JOIN
good forces

Forming partnerships for the goals

THEORY OF CHANGE 2020-2024

Because we cannot do it alone

JOIN's Theory of Change

JOIN's mission is to forming partnerships that empower women and girls in fragile environments to overcome violence in all forms and fulfil their potential.

Our Method of work is to form clusters of partnerships that promote learning and innovation. The figure illustrates the process.

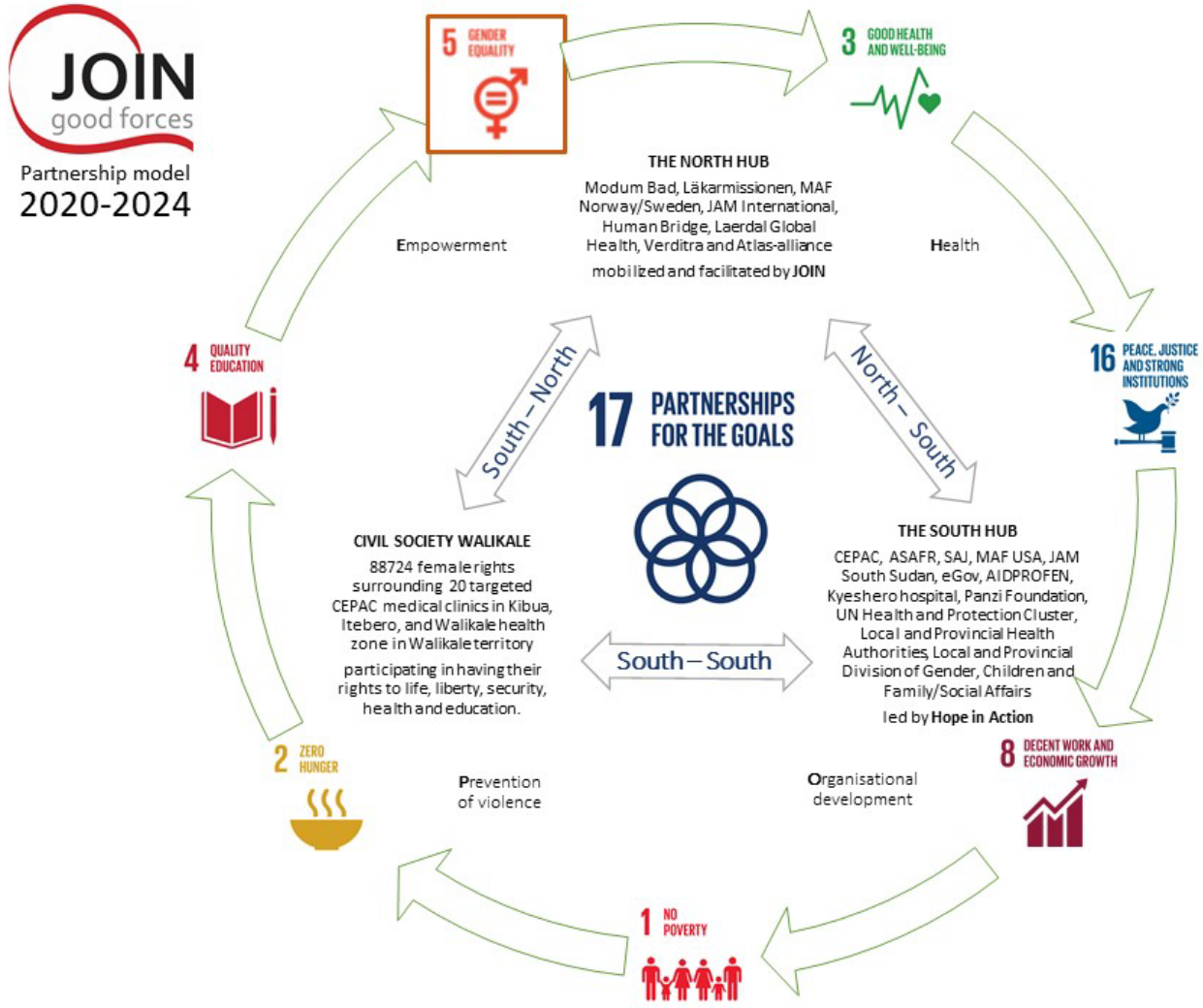


Figure 1: Clusters of partners formed for the sake of innovation and capacity building for Sustainable Development Goals.

JOIN is ready to take hands with good forces of all kinds and promote a partnership model anchored in five principles: 1) Readiness for collaboration (join), 2) Communality of purpose

(good), 3) Capacity to contribute (force), 4) Dedication to learning (innovation), 5) Reciprocal benefits (sustainability).

Readiness for collaboration is what make us discover communality of purpose between organisations. When empowering people living in fragile environments is the motivation, the unique capacity each partner possess is turned into something potentially bigger. Once convened, trust is built through clear stating of objectives, roles and what are the terms of reference. To build robust frameworks for joining organisations that together can accomplish sustainable results, truthful communications is key.

A hub is an assembly of partners sharing some communality of purpose and believing in collaboration towards shared outcomes. When knowledge sharing and strong ownership to finding solutions to robust problems is taking place, it is a breeding ground for innovation. In forming hubs with reciprocal benefits – a prerequisite for making it workable and sustainable, partners will be attracted and the SDG agenda revigorated.

Health, Organisational development, Prevention of violence, and Empowerment are thematic priorities – we are to be carriers of HOPE. Where hopelessness prevails pictures of a better future must be painted in acts and deeds. The heart in JOIN's logo points to love as the central motivation.

JOIN 2020-2024 Norad programme

The Theory of Change (TOC) for the 2020-2024 Norad programme builds on the organisational TOC presented above. In mobilizing the right partners into a commitment beyond contribution, a community of collaborative efforts constantly learning and improving, can push the limits to what can be accomplished. That's the rationale behind the capacity building project, as we realize that releasing synergy takes money and effort.

The **Safe Motherhood in Walikale** project is listed first as the upgraded 20 medical clinics becomes entry points in the One Stop Centre model for SGBV prevention. The **SGBV prevention and response in Walikale** project is in turn a platform for the **Women empowerment in Walikale** project, where the Fatherhood programme is located. The **Capacity building for the goals** project is enhance coordination, bolster implementation and promote improvements across the line.

There is a growing awareness of the role of men in empowering women, to promote or prevent. The Fatherhood programme has proven being a usable format to address a broad array of issues relating to women's position and rights. From the baseline study we learn that not one of the interviewees in leading positions were women. Structural and cultural violence must be addressed and challenged for women empowerment to be promoted. For those having no need of medical services all the other empowerment deliveries can be accessed directly.

PROGRAMME	Hope for Walikale
GOAL	Women and girls in reach of 20 targeted CEPAC medical clinics in Iterbero, Walikale and Kibua health zone, Walikale territory, DRC, have the rights stated in The Universal Declaration of Human Rights article 3 (life, liberty and security), article 25 (health) and article 26 (education), through
PROJECT 1	Safe Motherhood in Walikale
IMPACT 1	RIGHT TO HEALTH: Women and children in Kibua, Itebero and Walikale health zone live healthier
PROJECT 2	Holistic SGBV prevention and response in Walikale
IMPACT 2	RIGHT TO SECURITY: Women and children in Kibua, Itebero and Walikale health zone live safer
PROJECT 3	Women empowerment in Walikale
IMPACT 3	RIGHT TO EDUCATION: Women and girls in Kibua, Itebero and Walikale health zone live stronger
PROJECT 4	Capacity building for the goals
IMPACT 4	RIGHT TO LIFE: Women and girls in Kibua, Itebero and Walikale health zone live longer

Table 1: A listing of the Hope for Walikale Programme with projects and impact.

Each project is presented with its outputs, outcomes and desired impact and explanations given on causalities and underlying assumptions.

Thematic areas common to the history of JOIN's involvement in the DRC are found organized around three projects in a unified programme entitled Hope for Walikale. Safe Motherhood has been a recurring theme our partnership with Hope in Action, CEPAC and Heal Africa. Health, especially maternal and infant health, is together with the SGBV prevention and response, the biggest focus area in the intervention. Building on past and recent experiences the SGBV project is a continuation of a multisectoral response to sexual violence but with heightened attention to prevention mechanisms. The Fatherhood programme is given a new framing having women empowerment as the ultimate outcome.

PROGRAMME	Hope for Walikale
PROJECT 1	Safe Motherhood in Walikale
Outcome 1	Women and children in targeted health zones are healthier
PROJECT 2	Holistic SGBV prevention and response in Walikale
Outcome 2	Local communities in targeted health zones are resilient to SGBV and inter-ethnic conflicts
Outcome 3	Vulnerable children in conflict and post-conflict target areas are safe
Outcome 4	Children born from and affected by rape in targeted health zones have the same rights as other children
Outcome 5	SGBV victims in targeted health zones are regaining health and a dignified life
Outcome 6	SGBV cases from Itebero, Kibua and Walikale health zone are tried in court and perpetrators convicted
PROJECT 3	Women empowerment in Walikale
Outcome 7	Men in targeted communities display gender-sensitive behaviour
Outcome 8	Attendance levels for girls equal those of boys in targeted areas
Outcome 9	Women and girls in target areas, including those with disabilities, gets their right to education
PROJECT 4	Capacity building for the goals
Outcome 10	JOIN mobilized partners learn from each other and grow their capacity
Outcome 11	Hope for Walikale south partners learn from each other and grow their capacity
Outcome 12	A JOIN and JAM collaboration leads to expansion

Table 2: The outcomes of the Hope for Walikale according to projects.

The Hope for Walikale programme is a continuation of the efforts made in the SGBV sector by JOIN and partners since 2003. Whilst linking SGBV to war and conflict asserting it a weapon of war and even of mass destruction, JOIN is now widening the understanding of the term sexual gender-based violence to include civil and domestic occurrences. Further, in defining the term violence, JOIN is challenged to look beyond the visible acts of violence to comprehend the structural and cultural aspects preventing i.e. women and girls in achieving their physical and mental potential[1]. Inspired by efforts made by PMU, the Swedish Pentecostal Mission, JOIN is applying the iceberg illustration to address the need to look for root causes to violence against women and girls,

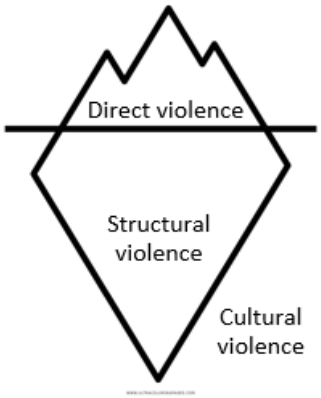


Figure 2: A conceptualization of violence inspired by the work of Johan Galtung.

The illustration below shows the application of the a more inclusive understanding of violence, seeing the intervention as empowering mechanisms to assist women and girls in their efforts to overcome all aspects of violence and have their rights.

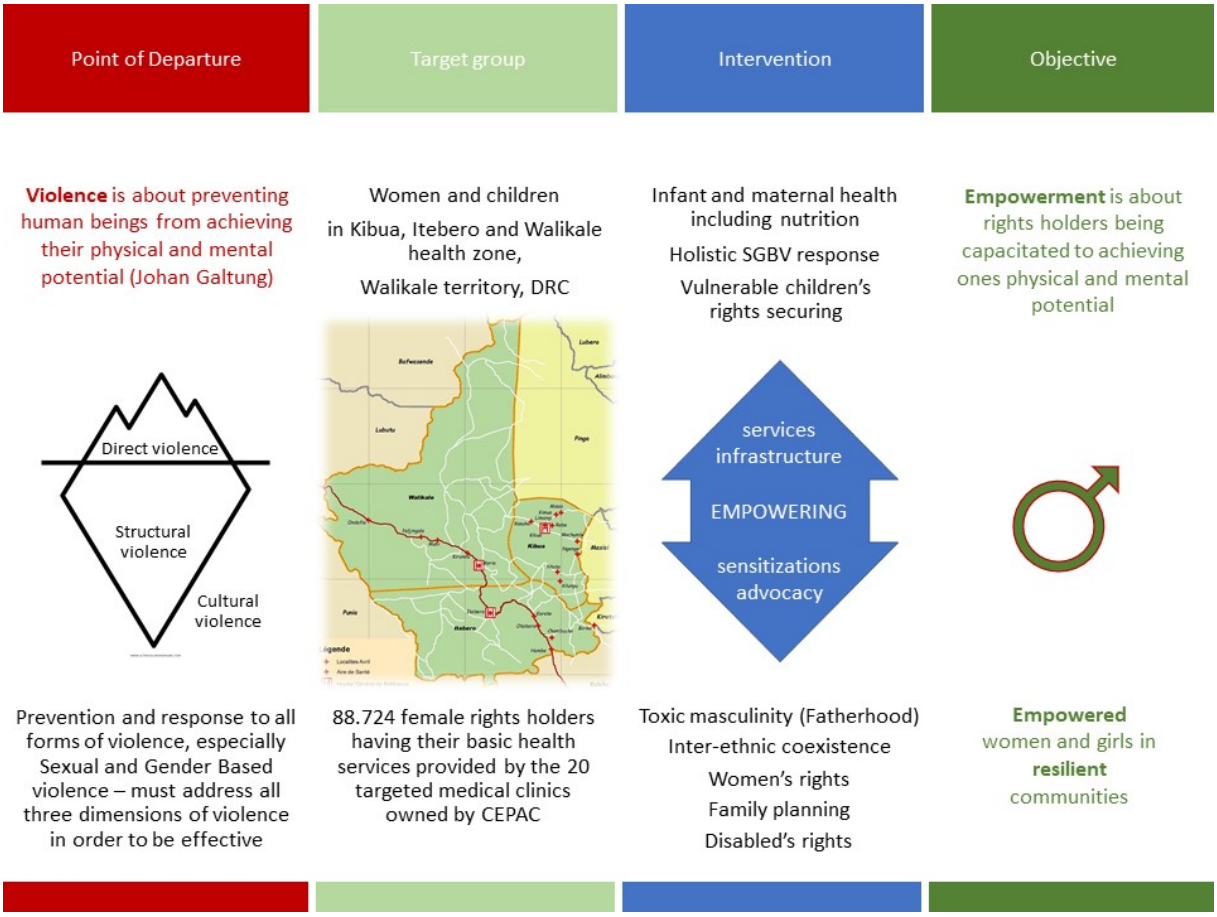


Figure 3: The Hope for Walikale intervention is based on a conceptualization of violence of direct violence rooted in structural and cultural aspects.

In strengthening the capacity of CEPAC to provide quality health services at the 20 targeted structure, rights holders are empowered to have the right to health. In sensitizing the community, fathers and duty bearers on gender equality, women and girls' right to life, safety, liberty and education are advocated for, in a way that includes the rights of people with

[1] Johan Galtung's conceptualization of violence as direct, structural and cultural.

disabilities. Baseline studies confirm the understanding of many women and girls being in a situation of powerlessness, suffering sexual abuse, child marriages, heavy work and deprived of schooling. Partners mobilized in the north, together with several implementing partners are attempting, in a collaborative manner with the civil society of Walikale to bridge some of the huge gap between this powerlessness and women and girls being empowered to have their rights, as illustrated below.

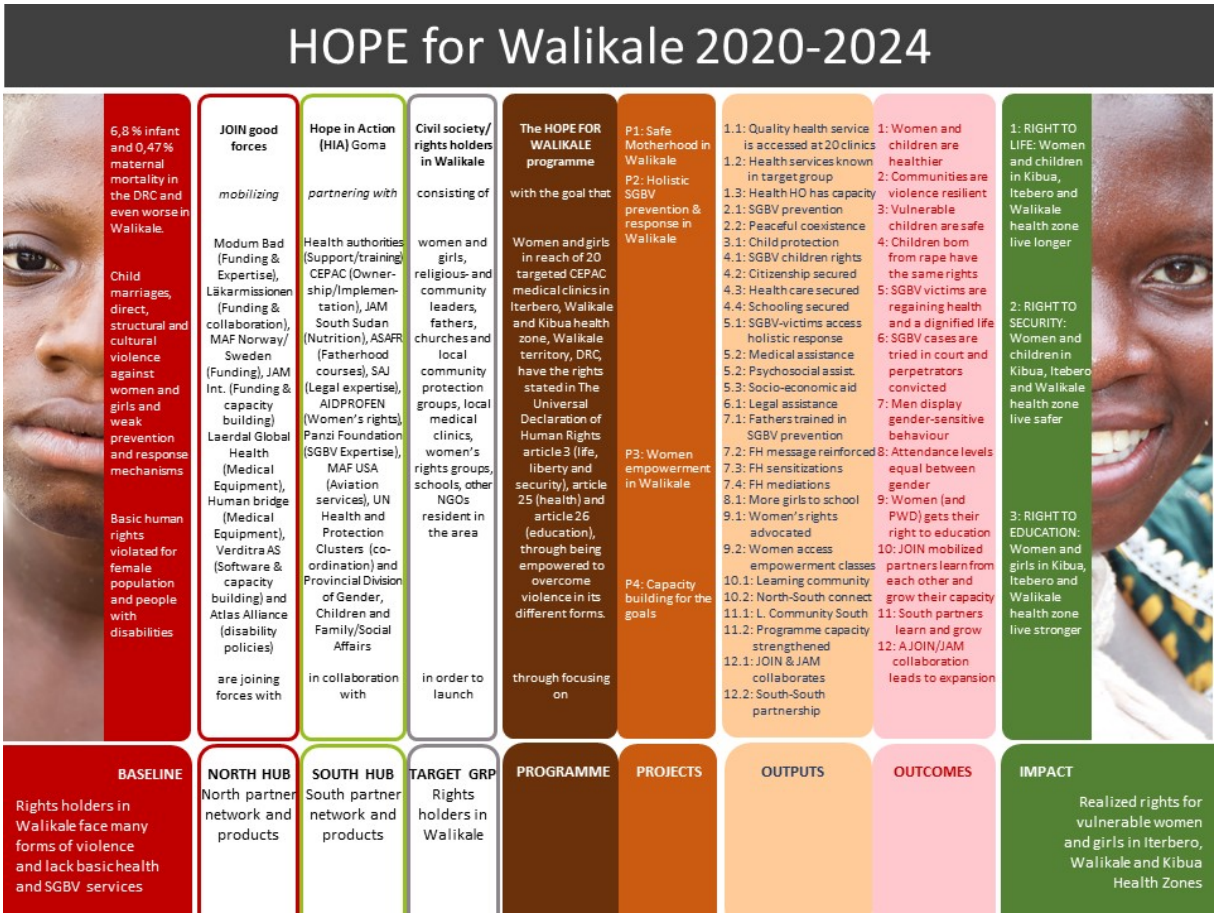


Figure 4: The figure illustrates the intervention creating a pathway from present situation to a better future for Walikale.

The projects are closely linked and geographically collocated in three neighbouring health zones, Walikale should be briefly introduced with the location of the 20 targeted medical clinics mapped. Walikale territory is situated between Bukavu and Lubutu (Maniema Province) on DR Congo National Road No. 2 in the valley of the river Lowa, 135 km to the west of Goma. There are three main ways to access Walikale Centre from Goma. The easiest and most secure way is by plane, but there are no internal flights between Walikale and Goma, that is why MAF is interested in setting up regular operations in the area.

Figure 5: Map of the 20 CEPAC owned medical clinics to be targeted in Walikale, Kibua and Itebero health zone.

Into this partly impassable area JOIN with partner intervene to strengthen local health services and open a way for people in need of reconstructive surgery to access that in Goma or Bukavu. The illustration under summarises the operations and how they link to each other.

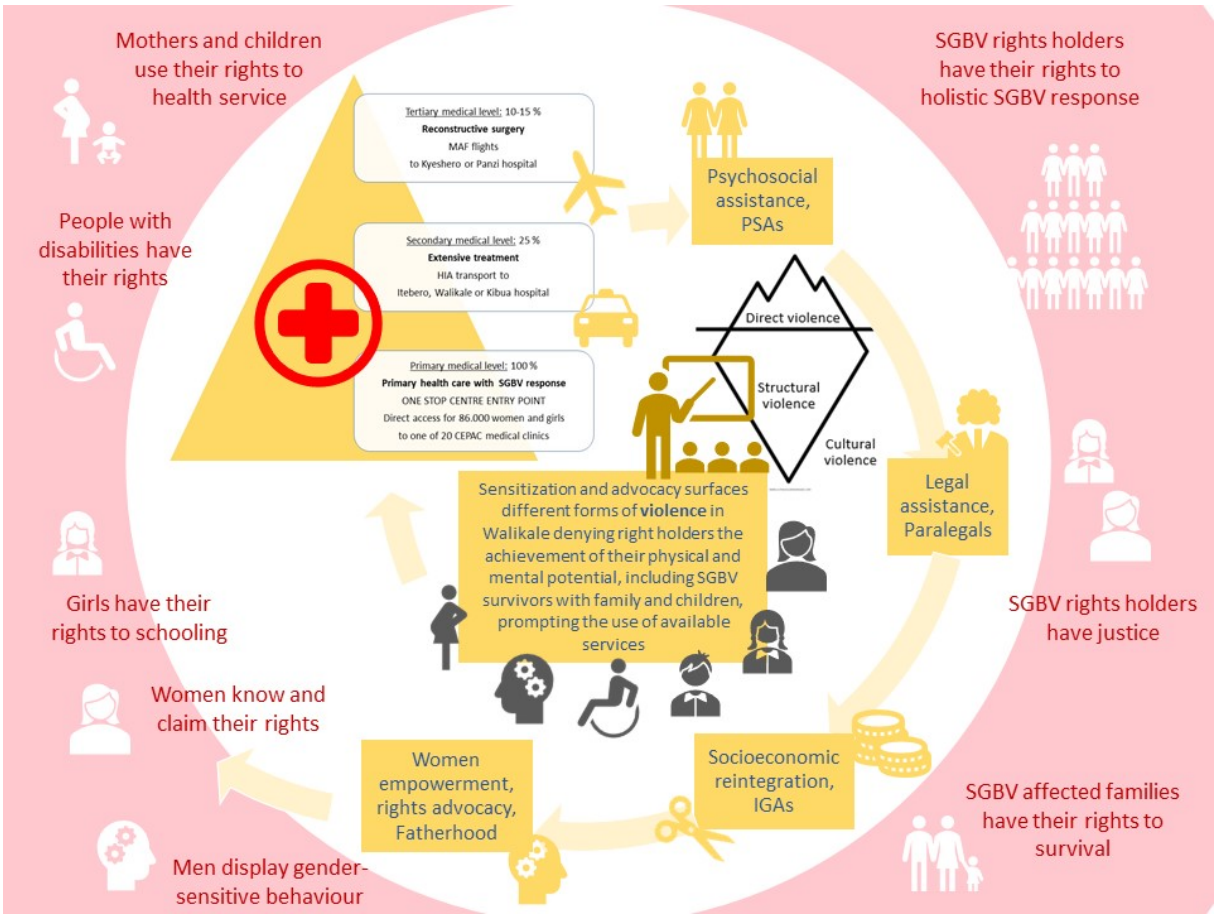


Figure 6: Services delivered in Walikale to address violence in its different form and result in women and girls having some fundamental rights.

Colour coded as the results framework outputs are presented as linked and leading to outcomes. The listing of the Project 1-3 with outputs and outcomes clarifies.

PROGRAMME	Hope for Walikale
PROJECT 1	Safe Motherhood in Walikale
Outcome 1	Women and children in targeted health zones are healthier
Output 1.1	Target groups of 20 chosen CEPAC medical clinics access quality health care
Output 1.2	Quality health service provision is known in targeted health zones
Output 1.3	CEPAC's North Kivu health office has the capacity needed to keep quality levels at their medical clinics

Table 3: Providing and promoting quality health services should lead women and children to use them.

Women and children (and the general population) in targeted health zones in Walikale territory can access quality health services.

PROJECT 2	Holistic SGBV prevention and response in Walikale
Outcome 2	Local communities in targeted health zones are resilient to SGBV and inter-ethnic conflicts
Output 2.1	Local communities in the target areas advocate for SGBV prevention
Output 2.2	Peaceful inter-ethnic coexistence is the norm in targeted local communities
Outcome 3	Vulnerable children in conflict and post-conflict target areas are safe
Output 3.1	Vulnerable children in target areas are protected and cared for
Outcome 4	Children born from and affected by rape in targeted health zones have the same rights as other children
Output 4.1	SGBV victims are followed up to assess status of their children
Output 4.2	Children born from or affected by rape have legal assistance if in need of citizenship
Output 4.3	Children born from or affected by rape have secured access to primary health services
Output 4.4	Children born from or affected by rape have secured access to primary schooling
Outcome 5	SGBV victims in targeted health zones are regaining health and a dignified life
Output 5.1	SGBV victims access holistic SGBV response
Output 5.2	SGBV victims have quality medical care (including Post-exposure prophylaxis (PEP) kits and transport till Kyeshero or Panzi hospital when necessary)
Output 5.3	SGBV victims have psychosocial quality care
Output 5.4	SGBV victims and vulnerable women have socio-economic reintegration
Outcome 6	SGBV cases from Itebero, Kibua and Walikale health zone are tried in court and perpetrators convicted
Output 6.1	SGBV victims have legal assistance including followed up through court cases

Table 4: The SGBV prevention and response project address both victims, children affected and local communities.

The health services at a local level is the entry point of the One Stop Centre where holistic SGBV response can is accessed.

PROJECT 3	Women empowerment in Walikale
Outcome 7	Men in targeted communities display gender-sensitive behaviour
Output 7.1	Fathers and mothers are trained in (SGB) violence prevention / women's rights
Output 7.2	The Fatherhood message is reinforces through fatherhood groups
Output 7.3	Men are challenged to change behaviour by former fatherhood participants
Output 7.4	Mediation and (re)integration activities related to gender are carried out by fatherhood participants
Outcome 8	Attendance levels for girls equal those of boys in targeted areas
Output 8.1	Girl school attendance is increasing among Fatherhood participants
Outcome 9	Women and girls in target areas, including those with disabilities, gets their right to education
Output 9.1	Women advocate their rights in targeted health zones and form rights groups
Output 9.2	Women access empowerment programmes provided by the Programme

Table 5: Overcoming violence is the underlying theme of the women empowerment project.

The Fatherhood course linked to the SGBV prevention is extended to a women empowerment project helping women and girls in all situations accessing education.

PROJECT 4	Capacity building for the goals
Outcome 10	JOIN mobilized partners learn from each other and grow their capacity
Output 10.1	North hub of partners mobilized by JOIN are a learning community increasing knowledge and innovation
Output 10.2	North and South hub collaboration increase effectiveness and efficiency
Outcome 11	Hope for Walikale south partners learn from each other and grow their capacity
Output 11.1	Hope in Action is a platform for collaboration between implementing partners
Output 11.3	Programme capacity for Walikale is strengthened throughout the periode
Outcome 12	A JOIN and JAM collaboration leads to expansion
Output 12.1	JOIN HO and JAM International collaborates to explore new possibilities
Output 12.2	A south-south partnership between JAM South Sudan and Hope in Action provides competence exchange between the countries

Table 6: The Capacity building for the goals project with outputs and outcomes.

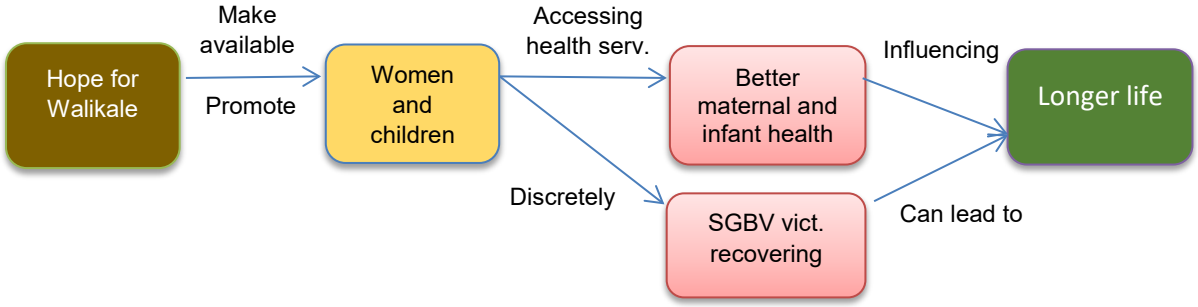
The Capacity building for the goals project sets up learning communities to strengthen knowledge sharing, innovation and more lasting results.

We don't find it necessary to outline in detail the 12 different outcomes with its 28 associated outputs, but only what's of greatest relevance to exhibit underlying assumptions.

The Safe Motherhood project

Outcome 1: Better health for target population

This outcome focuses on the effects of investing in health structures to provide much needed services, and that they in turn will be used if properly promoted. The positive health effects that could have on rights holders is evident. The links are as follows:



People access quality health services (output 1.1-1.3)

Output 1.1 focuses on lifting the quality of 20 chosen CEPAC owned medical clinic to the point of providing sustainable quality medical care to the 165.566 people that parishes for them, of them 88.724 women with 34.765 in reproductive age. An assumption built on is that the lack of alternative quality services in the area will increase user frequency once quality is lifted. Factors influencing on this could be if fees increase, the grave poverty of most people keeping them from spending money on health services even they are good. We recon the health services must be thoroughly promoted (output 1.2) and that pregnant sometimes be incentivised with baby kit to choose the safer but more expensive institutional birth as opposed to traditional home deliveries. Anther assumption is that the capacity building with CEPAC HO (output 1.3) will equip them to maintain the level of quality instilled through the programme once terminated.

The assumptions between outputs and outcome is that there is a lack of quality health services in targeted areas, as is confirmed in the baseline studies. The link between supply and demand in Walikale is not fully tested but the theory predicts that an increase in supply will increase the demand. To further stimulate the relationship, sensitizations are directed towards promoting health and towards advocating for rights. Experiences from previous projects points to economic capacity and availability of alternatives as two major detergents of behaviour towards using health facilities where health services are not free. Where alternatives are more distant or perceived as of much poorer quality, there is a willingness to pay some. But with access to free health care medical clinics requiring payment suffer. Seeing patient payment as

strengthening institutional capacity and thereby sustainability, the hindrances to having rights holders using the services will be overcome by trusted quality and lack of alternatives.

JOIN and partners have many years of experience with health capacity strengthening projects. Much of what JOIN, and before 2011, CRN has done together with Hope in Action is building health structures, whether small and rural or the big Kyeshero hospital in Goma. The assumption of a causality between availability and frequentation has proven to not always be true. Where patient payment is part of the financing structure the often very poor rural people show little loyalty to "their" health centre as who operates it changes with who's got project money. If you can get something free, why pay? If a new project overtakes a previous project people seem to expect equal terms. An expected increase in income through lifted quality of health personnel in JOIN's previous Norad project worked as assumed on every clinic expect for those sponsored with free health when chosen. In the Hope for Walikale programme none of the clinics come directly from a free health care situation.

One additional dimension is worth mentioning. Kurt Lewin became a pioneer in conceptualization of change when he advised that to "change the "quasi-stationary equilibrium" stage, one may increase the striving forces for change, or decrease the forces maintaining the status quo, or the combination of both forces[2]". *Hope for Walikale* is not a title at random but the signalling of an unfreezing of a situation where the forces of violence and hopelessness has kept people at bay in the presence of a magnitude of preachers of good news. In the words of our partner: "We must enter Walikale with action, not words. Only when they see things happening will possibilities open". Through re-building and putting equipment into their local health centres, hope gets the upper hand and movement is possible. JOIN advocate for a five-year project because it might take a good year to unfreeze, at least a couple of years to change mentalities and behaviour patterns and what's left to refreeze or stabilize a new situation.

Output 1.2 is to ensure knowledge on good health prevails with targeted population. Targeted sensitization campaigns focusing on reproductive health including family planning and basic issues as nutrition, hygiene and sanitation will advocate for prioritizing health and increase awareness of services available at the clinics. We are aware family planning still is a sensitive issue in many rural areas of the DRC. With the targeted clinics belonging to a church special attention has been given to promotion of contraceptives and reduction of family sizes. The assumption built on is that the assurance of full compliance to the programme given by the North Kivu CEPAC Health HO officer, Dr. Richard Kibandja turns out to be true. A great deal of influence with the local pastors exists through the leader of HIA, Banyene Bulhere, being a former president of CEPAC in the entire DRC.

Output 1.3 recognise sustainability in the Safe Motherhood project is impossible apart for involvement of the owner of the clinics. JOIN admits that CEPAC might not be the health structure owner with the best systems in place. But with Läkarmissionen, and indirectly PMU, partnering in the project, a coordinated effort to help lift the organization the Nobel Peace Prize winner Dr. Mukwege is head of is what's available through the programme and agreed among the Nordic partners of CEPAC. The great zeal shown by CEPAC in the baseline study and initial planning phase, gives JOIN reason to believe that they already feel empowered by the process and are eager to view everything happening in the light of them keeping up what's been lifted. Timing is always an issue and Walikale being a challenging environment, there are many unpredictable factors. The CEPAC Health HO sits at Kyeshero Hospital in Goma and to have the capacity needed to keep quality levels during and after programme, several capacity

[2] Kurt Lewin (1947) https://www.sciencedirect.com/science/article/pii/S2444569X16300087

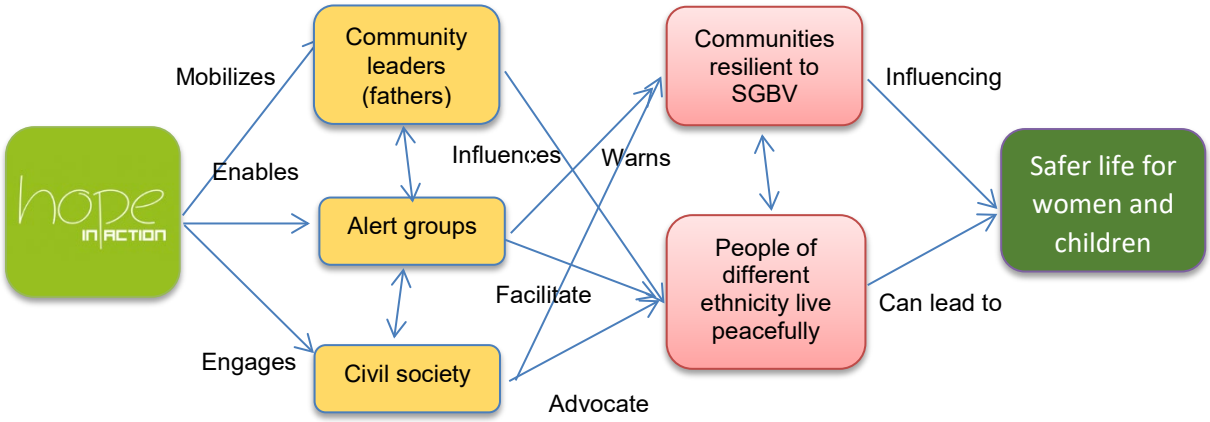
building projects are identified: Strengthening of communications, digitalization, advocating greater governmental financial involvement, financial models at health structures and organisational development are among these. Communications between Kyeshero, the office and the 116 CEPAC medical clinics in North Kivu supervised by HO is key but irregular. Handwritten indexes and patient journals call for digitalization along many lines. To get Congolese authorities pay salaries to medical clinics is a process where CEPAC risk falling behind other owners in creating sustainable health services. Linked with this is you grow a viable financial model independent of projects.

The SGBV project

Outcome 2: Communities are resilient to conflict and violence

The methodology leading to local communities being resilient to violence has been harnessed over several years as Hope in Action has won UN Pooled fund projects putting great emphasize on peace building through the strengthening of civil society. At project of this kind is currently run by HIA in parts of Walikale on UN funds. Along the outskirts of Walikale, Masisi territory, JOIN and Hope in Action have since January this year contributed to making six communities in Pinga and Mweso health zones protective environment against SGBV. So far in the project, what seem to be a key, is how the community is involved, as from the start, leading figures in the local communities are consulted and asked to provide candidates for different functions within the project. The local people form Community network for the protection of children (RECOPE), fathers' groups, become psychosocial agents, youth coaches, para legals and child coaches i.e. that heightens alert levels. In most cases will an intervention only need to revitalize these society protective mechanisms through resourcing them with some means.

Since it's so much in the interest of the local communities to keep alert levels high to protect their women and children, there shouldn't be a need for financial incentives to keep these voluntarily based services running. Still, with struggles on so many levels dispersing attention and often very unclear front lines blurring who's the enemy – JOIN and partners still see the need to hire good people recommended by the community to be held accountable for much needed resilience building activities.



The local community advocate for peace (output 2.1-2.2)

Previous experience from present project give evidences to a reduction of incidents of direct violence of domestic or inter-ethnic character due to heightened awareness and alertness. This is accomplished through making it a matter of attention and letting local people be the main players. It is not a situation where the implementing partner comes in to mediate peace, but to resource the preventive element already present in every local community. Since security is a prime motivation[3] the message communicated on radio, in churches, or most often, at open air sensitization meetings, sometimes with acting or cultural dances or a sports event – it is the locals that lead the chart. And that has implications on sustainability as they can continue from a volunteer position.

Outcome 3: Vulnerable children are safe

Decreasing their risk of being recruited into armed groups hang on many factors, but unattended children are more prone to risk and the safe zones created will change their situation to the better. The level of attending has varied through different projects of Hope in Action, sometimes even including finding new foster care parents. The level of attending is lower in this programme but still effective as the zones created for children to be safe is often respected, backed by local chiefs and even military commanders.

Effective protection of children (output 3.1)

Working from the premise of having local support for the need to protect children, Child Friendly Spaces with child coaches and community protection groups involved, give a basis for sensitization and activities. In the fashion of a children's club, activities and positive interaction creates a safe zone. Never entirely safe in an environment like Walikale, the biggest win is that orphans and children coming back from armed groups are not unattended but registered and followed up according to their needs.

[3] Maslow put the need for safety first in his Maslow need hierarchy

Outcome 4: Children born from rape have equal rights

They are sometimes called “snake children” and said to pose an immense challenge to the social fabric of the DRC. Children born from or affected by rape have been attended to in previous projects by JOIN, i.e. the cantinas set up to pay for school fees of children of survivors. The meaning of having the same right doesn’t speak of changes needed in the legal framework but on what happens in the local communities. To have the face of the enemy portraited in the face of a child no one asked for, poses many challenges on the emotional level. Acceptance can be rare, and children born of rape are sometimes ostracised or bullied. Moved by the plight to be more attentive to their situation and having some experience in working for the rights, their situation is now high on the agenda.

Advocacy and securing of rights (output 4.1-4.3)

In collaboration with our longstanding partner in legal matters, SAJ, legal clinics and para legal representatives are mobilized and supervised by SAJ for the sake of offering legal assistance to SGBV victims. They have broad experience from working in this field and will address legal status if there is a need of citizenship, the schooling situation and access to health. The Hope in Action responsible for executing the SGBV program is also in charge here.

Figure 7: Children born from rape is faced with much uncertainty in the DRC. These boys benefitted from previous programme.

Outcome 5: Holistic SGBV response in a One Stop Centre model

JOIN has argued the need to refine how SGBV prevention and response should be designed. The SGBV project continues the multisectoral approach with medical, psychosocial, socioeconomic and legal services all being part of what is needed to regain life and dignity. But unlike the previous model, those services do not necessary imply being geographically scattered or ordered in a way that implies everybody should use them all. The metaphor of a journey was the way to understanding what should take place for a survivor to be reinstalled. The illustration summarises the theory of change in previous Norad programme:

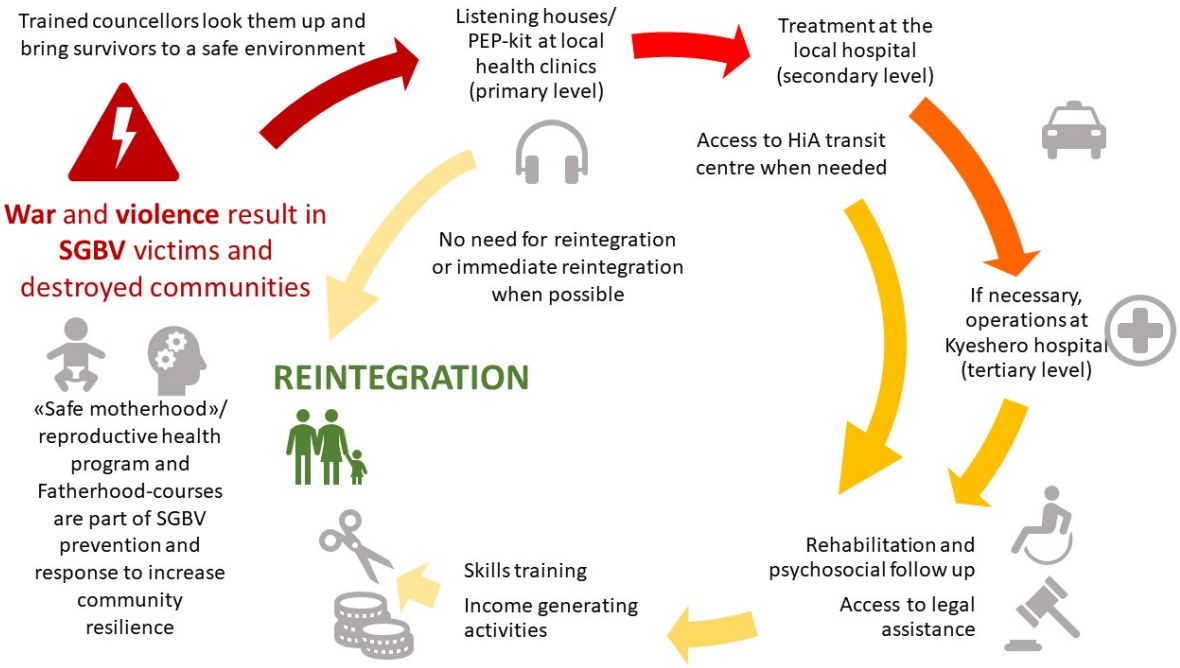


Figure 8: An underlying assumption in this model is the need to complete the whole journey to get back to start.

The idea of a process is kept in the renewed model but without having to leave your local environment. With only a minority of SGBV cased relating directly to insurgent activity, finding a safe space somewhere else is less important. On the contrary, helping victims discreetly to not reveal what has happened, can be hugely beneficial to situation of the children in the family, given that holistic assistance can be accessed continuing to live with the family. The cost of travel, extra burden caused by lack of coordination between services and limited access for survivors to choose what they need, has helped develop the idea of a One Stop Centre.

The services being provided in Walikale will look nothing like Dorcas house in Goma with all services at hand in one building, as there is no new centre being build. It is the principle of reference and connected quality services that earns the term. A 2014 study from Walikale points to 77.5% of SGBV victims seeking medical assistance at the health centre. From the discussion we read: "According to the respondents, health facilities remain the preferred locale where victims of sexual violence seek assistance. This is interesting in that other options such as hiding, auto-medication, or use of traditional medicine are not relevant. This raises the question of whether rural health facilities are accessible, suitably equipped, and manned with the necessary staff, both in terms of numbers and specialist training."[4]

Multisectoral assistance in a One Stop Centre Model (output 5.1-5.4)

The need for multisectoral assistance has been thoroughly confirmed. How it is best provided is disputable. This Gender-Based Violence (GBV) Quality Assurance Tool from WHO identifies three main models: "Health care for women subjected to violence must be integrated into existing health services as much as possible rather than offered only as stand-alone services. Care to address violence against women may be integrated into: • primary health centres and clinics • district and regional hospitals and other tertiary hospitals • one-stop centres" [5]. Since the Walikale services will be locally based, rely substantially on the capacities of Kyeshero (and to some extent Panzi) hospital, and resemble some of the One Stop Centre model, an

[4] *Kaboru BB, Andersson G, Borneskog C, Adolfsson A, Namegabe EN (2014) Knowledge and Attitudes towards Sexual Violence in Conflict-Affected Rural Communities in the Walikale District, DR Congo: Implications for Rural Health Services. Ann Public Health Res 1(2): 1009*

[5] https://www.who.int/reproductivehealth/publications/post-violence-care-in-health-facilities/en/

Table 3.1 Advantages and disadvantages of models of care for women subjected to violence[1]

Model	Advantages	Disadvantages
Primary health centres and clinics	• located close to the community • can provide some core services • can improve access for follow-up services and allow for continuity of care • if a good network is established, can improve access to an intersectoral network of services, including legal, social and other services	• may not be able to treat serious injuries or complications; referral needed • may not have laboratory or specialized services; referral needed • in small communities, where providers are community members, confidentiality and providers' fear of retaliation can be a challenge
District, regional and tertiary hospitals	• equipped to provide 24-hour-a-day services • may have laboratory and specialized services • care can be centralized in one department (gynaecology, reproductive health, HIV/STI) , emergency department, or distributed throughout the hospital	• accessibility may be reduced due to the distance some women must travel • if services are split across departments, can hamper delivery, especially if some services are available only during usual working hours
Model	**Advantages**	**Disadvantages**
One-stop centres	• more efficient and coordinated services • provide a full range of services (sometimes including police, prosecutors, social workers, counsellors, psychological support) • reduces number of times women have to repeat their story and time they spend seeking services	• more space and resources required • client load may be small (in rural areas, for example), raising cost concerns • may draw staff and resources out of other services • may not be fully integrated into general health services • if administered by the judicial system, tend to focus too much on prosecution and not on women's health • costly to sustain

overview is appropriate: From the list we find local accessibility, which in the Hope for Walikale programme will mean that at least 9 of the 20 CEPAC medical clinics will be given special attention with training and equipment in SGBV care provided. We also favour one first response or registering and keeping data for improved coordination.

This manual issued by WHO is currently being worked through by JOIN and partners to review previous experiences considering more articulated models. Both Panzi Foundation, CEPAC, the health and the protection cluster and health authorities in North Kivu is consulted on what would be the best set up of the SGBV response in Walikale.

But for some of the funding partners in the programme a neglect of the capacity build over years at Kyeshero hospital in Goma would not seem like the right move.

JOIN pursue digitalization as one of the means to combine being geographically spread but still coordinated in the providing of services and tracking of progress.

The One Stop Centre model of JOIN is illustrated on next page and shows the links between the different services, the referencing from the first response point, the local health clinic, to Walikale hospital or Kyeshero. It also favours the element of discretion.

In the words of the WHO manual: "To provide woman-centred care to women subjected to violence, you can plan and manage health-care services that offer women good-quality care that ensures privacy and confidentiality: 1) Ensuring privacy and confidentiality is critical for the safety of women who have been subjected to violence. A breach of confidentiality about sexual violence, intimate partner violence or their health consequences (that is, pregnancy, HIV, STI) can put women at risk of additional violence. Women need privacy and confidentiality assured to be able to disclose their experience of violence to health-care providers without fear of retaliation from

the perpetrator. 2) You need to ensure that infrastructure and patient flows promote safe and confidential consultations. Implement mechanisms of redress for any breaches of privacy or confidentiality. 3) Inform women about their rights as clients and hold staff accountable for violations of clients' rights.

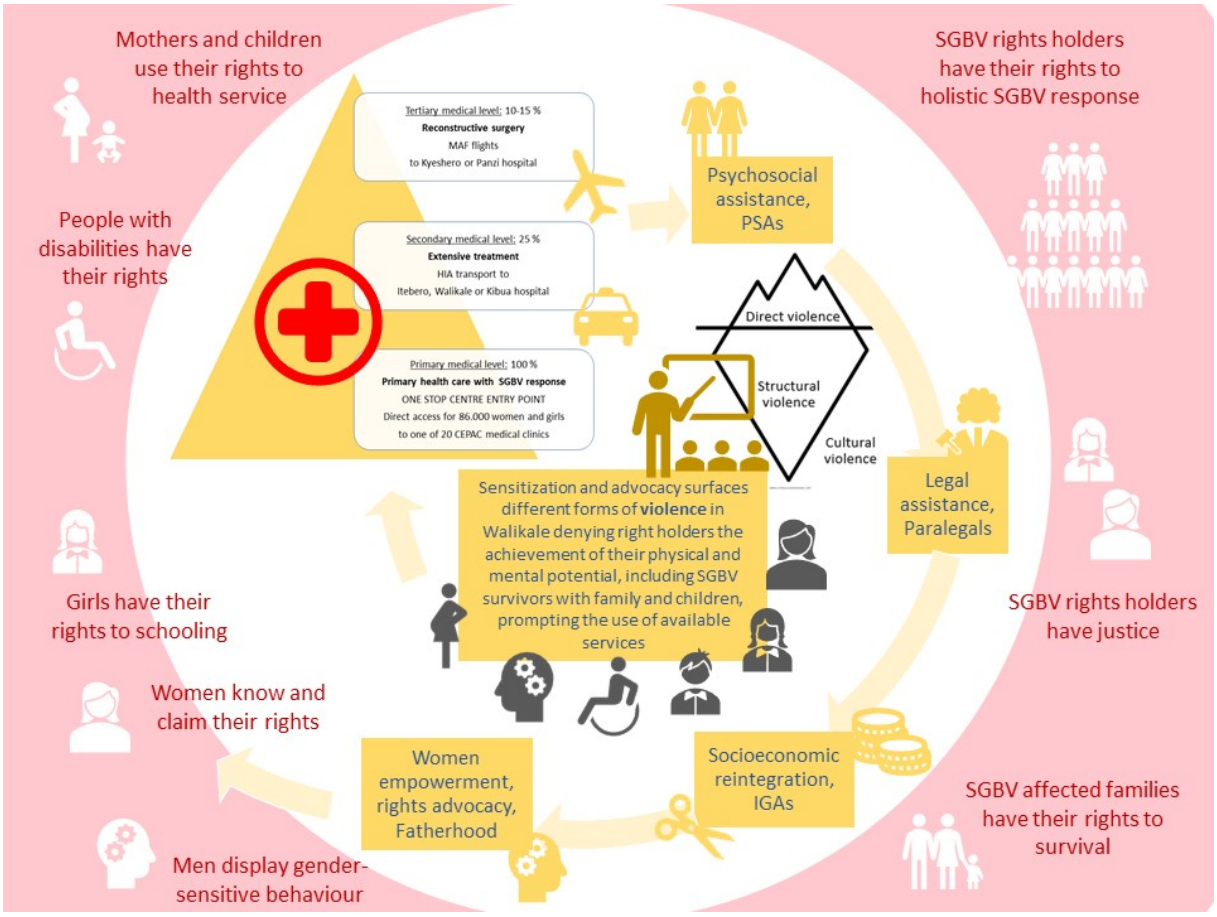


Figure 9: The One stop model of JOIN and partners.

Outcome 6: SGBV cases taken to court and perpetrators convicted

This follows the operations in previous and current programmes with a fruitful partnership with SAJ. JOIN is preoccupied with the fight against impunity and have contacted Physicians for Human rights and Panzi Foundation to discuss what could be the next steps.

Legal assistance all the way (output 6.1)

A close follow up of victims wanting to fling their case is what is emphasised. Narrative Exposure Therapy (NET) is also discussed within JOIN's subject team as a way to capture the stories of survivors at the first response place and recording it in a way that both avoid the re-traumatizing of survivors having to repeat their story multiple times, and to increase the weight of the testimony as evidence in court.

The Women empowerment project

Women empowerment is a much-discussed subject within JOIN with applications to business, education, advocacy and gender equality.

Outcome 7: Men holds the key and must change behaviour

The Fatherhood programme has proven a very useful platform to get men talk and reflect. Lasting impact is still disputable if the two weeks in class is what is measured. But fatherhood stirs a dialogue with possibly great consequences for women and children. It is this platform that is being used, to address school attendance and the rights situation for people with disabilities. It is also the connection point to pastors and religious leaders, so important for an unfreeze of bad customs and a move into something better to happen. Not least, what is reinforces in religious communication could either refreeze a better way of seeing the place and rights of women and girls or maintain the cultural and structural violence that keep women and girls from reaching their potential.

Make men advocate new behaviour (output 7.1-7.4)

The Fatherhood course is designed to be implemented through spreading the news and stirring a movement. That is what has happened many places and must happen in Walikale. ASAFR has recently been re-formatting the Fatherhood courses to lower the costs without loosing impact. It therefore a Fatherhood version 2.0 that will be implemented in Walikale, where women's rights are advocated more strongly and given more specific behavioural patterns for paternal domestic life, for example being responsible for sending their daughters to school and avoid giving them into marriage at age 14, which is often the case in Walikale. Hence, keeping girls in school is not just about learning but also to empower women to break free from devastating habits.

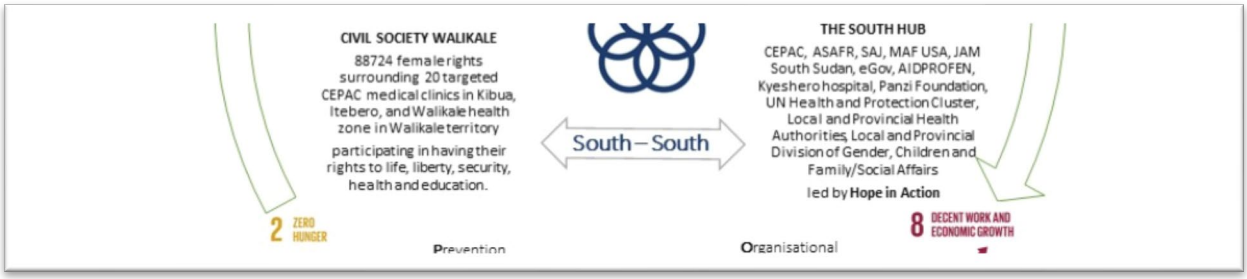
Outcome 8-9: Women gets their right to education & empowerment

The road to seeing this outcome fully realized in Walikale might take much more than five years. Since we take on the bigger and hidden parts of the iceberg (structural violence) and question how they can remain (the cold water preventing the iceberg from melting referring to culture countering female rights). Beyond looking at school attendance as a by-product of the Fatherhood courses, JOIN is helping to capacitate our implementing partner through entering in to a collaborative partnership with AIDPROFEN. Passy Mubalama is one of the exciting young voices from Eastern Congo, already voicing a positive message in many parts of the world that Congolese women can stand up, speak up and rise up. This will balance the Fatherhood approach as it focuses on what women can do already.

The advocating of their own rights brings change (output 8.1, 9.1 and 9.2)

Women empowerment is realising the difference one can make in standing up for one's rights. The programmes for women are not so much the output as is the advocating for their rights by the Walikale women. The forming of women's rights groups is an instrument for that to happen.

The capacity building project



Outcome 10-12: Partnerships for the goals

JOIN is advocating for approaching partnerships not just a way of making things happen but in doing so, to be able to take on bigger things. The successful implementation of the Walikale with all the risks and challenges implied, is a big win and maybe the biggest. But as argued in elsewhere in the application, Hope for Walikale represents so much more to JOIN than just another project or just another programme cycle. Innovation is a central value to JOIN and something not just needed when new products are developed. Innovation is needed in how we tackle the big challenges we are faced with as humanity.

We argue that the SDG 17 in not just another goal but what can the rest of the goals achievable. Being small JOIN is perfectly set up for partnerships.

Driving those partnerships into active learning communities with return for both programme implementation and partner capacity development is what can make the Hope for Walikale programme a platform for taking on bigger things; together with CEPAC if our ways of collaboration during the programme gave the expected outcomes. Together with JAM in new terrain if their involvement on nutrition in Walikale became the opportunity for accessing SGBV competence much needed in South Sudan.

The creating of learning communities sets the stage (output 10.1-12.2)

In making the forming of learning communities the outputs needed to see partnerships with an impact on the attainment of the SDGs, the capacity project puts indicators to the level of synergy taking place through good forces being joined. Not always the easiest task, it is the way to both effectiveness and efficiency in developmental initiatives and must be pursued actively at all levels. The aiding of Hope in Action into becoming a south hub is the right next step in many years of collaborating with people we have learned to know and appreciate. In inviting other organizations to the table, HIA is positively challenged a could avoid being set and satisfied from what they have accomplished. JOIN therefore see it as a necessary development where JOIN and HIA becomes less dependent on each other but more able to stimulate further growth.

The contribution of outcome on impact

IMPACT 1	RIGHT TO HEALTH: Women and children in Kibua, Itebero and Walikale health zone live healthier
IMPACT 2	RIGHT TO SECURITY: Women and children in Kibua, Itebero and Walikale health zone live safer
IMPACT 3	RIGHT TO EDUCATION: Women and girls in Kibua, Itebero and Walikale health zone live stronger
IMPACT 4	RIGHT TO LIFE: Women and girls in Kibua, Itebero and Walikale health zone live longer

Table 7: Impact lines to remember can help stay focused on the bigger purpose of the intervention.

Impact is difficult to measure and generally beyond what can be controlled or influences by the intervention. Still, some indicators are developed and links between outcomes and possible impact fathomable. A reduction in infant and maternal mortality due to increased use of better health services is not unprobeable. Feeling empowered is also generally good for how well you look after yourself or what choices you make. Still, a lot of other factors play in and clear causalities are difficult to establish.

A reduction in SGBV will similarly hang on lots of external factors. Still, community resilience can have an impact if norms are being changed and thresholds towards using violence rebuild. A rights-based perspective making what is claimed attractive and seen as commonly good, can at least help the buy-in factor of the programme. At it can serve as a catalytic tool in the learning community processes to be held responsible to what is the greater good of the programme.