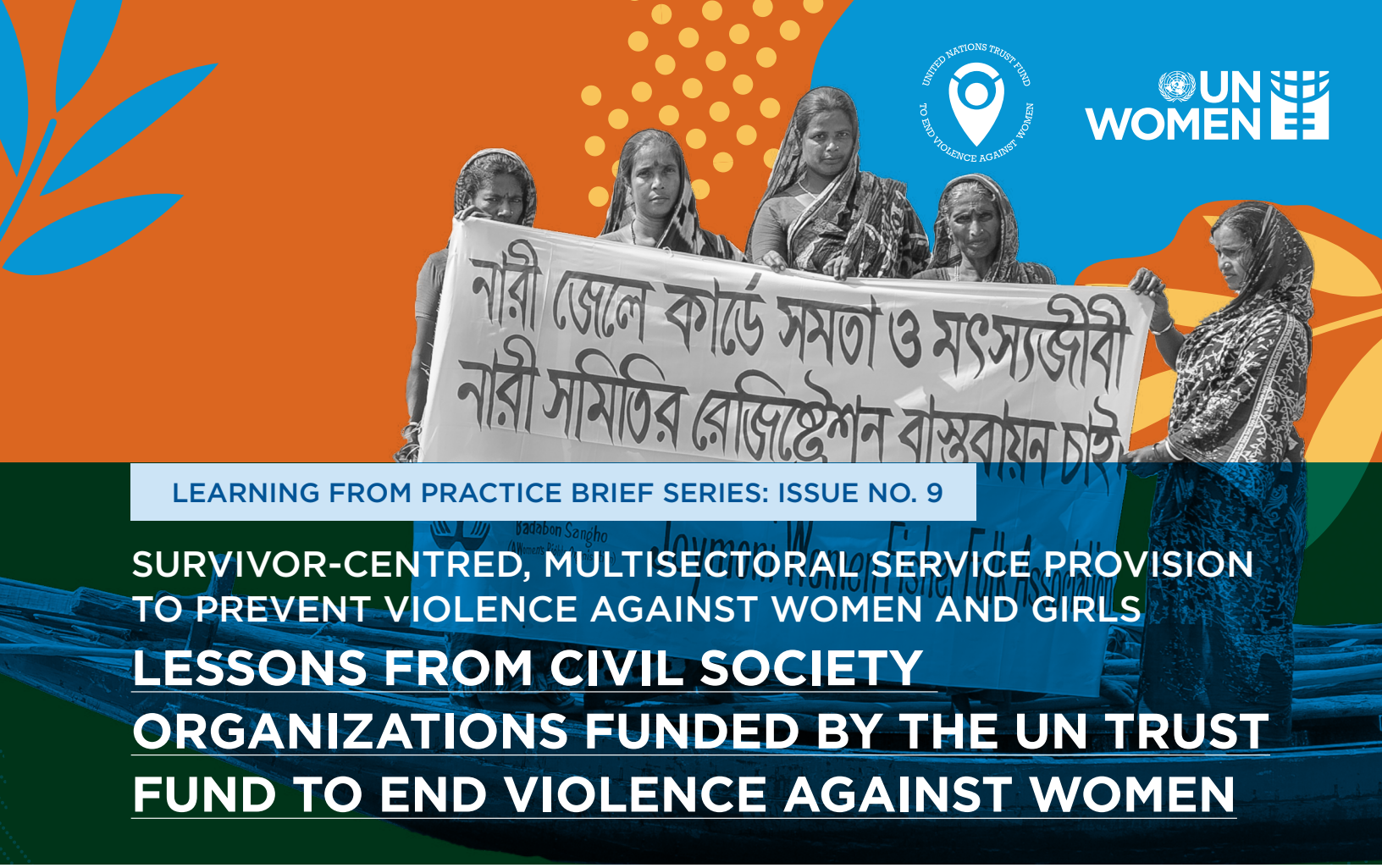


LEARNING FROM PRACTICE BRIEF SERIES: ISSUE NO. 9

SURVIVOR-CENTRED, MULTISECTORAL SERVICE PROVISION TO PREVENT VIOLENCE AGAINST WOMEN AND GIRLS

LESSONS FROM CIVIL SOCIETY ORGANIZATIONS FUNDED BY THE UN TRUST FUND TO END VIOLENCE AGAINST WOMEN

Women fisherfolk brought out protest against fishing ban decision. Photo: Yusuf Shahrier Muntaqim/Badabon Sangho (Bangladesh). Badabon Sangho leads a project that provides legal assistance to women landowners who are also survivors of violence and forced displacement.

Background

Good-quality services that are delivered in ways that respect women and their rights can reduce risk factors for violence against women and girls (VAWG) and support factors that protect against VAWG, and such services can also assist in the early identification of violence and reduce its reoccurrence. Furthermore, primary prevention interventions often lead to an increase in the number of women disclosing the violence they are experiencing or have experienced. Services for survivors therefore exemplify how VAWG prevention and response are connected in a mutually reinforcing cycle, both contributing to the eradication of VAWG.

This brief contributes to the debate on the link between prevention and services by focusing on the learning of civil society organizations (CSOs) that not only aimed to improve, provide and bolster services but also did so in a way that was survivor-centred and relied on multisectoral collaboration (MSC).

About this brief

This brief summarizes a longer synthesis review on the practice-based knowledge that eight CSOs gained in the process of developing and implementing 11 projects[1] that received funding from the United Nations Trust Fund to End Violence against Women (UN Trust Fund). Although all the grantees used services as their entry point into addressing VAWG, they differed in many ways.

Using selected monitoring and evaluation reports on their projects, a qualitative, inductive approach was taken to explore why and how responding to the needs of survivors[2] was their entry point, and why and how survivor-centredness and MSC played a role in their service provision. The practice-based insights from the projects were put into conversation with existing literature on prevention and response, survivor-centredness, service provision and MSC to highlight how learning from practice can contribute important lessons to the evidence base on services. This brief also aims to provide some practical tips and recommendations for practitioners, donors and policymakers, and researchers in the field of ending VAWG.

1 Three grantees – Physicians for Human Rights, the Al Shehab Institution for Comprehensive Development and the B92 Fund – received two rounds of funding from the United Nations Trust Fund to End Violence against Women and were therefore able to implement two projects each.
2 While fully recognising the ongoing debate on the terms "victim" and "survivor", this brief uses the term "survivor" to refer to both women and girls who have experienced and escaped violence, and women and girls who are still caught up in violent circumstances. This is because the grantees included in the brief used the term "survivor" in this way.

Case studies

Responding to the needs of survivors was the entry point into VAWG prevention for all the projects. However, the nature of the situation and the needs of survivors, and the specific approaches used and activities implemented to address them, were very different for each CSO. For example, Organización Nacional Indígena de Colombia (ONIC) and its partner organizations in Colombia focused on how indigenous survivors are made invisible in national policies and services, and worked to ensure that indigenous survivors were acknowledged and recognized, and received the services they needed. Physicians for Human Rights (PHR), on the other hand, in its work in the Democratic Republic of the Congo and Kenya, identified the failure of the forensic evidence chain as an issue to respond to (as it means that sexual violence survivors do not receive justice), and its projects focused on capacitating the service providers involved in the forensic evidence chain.

The eight grantees centred survivors in their projects in different ways. For example, World Hope International (WHI) in Cambodia and PHR in the Democratic Republic of the Congo and Kenya did not work directly with survivors. Rather, they capacitated the service providers and systems that are supposed to assist survivors. The Al Shehab Institution for Comprehensive Development (Al Shehab) in Egypt and Medical Services Pacific (MSP) in Fiji, on the other hand, did engage directly with survivors, by offering medical, legal and psychological services.

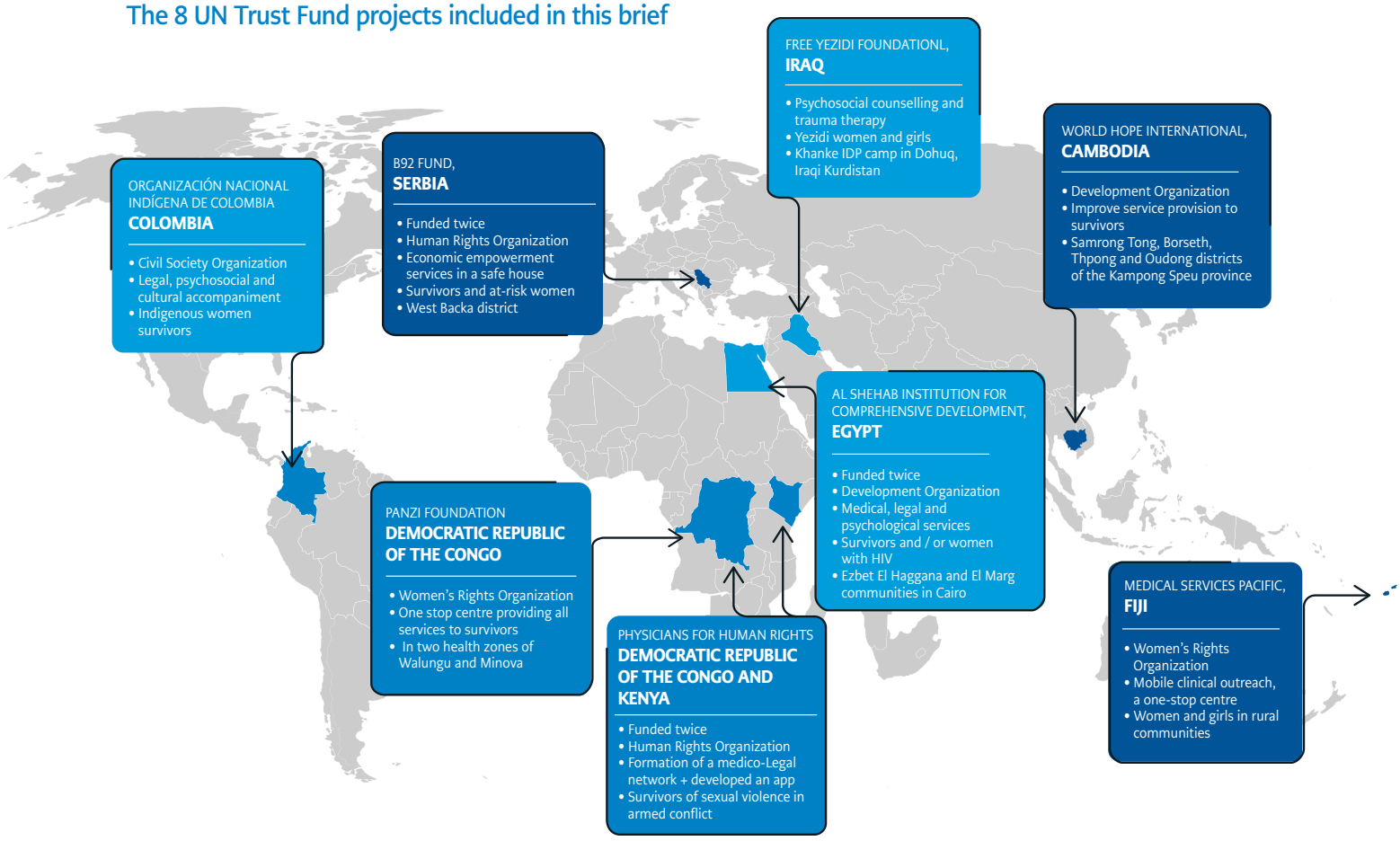
Although all of the projects focused on responding to survivors' needs, **they prioritized different services and engaged in different activities**. Some grantees focused exclusively on filling a specific gap in the services available to survivors. The Free Yezidi Foundation (FYF), in its work in the Khanke camp for internally displaced persons (IDPs) in Iraq, focused on providing psychosocial support to survivors, while the B92 Fund in Serbia focused on developing and implementing a new model of economic empowerment options and opportunities for survivors in safe houses. Other grantees aimed to provide integrated services to survivors. For example, the Panzi Foundation's scaling of its holistic Panzi model in the Democratic Republic of the Congo led to the development of two rural one-stop centres that provided medical, legal, psychosocial and socioeconomic support to survivors.

All of the grantees collaborated with multiple stakeholders across various sectors to ensure that survivors could access the service, or services, that they needed. Such collaboration was needed in all of the settings, but the grantees engaged in MSC with different partners in different ways and played different roles in the collaboration – including initiating, driving and leading the MSC. For example, PHR put significant effort into developing, promoting and sustaining MSC between the various sectors involved (law enforcement, health providers, prosecutors and judges) to ensure that the forensic evidence chain as a whole functioned for all survivors. ONIC and its partners, on the other hand, worked with multisectoral stakeholders to ensure that survivors received the specific services that they needed, for example medical assistance or legal advice.

A Community activist facilitating a discussion using a SASA! Faith power poster. This is part of a project led by WOLRED in Malawi which provides legal services to survivors of violence. Photo: Chimwemwe Livata/Women's Legal Resources Centre (WOLREC, Malawi).

FIGURE 1 :

The 8 UN Trust Fund projects included in this brief



Why is service provision important for VAWG prevention?

In 2019, the World Health Organization and UN Women, in collaboration with 12 other United Nations agencies and bilateral partners, launched the RESPECT Women: Preventing Violence against Women framework (RESPECT Women framework). This comprehensive framework on how to prevent VAWG is intended to inform policymakers and implementers and was designed based on existing global evidence, expert recommendations and practitioner consensus. It outlines seven interrelated intervention strategies critical to VAWG prevention. One of these strategies is ensuring that VAWG survivors receive the essential services that they need.

The RESPECT Women framework highlights that the delivery of good-quality services that respect women and their rights can reduce risk factors for VAWG and support factors that protect against VAWG. Such services can also contribute to the early identification of violence and reduce its reoccurrence. Furthermore, because prevention interventions often lead to an increase in the number of women disclosing the violence they are experiencing or have experienced, having services in place is necessary for prevention interventions. VAWG prevention and response are therefore connected, both contributing to the eradication of VAWG.

What can we learn from civil society organizations about service provision?

1. The fluidity of the link between prevention and response

Grantee activities reveal that prevention and response are viewed as mutually reinforcing, that working with and for survivors is an important element of prevention, and that activities typically associated with primary prevention are

also a crucial element of response. All of the grantees believe that their activities with and for survivors have a preventative impact in the long run. Furthermore, while all the grantees focused on service provision for survivors and at-risk women, many designed their programming to also include activities that were explicitly meant to prevent violence from occurring. Almost all included a focus on at-risk women, as a way of preventing imminent or recurring VAWG. For example, MSP's mobilized clinical outreaches in Fiji not only served survivors but also brought services to all women in marketplaces and remote communities, providing health care and information to help prevent at-risk women from experiencing violence.

While some grantees explicitly designed their programming focused on survivors to also have a primary prevention component, other grantees' work with survivors organically evolved to include some activities more directly focused on preventing violence from occurring, in response to survivors' needs and recognizing that prevention is important in serving survivors. For example, in Cambodia, WHI amended its programming mid-course and started doing smaller group sessions with men, in response to suggestions from survivors that there was a need to prevent violence by working with those who are most often the perpetrators. It also started working with couples, believing this could lead to longer-term changes that could reduce conflict and prevent violence.

Some grantees' understanding of prevention and response as an integrated whole was clear in the design of their programming. The Panzi Foundation's project in the Democratic Republic of the Congo focused on scaling up its holistic Panzi model, in which prevention and response are rolled out in an integrated manner. For example, its training of local leaders not only promoted prevention, with trained leaders speaking out against VAWG, but also contributed to response, with those leaders referring and accompanying survivors to the Panzi Foundation's one-stop centres.

Reflecting on grantee experiences and learning, it is clear that **prevention and response exist on a continuum, with grantees doing both prevention and response activities as part of their VAWG prevention programming.** The existence and fluidity of this prevention–response continuum is arguably best illustrated in the behaviour change interventions that a number of grantees implemented. For example, WHI in Cambodia included content focused on changing the beliefs, attitudes and behaviours towards survivors in their workshops with service providers. WHI also did norm change interventions with survivors, as survivors accepted the violence they were experiencing as a normal part of life and were not accessing the available VAWG services.

Although all the grantees see primary prevention as an important component of addressing VAWG, in certain circumstances they found it challenging to prioritize primary prevention:

> *I feel like prevention is a really big piece … [But] you cannot do this in a vacuum, because most of the time the violence is never reported. Women in developing and middle-income countries don't report sexual violence, so there has to be a contingency plan to respond to that [reality]. So I feel like it's really great to focus on prevention because that prevents the problem from happening in the first place … But there is still a need to have a really robust plan to respond to this violence as well (focus group discussion, 15 November 2021).*

High-risk settings may affect how a project's position on the prevention–response continuum and how programming and activities are prioritized. In these settings, the urgent and immediate needs of survivors, the lack of services available to them and an inability to engage in certain spaces and with certain perpetrators may lead to grantees choosing to engage with survivors only. Furthermore, organizations face a moral-ethical dilemma in these high-risk settings: can they prioritize and focus on primary prevention activities in the light of survivors' immediate needs?

2. Survivor-centred approaches to VAWG prevention

The grantees' projects revealed that survivor-centredness can be present in different elements of service provision – based on who was included, how survivors were included in the project and the project's strategies. First, projects could be labelled survivor-centred in terms of **who** they prioritized, namely survivors. Second, projects could be survivor-centred in terms of **how** they carried out their activities. This required constantly taking into account the emotional, practical and social needs of survivors. Third, projects could be survivor-centred in terms of how they were designed. Survivor-centredness required that the needs and abilities of the survivors that the project wanted to support were assessed to ensure that the project could best serve them.

From the grantees' experiences, it appears, however, that programming is best positioned to be survivor-centred if survivors are included and even prioritized in its design and implementation. Survivor-centred programming is programming that empowers and includes survivors and has survivors participate in design and decision-making overall. Furthermore, grantees' learning showed that survivor-centred projects should ideally also be adaptable to emerging or unexpected needs of survivors. Grantees emphasized that a project's and/or organization's survivor-centredness is reflected in how survivors are given agency in the process of accessing services.

Survivor-centredness can take on different forms in different organizations and projects, with survivor-centred approaches lying on a continuum. At one end of the continuum, an organization is survivor-centred in so far as it prioritizes responding to survivors' needs, but survivors are only beneficiaries of VAWG prevention programming. At the other end of the continuum, survivors are active participants in the design, implementation and learning connected to VAWG prevention programming. Where an organization is positioned on the continuum is not always only determined by the organization and can be influenced by many factors. Grantee experiences have illustrated that an organization can journey along the continuum, learning to centre survivors and their agency more in the design and implementation of projects.

Survivor-centredness is not simply a goal to achieve but, rather, a continuous process or journey. CSOs are constantly examining what it means to be survivor-centred, and striving to improve and evolve to become increasingly survivor-centred in their design, implementation and learning:

> *I think there's an ambition to be survivor-centred, especially in the provision of services … [But] what does that actually mean? [So people say] I serve survivors, therefore [the project is] survivor-centred. But actually [survivors] have played no role in designing the project and are not playing an active role in decision-making … I think we try to be survivor-centred … but there's a long way to go to actually make that meaningful (focus group discussion, 15 November 2021).*

The focus groups challenged the notion that only service provision has to be survivor-centred, as participants emphasized that **the experiences, needs and insights of survivors should guide primary prevention activities, too**.

3. The wide range and impact of civil society organization services

All of the projects discussed in this brief were designed to fill gaps in, build the capacity of or bolster existing services. Although not all the grantees engaged in the same services, a reflection on services provided by the 11 projects revealed 4 areas of services as emerging most often: medical services, legal services, psychological services and economic empowerment services.[3] **Reflection on the nature and range of these services contributes to the debate on general and specialized services,[4] as the activities implemented by many of these projects complexify the simplistic binary view of these services.**

A grantee's focus on providing specialized services to survivors did not mean that it did not also offer those same services to the community at large, as the B92 Fund's economic empowerment programme in Serbia illustrates. It designed the programme specifically to assist survivors in safe houses, viewing economic empowerment as an important step towards a life free from violence. Yet when implementing its programme, the B92 Fund also included at-risk women and women from the community in general. It did so because (a) it could include more women than only survivors, (b) survivors benefited from being with other women, and (c) working with at-risk women and other women from the community promoted the preventative impact of the programme.

Some of the services that grantees provided were general services that the grantees tailored to meet the specific needs of survivors. Some grantees intentionally focused on strengthening general services, which challenges the notion that CSOs can only be involved in specialized services. For example, PHR's work on strengthening the forensic evidence chain was fully focused on training and supporting the service providers involved in general services.

3 Economic empowerment interventions are usually viewed as part of prevention. While grantees recognized the preventative impact of economic empowerment, they also included economic empowerment components in their programming as a service for survivors.
4 The Istanbul Convention, in discussing services for survivors, distinguishes between "general services" and "specialist services". General services are provided by public authorities (e.g. social services, health services and employment services) and are not exclusively designed for the benefit of survivors; rather, they serve the public at large. Specialist services, on the other hand, are services especially designed to meet the specific needs of survivors, and are not available to the general public.

We learn from these CSOs that in ensuring that survivors receive the services they need, the distinction between general services and specialized services is complexified. Furthermore, CSOs play a role in providing and strengthening both kinds of services.

Grantees' experiences in fragile and resource-challenged settings have highlighted the need for and challenges of providing integrated services. Especially where organizations work directly with survivors (instead of working with the service providers that engage with survivors), they find it hard when they cannot provide all of the services a survivor needs:

> *For example, we are providing mental health sessions and then this [survivor] might need at the same time legal services … protection or shelter. So that is always what we are facing, we are always seeing this [that a survivor comes to us with needs we cannot address in our organization] (focus group discussion, 18 November 2021).*

Yet in resource-challenged settings it may not be realistic for a CSO to attempt extensive, holistic, integrated service provision. This means that **CSOs, especially those working in fragile settings, are often pulled in two competing directions in terms of service provision**. A lack of general service provision puts significant pressure on CSOs to fulfil a range of services. They can try to focus on a limited number of services and provide them adequately but accept that other needs of survivors will remain unaddressed or attempt to provide comprehensive services but risk that some of those services will be inadequate.

Irrespective of the services being facilitated or provided, a community volunteer element was an important part of service delivery in the projects of all the grantees. Community volunteers also emphasized the link between services and prevention. FYF in Iraq had a cadre of trained former beneficiaries that formed a critical part of its psychosocial support to survivors, at-risk women and the broader community in the Khanke IDP camp. These volunteers, all Yezidi women living in the camp and beneficiaries of FYF's services, were trained, supported and mentored to become empowered mental health and psychosocial support leaders in the community, reaching nearly 3,000 camp residents. FYF also offered lay counselling, group sessions on trauma stabilization, and conflict resolution for couples and families. FYF believes that these 30 volunteers – who named themselves the Harikara – were one of the strongest elements of its project.

Volunteers embody the link between services and prevention. For example, ONIC's project in Colombia capacitated indigenous women volunteers to accompany indigenous survivors, offering a pathway for accompaniment and support that was responsive to their unique needs. The volunteers not only accompanied survivors but also advocated around VAWG prevention in their communities in general. As they are embedded in their communities, these volunteers could be very influential in ensuring that VAWG prevention continues in the longer term.

Although a community volunteer element was an important part of service delivery in the projects of all the grantees, **there are certain challenges to engaging volunteers in service provision**. These experiences raise important questions about how the role of volunteering in VAWG prevention programming is recognized, budgeted for, compensated and capacitated to be sustainable.

Wellness Officer creating awarness with Market Vendor (Rakiraki).
Credit: Courtesy of Medical Services Pacific (Fiji).

4. Civil society organizations' role in multisectoral collaboration

All projects relied on some form of multisectoral collaboration (MSC). It was important to the grantees, as they view MSC as crucial to ensuring (a) that survivors receive the services they need, (b) the appropriateness and relevance of programming, (c) local ownership of programming and (d) the sustainability of programming outcomes:

> *I think the thing which was different with the Physicians for Human Rights, it was first that the training, all the ideas of training, came from us … They didn't come and bring tools which were already made … we began working on tools together, and tried to adapt the tools which are already there in our own context and our own reality. This was really something which was very different (Physicians for Human Rights, Final Evaluation Report).*

CSOs' experiences show that they are not always simply partners within the MSC structures created by other stakeholders. Rather, very often they start, coordinate and lead the MSC. Prior to PHR's projects, MSC around the forensic evidence chain on sexual violence already existed in the Democratic Republic of the Congo, with the police, health-care providers, lawyers and judges all supposed to play a specific role in ensuring that forensic evidence assists in the prosecution of perpetrators. PHR could therefore link with these multisectoral stakeholders who were already connected and knew they had a role to play. Yet PHR realized that the collaboration was very weak and ineffective, and it therefore worked to both strengthen the already-existing formal links between the service providers, and create new formal and informal networks of trained service providers from different sectors.

Grantees' experiences of MSC highlight that their collaborations could cross different sets of sectoral boundaries. MSC crossed the divides between (a) local, national and/or international stakeholders; b) stakeholders from the government, civil society and/or the private sectors; and (c) stakeholders from different disciplines, for example health, education, justice and law enforcement.

The grantees' MSC was focused on three main domains: training different service providers, establishing referral networks and ensuring that survivors were well-treated at the different service points, and advocacy around VAWG and survivors and their needs. Their activities in these domains counter perceptions that services and prevention are separate categories. MSC activities often integrated prevention and services, with each strengthening the other. For example, the B92 Fund's economic empowerment programming capacitated survivors in safe houses, at-risk women and women from local communities.

Grantee experiences highlighted the challenges of creating MSC between individuals and not between the institutions they represent. Individuals taking part in MSC may face resistance from their own institutions when they engage in and prioritize MSC. This emphasizes the importance of including and mobilizing institutions in collaborative endeavours.

COVID-19 AND SERVICE PROVISION

The COVID-19 pandemic brought many additional challenges to grantees striving to assist survivors. Many services were no longer available owing to COVID-19 mitigation measures, yet survivors' needs remained and often increased. For example, in the Khanke IDP camp in Iraq, FYF found that VAWG was increasing in the camp, as everyone was forced to stay in their tents owing to movement restrictions, adding tension to already stressful living conditions and limiting survivors' opportunities to access services. Yet many non-governmental organizations closed, abruptly ending many of the services that survivors were relying on.

Grantees developed several plans and strategies to ensure that they could continue to roll out their services. Al Shehab trained staff and some volunteers on the nexus between VAWG, HIV and COVID-19, so that they could cope better with the current situation. It also provided personal protective equipment for programme beneficiaries, developed strict health measures for meetings and activities, developed hybrid methods for most activities, rearranged its centres to allow for better COVID-19 prevention, conducted outreach events with smaller groups than originally planned and opened a hotline for psychological support. PHR replaced their forensic evidence training sessions with debriefing sessions for first responders and training sessions on vicarious trauma and self-care measures. This change in focus contributed to MSC overall, as it allowed relationships to continue (as PHR continued to engage with various stakeholders from different sectors), and even strengthened them, as partners saw how PHR prioritized them and their personal mental health.

The COVID-19 pandemic highlighted the importance of recognizing specialized services as essential services.

Where the specialized services that CSOs provide to assist survivors are not recognized as essential services, these CSOs cannot continue service delivery when governments place travel restrictions on all but essential services.

Grantee responses to COVID-19 also highlighted the fluid link between prevention and services, as well as between general services and specialized services, which is well illustrated by FYF's change of focus in their work in Iraq. Undocumented IDPs live outside the Khanke IDP camp as there is no space left in the camp itself. These IDPs are not formally acknowledged by the government and do not have the same rights as IDPs in the camp. During the COVID-19 pandemic, the situation of these "unofficial" IDPs became even more precarious, as they did not receive the food assistance and hygiene kits that IDPs in the camp received. Therefore, FYF decided to focus, during the pandemic, on providing for IDPs outside the camp, with the aim of serving the undocumented IDP community in general. It did this in response to the needs of those whose vulnerability to and risk of VAWG are compounded by multiple factors, but it also saw this as part of its violence prevention mandate.

Lessons learned

A number of key lessons have been learned from studying these CSOs' roles in service provision. First, the grantees' projects not only illustrate the fluidity of the prevention–response continuum but also serve as a warning against policies and funding that take a binary view that does not allow practitioners to design and continuously adapt programming to best serve survivors and suit the context. **Second, CSOs play a much more important role in providing and/or ensuring services for survivors than is currently recognized**, and they are challenging the divide between general services and specialist services, and between services and prevention. **Third, recognizing that CSOs play a role in both general and specialist services does not free States from their responsibilities towards survivors.** Rather, the fluidity of the connection between general and specialist services highlights the importance of State and non-State actors working **together** to respond to survivors' needs. **Fourth, CSOs are creating, leading and managing MSC around services, often in extremely challenging, high-risk settings.** Furthermore, MSC by grantees highlights that approaching prevention and services as separate categories creates a false dichotomy. Numerous MSC activities both improved services for survivors and contributed to prevention. **Finally, CSOs play a leading role in exploring what it means to be survivor-centred in VAWG prevention programming.** The survivor-centredness continuum highlights that grantees are different in terms of how and to what extent they centre survivors, underscoring the need for organizations to think critically about how they position survivors in their programming, including primary prevention programming.

Recommendations

Recommendations for practitioners

1. Develop and continuously adapt VAWG prevention programming, aiming to become increasingly survivor-informed and -led by ensuring that VAWG prevention programming (design and implementation) is determined by the nature of the survivors, the context and the forms of violence that they experience.
2. Explore the possibility (if resources and capacity permit) of taking the lead in creating, leading and managing MSC around service provision.
3. Avoid binary views of prevention and response when designing VAWG prevention programming, recognizing that service provision may be an entry point for prevention, or vice versa, and articulating in the programme theory of change how prevention will lead to response (or vice versa).
4. Recognize that community volunteers may be an important element of service provision, and ensure that they are carefully selected and adequately trained and supported.

Recommendations for donors and policymakers

1. Design policies and funding in ways that allow practitioners the flexibility to respond and adapt to their contexts, integrating prevention and response in ways that holistically address the particular aspects of VAWG that they have identified.
2. Recognize that CSOs, including smaller local women's rights organizations, can create, lead and ensure MSC on service provision, and support CSOs in this role (including financially).
3. Fund CSOs, especially women's rights organizations, as they are filling significant gaps in service provision and ensuring MSC that serves the needs of survivors.
4. Develop policies and funding that support the economic empowerment of survivors, which is a strategic space to enhance the link between prevention and response.

Recommendations for researchers in the field of ending VAWG

1. Conduct more research on CSOs and their role in service provision, both as providers of specialist support services and in relation to the fluid connection between general services and specialist services, and the role of CSOs in both.
2. Develop research and evaluation methodologies that can engage with an approach to ending VAWG that sees prevention and response activities and outcomes as closely linked.
3. Explore the prevention–response continuum, investing in evaluations that carefully unpack the likelihood of a preventative impact as a direct result of an effective response programme, and vice versa.
4. Conduct more research on the role of CSOs in creating, leading and coordinating MSC on service provision, exploring how they fulfil these roles and investigating how they can be best supported in doing so.
5. Conduct more research on survivor-centred approaches for prevention programmes, learning from CSOs that are taking steps to embody such approaches in their programming.

FURTHER INFORMATION:

This brief is authored by Elisabet Le Roux, and is part of a series of briefs produced by the United Nations Trust Fund to End Violence against Women. For the longer synthesis review on which this brief is based, and others in the series, see the UN Trust Fund Learning Hub.

Visit the UN Trust Fund evaluation library for access to over 100 final external evaluations of projects supported by the UN Trust Fund, including most of those mentioned in this brief. The library is searchable by country and theme.

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Activity for burned survivors to improve their physical mobility at the International Foundation for Crime Prevention and Victim Care (PCVC) Recovery and Healing Center. This is an example of developing survivor-centered services led by PCVC in India. Credit: Gomathi/PCVC (India)

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About the UN Trust Fund: The United Nations Trust Fund to End Violence against Women (UN Trust Fund) is the only global grant-making mechanism dedicated to eradicating all forms of violence against women and girls. Managed by UN Women on behalf of the United Nations system since its establishment in 1996 by United Nations General Assembly Resolution 50/166, the UN Trust Fund has awarded almost $198 million to 609 initiatives in 140 countries and territories.

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