TIP SHEET 1

Multisectoral GBV response

All survivors of GBV, regardless of their gender and sexual orientation, rarely report incidences of violence, and frequently do so when their physical wounds require urgent intervention. All, regardless of gender and sexual orientation, face physical, psychological and social consequences of the violence. And all require survivor-centred, multi-service responses consisting of medical, psychosocial, legal and economic support.

SDC-funded projects must ensure that multisectoral services are available; all or most services are either provided through One Stop Centres or through a well-linked and integrated referral system.

- **Low threshold entry point**: a survivor should have easy access to a service point and be able to first assess whether the service is trustworthy to disclose the experience of violence, e.g. a health post/clinic, a women and girl safe space, a community centre, a community-based first responder, etc.
- **Medical treatment and healthcare**: this includes provision of adequate clinical care for GBV survivors, including clinical management of rape and specialised services for pregnant women and girls, adolescent survivors, survivors with a disability, survivors from the LGBTIQ+ community, male or child survivors. For cases involving legal interventions, health services also include provision of medico-legal documents for survivors.
- **Case management**: GBV case management is a structured method for providing help to a survivor where one service provider takes responsibility for ensuring that survivors are informed of all the options available to them and that different issues and problems facing a survivor and their family are identified and followed up in a coordinated way, while providing the survivor with emotional support throughout the process.
- **Psychosocial support and mental health care**: this includes a range of services, from psychological first aid (basic emotional support), to more specialised psychosocial counselling or mental health care interventions to support survivors.
- **Safety and shelter**: this includes services such as safety planning for survivors in their current location/home, arranging alternative accommodation such as in shelters/safe houses, and/or police protection or even relocation.
- **Access to justice**: this includes providing information and support to survivors as they navigate law enforcement agencies/mechanisms. Service providers typically assist survivors in making a decision about pursuing formal justice mechanisms, e.g. police and legal redress. Survivors are then supported with documentation, provided with legal aid, and physically accompanied to police stations, courts, etc. When states are unwilling or unable to establish reparation programmes for survivors of conflict-related sexual violence, connect with and consult organisations that have expertise with implementing survivor-centred interim reparative measures.
- **Economic support**: some survivors might need assistance to access livelihood/economic support services and/or education/training to enable their independent survival or improve their family's livelihood (see Tip sheet 3: *Integrating economic interventions with GBV prevention and response*). Some survivors may need cash and voucher assistance (CVA) to meet their immediate emergency needs.

- **Helplines**: also called Hotlines, these are telephone and internet-based services that typically provide information, counselling, referral and support for survivors. Many face-to-face GBV service providers also offer some services remotely, over the phone or through the internet. During the COVID-19 crisis, this became a widely used mode of GBV service delivery.

One Stop Crisis Center (OSCC)

The One Stop Crisis Centre (OSCC) is typically set up under three types of institutions: medical or health facilities (most common), police stations, and women's centres. The SDC supports this model in many contexts. Many OSCCs offer several, but not all, services at their location; survivors are referred to other providers from the OSCC. For example, a hospital-based OSCC provides medical care as well as psychosocial support by psychologists, while for social and economic support, the survivors are referred to other agencies.

While the model makes sense, OSCCs often have a number of weaknesses:

a) a low number of survivors or mainly one type of cases (i.e. only sexual violence or only child survivors of sexual violence) access these services.

b) survivors do not return after they have been medically treated; survivors see no added value in coming back for psychosocial support.

c) lack of linkages with the communities.

? Essential questions to ask while reviewing the response component of a GBV project

The *IASC Minimum Standards for Gender-Based Violence in Emergencies Programming* explain the basic requirement for each component of the multisectoral response. When you design a project or check a proposal, be aware of what standards will be followed and whether adaptations are planned to challenges in the local context.

In addition and based on reviews of SDC-funded GBV projects, the following questions are essential:

1 How is the GBV response linked with health facilities?

For an OSCC based at the health center or hospital, check the following:

- Does every member of staff in the hospital know how to screen a patient for GBV and how to refer her/them to the OSCC? In other words, does the OSCC have a "whole-of-facility" approach?
- Do the hospital staff know what to do with a survivor if the OSCC is closed (OSCCs are sometimes closed at night or during the weekend)
- Is the OSCC integrated in the hospital in such a way that the survivor does not have to repeat her/their story at each point of the referral path (inside and outside the hospital)
- Are all health facilities in the catchment area of the OSCC well informed how to identify and refer a GBV survivor to the OSCC?

For a GBV response service **not based at the health center** or hospital:

Experience has shown that referrals to GBV services have gone up sharply when staff of health facilities were well trained in GBV. Trained doctors or nurses are able to understand that a woman who presents with a headache or a broken arm may actually be a survivor of GBV, they are able to ethically screen for GBV and provide appropriate information and care to the survivors, as well as refer her/them to specialised services as required. Because of easier access to health facilities and comparatively less stigma associated with accessing health services, many GBV actors work closely with the health sector as a key referral partner. In addition, integration in health services is also relevant because medication included in the PEP kit can be integrated in the list of essential medicines.

Check the following:

- Does the GBV response service collaborate with the health sector – at the very least as part of its referral pathway?
- Are all doctors and nurses in all health facilities well informed on how to identify and refer survivors of GBV to specialised services? Does the health facility provide clinical management of rape or is there a need to provide additional training?
- Do the health staff that work in the community know how to integrate GBV awareness in health sessions with different groups in the community?

Disclosure in health facilities

According to a report on GBV experienced by Rohingya refugees, "survivors of conflict-related sexual violence routinely disclosed experiences of sexual violence while seeking care for other health concerns, including acute injuries, pregnancy-related care, and psychosocial support".

Source: Green, L., McHale, T., Mishori, R. et al. "Most of the cases are very similar.": Documenting and corroborating conflict-related sexual violence affecting Rohingya refugees. BMC Public Health 22, 700 (2022).

2 How is the GBV service/OSCC linked to the community?

A big part of the follow-up support for a survivor needs to be provided in the community. One of the biggest weaknesses of centre-based GBV services is their unsystematic or non-existent link to the communities they serve. As a result, there is insufficient knowledge about and trust in the service; only few survivors will access the centre/safe space/OSCC. Furthermore, the follow-up of survivors and solidarity-building within the community is hard if the links between the community and service centres are not institutionalised. And even if the service at the OSCC is very good, survivors will not come back for support as the travel from their home might be too long and too expensive.

One way to fix this gap is through appointing qualified outreach workers and community-based staff. Outreach workers are typically employed by the OSCC or another GBV service center. They are qualified in providing case management and psychosocial support and make regular visits to the survivors or call them to a suitable place close to the survivor's location. Complementing the role of outreach workers, community-based first responders play an important role in maintaining linkages with the service center. They live in the communities of affected population, they have the unique advantages of familiarity, access and networks. They identify survivors, provide psychosocial first aid (PFA) and refer survivors to the visiting outreach worker/OSSC/ other services. Since community based staff come from the same communities where they are working, they may also be at risk of hostility from men and others in the community who might perceive them as a threat – it is important to address any such hostility. In addition to outreach workers and community-based staff, existing CBOs in the community can be mobilised for outreach and to be first responders.

To ensure sufficient community anchorage of the response service, check the following:

- Does the OSCC/GBV response service include **qualified outreach staff**, staff that spend the greatest part of their time in the communities?
  - Are these outreach workers trained in case management and psychosocial support?

  - Do they have basic knowledge of and skills to facilitate transformative family dialogues (not reinforcing gender power hierarchy in the households)
  - Do they have the capacity to guide less trained staff such as the community-based first responders or facilitators of solidarity groups?
- Are **community-based first responders** institutionally linked to the OSCC/GBV response service?
  - Are they trained in listening skills, psychosocial first aid and have knowledge about the referral pathway?
  - Are they regularly supervised and guided by the outreach workers and the staff of the OSCC/GBV response service?
  - Are they paid? – First responders are often women who are asked to volunteer. The project must make sure they receive adequate financial compensation so as not to add to their unpaid care burden.

Community-based first responders can also be facilitators of group discussions for prevention of GBV or of groups that are formed or strengthened to support persons affected by GBV.

3 How are OSCCs/GBV response services linked with GBV prevention?

GBV survivors typically continue to live in their communities whilst receiving GBV response services and their situation will not improve by the provision of GBV services alone. Their situation will improve if, in addition to providing GBV services, the stigma associated with being a GBV survivor is addressed, family dynamics improve, norms around acceptability of violence are changed and the prevalence of violence is ultimately reduced. GBV response projects that are not integrated with adequate prevention interventions should not be funded. See Tip sheet 2: *GBV prevention – critical reflection and collective action*. Although the components of GBV response and GBV prevention are developed under two separate outcomes, they are closely linked. In some SDC funded projects, healing and prevention have been successfully combined. See "Healing Together" in Tip sheet 2.

Check the following:

- Are staff members of the OSCC/GBV response service playing an active part in the prevention interventions?
- Are the community-based first responders involved in the prevention interventions and are they trained to facilitate critical reflections with individuals, families and groups?
- Do the prevention intervention facilitators understand what to do when a person discloses GBV?

Linking services to the community

Nepal: In 2022, the One Stop Crisis Centers supported by SDC engaged with 115 community-based psychosocial workers (CPSWs). The CPSWs identified 4,477 GBV survivors in the communities and referred them to different types of GBV services. They additionally reached 40,219 people across all 19 targeted municipalities with awareness raising activities on GBV and GBV services.

Source: UNFPA Nepal, GBV Prevention and Response project, Phase II, Annual Report 2022.

Burundi: To prevent delays in the treatment of rape survivors, the Centre Seruka employs a liaison officer who engages in social mobilisation activities in the communities. The liaison officer is in close contact with community facilitators who reflect with groups on GBV and its causes and effects. This close contact with the communities allows Seruka to ensure timely referrals and counter-referrals and to adjust its communication to the realities and circumstances of the violence in the communities, including very remote ones.

Source: Centre Seruka, Bujumbura.

4 How well are the staff trained?

The capacity of staff is the absolute centrepiece of every successful GBV project. Especially in humanitarian contexts, project staff and service providers often get a hotchpotch of training from different providers. Furthermore, all service providers, whether they are women or men, are products of the same society and influenced by prevalent social norms. They all need to develop a critical understanding of the root causes of GBV and transform their own attitudes and possible traumatic experiences related to gender, sexuality and GBV before they can provide good quality, gender-specific, response services to victims/survivors.

Check the following:

- Are qualified case workers (e.g. social workers/psychologists) hired for the project?
- Does the project have a systematic training plan for each category of staff?
  - Is training provided to all staff in the service, not just to the professionals – all staff in a facility who are in contact with survivors need to understand how to address and support them.
  - Does the training of psychologists/psychosocial counsellors include addressing sexual violence against children? Sexual violence against men?
  - Do the staff receive regular supervision to help them understand the cases as well as their own feelings towards the survivor, their own limits and vulnerabilities?
  - Is the team regularly coached and supported in the transformation of team internal conflicts, which are common and cause stress and burnout?

- Does the training include reflection on staff's own experience and the effects of the traumatic situation in which the work is taking place (conflict, displacement, disasters, etc.)?
  - Does staff engage in its own gender transformative process?
  - Does the staff reflect on own prejudice related to survivors, including male/LGBTIQ+ survivors?
  - International partner organisations of the SDC should commit to providing technical oversight, mentoring and backstopping from their regional/head offices to projects in countries where they have limited staff/capabilities.
- Is the security of staff members properly addressed and a genuine concern of the organisation implementing the project?
- Is there an adequate budget for all the above?

Sexual violence against children

In some countries, the number of children brought to the GBV service is higher than that of adult survivors. The community is shocked by the child abuse and children are less stigmatized by the crime. The stigma and shame for adult survivors, however, is often so strong that they do not access services.

Service providers in the Great Lakes region have found that parents, especially mothers, are strongly affected by the sexual violence against their children and must be included in the psychological treatment. A common reaction by the adults is anger, anxiety and often violence, even against the abused child. If parents can process what happened and can direct their anger at the perpetrators rather than the child, the outcome for the child is much better. The fathers' engagement in the treatment and his positive attitude and support for the child was found to have a significant impact on the child's psychological development.

Source: Dr Aziza Aziz-Suleyman, Coordinator of the Regional Psychosocial Programme, Burundi.

5 How does the project assist survivors with law enforcement agencies?

There is a widespread lack of trust in law enforcement agencies among GBV survivors, which is possibly the reason why they are amongst the least used GBV service providers by survivors across the world. Evidence and experience indicate that the police, for instance, do not respond adequately to survivors of GBV, and in many countries there are reports of rampant corruption in the police force, judicial offices and courts in dealing with GBV cases. Also, IPV survivors are often reluctant to approach the police, fearing criminal proceedings against their partners. Legal systems and laws in many countries are not survivor-centred and in many contexts GBV is either not criminalised or legal provisions are poorly enforced. Law enforcement and law enforcement agencies

are heavily influenced by and perpetuate patriarchal gender norms in their design and delivery. The legal process mostly takes long (years) and entails costs, including for travel to courts and lawyers, which often leads survivors to withdraw their complaints or not file a complaint. Additionally, criminalisation of same sex relationships in many countries ends up criminalising men, boys and LGBTIQ+ survivors of GBV instead of protecting them.

Critical engagement with law enforcement agencies on GBV

Some GBV projects supported by the SDC have found strategic ways to critically engage with law enforcement in favour of a survivor-centred approach, for instance by providing gender sensitisation training to police officers and establishing women's and children's service centres within police stations, training legal officers and judges on gender and on accurately reading and interpreting laws in favour of survivors. Even in severely restricted contexts, such as Gaza, SDC-supported projects have worked with Sharia judges for progressive interpretations of Sharia laws in favour of women: such as on laws related to custody of children, maintenance of wives and inheritance rights for women.

Sources: Chaujar, P. 2018. Mid-term Review GBV Prevention and Response Project in Nepal. UNFPA Kathmandu.

Chaujar, P and B. Weyermann, 2022. Light-touch review of SDC-funded GBViE projects in MENA region. SDC Bern.

If your project includes a component on access to justice, check the following:

- Does the project ensure that the survivor can make an informed choice about pursuing legal action?
- Does the project respect the decision of the survivor NOT to take legal action?
- Does the project provide legal aid if a survivor wants to take legal action; does the project accompany her/them throughout the process, including with psychosocial support and financial support to meet costs of often prolonged legal process?
- Make sure that *the number of legal proceedings* or *percentage of survivors who take legal action* is not considered an indicator of success for the project/survivor (as this can lead to the organisation pressurising survivors into initiating legal proceedings)
- Does the project engage in advocacy for transformation of laws and the legal system?
- How will the project mitigate risks associated with legal sanctions against same sex relationships affecting GBV survivors among men, LGBTIQ+ communities?

CRSV is a war crime. If CRSV against women, men and/or LGBTIQ+ communities is prevalent in your context, explore with your partners whether these violations are properly documented, following the principles of the Murad Code. Under international law, survivors of CRSV have a right to remedy and reparations. The SDC supports the

Global Survivor Fund which advocates for survivor-centric reparations and interim reparative measures.

Ensure that no hierarchy of survivors is created between survivors of CRSV and survivors of other forms of GBV in relation of access to services. All survivors have a right to a high-quality response.

6 Have shelter services been carefully planned?

Shelters are a critical, often life-saving, service which must be offered as part of any response to GBV. However, very few women opt for shelters. One main challenge is that shelter support is offered only temporarily, usually for very short periods of time, with poor prospects for what happens to the survivors after their time at the shelter is up. Often, they return to the same abusive situation (e.g. their home) or they are moved from one safe space to another with different service providers. Another key challenge is the right location – women often are only able to spend the night outside their home if they stay in a place that is acceptable to the community. Furthermore, shelters are not always planned for or equipped to support the children who accompany the survivors.

If you support a shelter, check the following:

- Have women's organisations been consulted to ensure the shelter is in a location that is acceptable to the community?
- How safe is the accommodation? Make sure the location and/or the shelter is not publicly advertised.
- How well are the shelter staff trained?
- Does the shelter provide psychosocial support and help the survivor to make a good decision about the way forward? How is the survivor supported, if she wants to return to her family? How is the survivor supported, if she wants to find an alternative location to live?
- How does the shelter address the fear, trauma and schooling of accompanying children?
- Does the shelter have links to the communities it serves? This will allow follow-up in case the survivor wants to return.
- Does the shelter have good links to experienced skills and business development partners to support survivors when they want to improve their financial situation and/or live independently?
- How does the shelter deal with survivors who cannot find a solution within the time that is allowed for a stay at the shelter?

7 How does the project address immediate economic needs of survivors?

GBV survivors are often in need of immediate assistance to meet their basic needs and/or to secure their safety. Cash and Voucher Assistance (CVA) must be integrated as part of a structured GBV case management process. Providing CVA as part of a survivors "case action plan" can serve as a complementary action to reduce the risk of GBV

and/or to support recovery. CVA offers discretion and flexibility and can provide GBV survivors with emergency and life-saving assistance as well as medium to longer-term support for recovery and healing. The SDC recommends that cash be made available as an option in every case management programme and follow-up to challenges that survivors may face.

While reviewing the CVA component of projects, check if:

- Cash is made available as an option to survivors as part of a case management process.
- Cash is made available without restrictions and conditions on the survivor (e.g. that she/they must leave her/their abusive partner).
- Potential risks are identified and discussed, including those related to the use of particular cash delivery mechanisms; a safety plan specific to the use of cash is developed.

See this link for more information on the use of CVA for GBV outcomes.

8 What is the role of women's organisations in GBV response projects?

Women's organisations are best suited to lead and implement solutions for GBV in their contexts. A whole range of women's organisations, from informal community-based organisations to national level organisations, as well as feminist leaders and activists have always been at the forefront of providing support to GBV survivors and advocating for changes in social/gender norms and systemic inequality. A GBV project design must be informed by the lived experience and expertise of such women's organisations and other national/sub-national organisations that have been addressing GBV in their contexts.

Check the following:

- Are there any women's organisations in the area where the project works?
- What role do they play in the design and implementation of the project?

For more details, see Tip sheet 4: *Supporting women's organisations*.

9 How can GBV response services become sustainable?

GBV will exist many decades from today, and hence programmes need to be designed for the long term, even if specific project support is for short durations. For long-term changes and sustainability, GBV response services need to be anchored in government policy and legislation so governments can be held accountable for GBV response services, including for adequate funding allocations, and for promoting gender equality. Governments at all levels must be part of the stakeholders engaged in SDC-funded GBV projects. While governments at national level are key stakeholders in the development and funding of national policies, legislation and programmes, governments at the local level/local authorities are entrusted with implementation of policies and could provide financial and other support to GBV projects. Working closely with local authorities and governments contributes to building political and administrative will to invest in local GBV service provision.

The following questions should be asked:

- How is the project strengthening government commitment and capacity to promote gender equality and GBV prevention and response? Explore potential for co-financing from the beginning of the project.
- To what extent are government services from different ministries coordinated to provide care?
- To what extent do government services at all levels ensure coordination of GBV actors? What skills do they need to ensure this coordination at all levels? (Mapping, data, supervision of centres offering services, database, negotiations, etc)
- Is the project building technical capacities in design and delivery of multisectoral GBV response services by state funded and supported GBV actors (e.g. hospitals, law enforcement, welfare offices, local organisations)?
- Is there a plan for handing over GBV service supported by the project to local actors (civil and/or state) – does the project provide hand-holding and capacity support during transition?
- Does the project invest in building a cadre of professionals in-country who can train and mentor others: psychologists, medical doctors and social workers who consolidate and further develop solid experience on GBV (e.g. through investment in specific programmes in universities, colleges, training institutes)?
- Is the project duration sufficient to work towards future sustainability? SDC-funded GBV projects must be designed for at least two 3-year cycles, plus, if possible, an inception phase for necessary preparatory work.

References and further readings

The full package of guidelines for integrated essential services for GBV survivors can be found here: Essential Services Package for Women and Girls Subject to Violence.

For more information on case management read Inter-Agency GBV Case Management Guidelines.

UNFPA (2019). The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming

GBV AoR (2021): Responding to violence against women based on their diverse sexual orientations, gender identities and expressions – an annotated bibliography of resources.

Jill Keesbury, W., Onyango-Ouma, Chi-Chi Undie, Catherine Maternowska, Frederick Mugisha, Emmy Kahega, Ian Askew. 2012. A Review and Evaluation of Multi-Sectoral Response Services ("One-Stop Centers") for Gender-Based Violence in Kenya and Zambia. Population Council: Nairobi, Kenya.