Localizing Responses to Gender-Based Violence: The Case of Women-Led Community-Based Organizations in Jordan

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While the rationale for localizing humanitarian health response is well established at the level of policy rhetoric, the operationalization of the concept and its mainstreaming into concrete practice still require clearer intentionality. With COVID-19 pushing more people further into vulnerability, placing local communities at the heart of humanitarian and development health efforts has never been more urgent. Focusing on Jordan, this essay brings attention to the significant toll of violence against women and girls in conflict-affected communities and the importance of empowering local actors with community knowledge and resources to prevent and respond to gender-based violence. The essay follows on from the research conducted for CARE Jordan's She Is a Humanitarian *report (2022) and draws on interviews I conducted with the heads of women's organizations in the summer of 2022. The essay explores the role of local women humanitarian actors as frontline responders, the challenges that hinder their role, and the advantages such actors enjoy, which, if harnessed, can achieve gains in accountability, health service quality, and gender equality.*

In recent years, Jordan has been weathering a deteriorating situation, caused by a confluence of factors including the conflicts in Iraq and Syria, the regional turmoil resulting from the 2011 Arab uprisings, and, more recently, the COVID-19 pandemic. Jordan hosts 760,000 refugees, which constitutes the second largest proportion of refugees per capita in the world.[1] Only 17 percent of refugees live in refugee camps, with the majority living in urban and rural areas across the country. The prolonged displacement of refugees has placed significant pressure on the country's already overstretched resources and services. The situation is severely impacting women and girls in Jordan, increasing gender-based violence (GBV) risks and incidents for refugees and host communities alike, and hiking demand for related health services.

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Jordan's refugee community is diverse. Approximately 88.5 percent of registered refugees are Syrian, 8.8 percent are Iraqi, and the remaining are other nationalities, including Somalis and Yemenis.[2] Social protection is provided to refugees and Jordanians through governmental services and civil society, with refugees relying more heavily on UN agencies and nongovernment actors and community-based mechanisms, including for a range of health services.[3] Women-led organizations are an integral part of these mechanisms providing services, as well as protection and empowerment programming that uplift women and meet survivors' needs. The essay unfolds in several parts to highlight their role in addressing rising GBV incidents, the challenges they face, and the role they could potentially assume with more effective support. In a country reeling from the impacts of regional conflict and the COVID-19 pandemic, there is a clear imperative to localize GBV services through support and empowerment of women-led community-based organizations as part of a broader localization agenda.

Gender-based violence is a multidimensional problem that finds root in gender inequality, harmful cultural norms, and the abuse of power.[4] More than 25 percent of married Jordanian women between the ages of fifteen and forty-nine have experienced a form of violence by a partner, and about one-half of women and more than two-thirds of men consider domestic violence to be justified in certain circumstances.[5] Refugee women and girls suffer additional risks because of displacement, conflict, separation of families, and disruptions to vulnerable livelihoods, support systems, and protection structures.

As a global health issue, GBV creates both immediate and long-lasting health impacts on physical and mental health, including injury, unintended pregnancy, sexually transmitted infections, depression, post-traumatic stress disorder (PTSD), and even death.[6] Other than PTSD and depression, intimate partner violence, which remains the most common form of GBV around the world, is consistently associated with protracted disabling sleep disorders, phobias and panic disorder, suicidal behavior, and self-harm and psychosomatic disorders.[7]

As elsewhere in the world, Jordan has experienced an increase in GBV incidents during the COVID-19 pandemic. A 2020 rapid assessment commissioned by the United Nations Population Fund – conducted in three governorates and the two refugee camps of Za'atari and Azraq – revealed that 69 percent of survey respondents and informants reported increasing prevalence of GBV. Emotional abuse and physical abuse, often by an intimate partner or member of the family, were the most commonly occurring forms of abuse. GBV remains underreported, and mobility restrictions, due to COVID-19 lockdowns, left survivors with fewer options for reporting and a decreased access to related services. Women shelters had to close their doors to reduce their staffing.[8] Survivors, especially of domestic violence and intimate partner violence, were hesitant to seek help when they were

stranded at home with their abusers. The lack of access to mobile phones also affected their ability to call for help.[9]

Refugee women in Jordan have also had varying degrees of access to critical health services. Indeed, twelve years into the Syrian crisis, the integration of Syrian refugees into existing service systems in Jordan is still limited. Parallel service structures continue to exist with different services being provided in camps and in urban areas to both out-of-camp refugees and host communities. As a result, services vary in quality, accessibility, and affordability.[10] In the Za'atari and Azraq camps, services are free at the point of access and adhere to international standards and norms. In urban areas, by contrast, not all services are free at the point of access and quality tends to be lower.[11]

Nevertheless, service gaps exist both in and outside of camps. Refugees are not always consulted on the design of programs. Outreach to communicate about available services is also deficient in many locations. This is particularly the case for GBV, for which there is a need for additional GBV hotlines that render less stigmatized access to services, as well as psychosocial specialists who can provide gender-sensitive quality of care. Some health care providers harbor victim-blaming, or other negative attitudes toward those seeking help. Such individual-level provider attitudes, in turn, inhibit reporting and access to services, and affect the delivery of quality services.[12]

Women, however, are not only victims or passive recipients of assistance.[13] Today women across the world are becoming a leading force in disaster risk reduction and emergency response, including health services. Though underrepresented in leadership positions, women make up more than 40 percent of the humanitarian workforce.[14] Their ability to take humanitarian action therefore enables participation by and accountability to crisis-affected populations.[15]

In a study of seventy countries over four decades that examined the most effective way to reduce women's experiences of violence, the most critical factor was the strength of women's organizations or the women's movement in that country.[16] It also found that women's participation at all levels is key to the operational effectiveness, success, and sustainability of peace processes and peacebuilding efforts.[17] When women are able to participate equally, humanitarian responses – including those related to health services – are also more effective and inclusive.[18]

Whether as individuals or as part of women-led organizations, women humanitarians play an active role in responding to immediate crises and carrying out longer-term development work. Operating at the grassroots level, women's organizations are quick to act as first responders providing material assistance and life-saving services and supporting awareness raising and risk communication. Furthermore, these organizations have a clearer understanding of the com-

munities they serve and will often provide a more contextualized response that leverages social capital and networks and helps deliver gender transformative and sustainable solutions.[19]

In Jordan, in light of the country's legacy as a host state to waves of refugees, including Palestinians, Iraqis, and most recently Syrians, the civil society to which these organizations belong has long been involved in humanitarian work. Women-led organizations are well represented within the sector, especially those that work within the humanitarian space. Women-led community-based organizations (CBOs) can access affected populations more easily and navigate complex local dynamics more readily, thereby providing culturally situated responses.[20]

Because of prevailing social norms, women's mobility in Jordanian communities is generally restricted. CBOs serve as one of the few public spaces in which women can gather and engage. Furthermore, the tribal nature of Jordanian society frowns upon referrals to more formal institutions. According to the heads of several women-led organizations, many GBV incidents in the country are addressed through informal mediation – whether by family members, tribal leaders, or CBOs – to "contain the situation and maintain family unity."[21] As a result, health-related GBV consequences, especially mental impacts, do not always receive proper attention. And yet, as female-only spaces, women-led organizations default as safe spaces for both Syrian and Jordanian women. When effectively supported, such organizations serve as entry points for quality services and information.

In recognition of their vital role, the localization of aid agenda calls for a greater inclusion of local actors to make humanitarian and development action more effective and efficient. As stated in the "Grand Bargain" at the World Humanitarian Summit in May 2016, the reliance on national actors – including nongovernmental organizations (NGOs) – should be more predominant in the future design and delivery of humanitarian assistance.[22] In fact, the Grand Bargain includes a section focused on promoting a "participation revolution" to "include people receiving aid in making decisions which affect their lives."[23] Gender equality and women's and girls' empowerment also emerged as an overarching theme of the Summit.[24] The first related commitment called for empowering women and girls as change agents and leaders, including by increasing support for local women's groups to participate meaningfully in humanitarian action. Of the thirty-two core commitments made at the Summit, the commitment to gender-responsive humanitarian programming received one of highest number of endorsements.[25] Financial support to grassroots women's groups was also pledged by various stakeholders, while others made commitments to capitalize on the expertise of local women and women's groups and to support them as agents of change.[26]

Despite strong international commitments toward localization and support of national actors, progress toward the concrete operationalization of localization

has been slow. The onset of the COVID-19 pandemic brought to the fore legitimate questions regarding local capacity and agency as well as the sustainability of local development and humanitarian efforts. Testing systems and local capacity, the pandemic served to expose many of the gaps between policy commitments to localization and realities on the ground, and thus catalyzed the need to accelerate progress.

Many governments, including Jordan's, prioritized the COVID-19 response over GBV-related health service provision and failed to pay adequate attention to the need to integrate GBV risk mitigation measures into their response plans.[27] Humanitarian funding for GBV fell sharply and humanitarian activities were significantly downsized. The UN-launched Global Humanitarian Response Plan included only USD 50 million (out of a total budget of USD 2.01 billion) for GBV programs in sixteen of the sixty-three countries slated to receive COVID-19 humanitarian assistance.[28]

Several health services in Jordan and elsewhere were also disrupted during the pandemic. Many organizations restructured their programs to focus on "critical only" interventions, such as case management, to the detriment of other important services. Activities related to early marriage, sexual and gender-based violence prevention, child protection and education, livelihood activities, and capacity-building were all downscaled or impeded as a result.

Humanitarian health interventions, including GBV services, were further challenged by precautionary measures taken by humanitarian organizations, and by mobility restrictions. International staff were often unable to stay in the countries in which they served because of their organizations' weakened medical defenses. This led to significant staffing gaps that national and local organizations had to step in and fill. [29]

With lockdowns and movement restrictions, GBV service providers, including women's organizations, started to adapt their service delivery. In particular, they switched to remote service provision through the phone, social media, or other online platforms. Providers established WhatsApp chat groups to support the delivery of food and medicines in the same community, while trainings and awareness-raising sessions continued on Zoom and case management/psychosocial support and timely referrals were provided via new hotlines. The interviewed leaders of Jordanian women's organizations reported that they frequently led online sessions and held informal gatherings at home to disseminate information about COVID-19 and provide guidance about how to mitigate health risks. They also continued to raise awareness on GBV through online sessions, and to receive survivors, sometimes at their own residences.

Formal support channels gave way to informal community-based support and a de facto localized approach, as many international organizations working in Jordan opted to rely more heavily on their local staff or national and local organiza-

tions.[30] Women-led CBOs continued to receive and manage cases with limited resources and to the best of their ability. Most of the smaller women's organizations shifted to addressing immediate needs, leveraging their grassroots network to access women and girls. Given their strong roots in their communities, they were able to do so more easily than other actors.

This localized approach nonetheless revealed many of the challenges local organizations regularly grapple with in humanitarian work. Despite stepping up to address community needs, women-led organizations reported decreased local and international funding and engagement. [31] In fact, funding levels fell short of the Grand Bargain commitment to fund local organizations at 25 percent, which ran contrary to the increased responsibilities these organizations shouldered during the pandemic.[32] Even though women's organizations served as the safest entry points for GBV services amidst rising violence levels, they were stripped of their resources, calling into question the extent to which the localization agenda, which calls for a more equitable model of cooperation among international organizations and local civil society, is being achieved.[33]

Even before the pandemic, women's organizations continued to face a host of structural challenges that circumscribed their role in humanitarian health delivery. Community-based organizations struggle with staff capacity and core funding shortages. They also confront knowledge deficiencies in technical standards, especially as they relate to these organizations' ability to recognize violence and differentiate between its types, and to conduct safe referrals and provide mental health and psychosocial support. The sustainability of services also remains an outstanding issue, as CBOs continue to be donor dependent, with services linked to project funding cycles.

Partnership modalities also affect the role of women-led CBOs and the localization of humanitarian health services. To begin, humanitarian funding from the biggest donors is channeled to local implementing organizations through international nongovernmental organizations (INGOs), meaning that local organizations cannot access funding mechanisms directly.[34] Second, formal collaboration with international organizations is usually project-based.[35] When working with grassroot organizations, INGOs also tend to prefer subgranting models that dole out small amounts to a large number of local partners at the expense of long-term partnerships that build organizational capacity, leadership, and agency. The reluctance of the donor community to make sustained, long-term investments in developing the capacities of a vetted group of local actors dampens the ability of local organizations to participate meaningfully in priority setting, as well as project design and implementation. Third, given their risk aversion, INGOs prefer to engage with relatively larger organizations that need less programmatic and operational support and that already participate in coordination mechanisms. This

tends to result in partnerships with a small number of national organizations that have staff and compliance capacity, rather than a larger number of smaller CBOs, some of which would likely include community-based women-led organizations.[36] Finally, the short-turnaround timelines associated with requests for proposals do not allow INGOs or local actors the time to take stock of service needs, or to assess what is already available and can be used to optimize results. While project funding is sometimes unearmarked, it is more often restricted to specific project activities, with limited opportunities to divert resources to institutional systems or provide services based on an independent assessment of needs rather than donor criteria.[37]

According to several women-led CBOs across Jordan, INGOs usually contract them to implement a set of predefined activities, including awareness raising, case management, psychosocial support, and referral. The proportion of funds they receive, the length and nature of engagement, and the capacity-strengthening modalities do not lend themselves to the development of meaningful partnerships, nor to impactful outcomes.[38] Moreover, strict limits on overhead costs are often insufficient to cover local actors' "real" operational costs and affect their capacity to retain staff long term. As a result of short-term project models, women-led organizations are particularly likely to report high staff turnover.

Overall, the lack of long-term engagement leaves local organizations in constant survival mode. Upward accountability to donors, mostly in the form of quantitative targets of beneficiaries reached, weakens downward accountability to beneficiaries for quality of services. Compliance with different donors' requirements detracts from the ability of local actors to focus on services, as they scramble to report on outcomes they did not necessarily define and focus on generating data on service "pockets" rather than on national needs and critical gaps. Furthermore, the lack of reporting on the value brought by *local* partners hinders both the construction of an equitable international-local relationship and the promotion of a vibrant and local civil society.[39]

During interviews with the heads of several women's organizations engaged in GBV prevention and response, respondents claimed that even before COVID-19, the internationally supported projects they ended up working on were short-term and disjointed.[40] They further reported that international organizations rarely engaged them in project design, and that local input was rarely sought beyond the facilitation of access to communities and information to improve understanding of local contexts. "They ask us to bring community members for their focus groups and don't share the findings with us," said one interviewee. By chasing after short-term funding for various development and humanitarian interventions, local CBOs are also losing the opportunity to develop deep sectoral and technical expertise, as the need to appeal to different donors leads them to prefer broad mandates. The lack of sustainable funding also drives competition between small local actors.

In spite of the challenges outlined above, there remains a strong imperative to localize GBV services. To begin, localization both allocates responsibility to local actors to ensure accountability to survivors of this kind of violence and builds the type of community ownership needed to change power structures that reinforce gender and other inequalities. But localization also has the potential to improve the effectiveness of both immediate and longer-term prevention and response, including health services, by capturing and sharing what works and what does not within a local context. And last, local organizations are best positioned to undertake the kind of long-term work needed both to change the belief systems and social norms that enable GBV, and to empower women.

Local organizations' GBV services are not always easy to classify as either humanitarian response or development.[41] In fact, CBOs provide spaces for connecting longer-term health needs and immediate humanitarian solutions, working toward sustainable outcomes that can then allow both humanitarian and development organizations to plan their exit. Given the protracted length of refugees' stays in Jordan, this connection between the development and humanitarian agendas is particularly important, and can help build sustainable solutions that in the long run will reduce the need for aid. With the right capacity, women-led CBOs can serve as drivers of social change at the community level, and lead policy change at the national level, leveraging both humanitarian and development efforts to reduce risk and vulnerability and empower women.

Indeed, intersectional analysis of GBV risks and needs confirms that women's empowerment and livelihood programming can complement GBV services.[42] Without this, women remain silent to abuse or resort to harmful coping measures. As first responders, strong women-led CBOs can encourage survivors to report GBV through survivor-centered reporting mechanisms, engaging survivors in their design. GBV, especially in a domestic context, remains chronically underreported in both Jordanian and Syrian families based in Jordan. The relatively high level of acceptance of GBV contributes to its perception as a minor problem and a "family matter" that does not merit external intervention. In addition, survivors who wish to avoid filing complaints are discouraged from seeking assistance, especially advanced medical services (as opposed to primary health care) because of a legal requirement for mandatory reporting to the police.[43]

Many victims of GBV in Jordan either are unaware of relevant services, succumb to social pressure, or fear social stigma and/or secondary victimization by gender-insensitive law enforcement officers and unsupportive family members. This is exacerbated by the limited capacities of existing service providers and large geographical distances to service centers. Available data also indicate that most survivors of GBV access services more than one month after the incident, highlighting the need for better outreach to inform both refugee and local communities of available services.[44]

As microcosms of their communities, women's organizations in Jordan can sometimes embody the conservative, patriarchal, and traditional values of their communities and may not recognize various forms of violence against women. At the same time, many of these same organizations have the potential to serve as vehicles for broader social change. Women's organizations can go beyond service delivery and engage in community mobilization, advocacy, and policy dialogue on necessary changes to the social norms that facilitate harmful behavior. In the same vein, community-based organizations provide much needed platforms for women to gather and connect, serving as a key enabling factor for women's humanitarian and political leadership and activism.[45] Heads of women's organizations often go on to run in local elections.

Related, a strengthened national system to prevent and respond to GBV, in which women-led organizations provide local solutions and track their impact, can help raise the profile of the civil society in Jordan. Beyond those organizations engaged in the provision of social services, this sector still suffers from low public trust. A raised profile could nudge the Jordanian government to ease legal restrictions over the sector and ensure more gendered policies.

And finally, grounding GBV prevention and response in grassroots organizations can help address service gaps in remote areas outside the capital Amman. In Amman, a wider range of services is available to women, including women's and girls' safe spaces, hotlines and helplines, GBV case management, security, legal services and documentation, psychosocial and mental health support, emergency cash assistance, education and shelters, awareness raising and advocacy, programs targeting men and boys, and parenting programs.[46] Empowering women-led organizations across the country can help meet the needs of underserved communities and reduce disparities between governorates.

Grassroots women's organizations are well-positioned to address GBV as a public health issue that requires a multisectoral approach and long-term engagement. They have the contextual knowledge of their communities and, with the right capacity, can bridge humanitarian services with development interventions to ensure transformative social change. At the same time, however, these organizations continue to face structural challenges that limit their role.

Localizing solutions to GBV will cultivate much-needed agency and ownership of these solutions and anchor responsibility for them in the communities from which they emerged. It will also ensure the kind of consistent funding that will give women-led organizations the flexibility to follow needs and tailor solutions that feed into broader societal change. While progress on implementing the commitment to localization has been slow, positive steps have been taken to embed the concept as a norm in humanitarian action.[47] More attention is still needed to bring localization commitments under the Grand Bargain into action on the

ground, and to domesticate and reshape them to align with local conditions, defining in the process the respective roles of international and local organizations in delivering and sustaining services and community-based intersectional responses to gender-based violence.

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