp; Mental Health Interventions, and Clinical Care for Child Survivors of Sexual Abuse)</i>	2011
UNFPA	<i>Minimum Initial Service Package (MISP) for SRH in Crisis Situations</i>	2020
UNFPA	<i>Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies</i>	2015



<b>AUTHOR</b>	<b>TITLE</b>	<b>YEAR</b>
UNFPA	<i>Addressing GBV Across Contexts: Guidance Note</i>	2022
UNFPA	<i>Managing Gender-based Violence Programs in Emergencies</i>	2012
UNFPA	<i>A Practical Approach to GBV: A Program Guide for Health Care Providers and Managers</i>	2001
UNFPA	<i>Guidelines for the Provision of Remote Psychosocial Support Services for GBV Survivors</i>	2020
UNFPA	<i>Guidelines for Establishing Hotlines to Support Survivors of Gender-based Violence</i>	2021
UNFPA	<i>Guidance on the Safe and Ethical Use of Technology to Address Gender-based Violence and Harmful Practices: Implementation Summary</i>	2023
UNFPA	<i>Guidance: How to Design and Set Up Cash Assistance in GBV Case Management</i>	2023
UNFPA	<i>Safe Spaces for Women and Girls (SSWG) Standardization and Technical Guidance - How to set up a SSWG in practice</i>	2017
UNFPA & Save the Children	<i>Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings</i>	2009
UNFPA, UN Women, WHO, UNDP, & UNODC	<i>Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines</i>	2015
UNHCR	<i>Sexual Violence against Refugees: Guidelines on Prevention and Response</i>	1995
UNHCR	<i>Sexual and Gender-Based Violence against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response</i>	2003
UNHCR	<i>UNHCR Handbook for the Protection of Women and Girls</i>	2008
UNHCR	<i>Working with Lesbian, Gay, Bisexual, Transgender &amp; Intersex Persons in Forced Displacement</i>	2011
UNHCR and Refugee Law Project (RLP)	<i>Working with Men and Boy Survivors of Sexual and Gender-based Violence in Forced Displacement</i>	2012
UN Women	<i>Review of Good Practices for Remote Service Delivery to Survivors of Violence in the Arab States Region</i>	2021
WHO	<i>Guidelines for Medico-legal Care for Victims of Sexual Violence</i>	2003
WHO	<i>Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines</i>	2013
WHO	<i>Responding to Children and Adolescents Who Have Been Sexually Abused</i>	2017
WHO	<i>Mental Health and Psychosocial Support for Conflict-related Sexual Violence: Principles and Interventions</i>	2012
WHO, UNFPA, & UNHCR	<i>Clinical Management of Rape and Intimate Partner Survivors: Developing Protocols for Use in Humanitarian Settings</i>	(2004) 2020

# Gaps and Barriers to GBV Service Provision in the Democratic Republic of Congo, Iraq, and South Sudan: Primary Research Findings

## Overview

In partnership with Women for Women International (WfWI), GWI is implementing a project titled Putting Survivors at the Center: Creating New Programming Models for Non-GBV Specialist Organizations to Support GBV Survivors. The aim of this project is to develop new programming models that build the capacity of non-gender-based violence (GBV) organizations—which are defined as organizations that do not implement GBV response programs, and who are not specialized in GBV service provision—to receive disclosures from GBV survivors, meet survivors’ basic and immediate needs, and facilitate access between GBV survivors and response services in accordance with best practices and local realities. The project is taking place in three countries: the Democratic Republic of Congo (DRC), Iraq, and South Sudan (SSD).

The project is being implemented over three distinct phases. The first phase (September 2022-August 2023) of the program was heavily research based and included wide-ranging consultative discussions with both global and local stakeholders on issues related to GBV service provision and the barriers preventing survivors from accessing these services across the three program locations. During this phase, original research was conducted through:

- ✓ Three “Design” workshops that took place in each country
- ✓ FGD with women and with adolescent girls
- ✓ FGD with community leaders and advocates
- ✓ KII with community members, NGO staff, and GBV specialists

Original research was combined with an extensive desk review of the challenges and/or barriers to survivors accessing specialized GBV services as well as consultations with global and local technical advisory groups composed of both GBV specialists and non-specialists. (see *Part I of this document*).

In total, 348 participants were included in this research through key informant interviews (KIIs), FGDs, and the in-country design workshops (Figure 1). Participants represented the following groups:

- ✓ NGOs and international NGOs
- ✓ UN agencies
- ✓ Government agencies
- ✓ School-based workers (e.g., social workers and counselors)



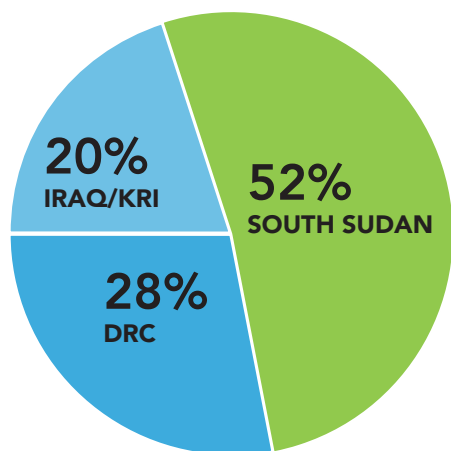
- ✓ GBV specialists/service providers
- ✓ Healthcare organizations (e.g., community health clinics, hospitals, etc.)
- ✓ Religious organizations

Marginalized groups were also represented in this research sample. Two FGD were conducted with adult women who were displaced (e.g., refugees and internally displaced persons) and one FGD was conducted with adult women with disabilities. One FGD was also conducted with adolescent girls in Iraq; data collection with adolescent girls was limited to prevent additional trauma and instead, specialists and other key informants were consulted about the status of adolescent girl survivors of GBV.

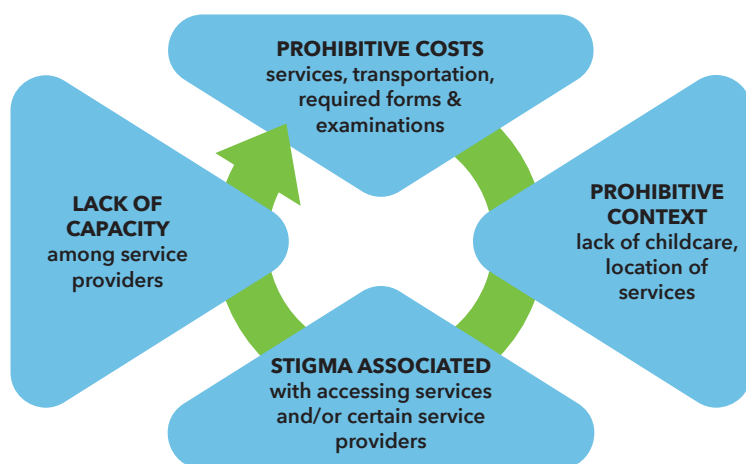
## Methodology

### THREE-DAY DESIGN WORKSHOPS IN-COUNTRY

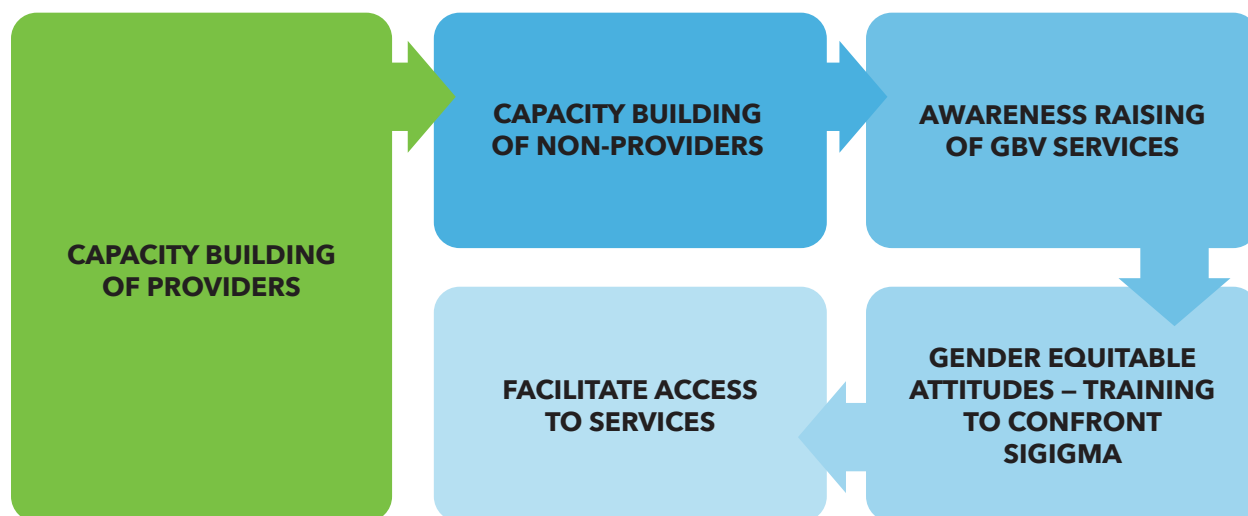
GWI used participatory action research methods to engage with local stakeholders through three-day “Design” workshops held in each country to discuss existing barriers and challenges, and to collectively identify a set of priorities and recommendations that might help to lower and ultimately remove these barriers facing survivors of GBV. On Day 1 of the workshop, GBV specialists were invited to participate and to discuss the barriers and challenges to service access and provision and to make recommendations for how to strengthen survivor access to services. On Day 2, non-GBV specialists were invited to discuss the same topics. Finally, on Day 3, a handful of representatives from each group were brought together to participate in a day of consensus-building activities with the goal of developing a set of concrete recommendations, based on findings from the entire workshop, to strengthen GBV service provision and to facilitate survivor access to specialized services. The findings from these workshops are summarized below in Figures 2 and 3.



**FIGURE 1** Number of Research Participants by Country



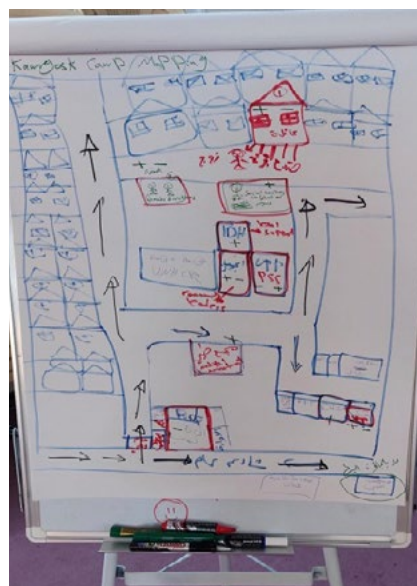
**FIGURE 2** Major Barriers/Challenges to GBV Service Provision and Survivor Access to Specialized Care, Design Workshops



**FIGURE 3** Recommendations to Strengthen Service Provision and Survivor Access to Specialized Care, Design Workshops

### FOCUS GROUP DISCUSSIONS AND KEY INFORMANT INTERVIEWS

In addition to the three design workshops, additional FGD and KII were conducted in each of the three countries with the aim to collect as much evidence about existing barriers and challenges to service provision, as well as the community-level recommendations for strengthening service provision and facilitating survivor access to specialized care. Focus groups employed two data collection tools. The



**FIGURE 4** Community Mapping Data Collection Tool, Visual Notes

first, Hypothetical Story, walks participants through a hypothetical scenario about a woman (and later, an adolescent girl) who has experienced GBV and asks participants first, to identify places in the community where she might get help; the types of experiences (e.g., positive or negative) she might experience when seeking help from different places; the types of services available to her; and lastly, what can be done to strengthen this woman and/or adolescent girl's access to specialized services. The second tool, Community Mapping, presents participants with a hypothetical story about a woman or an adolescent girl who has experienced GBV and asks them to visually map out the various support services, organizations, and actors within their community that the survivor could access (Figure 4).

Key informants were asked direct questions about the types of services a woman or an adolescent girl could receive following an experience of GBV and the potential experiences (positive or negative) she might have when accessing services at different organizations or when approaching different individuals for support.

# Accessing Specialized Gender-based Violence Services

## WHY DO SURVIVORS SEEK SUPPORT AND WHERE DO THEY GO?

Broadly, interviewee responses highlighted that survivors were most likely to seek support if (1) they needed outside intervention, (2) they were in immediate danger, and (3) if they had supportive families. Outside intervention was largely understood to be necessary primarily in instances where community or family-level mediation was unable to reconcile the survivor and the perpetrator. Interviewees noted that a survivor was also more likely to seek specialized services and care when they felt that their life, or the life (or lives) of their children, were in immediate danger. In these cases, survivors often fled to police and other judicial services. In contexts where safe spaces are available, survivors might also choose to seek shelter there. Finally, interviewees noted that another key determinant for survivors seeking specialized services was having supportive family members, “especially [male] relatives.”

Survivors seek help from a variety of actors across all three country sites and received both formal and informal types of support from these sources. Broadly, NGOs, government entities (e.g., police and judiciary), healthcare organizations, and UN agencies were all identified as places that can provide formal support. Formal support, in this research, includes any and all specialized GBV services, including case management, GBV medical care (e.g., CMR, PEP kits, etc.), SRH more generally, emergency healthcare, shelter, MHPSS, proper referrals, livelihoods support, and finally legal support. Informal support in the form of advice and mediation efforts was primarily provided by community-level actors and resources. For example, family and friends, religious organizations and leaders (e.g., sheikh or priest), and community leaders (e.g., village chief) were all seen as resources for advice and informal counseling; a place that survivors could go to safely tell their stories and to feel listened to; a place where they could receive spiritual guidance and support; and lastly, a place where they could potentially receive in-kind donations such as clothing.

The most common place that survivors sought help—both women and adolescent girls—were NGOs. These NGOs included not only those that offered specialized GBV services but also those that offered programming for women and girls (e.g., Women for Women International or Mercy Corps) as well as NGOs in other sectors (e.g., Islamic Relief). Relatedly, some interviewees reported that women survivors also seek support from different UN agencies; this was the case among survivors living in refugee camps or who had been displaced and were receiving other types of support from the UN. Community-level resources were also among the most common places that survivors sought support from. These include community leaders (e.g., sheikh, women and men leaders appointed by or who have received trainings from local NGOs, priests and other clergy); friends and neighbors; religious organizations (e.g., church or mosque); neighbors; and women’s groups (e.g., women’s groups associated with religious organizations or women’s rights organizations that are local to the community). Families were also an important source of support for survivors, although many respondents noted that this would only work if families were indeed supportive of women’s rights more generally and would recognize GBV.

Interviewees also recognized that survivors seek support from the government and the judiciary. This was the case in places like Iraqi Kurdistan (KRI), where the Kurdish government has installed several resources for survivors of GBV, including a government-run hotline to direct survivors to appropriate services as well as local support centers built for women and adolescent girls. In South Sudan, women reported turning to the police station in Yei, which has a gender desk to support survivors and others with cases of GBV.

In all three countries, interviewees noted that survivors could choose to seek support at the local courts, which would provide them with legal services in the case that they choose to pursue their perpetrators formally. Other interviewees noted that some survivors might seek support from NGOs that provide legal services, including those organizations that provide specialized GBV legal services. Often, however, when survivors did choose to seek services from the judiciary and/or government, they chose to seek support from the local police station. According to our interviewees across all three countries, the police station is often not the first choice for survivors. However, it is seen as a necessary support service if the survivor feels that they are in immediate danger or if they need additional support from non-community members (i.e., if community or family-level mediation has not worked).

Healthcare organizations, including hospitals and community clinics, were frequently cited as places where survivors commonly seek support. In places where the healthcare organization has a strong reputation within the community for handling GBV—for example, the Panzi Hospital in DRC—survivors were far more likely to access these organizations following an experience of GBV.

While it was not clear from the data when adolescent girls sought services (an issue largely related to their lack of autonomy, which is discussed later on in this document), many interviewees noted that girls would most likely seek support from family and their community, adults in their schools (such as school counselors or social workers), and finally, they might seek support at NGOs where they are already receiving services.

## **SURVIVORS' EXPERIENCES WITH DISCLOSURES AND SEEKING SPECIALIZED CARE**

All interviewees were asked to reflect on whether they believed certain service providers would provide survivors with a “positive” experience, a “negative” experience, or if the survivor would have “both” positive and negative experiences with a provider. The majority of places that survivors might seek services, including but not limited to NGOs, healthcare, the judiciary, police and other government services, community leaders, religious leaders, family and friends, and community members, were all seen as “both” negative and positive. Meaning, survivors could potentially have either a positive or a negative experience with a certain provider. However, interviewees most frequently indicated that survivors would have a “positive” experience seeking support from an NGO. Interviewees identified several characteristics of service providers, as well as additional services that are important for creating a positive experience for survivors seeking support:

- ✓ **ACCOMPANIMENT:** The survivor felt supported throughout the process of seeking services; someone from the organization provided clear information to the survivor about the types of services available and how to access them.
- ✓ **APPROACHABLE STAFF:** Staff at the organization where the survivor seeks support are helpful and are not judgmental toward the survivor. Interviewees also noted that approachable staff includes those who employ active listening and treat the survivor “with respect. They listen to her story and do not tell her what to do.”
- ✓ **EMPATHY AND SUPPORT:** Many interviewees identified empathy as a key characteristic for any positive experience a survivor might have seeking services and support. Survivors’ positive experiences seeking specialized services and support were also tied to whether the person or

organization the survivor discloses to is supportive. In this regard, interviewees highlighted those who were “understanding” and “had empathy” for the survivor.

- ✓ **TRUSTED BY SURVIVORS:** One of the most important factors that determined whether a survivor would have a positive experience with a person or organization following a disclosure was whether they trusted this person/organization. Relative to organizations, interviewees noted that “trust” was often tied to the organization’s reputation in the community. As one interviewee noted: “The organization is praised for its provision of high-quality services. This includes maintaining a safe environment and ensuring confidentiality in all transactions and interactions.” Another interviewee noted that trust among the community is tied to if “the location is recognized as a primary and secure destination for individuals seeking assistance.” Importantly, this trust often outweighed whether the organization provided specialized GBV care. Organizations that had a strong reputation and were embedded in the community, such as Islamic Relief in Yei and Women for Women International in the DRC and in Iraqi Kurdistan, had earned more trust among the local community than specialized GBV service providers and for this reason, survivors might choose to disclose to a staff member at these organizations or seek help from them rather than go to a specialized service provider.
- ✓ **CONFIDENTIALITY:** Relatedly, all interviewees stressed the importance of confidentiality for a survivor to have a positive experience following a disclosure and/or seeking specialized GBV services. This was especially important in small communities, as one woman from a refugee camp noted: “Most of the time, [survivors] visit NGOs secretly through [the referral of] a friend, their sister or mother. When they feel it’s confidential, they tell the story to the social worker or case management service providers [there].”
- ✓ **ACCESSIBILITY:** Interviewees in all three countries highlighted that the accessibility of specialized services—whether they were available nearby or within the survivor’s own community—was critical for the survivor to have a positive experience.
- ✓ **PROVIDER CAPACITY FOR GBV:** Among interviewees, it was important that service providers had a strong capacity for GBV services, including the ability to provide proper referrals to the survivor as well as to give the survivor good advice without judging them or pressuring them into making certain decisions. As one interviewee from a local INGO in Federal Iraq mentioned, it is important for the service provider to have a strong capacity to handle GBV cases so that the survivor can receive the “medical and other attention she needs” without needing to visit multiple organizations.

Relatedly, interviewees highlighted the dominant characteristics of organizations and/or people that make them a “negative” or “bad” place for a survivor to seek help from or disclose an experience of GBV to. Lack of trust, lack of confidentiality, lack of commitment to and respect for survivors of GBV, a lack of service provider capacity, and the overall poor treatment of survivors (e.g., non-gender equitable attitudes among service providers, community members, and family) were all identified as part of survivors’ negative experiences accessing specialized services and support following an experience of GBV. Accessibility issues were also considered to be part of a survivor’s negative experience seeking services: The cost of services, the long distances between the service provider and the survivor’s home, overcrowded centers and lack of appointment availability, and the overall absence of comprehensive GBV services available at certain centers all contributed to survivors’ negative experiences seeking services.

## ADOLESCENT GIRLS' EXPERIENCES WITH DISCLOSURES AND SEEKING SPECIALIZED CARE

Adolescent girls' experiences of disclosure and seeking specialized GBV services largely mirror those of adult women. However, girls' experiences were often exacerbated by their lack of autonomy because of their status as minors. For that reason, girls often are not allowed to go unsupervised (i.e., without adult supervision from a family member) to organizations where they might receive specialized services. This means that girls often experienced breaches in confidentiality simply because they must be accompanied by an adult when seeking specialized services.

In one FGD with adolescent girls, interviewees noted that another main reason for their negative experiences seeking specialized support is the stigma associated with young girls and GBV. Girls "are insulted" and "endangered more" when the community learns that they have experienced GBV. "The girl is more to blame," noted one interviewee, "and they [family and community] don't support her." Some noted that following a disclosure of GBV, the community and extended family often blames the parents of the survivor for "poor upbringing" as the reason for GBV. In South Sudan, members of a focus group of adult women community leaders noted that girls might also have negative experiences when disclosing or seeking specialized services because of the gender inequitable attitudes of the family and community members to whom they disclose, including school social workers.

Adolescent girls' experiences are considered positive when confidentiality is protected, when they received support and proper advice from those to whom they disclosed, when they are treated with respect, and when the service is easily accessible.

## Barriers to Gender-based Violence Services

Barriers to accessing specialized GBV services were cited more than 200 times over the course of the formative research phase. These barriers were coded according to several thematic areas. These include:

- ✓ Accessibility Issues
- ✓ Family Pressure
- ✓ Fear (of retaliation, exacerbation of violence, etc.)
- ✓ GBV is not considered a priority (politically, within the community, individually, etc.)
- ✓ Husband (any/all reasons associated with pressure from or fear of a spouse)
- ✓ Lack of Awareness
- ✓ Lack of Confidentiality (fear that confidentiality will be broken if a survivor seeks services)
- ✓ Social and Cultural Norms

Overall, barriers associated with social and cultural norms—for example, community stigma that often prevents women from pursuing specialized GBV services—were most cited, followed by a lack of awareness on the part of the survivor about the existence of GBV services, limited provider capacity (e.g., service providers claiming to provide GBV services but who lack specialists and/or resources to provide the services), and accessibility issues. Other commonly cited barriers include overall fear



of reporting (due to, for example, a fear of retaliation or further violence), legal barriers, and the fear that confidentiality will be broken if a survivor seeks support from a specialized provider. These are discussed in detail below.

## SOCIAL AND CULTURAL NORMS

“Shame,” “gossip,” “judgement,” “stigmatization,” and “victim blaming” were all cited as key social and cultural barriers/challenges to accessing specialized GBV care. Among key stakeholders, concerns about victim blaming as well as the gender discrimination embedded within cultural and traditional norms were seen as they main reasons preventing women and girls from reporting instances of GBV. As one community leader in Yei noted:

**“Culture is our biggest enemy [it] makes women fear to come and seek services. [T]hey hide because they say it brings shame should people know that someone [was] raped.”**

Others reported that “shame” was not just external, but internal, and that many women choose not to report to preserve the privacy of their marriages and what occurs within the realm of the household. Concerns of privacy and the loss of confidentiality were therefore compounding factors relative to the fear of shame, stigma, and gossip that survivors worried they would face should they disclose. Across all three countries, a “culture of not reporting family matters” was a major barrier preventing or deterring survivors from seeking services, largely due to the shame that would befall both survivors themselves and their extended families. In the DRC, a FGD with male community leaders trained on gender equality pointed to the “customs here in Bududo [where] a woman cannot accuse her husband.”

## FAMILY AND COMMUNITY PRESSURE

**“Women are not well supported, not only by their families but also by the community.”**

**–Community Leader, Budodo, DRC**

Interviewees frequently noted that normative expectations around how women should behave within marriage—for example, respecting their husbands, which includes not accusing them of sexual assault or violence—were part of the reason why community or family mediation was preferred instead of seeking specialized GBV services. Mediation, however, often reinforces dominant cultural and social norms that demand or expect women’s subservience to their husbands. In one focus group with women community leaders in the DRC, interviewees noted that because “our culture does not allow [the survivor] to complain about her husband,” she cannot report the case to a formal provider. Were she to proceed with a formal complaint, or if she was to seek specialized care and confidentiality was broken, and her family found out, she would risk social isolation and the “loss of the respect and consideration of her in-laws,” something that can “make life very difficult.” Others noted that the stigma and shame associated with survivorship might actually lead to more violence at the hands of both the perpetrator and even the survivor’s family or extended family. She might fear her “family’s reaction [which] might mean more physical or verbal violence, or [victim blaming].” This goes alongside intimidation from the survivor’s own family and her in-laws, which frequently leads to survivors abandoning any legal processes they

may have started against their perpetrator and from seeking further treatment (or any treatment at all) from specialized GBV service providers.

Other interviewees reported that survivors were often afraid of the reactions of their husbands should they choose to seek specialized GBV services or report an incident of GBV. “[Survivors] face rejection from their husbands after being victims of sexual violence,” noted one interviewee, “and they [can be] divorced and left to their own sad fate” as a result. Some interviewees highlighted that survivors just “want to protect their husbands,” while others noted a “fear of repeated attack when the husband hears of [the survivors] report.” For survivors with children, these fears were often tied to the husband’s power to take custody of the survivor’s children without her consent following a report of GBV. “If she reports it might become worse [for her] because she might lose her children,” noted one interviewee from the DRC, especially in the case of divorce: “In most cases, women can’t afford [the cost of] children” and are therefore compelled to “leave them with [the] husband when divorce happens” because of their financial issues. Other interviewees highlighted that some survivors who are married and who have children will forego reporting or seeking specialized services in order to prevent her children from harm: “She doesn’t want to destroy her household since her children might suffer,” noted one interviewee.

## **DISCRIMINATION AGAINST WOMEN**

Other social expectations around gender were cited as barriers that make it exceedingly difficult for women to report instances of violence or to seek help from a specialized GBV service provider. Across all three countries, interviewees pointed out that “women are not [seen as] decision makers” in their households with respect to their children, their spouses, or even their own wellbeing. Some interviewees highlighted “honor codes and moral boundaries” as major barriers to women reporting an incident of violence and seeking support: “Some women and girls feel reluctant to report their cases due to fear of losing [their] dignity” because of these cultural and traditional moral norms around sexual violence. Importantly, concerns over dignity and morality emerged in a telling discussion with one healthcare provider, who offered that survivors are afraid to report an experience of sexual violence “because they are afraid to say that another man had sexual intercourse with them.” When framed this way—as “sexual intercourse” rather than “sexual violence”—the non-consensual nature and violence of the act is hidden. This centers discussions about the “morality” or “dignity” of the survivor, rather than focusing solely on the violence of the perpetrator as a crime and providing care to the survivor to meet their needs. Issues of morality and dignity are also intrinsically tied to the identity of the perpetrator and whether the act of violence took place within the confines of marriage. As the interviewee above phrased it, women are “afraid to say that another man” perpetrated this act of violence. Here, the term “another man” implies that the act of GBV occurred outside of the confines of marriage and that this—and not necessarily the act of violence itself—is where the morality or dignity of the survivor might be called into question.

While many interviewees described gender discrimination in their responses—for example, citing that women should respect (and obey) their husbands, that women were not granted bodily autonomy within a marriage, that women were not made aware of their legal rights, etc.—some clearly noted that “discrimination against women” was the primary reason that women and girls do not report or seek services following an experience of violence. Here, the term “another man” implies that the act of GBV occurred outside of the confines of marriage and that this is where the morality or dignity of the survivor might be called into question, rather than calling into question the violence of the act and the morality or dignity of the perpetrator.



Women with disabilities also reported that social and cultural norms, including discrimination against both women and PwD, served as powerful deterrents to survivors seeking specialized services. However, they reported the compounded or intersectional norms that bar them from reaching specialized services. “Women living with disabilities don’t have the same considerations in society,” noted one focus group participant from Bukavu, so the community “may or may not help the [survivor]” because of these internal biases towards those with disabilities. “We are simply excluded from society,” noted another participant from the same focus group discussion. She indicated that even when programs or services do exist, these largely do not accommodate the needs of survivors with disabilities. Others noted that the stigma associated with having a disability marks women with disabilities in a way that makes it difficult for them to participate in everyday life and to meet the normative gender expectations of society. One focus group participant gave the example of marriage, noting that women with disabilities are frequently seen as a burden by their families and their communities. Marriage is seen as a sort of “relief” of this burden; for this reason, one woman noted, a survivor with disabilities might not report or seek services, because she does not want to lose the small gain in social status and protection that marriage grants.

## LEGAL BARRIERS

Findings in all three countries cited similar concerns about weakened judiciary systems, poor treatment of survivors who seek justice, limited political interest on the part of police and other judiciary members to prosecute or investigate cases of GBV, and very high levels of corruption as critical barriers to justice for survivors. Concerns about community-level mediation were also communicated during the formative research stage, including the reality that local chiefs and village leaders were, in some places, losing their prestige because of the conflict, making it even more difficult for survivors to find some sort of justice through CIJ systems (whereas before the onset of conflict, they were able to). In KRI, study participants mentioned concerns about the lack of coordination between government actors working on GBV response and service provision and civil society. More importantly, they worried that gaps in service provision and response might arise given the current shift away from a humanitarian funding model toward a development model across Federal Iraq and KRI. Other respondents noted the lack of commitment on the part of government and other legal actors (judiciary and police) to prosecute cases of GBV. Across all three countries, participants cited worries about the capacity of the formal and informal justice systems to implement a survivor-centered approach due to a lack of training and/or a general lack of concern for GBV and other “women’s issues.”

## LACK OF AWARENESS OF SPECIALIZED GBV SERVICES

Another major barrier to specialized care is the lack of awareness within the local communities about available GBV services and how to access them. “Women lack awareness about what service[s] and help NGOs may provide to survivors,” noted one respondent. Another pointed out that the lack of awareness among survivors is further exacerbated because they are approaching the wrong people for support: If they approached the “right people to seek help,” she continued, they would know that they can get some help. Lack of awareness on the part of service providers and community leaders was also mentioned a handful of times by different informants, who noted that providers’ “limited knowledge about the prevalence and impact of GBV, as well as [other] available support services” has a detrimental impact on survivors who have already disclosed (i.e., those who might now be deterred from returning for a follow-up) and those who have not yet reported (i.e., those who have heard poor reviews of certain service providers and therefore choose to avoid seeking services there).

## BARRIERS RELATED TO SERVICE PROVIDERS

### LIMITED PROVIDER CAPACITY

Even when specialized GBV services are available, many respondents noted that providers often have limited capacity to ensure that a wide variety of high-quality GBV services are regularly available. While the issue of funding for GBV programming was cited by a GBV specialist as a primary reason for this limited capacity, many respondents noted more pressing issues related to:

- ✓ The lack of coordination between providers
- ✓ Lack of specialized knowledge about GBV
- ✓ Lack of knowledge about the referral pathways
- ✓ Lack of specialists
- ✓ Lack of internal guidelines/procedures for GBV cases

Community leaders in the DRC noted the frustrations facing survivors who are not properly referred. As one woman noted: “The [survivor] might miss out on assistance if she goes to several places because of the hassle [of visiting] several providers due to the lack of coordination.” Another community leader in Yei reported the lack of communication between “partner” organizations, or organizations that provide GBV services and those who do not, to ensure that survivors are properly referred. In KRI, several respondents from NGOs working in the region noted similar difficulties and pointed out how the lack of coordination exacerbates the lack of knowledge about the referral pathways and makes it difficult to keep them up to date. This lack of information, according to women community leaders from areas around Bukavu, DRC, makes it difficult to ensure that survivors are being properly referred to high-quality services. Instead, because organizations are unaware of the updated referral pathway, survivors might be mistakenly sent to a location that does not provide (or no longer provides) the service they need. This is a particularly problematic barrier given the reality that, based on findings from this research, survivors are most frequently motivated to seek external support services when they are in immediate danger or in need of immediate help. In these critical moments, it is crucial that survivors are correctly guided to appropriate care rather than to a provider that does not have the capacity to support them.

### CONFIDENTIALITY ISSUES AND LACK OF TRUST IN SERVICE PROVIDERS

“There is a fear of [a] lack of confidentiality. Women are afraid to speak out...because it could be disclosed to their husbands and then cause them problems at home.”

–Key Informant Interview, DRC

A major deterrent to survivors seeking specialized GBV support is the fear that their identities and any information related to their cases will be spoken about or leaked into the community. As discussed earlier, fears that confidentiality will be broken following a disclosure of violence are intertwined with the shame and stigma associated with GBV. To avoid this stigmatization and shame, survivors will

frequently forego seeking specialized services if they believe that confidentiality might be threatened. In small communities, like refugee camps, these fears are often exacerbated by stigmas associated with certain NGOs or even buildings that are known for offering GBV services. In one FGD with displaced women living in a refugee camp, respondents noted general hesitancy to access a “normal” (i.e., not GBV/SRH) clinic for care because of gossip in the community that often shamed patients seen at this clinic as “crazy.” Even if confidentiality between the provider and the survivor is protected, as one respondent noted, “people [still] might know about their visit to [the provider] due to the close[ness] of the community, especially in small villages and communities.” In a FGD with women community leaders from Bukavu, respondents noted that small communities also meant an increased likelihood that a survivor might meet or see someone they know while they are accessing specialized care. One respondent gave the example of how a “breach of confidentiality [can] lead to more harm especially when [the] social worker” the survivor meets or speaks with “works inside the same community.”

Alongside fear of confidentiality breaches, many survivors have a broad distrust of service providers. Reasons for this distrust varied, from a lack of women providers and/or specialists for survivors to sit and speak with, to feeling as though the provider was not truly interested in listening to the survivor’s story. Interviewees reported that distrust was often the result of an organization’s poor reputation among community members while others noted that sometimes the “solutions” proposed by providers did not “fit with the community’s traditions.” One respondent noted that some solutions proposed by providers were “temporary and not practical for women.” Some respondents noted that it was not necessarily distrust in the organization but rather, with the employees whom they feared, as mentioned above, might breach confidentiality or have biased attitudes toward survivors.

## LOGISTICAL BARRIERS AND ISSUES

Logistical issues present another set of key barriers preventing survivors from accessing specialized GBV care. For many respondents, the lack of service providers within local communities often meant that survivors would need to travel far distances to access the specialized care they needed. This was exacerbated by the costs associated with travel and the inability of many survivors to abandon their everyday responsibilities to spend large amounts of time traveling to seek specialized care. Poor infrastructure also was cited as a barrier to physically accessing service providers. For women with disabilities, these logistical barriers were exacerbated: interviewees noted the difficulties facing women with disabilities and their limited mobility, as well as the lack of support available for PwD at organizations that provide specialized GBV services. Key among these lacking services is communication support: “For a blind person, you need an attendant; for a mute person, you need an interpreter; and for a person with a [physical] disability, you need accessibility and adapted transport,” which, according to interviewees, were almost always unavailable at service provider locations.

The primary logistical barrier to accessing specialized services for all survivors is financial. “Without money, you can’t get anything,” noted one respondent. “Because when you ask [for a service] they will ask you for money,” she continued. Besides payments for formal services, such as visits to a healthcare clinic, respondents also noted fees associated with transportation costs as well as fees to pay bribes to police and other officials within the judicial system to accept or file their cases. Women with disabilities are particularly vulnerable to financial issues, as many are unable to work or are limited in their ability to make financial decisions by family members.

## ADOLESCENT GIRLS' EXPERIENCES

Adolescent girls reported their experiences of seeking GBV specialized services more negatively than adult women. Above all, the lack of confidentiality was a primary issues for adolescents for two reasons. First, in almost all of the country settings, adolescent girls must seek the consent of a family member before accessing specialized services. In these cases, girls must often risk disclosing an experience of violence to a family member first in order to access services, something that largely deters adolescent survivors from reporting an experience of GBV and seeking additional help. Second, adolescent girls are also at risk of confidentiality loss. In Federal Iraq, KRI, and South Sudan, key informants indicated that girls also faced specific types of stigmatization, as the loss of their "honor" might mean the loss of material resources or social standing for their families, again making it far more difficult for adolescent girls to even consider seeking support from specialized service providers.

## Organizational and Community Leaders' Experiences Receiving Disclosures

KII also gathered information, when possible, about experiences of receiving disclosures for both individuals and organizations. Both community leaders, including religious leaders, and staff from local NGOs noted that they receive spontaneous disclosures of GBV from women and girls. Importantly, the majority of these respondents noted that when they receive a disclosure, their first reaction is to provide some type of informal psychosocial first aid (PFA). As one religious leader in Bukavu noted, the goal is to provide "encouraging words to the survivors" to let them know that "it's not the end of the world [and] that they can still cope and live a better life." Another religious leader noted that "the first thing we offer the victims is prayer, to calm, strengthen, and reduce the pain in the survivor that was caused by [the] criminal act towards her." Another pastor in Budodo reported that, "I make [the survivor] feel welcome, listen to them, and give advice."

Following this initial offering of informal PFA, a handful of key informants indicated that the next step is to refer the survivor to appropriate services. These responses, however, generally appeared in interviews with key informants from NGOs and other organizations where awareness about GBV is often higher than it is among community-level resources. For example, the majority of respondents affiliated with religious associations, such as priests or women's groups within the church, frequently noted offering family mediation or counseling to the survivor before providing them with information about referrals to GBV specialist services. One respondent noted that following a disclosure, they would focus on "mediation with the husband and [the survivor]" to ensure that the survivor "was safe" following the incident. Beyond this, however, very few respondents identified an internal protocol at their organization that outlined a set of standard practices they should follow after receiving a disclosure. Among respondents from non-GBV specialist NGOs, only a few noted having formal protocols for responding to disclosures and instead relied primarily on providing PFA and referring the survivor.

# Recommendations to Improve GBV Service Provision and Support

## STRENGTHENING PROVIDER CAPACITIES

During these interviews, as well as during the three in-country design workshops, data was collected on the suggested recommendations for improving GBV service provision and support. The most frequently cited recommendations fall under the umbrella category of strengthening provider capacity. The majority of recommendations in this category highlighted the need for capacity building trainings for GBV service providers. These trainings ranged from trainings on technical aspects of service provision for providers to building the capacity of service providers to treat survivors with gender equitable and empathetic attitudes. Improving the quality of available services was also included in this category of recommendations. Many interviewees noted the need for capacity building among NGO providers to ensure that they are “consistent with their support to survivors” and that they “balance their support to [all] survivors [and] not only focus on rape cases.” Others noted that personnel working at these organizations, including healthcare organizations and NGOs who provide specialized care, should be trained both on GBV as well as on gender equitable attitudes to ensure that survivors are receiving the best care and the best personal treatment possible. Alongside this capacity building, many recommendations highlighted a need to hire temporarily or long-term a GBV specialist to provide this type of support and capacity building for specialist organizations. Relatedly, several GBV specialists identified the need to standardize “what we call response packages in the field of GBV,” noted one specialist, “so that when I say that I’m an actor who provides medical care and that you also provide medical care it means that we’re doing the same thing.”

Another key area of concern raised under “strengthening provider capacity” was the need for better resources. Both formal service providers and informal service providers, such as religious organizations, expressed a desire for better financial and material resources to enable them to provide better support for survivors. For formal providers, especially healthcare clinics, recommendations included providing long-term financial support so that clinics could ensure that they were stocked on the necessary medications and supplies to treat GBV survivors. Recommendations also expressed the need for better salaries for workers staffing these organizations, as a way to ensure that they could be available to survivors more frequently instead of, for example, only being at the clinic one day a week due to shrinking salaries for staff. In contexts where the federal government’s overall commitment to GBV was minimal or where conflict was preventing the government from assuming its normal duties, the need for financial and material resources to support service providers is crucial, according to respondents. As one GBV specialist from South Sudan noted, “the government really needs to assume its responsibilities in state structures for medical care and other” types of care to ensure that service providers, even those in remote areas, are able to sustain their services. In KRI, the desire for financial and material resources for service providers was equally crucial due to the shifting context of development funding. Now, as Federal Iraq/K RI moves away from a humanitarian funding model to a development one, interviewees noted that many GBV service providers have lost funding and are no longer able to provide the life-saving services that they had previously been offering, leaving survivors without any adequate coverage or support in their absence.

Another critical recommendation identified to build provider capacity was strengthening providers’ ability to practice and maintain confidentiality. As mentioned earlier, breaches in confidentiality, both

real and anticipated, serve as a major barrier to survivors accessing specialized services. And, in some cases, the fear of a breach in confidentiality can deter a survivor from disclosing or attempting to access specialized services. To address these issues, interviewees and workshop participants in all three countries emphasized the need for capacity building and awareness-raising about the importance of maintaining confidentiality among both GBV service providers and non-GBV specialist organizations, as well as community-level advocates and community leaders. Relatedly, recommendations also included suggestions to strengthen provider capacity on issues of data security and management

## **EMPOWERING COMMUNITY-LEVEL ADVOCATES AND RESOURCES**

Although community-level advocates and resources might not provide formal GBV services, they were largely understood by interviewees in all three countries as key components in the landscape of GBV response and service provision. Community leaders and organizations, such as religious organizations, are frequently the place that survivors turn to for support given the high levels of trust and respectability that these organizations and leaders have in their communities. Recommendations to empower and strengthen community-level advocates and resources therefore emerged as a key area of action in all three countries. These recommendations included capacity building to community leaders and local organizations on how to best handle disclosures. This was of particular importance because of the volume of disclosures received by these organizations and the lack of a standardized approach used when handling disclosures. As well, many KII noted a desire to participate in the collective response to GBV and wanted to support the efforts led by larger NGOs from outside of their communities. For example, a community leader in Budodo noted that “we [community leaders] feel excluded”: they pointed out that whenever local NGOs received trainings on supporting survivors, as just one example, they were often not included in the trainings even though they “want to be involved every time there are workshops or training courses” on these issues. One interviewee affiliated with a non-GBV organization in the DRC similarly noted that “all influential people, village elders and even village chiefs, need to be involved in...the fight against GBV.” This includes both awareness-raising activities as well as trainings on the best practices for providing support to survivors following a disclosure of GBV. Another community leader in Bukavu stressed that it is important to build the capacity of community leaders because communities should play an active role in addressing these issues rather than having an “outsider” or outside organization come in and dictate how to respond to these issues.

Several recommendations centered on the idea of developing forums for exchange and open discussion between community leaders and organizations with both GBV specialists and non-GBV specialist organizations that are active within the same communities with the goal of sharing experiences about GBV. Several religious leaders interviewed in Yei emphasized the importance of such open communication, noting that since the “church is part of [everyday] life” in Yei it should also be “aware of everything” that is happening in the community, including outside efforts to build the community’s capacity to respond to GBV and support survivors. Other community leaders, such as the graduates of WfWI’s Stronger Women Stronger Nations year-long women’s empowerment program, mentioned that they would like to see some additional support so that they could continue to do their work as women’s rights advocates in the community, a part of which includes raising awareness about GBV and providing survivors with appropriate referrals to specialized services. Relatedly, many of these community leaders and actors also advocated for a community-based response mechanism for GBV, for example, by establishing community-level units, that can support survivors and refer them to the appropriate services following a disclosure.



## RESPONDING TO ACCESSIBILITY ISSUES

A key barrier to survivor access to specialized GBV service providers, accessibility issues were a main source of focus among the recommendations collected. Broadly, the majority of these recommendations focused on the need for financial support for survivors. This type of financial support included money to pay for transportation services to get to the service provider, as well as money to pay for any of the services a survivor might need once they access the provider. Other suggestions included NGOs establishing a trusted transportation service that survivors could use when they needed to access specialized services. Other recommendations highlighted the importance of “bringing specialized services closer to women,” as one community leader from the DRC noted.

Accessibility issues were a key barrier to survivors with disabilities as well, and several recommendations emerged targeting this specific group of survivors, including making hospitals and medical clinics universally accessible; providing trainings to service provider staff to raise awareness about disabilities and specifically survivors with disabilities; and establishing hotlines and helplines, when possible, so that survivors with physical disabilities can more easily contact someone for support following an incident of violence.

## AWARENESS-RAISING

One of the most frequently cited recommendations that emerged during this formative research was the need for major awareness-raising campaigns. The main type of awareness-raising needed in each of the three country contexts was about the types of GBV services available to survivors. As a GBV specialist in South Kivu noted, “in order to access services, the survivor must be informed.” In other words, no matter how many service providers and support organizations are available in any given area, if the survivor is not aware of these services, they will not try to seek specialized care. Recommendations included “campaigns, brochures, and door-to-door initiatives” as well as awareness-raising events and workshops held in community spaces and schools.

Relative to adolescent girls, respondents noted that it was important to also raise awareness about GBV with parents, schoolteachers, and other adults who spend time with adolescents. As well, several recommendations noted the equal importance of awareness-raising campaigns for both adolescent girls and adult women on women’s rights and gender equality more broadly to help “build their confidence and empower them,” as one interviewee noted.

Alongside awareness-raising for survivors, women, and girls, recommendations mentioned the need for awareness-raising campaigns among the community and with both GBV specialist and non-GBV specialist organizations on issues of GBV as well as gender equitable attitudes. Many of these recommendations stressed the need for trainings on GBV sensitivity with the aim of challenging and ultimately changing biased or gender discriminatory attitudes that affect how survivors are treated. These recommendations complement recommendations to build the awareness of GBV and non-GBV organizations to support PwD survivors, as many key informants and interviewees noted the lack of knowledge about disabilities in their communities and the resulting bad treatment of survivors with disabilities by service providers and others.



## LEGAL RECOMMENDATIONS

Recommendations also emerged regarding the issue of legal services and support to survivors. By far, the most common recommendation was to conduct awareness-raising with policy makers to strengthen and/or implement legislation that penalizes GBV in all its forms. Respondents from all three countries noted that the lack of strong legislation for GBV is missing and impunity for perpetrators is largely the norm. As one respondent from KRI noted, there is a strong need for some type of oversight mechanism at local police bureaus to ensure that survivors are treated with respect, that their cases are properly documented, and that they are not exploited when they try to report their cases.

Recommendations from South Sudan mirrored many of these complaints and were especially concerned with the potential exploitation that survivors might face should they choose to pursue a formal legal case against their perpetrators. In all three countries, recommendations highlighted potential strategies for dealing with corruption within government and other legal entities. Others recommended trainings for police bureaus and even judges on gender equitable attitudes with the aim of ensuring that survivors are treated with respect should they choose to pursue a formal legal case against their perpetrator. Finally, some interviewees noted the importance of strengthening the capacity of legal aid organizations to work on cases of GBV.

## INCREASE WOMEN'S SOCIOECONOMIC EMPOWERMENT

Another key recommendation that emerged during this research was the need for more programming that supports women's socioeconomic status, and the need for NGOs to see this programming as complementary to GBV services. For many interviewees, poverty was one of the main barriers preventing survivors from accessing specialized GBV services and leaving abusive or violent situations in the household. To remedy this, many respondents believe that socioeconomic support should be provided to survivors, for example, through livelihoods trainings, the provision of in-kind and non-food items (NFIs), and small economic support packages for survivors as they work to reintegrate themselves into their communities following an experience of violence. Income-generating activities in particular emerged as an important recommendation, especially by those advocating for survivors with disabilities. Giving women with disabilities the opportunity to survive on their own, noted one community leader, will help them to live independently and can help them to gain respect in the community. Several recommendations indicated that village savings and loan associations (VSLAs) can serve as a key locus of support for survivors.

## INCREASE IN WOMEN'S AND GIRLS' SAFE SPACES

Across all three sites, several recommendations emerged around the theme of increasing the number of and building the capacity of women's and girls' safe spaces. Recommendations highlighted the need for traditional safe spaces—in other words, shelters where survivors can stay in the case of immediate danger—and more flexible spaces that create room for women and girls in the community to engage with each other in a safe and inclusive space. Within these spaces, women would also be able to receive different types of support, such as economic livelihoods training (see previous section), educational training (e.g., literacy programs), gender equality trainings and GBV awareness-raising, as well as information about specialized GBV services (referrals), and psychosocial support (PSS), among other things. The goal of such centers would also be to provide women and girls with a place to speak with each other and potentially a psychosocial support (PSS) specialist about some of the difficulties they are facing in their lives; this would ideally serve as a potential facilitator to specialized GBV services in cases where it is needed and/or necessary.

## Conclusion

The research and primary findings presented in this paper are at the foundation of the pilot projects that will be developed during the second phase of the PSAC project. Based on these findings, the team has identified three thematic areas that the PSAC pilot programs will address:

- ✓ The improved immediate handling of GBV disclosures,
- ✓ Connecting to and supporting existing GBV specialist services, and
- ✓ Strengthening medium and long-term support to GBV survivors.

Overall, six program models have emerged that fall under these thematic areas. The pilots will be implemented across six different program sites in three different countries (the DRC, Iraq and Iraqi Kurdistan, and South Sudan). While some activities will be piloted in all of the program sites, some will only be piloted in one place. The overarching aim of these pilots is to produce maximum learning and knowledge about the types of interventions that can build the capacity of non-GBV specialist organizations to respond safely and appropriately to spontaneous disclosures of GBV during their routine programming.

These activities will be piloted over the course of 12 months and will be closely tracked by monitoring and evaluation (M&E) tools, both quantitative and qualitative, by program staff. Halfway through the pilots, there will be a midpoint workshop to analyze early findings from the data collected from all of the programs. During this midpoint workshop, the team will identify the strengths of the pilots and will make any necessary changes to the pilot activities. The final phase of the project will focus on consolidating learning and sharing out best practices.

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