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E2A EVIDENCE TO ACTION for Strengthened Reproductive Health

MARCH 2020

Strengthening the Response to Sexual and Gender-Based Violence in Nigeria

TECHNICAL REPORT | E2A PROJECT

ACRONYMS AND ABBREVIATIONS

AFP	Advance Family Planning
AYRH	Adolescent and youth reproductive health
CSO	Civil society organization
E2A	Evidence to Action
HIV	Human Immunodeficiency Virus
M&E	Monitoring and evaluation
MOE	Ministry of Education
MOH	Ministry of Health
MOJ	Ministry of Justice
MWASD	Ministry of Women and Affairs and Social Development
NGO	Nongovernmental organization
OCA	Organizational capacity assessment
PEP	Post-exposure prophylaxis
RH	Reproductive health
SARC	Sexual assault referral center
SGBV	Sexual and gender-based violence
SOP	Standard operating procedure
STI	Sexually transmitted infection
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships.[1] SGBV not only undermines the safety, dignity, and overall health status of the millions who experience it, but also affects the economic stability and security of nations.[2] Women across the world, regardless of income, age or education, are subject to physical, sexual, psychological and economic violence. SGBV is a global pandemic that affects one in three women.[3] In Nigeria, 31% of women have experienced physical violence and 9% have experienced sexual violence.[4] High rates of SGBV in Nigeria and globally necessitate a strong and sustained service response, particularly through front-line service providers such as sexual assault referral centers (SARCs).

In 2018, Pathfinder International, through the Evidence to Action (E2A) Project and with funding from United States Agency for International Development (USAID), implemented the Strengthening the Response to Sexual and Gender Based Violence Project. The project aimed to strengthen the response to SGBV by supporting 10 existing Sexual Assault Referral Centers (SARCs) in nine states across Nigeria. These SARCs provide essential medical, forensic and counseling services to SGBV survivors as well as referrals and linkages to other support the survivors may require. As SARCs are critical front-line responders for people experiencing SGBV, the project focused on enhancing their capacity to sustain their provision of quality, comprehensive services and strengthening their relationships with other organizations, governments, and communities to create a comprehensive, sustainable approach to SGBV prevention and response. This technical brief documents Pathfinder/E2A's strategy to strengthen the SARCs and the results achieved through their enhanced capacity to respond to SGBV in Nigeria.

1 The UN Refugee Agency. Sexual and Gender Based Violence. UNHCR. 2019 [cited 5 November 2019]. Available from: https://www.unhcr.org/sexual-and-gender-based-violence.html

2 Gender-Based Violence (Violence Against Women and Girls). World Bank. 2019 [cited 4 November 2019]. Available from: https://www.worldbank.org/en/topic/socialdevelopment/brief/violence-against-women-and-girls

3 Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization (WHO); 2013.

4 National Population Commission (NPC) [Nigeria] and ICF. 2019. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF.

Sexual and Gender-Based Violence in Nigeria

Sexual and gender-based violence (SGBV) is a public health challenge, a human rights violation, and a barrier to civic, social, political, and economic participation. The 2018 Nigeria Demographic and Health Survey found that among women aged 15 to 49 years, 31% have experienced physical violence and 9% have experienced sexual violence.[5] Four percent experienced sexual violence before age 18.[6] More than half of women (55%) who have experienced physical or sexual violence never sought help to stop the violence; for those who did, women's own families were the most common source of help (73%).[7] Only 1% sought help from doctors or medical personnel, the police, or lawyers.[8] There is a widespread reluctance to speak about SGBV, largely because of its domestic, family and community nature, as well as fear of stigmatization; this lack of openness leads to significant under-reporting. SGBV is significant in all strata of economic and social activities in the country and is exacerbated by rigid sociocultural norms, harmful traditional practices, and a dual legal system that recognizes customary law but lacks both basic protections and enforcement of gender-related issues. Acts of violence against women in Nigeria occur across cultures, social class and ethnic groups.

While much of the focus of SGBV is on women, sexual violence can also be directed against men. Data from supported sexual assault referral centers (SARCs) show that 14% of the SGBV survivors who reported to the SARCs were males and most often boys under 14 years old. Many believe that official statistics vastly under-represent the number of male survivors, and it has also been suggested that males are even less likely than female survivors to report an assault to the authorities.[9]

The damaging effects of conflicts in certain parts of Nigeria, particularly the insurgency in the north east, such as displacements, destruction of community structures, poverty and lack of resources, also increase the risk of SGBV. The United Nations High Commissioner for Refugees (UNHCR) 2018 report on SGBV in northeastern Nigeria notes that survival sex and sexual exploitation also play a role, adding to the numbers of people experiencing SGBV, especially in internally displaced persons' camps.[10]

The Nigerian government's response to SGBV and its prevention is directed and implemented by multiple ministries at national and state levels. The Ministry of Health (MOH) oversees management of SGBV health issues. The Ministry of Women Affairs and Social Development (MWASD) is responsible for ensuring that policies on gender equity are implemented, SGBV survivors' needs are addressed holistically, and stakeholder interventions at the community level are responsive, promoting local participation. The

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[5] National Population Commission (NPC) [Nigeria] and ICF. 2019. *Nigeria Demographic and Health Survey 2018*.Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF.

[6] *Ibid.*

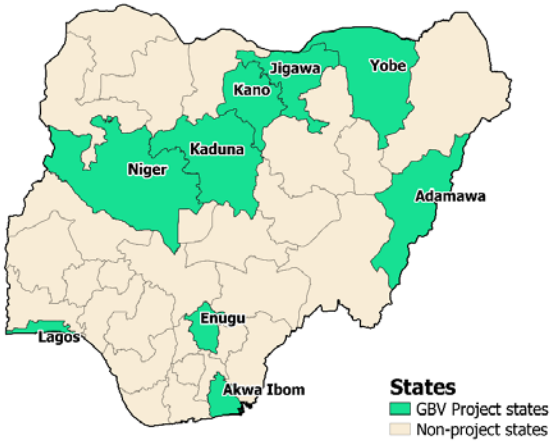
[7] *Ibid.*

[8] *Ibid.*

9 World report on violence and health. Geneva, World Health Organization, 2002.

10 UNHCR Report on Sexual and Gender-based violence response in Borno, Adamawa & Yobe States 2018. Available at: https://data2.unhcr.org/en/documents/download/66177 [cited 4 November 2019]

FIGURE 1: MAP OF NIGERIA SHOWING STATES WITH SARCS SUPPORTED BY THE PROJECT



MWASD, in conjunction with the Ministry of Education (MOE), is also responsible for education and gender awareness training in both formal and informal education processes.[11] The Ministry of Justice (MOJ) is responsible for providing legal support service for SGBV survivors and their families.

SARCs, typically embedded within a health facility, provide essential services for SGBV survivors, including immediate emergency medical treatment; forensic medical examination services; advice on sexually transmitted infections (STIs), including HIV and the risk of pregnancy; immediate and ongoing counseling support; support in contacting the police, social welfare department, or civil society organizations (CSOs) where appropriate and where the survivor requests it; and advice and ongoing support throughout any police investigation and prosecution. The SARCs also serve as focal points for advocacy and community outreach work to address issues of SGBV within host communities and contribute to growing the evidence base on SGBV in Nigeria. SGBV survivors can walk into the SARC or can be referred by any number of agencies including the police, hospitals, and CSOs/NGOs. All cases are dealt with confidentially and victims are not required to report their case to any other agency if they do not want to do so.

There are significant gaps in the coverage and quality of SGBV services in the country. There are few dedicated SARCs and most health facility staff in Nigeria are not trained to specifically address SGBV, although they may provide post-SGBV treatment and services. As of November 2019, there were 15 SARCs across the country. This lack of dedicated SGBV response facilities leads to challenges in the access to and provision of services across the country. The few available SARCs also face understaffing and underfunding. This affects the SARCs' ability to not only provide services but also to improve operational capacity, which is important for improving efficiency and sustainability.

Strengthening the Response to Sexual and Gender-Based Violence in Nigeria

To strengthen the sustained response to SGBV in Nigeria, E2A implemented the Strengthening the Response to Sexual and Gender-Based Violence Project, which worked with 10 existing SARCs in nine states across the country to meet the following objectives: to support and strengthen the capacity of SARCs to provide essential health services to SGBV survivors; strengthen the capacity of SARCs to solicit, manage, and administer additional funds, thereby contributing to organizational sustainability after USAID

11 Federal Ministry of Women and Social Development. National Guidelines and Referral Standards on Gender Based Violence in Nigeria.

support ends; and improve the collection, analysis, and uses of data by SARCs to better understand SGBV in Nigeria and to guide future prevention and response programming. The project provided technical and financial support through sub-grants over a two-year period, with seven SARCS receiving support from 2018, and three additional SARCs (in Adamama, Lagos [Mirabel Centre], and Yobe) receiving support in 2019. Project support to all SARCs ended in September 2019.

TABLE 1: NAMES OF THE SARCS SUPPORTED IN EACH STATE

STATE	NAMES OF SARCS
Adamawa	Hope Centre
Akwa Ibom	Agape SARC
Enugu	Tamar SARC
Jigawa	Jigawa SARC
Kano	Waraka SARC
Kaduna	Salama SARC
Lagos	Women at Risk International Foundation (WARIF)
	Mirabel Centre
Niger	Rayuwa SARC
Yobe	Yobe SARC

Most of the selected SARCs were established by programs like the Justice for All program (funded by the United Kingdom government's Department for International Development) and the Managing Conflict in Nigeria Program (funded by the European Union) in collaboration with the state MWASD, MOH, and MOJ. These SARCs are now managed by the SARC management committees, which each consist of representatives of the state MWSD, MOH, MOJ, and other relevant departments and agencies. However, the SARCs in Lagos state were founded by individuals or organizations and function as nonprofit organizations with an independent board of directors. Eight of the ten project-supported SARCs are located in public tertiary or secondary health facilities; the other two, located in Enugu and Lagos (WARIF), are free-standing, independent centers. These SARCs were chosen through a competitive bidding process and selected SARCs demonstrated competency in providing clinical services to GBV survivors; integrated SGBV services into other routine services to ensure survivors were provided all necessary clinical services without stigma and/or discrimination; demonstrated linkages to provide SGBV survivors with ancillary services to protection, counseling and reintegration, and perpetrator prosecution; had a physical presence with basic facilities to deliver services; had a management committee in place; were legally registered in their state; demonstrated the capacity to judiciously use and manage funds; and were a member of the SARC National Network in Nigeria.

Services Provided by the SARCs During Project Implementation

Primary prevention: These are activities aimed at the prevention of SGBV. The SARCs visited schools to sensitize students and teachers and visited traditional and religious leaders in communities to sensitize them to SGBV. The SARCs also conducted awareness campaigns using information education and communication materials, radio, and television.

Secondary prevention: This is the immediate response after the violence has occurred to deal with the short-term consequences. The SARCs provided SGBV survivors with comprehensive services including treatment of injuries, forensic examination, pregnancy testing and emergency contraception, HIV testing services, post-exposure prophylaxis (PEP) for HIV, STI prophylaxis, and trauma counseling by trained experts.

Tertiary prevention: These are approaches that focus on long-term care in the wake of violence (reduce disability and promote rehabilitation/recovery). Although some SARCs provide a few tertiary prevention activities like legal services and skills acquisition services, the SARCs mainly refer clients for tertiary services. These typically include legal services, safe homes, education services, psychosocial services, skills acquisition services, and other medical services such as psychiatry services, family planning services, and anti-retroviral therapy.

Although SARCs focus on secondary prevention of SGBV, they are also involved in some primary and tertiary prevention activities.

Given the crucial role of SARCs to Nigeria's SGBV response, the project targeted them for capacity strengthening to enhance and sustain the services they provide. As a first step, the project carried out an organizational capacity assessment (OCA)[12] of each SARC, working with SARC staff and management committee members to assess nine capacity areas: strategic planning, program improvement, organization culture of sharing, monitoring and evaluation (M&E), governance, partnership, finance, sustainability, and human resources. The assessment helped the SARC staff and management committee members reflect on its processes and functions. Using the initial OCA results, the project, SARC staff, and the management committees developed an action plan to strengthen the capacity of each SARC, which then served to guide project support.

The OCA showed that all SARC staff and management committee members needed capacity building in a number of areas to strengthen their ability to respond to SGBV. Throughout implementation, the project carried out capacity building activities to improve service delivery, outreach and community engagement, operational capacity, M&E and external engagement and coordination.

[12] The Organizational Capacity Assessment (OCA) is a structured tool for a facilitated self-assessment of an organization's capacity followed by action planning for capacity improvements. More details available at: https://usaidlearninglab.org/library/organizational-capacity-assessment

BUILDING CAPACITY FOR SERVICE DELIVERY

Improving Capacity for Provision of Quality SGBV Services

The project conducted training of SARC staff to improve their capacity for service delivery. Participants were selected based on the services they provide or supervise in the SARCs as follows:

- 20 SARC service providers were trained on SGBV service delivery: This was aimed at building the capacity of SARC doctors, nurses, and counselors to understand the clinical pathways and to ensure that the key elements of care are provided to SGBV survivors as well as update them on compliance to USAID family planning requirements.
- 29 SARC health providers were trained on forensic medical examination: Nurses and doctors in the SARCs were trained on the specific approach needed for survivors of sexual violence including adequate counseling; the aspects of proper history taking; careful, detailed, and objective forensic medical examination; standard pattern of documenting and reporting injuries; medical treatment and follow up; approach to court room processes; and integrating working with people with disabilities.
- 24 counselors were trained on counseling services: The training focused on recommended practices for counseling, including child counseling and counseling survivors with special needs.

Standard operating procedures (SOPs) were developed and made available to the SARCs to aid quality service provision. These SOPs provided guidance to SARCs in providing respectful and adequate services to SGBV survivors, including in the provision of post-exposure prophylaxis (PEP) and emergency contraception, collecting forensic samples and evidence, providing referrals to SGBV survivors, and receiving and handling pediatric survivors. Additional support was provided to the SARCs through the procurement of medical equipment and consumables to ensure that they were prepared to provide quality care and adequately manage the activities.

Strengthening the Referral and Linkage System

One critical service SARCs provide is connecting survivors with other services they may need, including legal services, safe homes, education services, psychosocial services, skills acquisition services, and other medical services (e.g., psychiatry services, family planning services, and anti-retroviral therapy). SARCs mapped out programs and organizations that provide these services and developed a relationship to make the referral process seamless for the SGBV survivor. A referral directory was developed for each state with contact details of focal persons in the identified organizations and programs. Going forward, SARCs can easily ensure the relevance of the directory by updating their electronic records of identified organizations and programs and printing the up-to-date directories.

The national referral forms and registers, which health facilities usually use to document referrals within the health system, were also introduced to the SARCs to ensure proper documentation of referrals for other services. This improved the efficiency of referrals and linkages to organizations and programs that provide other services required by the survivors, but not available in the SARCs.

BUILDING CAPACITY FOR SARC OUTREACH AND COMMUNITY ENGAGEMENT

In addition to strengthening the SARCs' ability for quality service delivery and organizational capacity, the SARCs were also supported to conduct various sensitization visits and campaigns to raise awareness on SGBV and the services available at the SARCs.

Sensitization Visits

The SARCs were supported to conduct sensitization visits to communities and to encourage traditional and religious leaders to speak out against the culture of silence and stigmatization of SGBV, especially the harmful tendency to prioritize community and family integrity above the well-being of the survivor. During these visits, communities were charged with taking collective action against SGBV in their respective localities. SARCs visited about 60 traditional and religious leaders in the nine supported states.

The project also supported the SARCs' work with young people to promote gender equitable norms and behaviors. SARC teams visited approximately 150 formal and informal schools to sensitize the boys, girls, and teachers about SGBV issues, promote respectful relationships, and provide information on the services available at the SARCs for SGBV survivors. Four SARCs developed special programs to provide young girls with relevant information on SGBV and the prevention of sexual violence. Two other SARCs formed SGBV clubs with the aim of using peer group influence to provide correct information about SGBV with other students. With the approval of state MOE, the SARCs formed a total of 38 SGBV clubs. All SARCs conducted sensitization visits to the police force in their states to promote better collaboration between the SARCs and the police, with SARCs educating police on better management and processing of SGBV client cases and encouraging them to refer SGBV survivors to the SARCs for medical services.

Drama session to create awareness on SGBV in Jigawa State. Photo credit: Aisha Abubakar

The SARCs were also supported to develop information, education, and communication materials. These included fliers, banners, posters, customized t-shirts, and caps with short messages on the prevention of rape and other SGBV, which they used during the sensitization visits.

Awareness Campaigns

Public education campaigns using radio and television were developed to raise awareness on SGBV. The project supported the development and airing of radio jingles on different radio stations in English and other local languages (Igbo, Nupe, Hausa, Fulfude, and Pidgin). The jingles were used to sensitize the public about SGBV, promote non-violence, and inform the public about the services SARCs provide. The SARCs participated in radio and TV call-in programs to sensitize the public on SGBV issues. Callers asked questions on SGBV and activities that the SARCs conducted. All of the SARCs also have hotlines for enquiries about their services. Callers can also receive counseling through the hotlines.

The 2018 International Day for the Eradication of Violence Against Women, which kicked off 16 days of activism against SGBV, renewed the commitment of the government, communities, individuals, and civil society organizations to ending violence against women and other forms of SGBV. The SARCs were supported to carry out activities like road shows, dramas, symposia, radio call-in programs, and TV talk shows to educate communities about SGBV and restate the SARCs' commitment against SGBV.

During this period, the office of the vice president of Nigeria organized the first-ever national conference on SGBV. During the conference, the vice president called for Nigerians to never become accustomed to condoning the abuse of its most vulnerable people or to turn a blind eye to exploitation and called for women and girls to be treated with equality and dignity. The project supported state-level participants to attend the conference.

Agape SARC's commemoration of the international day for the eradication of violence against women.

Photo credit: Elijah Atah

BUILDING OPERATIONAL CAPACITY

Improving Capacity for M&E

Monitoring and data review are crucial to ensure the quality of services that the SARCs provide. There are currently no national tools for the collection and reporting of data on SGBV. Most SARCs were not keeping adequate records of their services, and those that did mainly used paper-based systems. There was also poor data use for decision making and planning in the SARCs and among SARC management committees. The project developed tools to adequately capture and report monthly aggregated data to relevant ministries on SARC services provided. The project also provided M&E training for 30 SARC staff, covering the basics of M&E, data use and data visualization, and how to complete the developed tools. The SARCs started holding monthly data review meetings where the SARC staff and management committee members met to discuss the data collected in the previous month and develop an action plan to address any issues observed. Data quality assessments were also periodically conducted with the SARC to improve quality of the data and build the capacity of the SARC staff to record services provided using standardized tools. The SARCs were also mandated to submit monthly reports to the state MWASD, MOH, and MOJ.

Improving Capacity for Finance and Grant Management

The baseline OCA showed that the SARCs had weak financial systems: all SARCs had minimal or no established system for accounting. Thirty SARC staff and SARC management committee members were trained on financial and grant management, and 35 staff and committee members participated in trainings for organizational policy and systems development. SARCs were also supported to develop SARC-specific resource mobilization plans, primarily to strengthen their finance systems and develop policies and procedures to build and nurture sustainable organizations.

Fifty SARC staff and management committee members participated in a proposal development workshop to strengthen their capacity to develop proposals for external funding. Thirty SARC staff and management committee members also participated in a grant management workshop with the aim of building capacity of the SARCs to understand basic grant policies and manage grants efficiently.

Improving Capacity for Advocacy

Fifty SARC staff and management committee members participated in a SMART advocacy workshop where they learned how to use the evidence-based advocacy approach, Advance Family Planning (AFP) SMART,[13] to achieve the SGBV project objectives and goals. During the workshop, SARC staff and management committees learned how to develop specific advocacy messages and conduct effective advocacy visits to stakeholders.

[13] *Advance Family Planning (AFP) SMART Advocacy is a nine-step approach to evidence-based, locally driven advocacy strategy. While intended for family planning advocates, the approach can be adapted for use in any sector. More details available at https://www.advancefamilyplanning.org/*

Providing Mentorship and Supportive Supervision

The project provided technical support to the SARCs in service delivery, programming, documentation, M&E, and finance and grant management. A mentorship team (consisting of the programs, M&E, and finance and grant management staff of Pathfinder) visited each SARC periodically and provided on-the-job training and mentorship to SARC staff and management committee members based on identified needs. An action plan was developed with the SARC staff and management committee members after each visit, and this was reviewed during subsequent visits. These visits helped to improve the quality of services provided, data quality, and the finance management processes.

BUILDING CAPACITY FOR EXTERNAL ENGAGEMENT AND COORDINATION

In addition to conducting mentorship and supervision visits to the SARCs, the project encouraged the SARCs to learn from each other and improve external collaboration. They were supported to improve coordination among the various ministries, department, and agencies involved in SGBV and to strengthen the referral systems for SGBV survivors.

Improving Learning Between the SARCs

The project provided a forum for SARCs to meet, learn from each other, and work together to improve their practices. A project review meeting was held with representatives from each supported SARC to share best practices and success stories and harmonize innovative strategies, as well as foster a strong SGBV response network and peer system for learning, communication, and effective partnerships. By the end of the meeting, the SARCs had each developed quality improvement plans to be implemented over an agreed-upon period, depending on SARCs' individual needs and schedules. The SARCs also learned techniques from each other to positively engage the police in SGBV interventions.

The project also supported representatives from the SARCs to attend the fourth SARC Network meeting in Abuja, Nigeria. The government of Nigeria, with support from the British Council and Pathfinder, led the meeting, which aimed to determine how best to improve government support to SARCs. All 13 SARCs in the country participated, together with a broad selection of stakeholders including representatives from MOH, MWASD and MOJ, the office of the vice president, the police, the National Agency for the Prohibition of Trafficking in Persons, and civil society. Meeting participants considered what actions could be taken to enhance service delivery, support, and response to persons with disabilities who have been survivors of sexual assault. Each SARC presented their achievements, challenges, and plans. One major agreement which came out of the meeting was for the representatives of the line ministries to work in collaboration with the SARC management to carry out advocacy toward the domestication of the Violence against Persons Prohibition (VAPP) Act.

Improving Coordination by SARC Management Committees with Relevant Ministries and Bodies

The SARC management committees were established to promote a greater level of ownership, commitment, and collaboration by key state ministries and agencies to ensure the long-term sustainability of the SARCs. At program inception, the SARC management committees, though in existence, were mainly inactive. The project worked to strengthen the SARC committee members to function optimally to advocate for funding and provide supervisory oversight to the SARCs. Several advocacy wins were achieved, such as dedicated allocations to SARCs in the state budgets.

SGBV requires a multisectoral approach to realize any success. The project supported the SARCs to hold quarterly management committee meetings to promote better coordination of state response to SGBV. The meetings usually had in attendance representatives of the MWASD, MOH, MOJ, police force, and CSOs.

RESULTS

Improved SARC Organizational Capacity

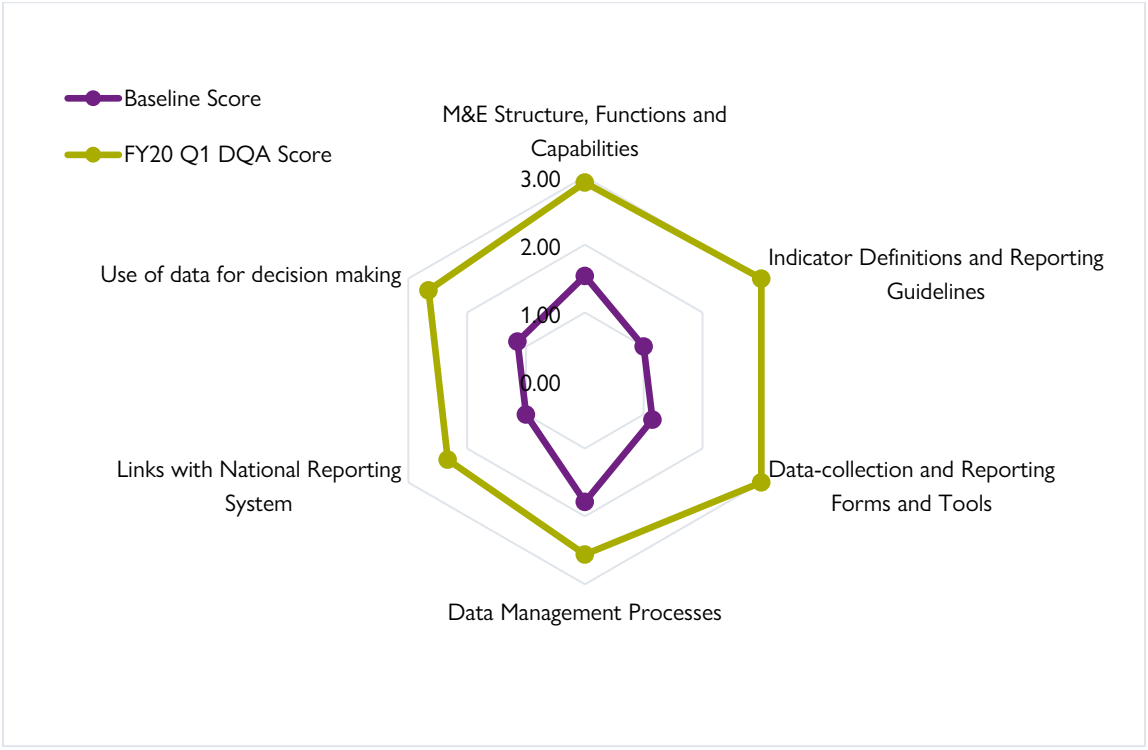
At the endline OCA, an improvement was seen in all nine capacity areas across all 10 SARCs (Figure 2), most significantly in the financial management and M&E capacity areas. Baseline OCAs were conducted in April 2018 for the seven original SARCs and in February 2019 for the three additional SARCs. Implementation started after the baseline and continued through September 2019. Endline OCAs were conducted in December 2020. Also, during the endline OCA, recommendations were provided to the SARCs where weaknesses were still observed.

FIGURE 2: BASELINE AND ENDLINE OCA SCORES OF NINE CAPACITY AREAS

Improved Capacity for M&E

Throughout the project, SARCs and project staff conducted periodic data quality assessments to assess the M&E system and SARC data. A Routine Data Quality Assessment (DQA) tool[14] was used to assess data quality of specific indicators by checking reported results from the registers against the Monthly Summary Form and conducting audits of randomly selected client folders and case files. A review of all data quality assessments at project end found an improvement across all M&E components in all SARCs from baseline to endline. For example, SARC staff started to better use data for decision-making by identifying communities with high number of SGBV cases and planning outreaches and sensitization in those areas. SARCs also started to hold data review meetings in which they looked at the previous month's data and used the data to guide their focus for the subsequent month.

FIGURE 3: AVERAGE DQA SCORE FOR EACH M&E COMPONENT



[14] The full routine DQA tool can be found at https://www.measureevaluation.org/resources/publications/ms-17-117/at_download/document.

Improved Capacity to Solicit, Manage, and Administer Additional Funds

Through capacity building activities to solicit, manage, and administer funds, the SARC staff and management committee achieved several advocacy and sustainability wins. As a result of SMART Advocacy training and visits to state governments, SARCs achieved the following:

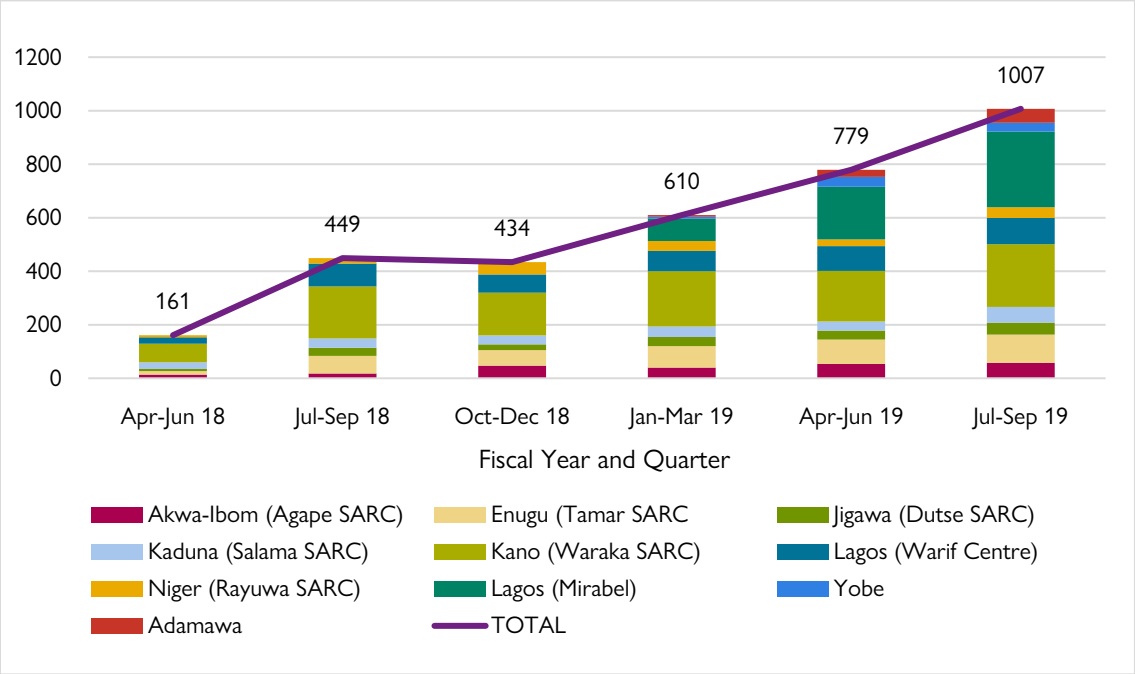
- SARCs in Adamawa, Enugu, Niger, Jigawa, and Kaduna now have a dedicated budget allocation in the state budget.
- Kano State Drugs Management Agency now supports the SARCs with some medications to be given for free to survivors who report to the SARC.
- WARIF (in Lagos) now receives free PEP for eligible SGBV survivors from a USAID-funded HIV project in the state.
- The state MOH in Jigawa now provides free services to SGBV survivors who visit the SARC.
- SARCs have submitted proposals for additional funding. WARIF received funds from the Spotlight Initiative and Mirabel received funds from UNICEF

Additionally, at the first-ever national conference on SGBV in 2018, Pathfinder was one of the beneficiaries of the award given to SGBV "response heroes" in the country in recognition of their support to SARCs.

Improved Capacity for Service Delivery

A total of 3,440 clients reported to the SARCs and received services from May 2018–September 2019, with a trend of increasing numbers of clients over this period (see Figure 4). Data are reported for seven SARCs from April to December 2018 and for ten SARCs from January to September 2019; the addition of three new SARCs in 2019 contributes to the increase in numbers of clients seeking out the SARCs. The effort by the SARCs to raise awareness contributed to the continuous increase in clients seeking out the SARCs.

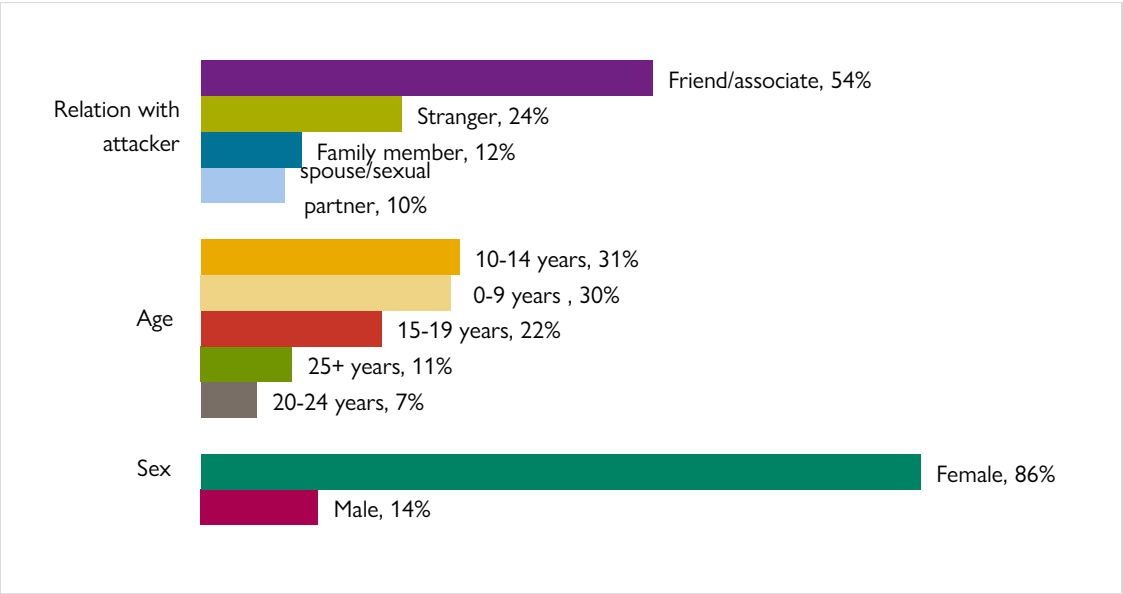
FIGURE 4: NUMBER OF SGBV SURVIVORS REPORTING TO THE SARCS BY SARC



**The 3 additional SARCs started reporting in March 2019*

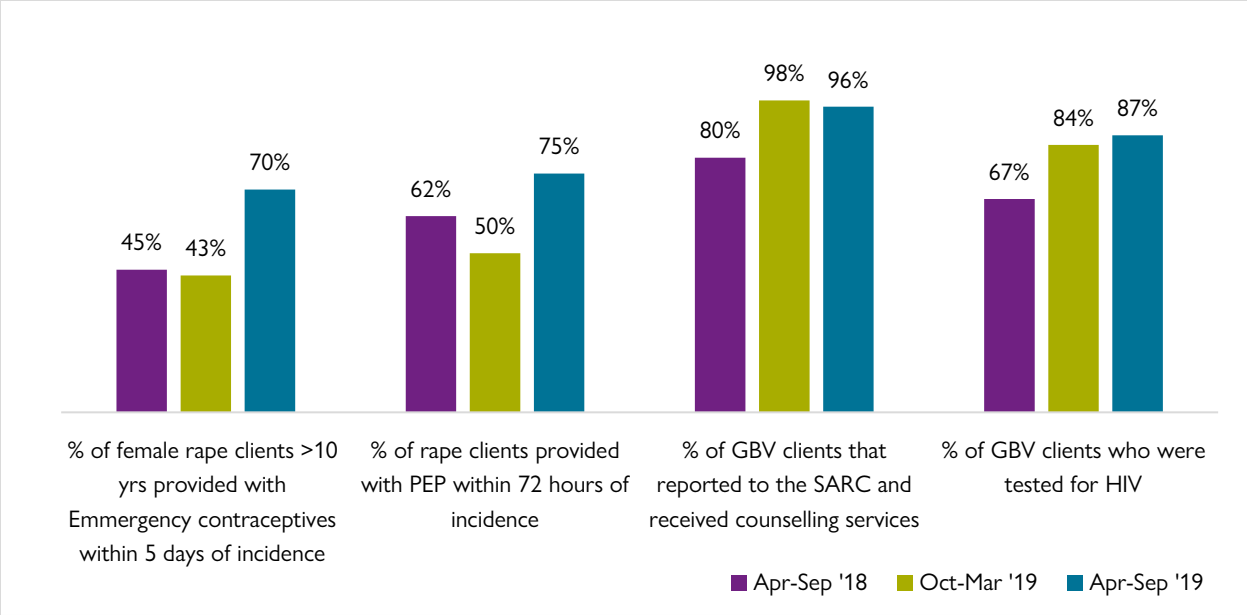
Of the clients reporting to the SARCs, 86% of the survivors were female and 14% were male, and 61% were 0–14 years old, 29% were 15–24 years old, and 11% were 25 years and above. With respect to the perpetrator, 76% were known to the survivors while 24% were strangers. No significant shifts were seen in demographics of clients, for instance in age or sex, seeking services over time.

FIGURE 5: CHARACTERISTICS OF SGBV SURVIVORS THAT REPORTED TO THE SARCS



The SARCs also showed an increase in the percentage of clients receiving their services. Provision of emergency contraceptives and PEP increased from 45% to 70% and 62% to 75%, respectively, from the baseline period (April–September 2018) to the final period of implementation (July–September 2019).

FIGURE 6: IMPROVED CAPACITY FOR SERVICE DELIVERY



LESSONS LEARNED

Over the course of the project, E2A/Pathfinder learned several lessons about how best to facilitate the provision of essential SGBV services and promote efficient functioning of SARCs.

Lessons for Effective SARC Functioning

- Continuous mentorship and supportive supervisory visits had great impact in building SARC staff capacity to achieve effective and efficient SGBV service delivery. Regular technical assistance to SARCs boosted efficiency as well as the quality of service delivery.
- Continuous engagement of the management committee members in planning and implementation contributed to the success of the SARCs through improved management oversight function of the SARCs and members' involvement in key activities such as advocacy visits to stakeholders and community engagement events.

- Strengthening data collection, management, and use was a critical aspect of SARC capacity building. Data are crucial for evidence-based SGBV programming, and SARC data, shared with government agencies, provided valuable evidence on the experience and scale of SGBV. The project noted, however, that data from the communities are also required to provide a comprehensive picture to guide SGBV programing and evidence-based advocacy.

Lessons for Effective SGBV Response

- Building SARC capacity to continuously and systematically engage with the state and federal government has increased government responsiveness to SGBV.
- Addressing SGBV requires a comprehensive and multidisciplinary approach, and sustainable action requires ongoing synergy and coordination among all relevant ministries, department agencies, and stakeholders. Increasing stakeholder engagement and involvement is an important way to build a coordinated response to SGBV at community, state and national levels.
- Strategic advocacy works. AFP SMART is popular and powerful and has been proven over time to achieve sustainable funding, policy, and project results. It can be successfully applied for short, one-time advocacy. It is flexible and dynamic, a critical factor for evidence-based opportunistic advocacy.

CONCLUSION

The project contributed immensely to improving the capacity of the SARCs to respond adequately to SGBV and increase awareness about SGBV and services for survivors. The OCA showed an improvement in all observed capacity areas of the SARCs, and there was a continuous increase in patronage of the SARCs from project baseline to endline, a period of just over one year. It is expected that the SARCs will continue to provide quality services to SGBV survivors through the increased capacity of SARC staff and management committees.

The capacity of the SARC management committee was also built to advocate for increased support and funding. As a result, the SARCs have received additional support, partnerships, and commitments from government and other stakeholders, laying a strong foundation for sustained provision of services to survivors. However, continuous engagement is required to sustain the gains of the project. Also, the SARCs will have to continue to submit proposals to funders to support their work.

The quality of documentation has also improved, as data collection and reporting tools are available for use at the SARCs. It is expected that the SARCs will continue to use these tools and contribute to the

body of evidence on SGBV in their states. The financial records of the SARCs have improved, thereby improving their accountability and transparency in the provision of quality services.

Increased capacity and successful advocacy efforts of the SARCs show promise for sustaining gains realized through the project and reaching more SGBV survivors with high quality services. However, their continued success will require commitment from stakeholders at the national and state government levels.

Actions to Sustain a Strong SGBV Response

This project was an important step in ensuring that SARCs can provide quality, comprehensive services for SGBV survivors. To sustain a strong service response to SGBV, the following actions are recommended:

- To ensure that all survivors, irrespective of their location in the state, have access to SGBV services, more SARCs should be established in all senatorial districts in all the states, and all health facilities should be equipped to provide immediate SGBV services.

- All SARCs should have budget lines in the state budget and there should be timely release of funds to enhance smooth and uninterrupted service provision in the SARCs.

- There should also be an increase in human resources providing services in the SARCs. To combat the lack of nurses and doctors, the MOH can post resident doctors and nurses while the MWASD can post counselors to the SARCs. This will ensure that survivors can access quality services.

- Finally, the MOJ, police, and the SARCs need to collaborate more effectively to ensure all perpetrators are prosecuted and justice is served.

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