WHO Case Studies

Country: Nigeria

Stand To End Rape Initiative

Brief introduction to the organization: Stand To End Rape Initiative (STER) is a youth-led social enterprise against sexual violence, providing prevention mechanisms and supporting survivors with psychological services. The organization's work also includes establishing or enhancing existing helplines for adolescents, sensitizing and alerting healthcare workers, community workers, and support networks working on Sexual and Gender-Based Violence (SGBV) and adolescent-specific vulnerabilities.

Were you delivering services to young people before the COVID-19 crisis?

We were providing a collection of services to support survivors of rape before the COVID-19 crisis. Part of these services included medical support and providing physical help to clients in accompanying them to the hospital for prompt access to healthcare. In addition, we provided referrals to legal services in-person and virtually to discuss the terms of cases, review evidence, report cases, and follow up as necessary, including facilitating prosecution in court. Furthermore, we provided psychosocial support in facilitating weekly therapy sessions for survivors of rape.

What new approaches did you use to respond to the barriers created by the COVID-19 pandemic to reach young people?

We had to adapt to provide virtual support to survivors while reducing physical contact due to the increased threat of COVID-19 infection if we maintained our existing model. This included dedicating more time to using our phone services to guide survivors and linking them to appropriate service providers. We found a way to provide mental health counseling via Zoom and Skype while adopting text message counseling for clients that preferred to write.

We had to wait until the lockdown restrictions were eased to support the movement of survivors in seeking justice. For the cases we managed to support, survivors were aided to go to service providers during work hours while wearing face masks. We arranged transportation for them and set appointments to ease the process. However, we could not provide any in-

person accompaniment due to the associated health risks. Nevertheless, we managed to process an average of 30 cases per month during the lockdown and started preparing for the second wave, which is expected to introduce new restrictions.

When the lockdown eased, we carried out community engagement activities to sensitize people about the likelihood of an increase in SGBV and inform them on how to prevent and manage SGBV during the outbreak. The involved staff members were given face masks, practiced social distancing, and followed other precautions to prevent the spread of COVID-19.

Meanwhile, we have joined in with other civil society organizations to target advocacy at the Ministry of Women Affairs to ensure that survivors of rape are prioritized. As a result, they are granted full access to the services they need, including shelter, legal and health services. This is in the hope that the government's response to the second wave is gender-sensitive and responsive and that SGBV-related services are included in the national response plan.

Why did you decide to use these approaches?

When the COVID-19 pandemic started, our system had to change to minimize physical interaction with our beneficiaries to reduce the risk of contracting and spreading COVID-19. As a team, we first reviewed best practices from other countries on responses to GBV during COVID-19. We looked at our client data and affirmed that most clients opted for virtual support even before the outbreak of COVID-19. We then decided to test a suite of virtual services and try out other documented best practices where possible. Based on feedback from our beneficiaries on these initial tests, we optimized our delivery model to make it more convenient for survivors of SGBV.

In this respect, we had to use several virtual platforms to provide adequate support to our beneficiaries while preventing the spread of COVID-19. However, the Nigerian government did not prioritize SGBV as part of emergency cases, and by extension, did deem the provision of related health, psychosocial and legal services as essential.

For legal counseling, the courts were closed, and only emergency cases were attended to, which was done virtually via Zoom. As a result, no in-person cases were processed, while police officers were not available. Some of the usual officers were reallocated to lockdown law enforcement. In addition, service providers for SGBV care were affected by mobility restrictions during the lockdown.

Once the lockdown severity was reduced, rape cases were still not prioritized in the processing of backlog cases, despite the easing of restrictions. There was no evidence to work with for some cases, and it took a lot more effort to support survivors to gather additional evidence.

This negatively impacted young women's access to justice, and our services sought to bridge this gap in the best way possible.

How are you working to find out if these approaches are having the desired impact?

We used an internal data matrix compiled by a research team that frequently engaged survivors to understand in real-time how beneficial the services were for them. Initial feedback from beneficiaries highlighted that the service was confidential and convenient. They did, however, note that they still preferred an in-person touch. We also conducted random checks with clients to see how they were coping one and two months after their case was handled. We decided to continue with the process, both remotely and in person, responding to each client's preferences based on the feedback.

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