GBV Emergency Preparedness & Response

PARTICIPANT HANDBOOK

> **THE INTERNATIONAL RESCUE COMMITTEE:** *Since 1996, the IRC has implemented targeted programs to promote and protect the rights of women and girls in contexts affected by acute and protracted emergencies. The IRC has earned a reputation as a global leader with unique knowledge, expertise and capacity in GBV response and prevention programming.*

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INTRODUCTION

The problem of gender-based violence (GBV) in humanitarian settings has gained traction in recent years, with increased attention to the risk and severity of violence women and girls face in crises such as Pakistan, Haiti, Libya, and Côte d'Ivoire. Gradually, this has led to recognition of how conflict and natural disasters can also weaken social structures and, as a result, increase women and girls' exposure to abuses in the long term.

The development of international guidelines, most prominently the Inter-Agency Standing Committee (IASC) *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings,* has been critical in helping to keep women and girls on the

> **NOTE:** For the purposes of this handbook, the terms emergency and crisis are used interchangeably and apply to both conflict and natural disasters.

emergency agenda.[1] These guidelines have also promoted greater understanding of GBV response priorities and standards. Despite this, many humanitarian actors and policymakers do not yet view violence against women and girls as an issue that warrants urgent response during emergencies. There is a failure to prioritize the needs of women and girls, leaving GBV largely unaddressed for weeks, months or years after emergency onset and resulting in long-term consequences for individuals, families and communities. This also means a more limited allocation of resources for GBV programming and a dearth of GBV experts that are prepared to lead effective response efforts.

Over the past decade, the IRC has identified some key lessons in designing and implementing GBV programming:

- A one-size-fits-all approach to GBV programming in emergencies is not effective. A consistent but flexible framework is necessary.

- Establishing GBV services in an emergency context is not the same as establishing GBV services in a protracted or post-conflict context and thus, the skill set of staff to initiate responses in emergency settings should be recognized as related but distinct.

- When designing interventions in emergency settings, responders must consider and begin to incorporate efforts to address the long-term needs and rights of women and girls.

- GBV programs must be established at the earliest possible intervention in order to support women and girls and protect them from violence.

This Participant Handbook, *GBV Emergency Preparedness & Response*, is part of IRC efforts to equip field-based practitioners with the skills and knowledge necessary to effectively and rapidly launch a response to GBV in emergencies. The content of this handbook and the accompanying curriculum is designed to complement existing training materials and resources developed by other agencies and experts, and operationalize key guidelines, including those from the IASC.

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[1] Inter-Agency Standing Committee, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, 2005.

PARTICIPANT HANDBOOK

This Participant Handbook is designed as an accompanying document to the IRC's Gender-Based Violence Emergency Preparedness & Response training. This training will support you to:

- Adapt and use appropriate information collection tools to lead GBV-specific rapid assessments in emergency settings;
- Generate and prioritize recommendations for action, in line with international best practices;
- Design and implement interventions to prevent and respond to GBV in emergencies;
- Adapt existing activities and support for women and girls to emergency contexts and constraints;
- Tailor non-GBV-specific sectoral activities to include and prioritize women and girls in emergencies;
- Enhance the preparedness of organizations in emergency-prone contexts to respond to the needs of women and girls by preventing and responding to GBV.

Participants in the training should have some prior experience working with women and girls, particularly in the fields of social work, case management, counseling, and related fields. Participants should also have some basic knowledge and/or experience of working with survivors of GBV.

METHODOLOGY

This training follows methodologies that support adult learning - it is not designed as a series of lessons in which you will be taught information verbatim; rather it will allow you to bring your own experiences and learning, using this as the foundation for understanding. The methodology is highly participatory; exercises and activities are intended to prompt questions and reflection, leading to shared learning. Participation is therefore about more than listening and repeating information; you are encouraged to think critically about information that is presented, and share your thoughts and questions with the group as the training progresses. It is also recommended that you spend a few minutes after each day of the training reviewing your own notes and reflections and noting any remaining questions that you might have for the next day.

HOW TO USE THIS GUIDE

This Participant Handbook is structured to follow the flow of the training. The guide will remain a reference as you move into implementing GBV response and preparedness programming in emergencies.

Each session includes the following sections, marked by the relevant icon:

Learning Objectives: the intended outcome of each session is highlighted to allow you to follow the training process and manage your own learning.

Notes & Reflections: This space allows you to take notes on what you are learning and how this relates to your own experience. You can use it to note down key information that seems particularly relevant to you; in addition, many sessions will include a 'What Does This Mean for Me?' section where you will be encouraged to

reflect on how the information presented and discussed in the session applies to your work, or that of your organization.

Burning Questions: As the training is designed in such a way that each session builds on the last, there may be some questions or discussions prompted early in the training that are not discussed or answered until later sessions. While you should feel free to raise questions as they occur, you can also use this space to note them in order to ask later.

Individual Reflection: At the end of relevant sessions, a section is provided for your own individual (and organizational) reflection on how this information applies to you, and where your focus and strengths lie in emergency response and preparedness.

Lastly, the Annexes contain additional information, and Annex 3 in particular provides links to other resources to support your learning.

KEEPING YOURSELF SAFE AND WELL

This training focuses heavily on Gender-Based Violence and crises; both of these topics may be difficult for some participants to think about and discuss. It is not easy to talk about violence or abuse, especially when you may have some kind of connection to someone who has experienced violence. It is important to think about how we look after ourselves and each other throughout this training, to make sure we maintain a safe learning environment.

This training is not about personal disclosures. If you want to give examples during the training, you may want to do so in the third person (e.g. 'I heard an example…', or 'I know someone who…') to keep yourself safe.

If you feel uncomfortable during the training, you may need to step outside for a moment – that is fine. You are also encouraged to talk to your facilitator if you find things are becoming uncomfortable for you. If you need support for yourself or someone you know who has experienced violence, contact your supervisor or the facilitator of the training outside the training itself. They will help you find the support you need.

The below are some self-care techniques and exercises that may be used during the training and can also serve as resources for you in your work (as an individual or with staff).

Chair Yoga

Seated Neck Rolls

Sit up straight in a chair. Gaze up to the ceiling, keeping your neck long. Bring your left ear down toward your left shoulder and hold. Roll your head down toward the ground and bring your chin to your chest and hold. Roll your head to the right and bring that ear to your right shoulder. Inhale and exhale through the nose in a slow and controlled manner. Repeat twice.

Seated Mountain Pose

Sit up straight in a chair. Roll your shoulder blades up, back and down, arms relaxed at your sides.

Pull your belly button in to your spine to engage your abdominal muscles, and keep your feet flat on the floor, if possible. Inhale through the nose and raise your arms overhead. Keep your arms shoulder width apart, and relax your shoulders. If you feel your shoulders creep up around your ears, relax them. Gaze in between your hands, to the ceiling. Stay here for five breaths.

Seated Eagle Arms

Sit up straight in a chair. Roll your shoulder blades up, back and down, arms relaxed at your sides. Pull your belly button in to your spine to engage your abdominal muscles, and keep your feet flat on the floor, if possible. Extend your arms out in front of you at 90-degree angles, palms facing each other. Place your right arm under your left and press the backs of your palms together. Inhale and sit tall, then exhale and tuck your chin to your chest to stretch the back of the neck. Hold the pose for five breaths, then switch arms and stay for another five breaths.

Seated Forward Fold

Sit up straight in a chair. Roll your shoulder blades up, back and down, arms relaxed at your sides. Pull your belly button in toward your spine to engage your abdominal muscles, and keep your feet flat on the floor, if possible. Spread your legs slightly wider than hip distance apart. Exhale and hinge from the hips, slowly lowering your hands to the floor (or in contact with your thighs or shins). Slowly round your upper back, lowering your chest in between your legs and relaxing your head and neck down. Allow your shoulders to relax and round. Stay here for five breaths. Inhale and slowly roll up, lifting your head up last.

Seated Cat/Cow

Sit up straight in a chair. Roll your shoulder blades up, back and down, arms relaxed at your sides. Pull your belly button in to your spine to engage your abdominal muscles, and keep your feet flat on the floor, if possible. As you inhale, arch your back (leading with the chest) and look up toward the ceiling. Lift the chin and allow your arms to relax next to you. As you exhale, round your spine and let your head drop forward. Tuck the chin and allow your shoulders to roll. Repeat five times, moving fluidly from cat to cow with each breath.

Standing Forward Fold with Chair

Begin by standing about an arm's length behind a chair. Your feet should be directly under your hips; your shoulders should be back and down, with your abdominal muscles engaged. Inhale and reach for the chair, allowing your body to roll down. Bend your knees slightly to prevent locking them, and allow the head to hang. Stay for five breaths, and then roll up slowly.

Seated Forward Bend with Chair
Sit on the floor in front of your chair with your legs extended in front of you, under the chair. Keep the chair close enough to your body that you can touch it with your hands when the arms are outstretched. Pull your belly in to your spine to engage your abdominal muscles and flex your feet to engage your legs. (Bend your knees if you cannot straighten them.) Hinge from the hip to place your hands/forearms onto the chair, and then allow your chin to drop toward your chest and your upper back to round slightly forward. Stay here for five to 10 breaths, then slowly roll your chin and chest up

Deep Breathing

Imagine you have a balloon inside your stomach. Place one hand below your belly button, and breathe in slowly through the nose for four seconds, feeling the balloon fill up with air – your belly should expand. When the balloon is full, slowly breathe out through your mouth for about four seconds. Your hand will rise and fall as the balloon fills and empties. Wait 2 seconds, then release. Repeat a few times. When belly breathing, make sure the upper body (shoulders and chest area) is fairly relaxed and still.

Visualization

Find a quiet place and close your eyes. Think of the most calm, peaceful place you have ever been. Picture yourself in that place. Describe what it: Looks like, sounds like, Smells like, Feels like. Think of all the small details, like the breeze, the feeling of the grass or whatever else might be in your space. Imagine yourself in the place and breathe deeply for several breaths. Return here when you are feeling stressed or worried.

Muscle Relaxation

Make a fist with each hand and squeeze each hand tight. Squeeze… Squeeze… Squeeze…and Relax. Now, while you squeeze your fists again, tighten your arms to squeeze your body, squeeze… Squeeze… Squeeze… Relax. Now, this time also squeeze your legs together while making a fist and squeezing your arms together, squeeze… Squeeze… Squeeze... Relax. Repeat. Shake out your hands, arms and legs.
If you have the time, you can do this exercise by individual muscle group – i.e. starting with the left foot, left calf, left thigh, left buttock, moving to the right leg, then left hand, arm, shoulder, right arm, then then back, face, etc.

Writing it Out

Divide into pairs or small groups. Explain that you'll be asking them to write about a difficult or stressful experience in your work, and then they will read what they wrote to their partner/others in the group. They will not need to hand in what they wrote, and can choose not to read out what they wrote if they choose. Ask them to spend 5 minutes writing about a difficult work situation and what helped them to manage the situation.

After 5 minutes, ask them to spend 5 minutes reading what they wrote to their group. Listeners should not give advice or analyze what is said, they should only listen. After everyone in the smaller groups has had a chance to read, return to the full group. Debrief - what was the experience like? Did anything surprise you? What was difficult, what was useful?

Success Stories

When suffering is so pervasive and the needs so enormous, it can seem as though no matter what we do, it is never enough. This exercise is designed to help staff recognize even small accomplishments.

At the end of a work-day, gather staff together and ask each person to talk about one success they had during that day or that week – no matter how small. If someone is unable to come up with a success, other team members should help them. Doing this on a regular basis can begin to

help staff recognize what they are accomplishing, rather than focus exclusively on what still needs to be done. This can be a helpful – and simple – strategy against burnout.

Sculpting

One group member volunteers to be the sculptor, while several other group members volunteer to be the "clay." The "Sculptor" is asked to sculpt their image of a particularly stressful situation. The Sculptor does not tell the story, but rather asks the volunteers to assume positions that represent the stressful experience. The Sculptor can then join in and become part of the sculpture. Other group members are invited to gather around and view the "sculpture" and describe what they see. The leader then asks those serving as clay to break the position.

The Sculptor is then asked to "sculpt" their image of "freedom from the stress" – using the same volunteers. The Sculptor can then enter the sculpture, as well. Once again, other group members are invited to gather around and describe what they see. The leader then asks the volunteers to break the position.

Finally, the leader asks the volunteers to assume the original position (of stress), and – as the leader slowly counts to 10 – slowly transform the original sculpture of stress into the second sculpture of freedom from stress.

The leader asks all to return to their seats, and de-briefs the experience with participants, asking what it was like for them to assume the original position, how it felt in their bodies, etc. and how it then felt to move into the freedom from stress position.

SESSION 1: TRAINING OUTCOMES & EXPECTATIONS

Learning Objectives:

- Review expectations and training outcomes.
- Establish group ground rules.

TRAINING OBJECTIVES

This package is designed to provide the theoretical knowledge and practical skills necessary to:

- Adapt and use appropriate information collection tools to lead GBV-specific rapid assessments in emergency settings;
- Design and implement interventions to prevent and respond to GBV in emergencies;
- Adapt existing activities and support for women and girls to emergency contexts and constraints;
- Tailor non-GBV-specific sectoral activities to include and prioritize women and girls in emergencies;
- Enhance the preparedness of organizations in emergency-prone contexts to respond to the needs of women and girls by preventing and responding to GBV.

TRAINING EXPECTATIONS

What do you expect to gain from this training?

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PRINCIPLES OF THE TRAINING

All content within this training is guided by principles outlined in key guiding documents, including the UNHCR guidelines on sexual violence response and prevention.[2] These include:

Guiding Principle #1: Safety

The safety and security of the survivor and others, such as her children and people who have assisted her, must be the number one priority for all actors. Individuals who disclose an incident of gender-based violence or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them.

Guiding Principle #2: Confidentiality

Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed con- sent of the person concerned. Confidentiality promotes safety, trust and empowerment. In the context of this training, respecting this principle means setting a strong ground rule about confidentiality with all participants, respecting this rule as a facilitator and reminding participants not to share any personal information that may be revealed within the training room.

Guiding Principle #3: Respect

All actions are guided by respect for the choices, wishes, rights, and dignity of the survivor.

Guiding Principle #4: Non-Discrimination

Survivors of violence should receive equal and fair treatment regardless of their age, race, religion, nationality, ethnicity, sexual orientation, or any other characteristic.

Notes & Reflections

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[2] United Nations High Commissioner for Refugees, *Sexual Violence against Refugees: Guidelines on Prevention and Response,* Geneva, 1995.

SESSION 2: WOMEN, GIRLS, AND GENDER-BASED VIOLENCE IN EMERGENCIES

Learning Objectives:

- Establish a common understanding of gender-based violence.
- Recognize characteristics of emergencies – natural and human-made disasters – and how these characteristics impact and present specific risks to women and girls.

Coming to a common understanding of GBV can be challenging; but in its absence, there is often confusion among those working to address it. The below definition has been adapted from the IASC *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings:*

> ***GENDER-BASED VIOLENCE*** *is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.*

> *The term gender-based violence highlights the gender dimension of these types of acts; or in other words, the relationship between women and girls' subordinate status in society and their increased vulnerability to violence.*

> *GBV can be sexual, physical, psychological and economic in nature, and includes acts, attempted or threatened, committed with force, manipulation, or coercion and without the informed consent of the survivor.*

A **SURVIVOR** is a person who has experienced gender-based violence.

In some contexts, it might be more acceptable or relevant to use the term "violence against women and girls," or VAWG, although some GBV partners are resistant to this term because it excludes boys. Because the vast majority of survivors of GBV are women and girls, this handbook focuses specifically on them. It is important to recognize, however, that boys are vulnerable in emergencies and that emergency responders must understand the unique needs of boys who experience GBV.

WHY FOCUS ON SEXUAL VIOLENCE?

Historically, GBV work in emergencies has focused largely on sexual violence during the immediate response period. However, the IASC Guidelines explain why humanitarian actors focus on sexual violence during the immediate response to emergencies:

> *Because of its immediate and potentially life-threatening health consequences, coupled with the feasibility of preventing these consequences through medical care, **addressing sexual violence is a priority in humanitarian settings**. At the same time, there is a growing recognition that affected populations can experience various forms of GBV during conflict and natural disasters, during displacement, and during and following return. In particular, **intimate partner violence** is increasingly recognized as a critical GBV concern in humanitarian settings.*

> *These additional forms of violence—**including intimate partner violence and other forms of domestic violence, forced and/or coerced prostitution, child and/or forced marriage, female genital mutilation/cutting, female infanticide, and trafficking for sexual exploitation and/or forced/domestic labor**—must be considered in GBV prevention and mitigation efforts according to the trends in violence and the needs identified in a given setting.[3]*

Because this handbook and the accompanying program model are focused on the period of acute emergency response – from crisis onset to 12 weeks – there is a distinct emphasis on response to and prevention of sexual violence. It is important, however; to ensure that other forms of violence are taken into account and addressed wherever possible, and that programming is adapted to the context.

HUMAN RIGHTS FRAMEWORKS

Acts of GBV violate a number of human rights principles protected by international human rights agreements and conventions and domestic law. Some of these rights include:

- The right to life, liberty and security of the person.
- The right to the highest attainable standard of physical and mental health.
- The right to freedom from torture or cruel, inhuman, or degrading treatment or punishment.
- The right to freedom of opinion and expression.
- The right to education and personal development.
- The right to protection against all forms of neglect, cruelty and exploitation.

These rights, enshrined in international human rights and international humanitarian law, are guaranteed to both women and men, "without distinction of any kind such as race, color, sex, language or other status."[4] However, their application is inconsistent and varies between regions and countries.

The **Universal Declaration of Human Rights** (UDHR), adopted by the UN General Assembly in 1948, recognizes "the inherent dignity and of the equal and inalienable rights of all members of the human family" and represents the first global expression of rights to which all human beings are inherently entitled.[5] While the UDHR is not binding, its acceptance by all UN member states gives great moral weight to the fundamental principle that all human beings must be treated equally, without discrimination and with respect for their natural worth as human beings.[6]

A number of separate conventions reinforce women's rights. Chief among these is the **Convention on the Elimination of All Forms of Discrimination against Women** (CEDAW), adopted by the UN General Assembly in 1979, and its optional protocol. CEDAW was the first legally binding international convention to set out principles on rights of women in all fields, addressing both *public and private* acts of violence and provides specific recommendations for states, including prevention, reporting, and legal protection.

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[3] Inter-Agency Standing Committee, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, 2005.
[4] Universal Declaration of Human Rights, 1948.
[5] Universal Declaration of Human Rights, 1948
[6] UNICEF, *Convention on the Rights of the Child*. http://www.unicef.org/crc/index_30160.html

The CEDAW Committee reviews national reports submitted by the State parties and also makes recommendations on any issue affecting women to which it believes the States parties should devote more attention. In 1992, the CEDAW Committee adopted **General Recommendation 19**, which requires national reports to the CEDAW Committee to include statistical data on the incidence of violence against women, information on the provision of services for survivors, and legislative and other measures taken to protect women against violence in their everyday lives, such as harassment at the workplace, abuse in the family and sexual violence.[7]

The **Declaration on the Elimination of Violence against Women**, adopted by the UN General Assembly in 1993, is not legally binding but has been nonetheless influential. It was the first international human rights instrument to exclusively and explicitly address the issue of violence against women and asserts that violence against women violates, impairs or nullifies women's human rights and fundamental freedoms. The Declaration also sets forth a definition of gender-based violence, defining it as, "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[8]

UN Security Council Resolution 1325 calls on all parties of the armed conflict to: "protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict."[9] It was the first formal and legal document from the United Nations Security Council that required parties to an armed conflict to respect women's rights and supported the participation of women in peace and reconstruction efforts.

SCR 1325 stresses "the importance of [women's] equal participation and [their] full involvement in all efforts for the maintenance and promotion of peace and security, and the need to increase their role in decision-making with regard to conflict prevention and resolution." It also calls for the increased participation of women and the incorporation of gender perspectives in all United Nations peace and security efforts, including demobilization, disarmament and reintegration and security sector reform efforts.

UN Security Council Resolution 1820, adopted in 2008, affirms the link between the maintenance of international peace and security and sexual violence in conflict situations. In line with Article 7 of the Rome Statute of the International Criminal Court, Resolution 1820 reminds Member States to the UN that "rape and other forms of sexual violence can constitute a war crime, a crime against humanity, or a constitutive act with respect to genocide," and stresses "the need for the exclusion of sexual violence crimes from amnesty provisions in the context of conflict resolution processes."

Convention on the Rights of the Child (CRC) is the primary international legal instrument for children's rights. Several articles in the CRC specifically refer to children in war, including Article 38 on armed conflict and Article 39 on the rehabilitative care of child victims of armed conflicts.

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[7] Global Governance Watch, *The Convention on the Elimination of All Forms of Discrimination Against Women*. [Available online: http://www.globalgovernancewatch.org/human_rights/the-convention-on-the-elimination-of-all-forms-of-discrimination-against-women.]

[8] United Nations, *The Declaration on the Elimination of Violence Against Women,* A/RES/48/104, 1993.

[9] UN Security Council 1325, 2000.

Human rights become enforceable as they become codified as conventions, covenants or treaties, or as they become recognized as customary international law.

UDHR, CEDAW and the CRC all identify human rights and freedoms that signatories must recognize and protect.

SCRs 1325, 1612, 1820, 1882, 1888, 1889 and 1960 are binding for all UN Member States and require them to take immediate action and punish all perpetrators of violence against women and girls in conflict and post conflict settings.

In **UN Security Council Resolution 1612**, adopted in 2005, the Security Council called for the implementation of several structures and systems to better monitor and address violations of children's rights perpetrated by armed forces and groups. In particular, the Security Council requested that the Secretary-General establish a Monitoring and Reporting Mechanism (MRM) on children and armed conflict to provide timely and reliable information to the Council on six violations of children's rights in situations of armed conflict, including rape and other grave sexual violence against children. Today, in a number of conflict-affected countries, UN Country Teams have established Monitoring and Reporting Mechanism (MRM) taskforces, typically led by UNICEF or a peacekeeping operation, to collect and analyze information and share it with the Secretary-General's office.

In **Resolution 1820,** adopted in 2008, the UN Security Council called for an end to the use of brutal acts of sexual violence against women and girls as a tactic of war and an end to impunity of the perpetrators. It requested the Secretary-General and the United Nations to provide protection to women and girls in UN-led security endeavors, including refugee camps, and to invite the participation of women in all aspects of the peace process.

UN Security Council Resolution 1888, adopted in 2009, detailed measures to further protect women and children from sexual violence in conflict situations, such as asking the Secretary-General to appoint a special representative to coordinate the mission, to send a team of experts to situations of particular concern, and to mandate peacekeepers to protect women and children.

UN Security Council Resolution 1889, also adopted in 2009, reaffirmed Resolution 1325, condemned continuing sexual violence against women in conflict situations, and urged UN member states and civil society to consider the need for protection and empowerment of women and girls, including those associated with armed groups, in post-conflict programming.

In **Security Council Resolution 1960,** adopted in 2010, the UN Security Council encouraged the UN Secretary-General to include detailed information on parties to armed conflict that are suspected of being responsible for sexual violence and states the intention of the Security Council to use the information for further engagement with UN procedures, including sanctions. It requested that the Secretary-General use information gathered from monitoring of conflict-related sexual violence to engage in a coordinated approach within each country. Further, it encouraged Member States to provide military and police personnel with adequate training on sexual and gender-based violence and to deploy more women personnel to UN peacekeeping missions and reinforced the zero-tolerance policy on sexual exploitation for the peacekeeping forces.

Through **Security Council Resolution 2242** of 2015, the Council decided to integrate women, peace and security concerns across all country-specific situations on its agenda. In the area of

peacekeeping, the Council urged the Department of Peacekeeping Operations and the Department of Political Affairs to ensure that gender analysis and technical gender expertise were included throughout all stages of mission planning, mandate development, implementation, review and mission drawdown. It called on the Secretary-General to initiate a revised strategy, within existing resources, to double the numbers of women in peacekeeping operations over the next five years.

NOTE: THE ROLE OF THE STATE IN PROTECTING RIGHTS

Protecting and upholding individual human rights is the primary responsibility of the state where those individuals reside. This is true even in fragile or failed states. These responsibilities may generally be divided into two types of actions: Actions taken to prevent future sexual violence and reduce women and girls' exposure to risks of sexual violence, and actions to ensure that measures are in place to respond when sexual violence is reported.[10]

In many instances, there is a gap between what the state should be doing and what is actually happening on the ground. In some cases, state actors themselves may be perpetrating human rights violations.

A state's unwillingness or inability to protect the rights of its people and an absence of law and order during conflicts and emergencies creates an environment of impunity for perpetrators of sexual violence. When states are unwilling or unable to uphold their obligations under international law, the international community, in the form of the UN and NGOs, provide protection and provision of basic human rights.

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[10] Inter-Agency Standing Committee, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, 2005.

The below table provides an overview of key Security Councils Resolutions on women, peace and security, and children and armed conflict.[11]

Resolution	Women's Leadership in Peace-making & Conflict Prevention		Prevention of & Response to Conflict-related Sexual Violence			Children & Armed Conflict	
	1325 (2000)	1889 (2009)	1820 (2008)	1888 (2009)	1960 (2010)	1612 (2005)	1882 (2009)
Description	First SCR to link women to the peace and security agenda; addresses the impact of war on women and their contribution to conflict resolution and sustainable peace	Addresses women's exclusion from peace-building planning and institutions, and consequent lack of adequate funding for their needs, including safety and services	First SCR to recognize conflict-related sexual violence as a matter of international peace and security, that requires peacekeeping, justice, and peace negotiation response	Strengthens tools for implementing 1820 through assigning leadership, building judicial response expertise, addressing gaps in prevention and response and reporting mechanisms	Expands mandate to comprehensively address sexual violence when used as a tactic of conflict or resulting as a consequence of conflict; strengthens architecture for holding perpetrators accountable by listing perpetrators, and establishing monitoring, analysis and reporting arrangements	Establishes a monitoring and reporting mechanism for six grave violations against children in armed conflict – killing or maiming of children; recruiting or using child soldiers; attacks against schools or hospitals; rape or other grave sexual violence against children; abduction of children; and denial of humanitarian access for children	Strengthens the monitoring and reporting mechanism by expanding the 'trigger' violations (killing, maiming, rape and sexual violence are new triggers under SCR 1612 monitoring and reporting mechanism)

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[11] Adapted from UN Women

EMERGENCIES

Emergency response is the most challenging time to implement programming in a strategic and effective manner. Understanding different types of emergencies is essential for an effective GBV response. It influences our ability to address the vulnerabilities and needs of women and girls in diverse contexts, and to identify the variety of obstacles to their access of life-saving services.

This section will help you understand characteristics of diverse types of emergencies and how they will impact response. It is important that you keep in mind at all times, however, that each emergency you encounter in the field will be unique and will require ongoing analysis to ensure that your approach to response and prevention is both effective and appropriate.

For the purpose of this manual, we define EMERGENCY as any situation in which the life or well-being of civilians affected by natural disaster, conflict or both has been or will be threatened unless immediate and appropriate action is taken, and which demands an extraordinary response and exceptional measures.[12]

This definition of emergencies is purposefully broad and includes natural and human-made crises, as well as contexts in which both of those play a factor. The below table highlights some commonalities and differences between natural disasters and conflict. As you review, reflect on how each characteristic of an emergency might impact women and girls' exposure to risk.

Characteristic	Natural Disaster	Conflict
Risk to life	Within hours or days if relief is delayed	Often sustained and cumulative
Length of initial response	Weeks; followed by recovery	Months or years; may evolve into reconstruction and recovery
Scope	May affect several countries, or several states within one country, and lead to large-scale displacement Requires coordination with multiplicity of actors	May affect several countries and lead to large-scale, sustained displacement Requires coordination with multiplicity of actors
Role of national governments	International assistance extended when requested by affected government Relief efforts designed to support the affected government to respond	Can involve a failed state or one in which the state's legitimacy is under dispute Government may be complicit in the conflict Government may reject or be hostile toward relief efforts Requires diplomacy and development of relationships with parties to conflict

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[12] Adapted from: United Nations High Commissioner for Refugees, *Handbook for Emergencies*, Third Edition, July 2007.

Role of military actors	Military may play expanded role for logistical support and direct delivery of aid Military does not always prioritize basic principles of humanitarian aid Prevention of sexual exploitation and abuse is critical due to possible absence of or inconsistent compliance with internationally accepted codes of conduct	Government military and/or non-governmental armed actors may block aid or use it in an attempt to gain international legitimacy and recognition Possible presence of external forces as peacekeepers Military does not always prioritize basic principles of humanitarian aid Prevention of sexual exploitation and abuse is critical due to possible absence of or inconsistent compliance with internationally accepted codes of conduct
Role of national NGOs and civil society	May have also experienced significant loss of staff, infrastructure and resources	May be weak or limited in capacity to respond due to insecurity May face direct threats or restrictions from actors to the conflict Prevention of sexual exploitation and abuse is critical due to possible absence of or inconsistent compliance with internationally accepted codes of conduct
Donor response	Donor response may be channeled directly to a recipient government	Donor response often channeled directly to relief organizations UN may facilitate the process

Crises in conflict-affected areas such as the eastern Democratic Republic of Congo, Darfur and Afghanistan are typically characterized by extensive violence and loss of life; massive population displacement; hindrance or prevention of humanitarian assistance by political and military constraints; widespread societal and economic damage; need for large-scale humanitarian assistance; and significant security risks for humanitarian staff in some areas.[13]

Natural disasters, like conflicts, have a serious impact on the functioning of communities and societies. Disasters such as the 2010 earthquake in Haiti and the 2004 tsunami in Indonesia resulted in massive loss of life; separation of families; displacement of thousands of people; and the destruction of livelihoods, homes

"All too often the human rights of disaster victims are not sufficiently taken into account. Unequal access to assistance, discrimination in aid provision, enforced relocation… gender-based violence, loss of documentation, recruitment of children into fighting forces, unsafe or involuntary return or resettlement, and issues of property restitution are just some of the problems that are often encountered by those affected by the consequences of natural disasters."

-Brookings-Bern Project on Internal Displacement, *Human Rights and Natural Disasters: Operational Guidelines and Field Manual on Human Rights Protection in Situations of Natural Disaster,* 2008

and national infrastructure. Natural "hazards" become "disasters" when local coping mechanisms are

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[13] Office for the Coordination of Humanitarian Affairs, *Orientation Handbook on Complex Emergencies*, 1999.

exceeded and communities are unable to manage their impact.[14] Climate change has been linked to increases in the number of natural disasters experienced around the world, a trend that is not likely to change in the foreseeable future.

Contexts in the midst of long-term civil unrest that are thrown into further chaos by natural disaster or epidemic also present immense protection challenges for women and girls. The fragility already present in such contexts is exacerbated by natural disaster's impact on lives, livelihoods, infrastructure, local economy, the capacity of existing service providers, and social structures.

It is important to remember that the consequences of emergencies will differ between men and women, young and old, and an individual's vulnerability to abuse, exploitation and violence.

STANDARDS AND GUIDELINES

THE SPHERE PROJECT

Humanitarian actors involved in emergencies are guided by a set of voluntary principles and guidelines on minimum standards for humanitarian involvement in responding to emergencies. These standards were created by humanitarian actors, NGOs and the Red Cross/Red Crescent Societies in 1997 and are collectively called The Sphere Project's *Humanitarian Charter and Minimum Standards in Disaster Response*. The most recent update was released in 2011.

The Sphere Project was the first organization to establish minimum standards that people affected by disasters have a right to expect from humanitarian actors. Two core humanitarian values guide The Sphere Project:

1. All possible steps should be taken to alleviate human suffering arising out of calamity and conflict.

2. Those affected by disaster have a right to life with dignity and therefore a right to assistance.

The Humanitarian Charter affirms the fundamental importance of the following three principles:

- The right to life with dignity;
- The right to protection and security;
- The right to receive humanitarian assistance.

There are no specific standards on GBV within The Sphere Standards. However, each of the standards recognizes sexual violence programming and gender as cross-cutting issues. The most specific guidance offered on sexual violence programming is found within the Minimum Standards in Health Services. There is also some related guidance in each chapter in the section titled "Vulnerabilities and capacities of disaster-affected populations." Excerpts from Sphere minimum standards in disaster response related to GBV are found in the table below.

MINIMUM STANDARDS IN DISASTER RESPONSE RELATED TO GBV	
Protection Principles	Protection Principle 3: Protect people from physical and psychological harm arising from violence and coercion People are protected from violence, from being forced or induced to act against their will and from fear of such abuse.

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[14] International Federation of the Red Cross, *World Disasters Report*, 2009.

	Guidance note 13: *Women and girls can be at particular risk* of gender-based violence. When contributing to the protection of these groups, humanitarian agencies should particularly consider measures that reduce possible risks, including trafficking, forced prostitution, rape or domestic violence. They should also implement standards and instruments that prevent and eradicate the practice of sexual exploitation and abuse. This unacceptable practice may involve affected people with specific vulnerabilities, such as isolated or disabled women who are forced to trade sex for the provision of humanitarian assistance. Protection Principle 4: Assist people to claim their rights, access available remedies and recover from the effects of abuse The affected population is helped to claim their rights through information, documentation and assistance in seeking remedies. People are supported appropriately in recovering from the physical, psychological and social effects of violence and other abuses. **Guidance note 7:** *Healthcare and rehabilitation support:* People should be supported in accessing appropriate healthcare and other rehabilitation support following attacks, gender-based violence and related problems
The Core Standards	Core Standard 6: Aid worker performance Humanitarian agencies provide appropriate management, supervisory and psychosocial support, enabling aid workers to have the knowledge, skills, behavior and attitudes to plan and implement an effective humanitarian response with humanity and respect. **Key actions:** Establish codes of personal conduct for aid workers that protect disaster-affected people from sexual abuse, corruption, exploitation and other violations of people's human rights. Share the codes with disaster-affected people (see guidance note 3). **Guidance note 3:** *Aid workers' control* over the management and allocation of valuable aid resources puts them in a position of power over the disaster-affected population. Such power over people dependent on assistance and whose protective social networks have been disturbed or destroyed can lead to corruption and abuse. Women, children and persons with disabilities are frequently coerced into sexually abusive situations. Sexual activity can never be demanded in exchange for humanitarian response (aid workers and military, state or private sector personnel) should be party to abuse, corruption or sexual exploitation. The forced labor of adults or children, illicit drug use and trading in humanitarian goods and services by those connected with humanitarian distributions are also prohibited.
Minimum Standards in Water Supply, Sanitation and Hygiene Promotion	The use of communal water and sanitation facilities, for example in refugee or displaced situations, can increase women's and girls' vulnerability to sexual violence and other forms of gender-based violence. In order to minimize these risks, and to ensure a better quality of response, it is important to ensure women's participation in water supply and sanitation programs. An equitable participation of women and men in planning, decision-making and local

	management will help to ensure that the entire affected population has safe and easy access to water supply and sanitation services, and that services are appropriate.
	Excreta disposal standard 2: Appropriate and adequate toilet facilities
	Guidance note 5: *Safe facilities:* inappropriate siting of toilets may make women and girls more vulnerable to attack, especially during the night. Ensure that women and girls feel and are safe when using the toilets provided. Where possible, communal toilets should be provided with lighting, or households provided with torches. The input of the community should be sought with regard to ways of enhancing the safety of users.
Minimum Standards in Food Security, Nutrition and Food Aid	Assessment and Analysis Standard 1: Food Security
	Food security - food transfers standard 5: Targeting and distribution
	Guidance note 3: *Distribution for 'dry' rations:* …selection of the recipients should consider the impact on workloads and possible risks of violence, including domestic abuse.
	Guidance note 4: *Distribution methods for 'wet' rations:* Exceptionally, a general food distribution can be a cooked meal or ready-to-eat food for an initial period during an acute emergency. These rations may be appropriate when, for example, people are on the move, extreme insecurity and carrying food home would put beneficiaries at risk of theft or violence.
	Guidance note 6: *Minimizing security risks:* Food distributions can create security risks, including diversion and violence… Specific measures to prevent, monitor and respond to gender-based violence, including sexual exploitation associated with food distribution, should be enforced. These include segregating men and women, for example through a physical barrier or by offering separate distribution times, informing all food distribution teams about appropriate conduct and penalties for sexual abuse, and including female 'guardians' to oversee off-loading, registration, distribution and post-distribution of food.
	Food security - livelihoods standard 2: Income and employment
	Guidance note 5: *Risk in the work environment:* …Practices for increasing safety in transit include securing safe access routes to work, ensuring routes are well lit, providing torches, using early warning systems (which may utilize bells, whistles, radios and other devices) and security norms, such as traveling in groups or avoiding travel after dark. Particular attention must be paid to women, girls and others at risk of sexual assault. Ensure that all participants are aware of emergency procedures and can access early warning systems.
Minimum Standards in Shelter, Settlement	Shelter and settlement standard 4: Construction
	Guidance note 1: *Participation of the affected populations:* Participation by the affected population in shelter and settlement activities should be informed by existing practices though which housing and settlements are planned, constructed and maintained.... The provision of assistance from

and Non-Food Items	volunteer community labor teams or contracted labor can complement the involvement of individual households. Such assistance is essential to support female-headed households, as women may be at particular risk from sexual exploitation in seeking assistance for the construction of their shelter.
Minimum Standards in Health Services	Healthy systems standard 5: Health information management **Guidance note 4: *Confidentiality:*** Adequate precautions should be taken to protect the safety of the individual, as well as the data itself. Staff members should never share patient information with anyone not directly involved in the patient's care without the patient's permission. Special consideration should be given to persons with intellectual, mental or sensory impairment, which may compromise their ability to give informed consent. Data that relate to injury caused by torture or other human rights violations including sexual assault must be treated with the utmost care. Consideration may be given to passing on this information to appropriate actors or institutions if the individual gives their informed consent. Essential health services - sexual and reproductive health standard 1: Reproductive health **Guidance note 1: *Minimum Initial Service Package:*** The MISP defines those services that are most important for preventing RH-related morbidity and mortality among women, men and adolescents in disaster settings. It comprises a coordinated set of priority RH services that must be implemented simultaneously to prevent and manage the consequences of sexual violence, reduce the transmission of HIV, prevent excess maternal and newborn morbidity and mortality, and begin planning for comprehensive RH services as soon as the situation stabilizes. Planning for the integration of good-quality comprehensive RH activities into primary healthcare at the onset of an emergency is essential to ensuring a continuum of care. Comprehensive RH care involves upgrading existing services, adding missing services and enhancing service quality. **Guidance note 3: *Sexual violence:*** All actors in disaster response must be aware of the risk of sexual violence including sexual exploitation and abuse by humanitarians, and must work to prevent and respond to it. Aggregate information on reported incidents must be safely and ethically compiled and shared to inform prevention and response efforts. Incidence of sexual violence should be monitored. Measures for assisting survivors must be in place in all primary-level health facilities and include skilled staff to provide clinical management that encompasses emergency contraception, post-exposure prophylaxis to prevent HIV, presumptive treatment of sexually transmitted infections (STIs), wound care, tetanus prevention and hepatitis B prevention. The use of emergency contraception is a personal choice that can only be made by the women themselves. Women should be offered unbiased counseling so as to reach an informed decision. Survivors of sexual violence should be supported to seek and be referred for clinical care and have access to mental health and psychosocial support.

	At the survivor's request, protection staff should provide protection and legal support. All examination and treatment should be done only with informed consent of the survivor. Confidentiality is essential at all stages.

All humanitarian organizations and actors are encouraged to be "Sphere compliant" and many donors require it. The Sphere Project encourages all humanitarian actors to engage in a broad process of collaboration and an expression of commitment to quality and accountability.

THE IASC GBV GUIDELINES

An IASC task force developed the *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings* in an effort to improve the accountability of all humanitarian actors to address GBV. The initial discussions of the task force concluded that there was greater need to integrate GBV interventions into all humanitarian planning and programming, with the goal of multi-sectoral responsibility and mutual accountability. The guidelines were reviewed and updated in a multi-year participatory process, culminating in the 'Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery' being published in 2015: The IASC GBV guidelines:

> The **Inter-Agency Standing Committee** was established in 1992 to strengthen coordination of humanitarian assistance. The IASC is the primary mechanism for facilitating interagency decision-making in response to complex emergencies and natural disasters. Representatives of a broad range of UN and non-UN humanitarian partners form the IASC.
>
> **For further information:**
> **www.humanitarianinfo.org/iasc**

- Are a set of good practices that promote and facilitate coordination and information sharing;
- Emphasize sexual violence in the early phase of any emergency – while also addressing other types of GBV; and
- Provide guidance on specific, minimum, life-saving interventions for preventing and responding to GBV in humanitarian emergencies.

The IASC GBV guidelines are built on the fundamental premise that all humanitarian actors must take action, from the earliest stages of any emergency, to prevent GBV and provide appropriate assistance to survivors. They focus specifically on the early stages of an emergency and can, in theory, be implemented without specialized GBV training or preparation. However, these guidelines are not limited to emergencies and can also help build a foundation for long-term interventions.

The guidelines are applicable in any emergency setting, regardless of whether the "known" prevalence of sexual violence is high or low. It is important to remember that sexual violence is under-reported even in well-resourced settings worldwide, and it will be difficult if not impossible to obtain an accurate measurement of the magnitude of the problem in an emergency.

> In natural disasters including Cyclone Nargis in Myanmar in 2008 and the 2010 earthquake in Haiti, police and humanitarian organizations reported an increase in **human trafficking** after the crisis. Girl children and adolescent girls were extremely vulnerable to this trafficking, particularly if they had been separated from their families and communities of origin during the disaster. In Myanmar, police reported that traffickers disguised themselves as aid workers and made promises of work abroad in order to entice their victims (reported by the Associated Press, 3 July 2008).

"It is important to remember that GBV is happening everywhere. It is under-reported worldwide, due to fears of stigma or retaliation, limited availability or accessibility of trusted service providers,

impunity for perpetrators, and lack of awareness of the benefits of seeking care. Waiting for or seeking population-based data on the true magnitude of GBV should not be a priority in an emergency due to safety and ethical challenges in collecting such data. With this in mind, all humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions … regardless of the presence or absence of concrete 'evidence'."[15]

GBV emergency response has traditionally focused on conflicts in which rape is used as a tactic of war. This has been seen in conflicts including Sierra Leone, Liberia, Darfur and the Democratic Republic of Congo, all characterized by a high presence of armed actors, systematic and widespread sexual violence and a non-functioning state. Sexual violence is also a principle concern in GBV emergency response to natural disaster, which is often followed by chaos and social breakdown. Experience shows, however, that contextual factors associated with both conflict and natural disaster put women and girls at extreme risk not only of sexual violence, but all forms of GBV.

Increases in intimate partner violence have been reported in the wake of natural disasters including the Mt. Pinatubo eruption in the Philippines and Hurricane Mitch in Nicaragua. In such cases, women living in a violent relationship before the disaster may experience violence of increasing severity post-disaster, if separated from support systems that previously offered some measure of protection.[16] The anxiety and powerlessness that displaced populations experienced in the wake of disaster can also contribute to increases in family-level violence.

In cases of displacement resulting from either conflict or natural disaster, inadequate facilities and limited resources also expose women and girls to the risk of sexual and economic exploitation, trafficking and other forms of GBV. Women and girls' exposure to risk in these settings comes as a result of socially constructed gender roles and discrimination. They have more limited access to resources, including control over economic capital, education, skills training, employment, secure housing, transportation, information, decision-making, social networks and influence. At the same time, women most often remain the primary caregivers for children and other family members, responsible for supporting multiple people during an emergency despite their limited access to resources and economic opportunities. This can increase risks of sexual and economic exploitation, trafficking, sexual violence and other types of violence.

Despite the recognition of how conflict and natural disasters and their aftermath increase women and girls' vulnerability and exposure to violence, quality GBV interventions are still lacking. They are hindered, in part, by the international community's failure to recognize GBV as a life-threatening, public health and human rights issue deserving an urgent response at the onset of an emergency. This is particularly true during natural disasters, when the primary focus in the crisis phase is dominated by food aid, access to clean water, and provision of shelter, and many humanitarian actors do not recognize the need to address GBV. Anecdotal evidence indicates that humanitarian actors are more likely to prioritize and address sexual violence and other types of GBV in a response to a conflict-related crisis than they are at the early onset of a natural disaster.

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[15] Interagency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*, 2015.
[16] World Health Organization, *Violence and Disasters,* 2005.

SEXUAL VIOLENCE

Sexual violence is a serious, life-threatening issue affecting women and children. Though survivors of sexual violence can be men, in most cases, survivors are women because in most cultures, most countries and most societies, women are in a disadvantaged position compared to men. During acts of sexual violence, unequal power relationships are abused through the use of force or other means of coercion or threat. In circumstances of sexual violence, a survivor has no choice to refuse or pursue other options without severe social, physical, or psychological consequences.

In the early stages of an emergency, sexual violence is the most immediate and life-threatening form of GBV. This includes rape and the exchange of sexual acts for food, services or protection. The type and extent of sexual violence depends on the emergency. Sexual violence against women and girls has been widely reported in conflict settings and during displacement. Violence against women and girls may increase as the systems and structures that protect them – including their families and communities, law enforcement, community norms, or religious codes – are weakened or destroyed.[17]

Increasing evidence suggests that a wide variety of forms of gender-based violence are also exacerbated in emergency settings, including intimate partner violence, forced prostitution, early/forced marriage, female genital mutilation/cutting, and sexual exploitation.[18] Many of these forms of violence may include, or are other expressions of, sexual violence, and should also be considered in response programs, depending on the context.

It is important to remember that sexual violence is under-reported even in well-resourced settings worldwide, and it will be difficult if not impossible to obtain an accurate measurement of the magnitude of the problem in an emergency.[19]

SEXUAL VIOLENCE IN CONFLICT SETTINGS

The long history documenting the relationship of rape and war, suggests there is a causal link between the two. There is no one theory to explain why rape has been a consistent element of conflict and displacement.

Sexual violence has been used against women in wartime for many reasons, including as a form of torture, to inflict injury, to destroy the essence of a community, to extract information, to force a population to flee, to forcibly impregnate, to degrade and intimidate, and as a form of punishment for actual or alleged actions committed by the women or their family members. For example, women may be targeted for sexual violence in order to reach absent male relatives who may have fled or have joined the armed forces or an armed group. Targeting women in this way is a symbolic demonstration of the fact that men are not able to protect women and that the sexual assault of specific women has brought "dishonor" upon an entire family or community.

The presence of sexual violence in conflict can be viewed in two principle categories:

1. Sexual violence used as a method of warfare; and

2. Opportunistic sexual violence as a consequence of conflict and displacement.

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[17] Introduction to Child Protection in Emergencies: An Interagency Modular Training Package, CD-ROM.

[18] Inter-Agency Standing Committee, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, 2005.

[19] World Health Organization, *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, 2007.

SEXUAL VIOLENCE IN NATURAL DISASTERS

Though typically overlooked, sexual violence is often a risk following natural disasters, which (like conflicts) lead to a breakdown in social networks and systems that protect women and girls in times of peace and stability. Humanitarian actors designing responses to natural disasters rarely undertake measures to reduce this risk of sexual violence and the issue as a whole receives very little attention from the humanitarian community, the media, donors and other stakeholders.

The gaps in recognition and response to sexual violence at the onset of the emergency mean that crucial protection systems and response services are implemented long after the initial days of a crisis. In the aftermath of natural disasters such as Hurricane Katrina in the United States and the 2004 tsunami, communities were displaced in mass emergency temporary shelters. These shelters often failed to incorporate elements of preventative safety measures to reduce the risk of sexual violence for women and girls.

The humanitarian community typically prioritizes healthcare, water and sanitation services, and shelter from the onset of a response to a natural disaster, often preferring to wait until later in an emergency to address sexual violence. This leaves vulnerable populations, specifically women and girls, at high risk of preventable acts of sexual violence, including rape, sexual abuse and exploitation as well as domestic violence. As response and recovery efforts progress, displaced populations remain in unstable situations. This may lead to an increase in other forms of GBV, such as domestic violence, as gender roles and power dynamics between partners change.

Notes & Reflections

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Burning Questions

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SESSION 3: ASSESSMENTS – WHAT DO WE NEED TO KNOW TO START PROGRAMMING?

Learning Objectives:

- Understand why and how we gather information to inform GBV interventions in emergencies.
- Understand ethical considerations when designing and carrying out assessments.

An assessment is a process undertaken to collect and analyze information in order to better understand a particular issue. In humanitarian settings, NGOs and UN agencies carry out assessments to identify community needs and gaps, and then use this information to design effective interventions. Historically, the issue of GBV has been left out of standard humanitarian needs assessments.

GBV-specific assessments may be carried out to improve our understanding of the nature or scope of violence against women and girls, to evaluate a program or service, to identify gaps in support, or to identify local attitudes and behaviors related to sexual violence and other forms of GBV. A credible and thoughtful assessment is a highly valuable tool for internal and external advocacy efforts, and can increase funding and action to address sexual violence in emergencies. The more accurate an assessment, the more appropriate the response will be; good assessments produce good interventions.

Four basic questions that GBV staff seek to answer in assessments are the following:

1. What is happening?

   - *What is the problem and what are the priorities?*
   - *What are the risks for violence against women and girls?*
   - *What type of violence is occurring? Why is it happening?*
   - *Do women and girls have needs that are not being met?*

2. What interventions will best address the problem?

3. What is already being done to address the problem and who is doing it?

4. What could and should we do to complement these efforts?

   - *What is our capacity to implement these interventions?*
   - *What resources are available?*

All information collected ultimately must be used to design and improve the interventions or to advocate for improved action on behalf of women and girls; collecting information that will not be used is a waste of both staff and beneficiary time, which is highly unethical in a context in which beneficiaries may be struggling to survive. While there may be other information that interests you, effective assessments **only** collect information that may be used for programming and advocacy.

GBV assessments seek to identify and improve GBV actors' understanding of the nature of violence against women and girls, protective and risk factors for violence, and available services. It is of extreme

importance that both emergency responders and GBV staff recognize that the aim of assessments is not to identify whether GBV is happening or to identify survivors. We know GBV, and particularly sexual violence, is present in war and peacetime, in emergency-affected communities, refugee settings and IDP camps. Assessments aim to determine how women and girls are at risk for GBV—where and how gender-based violence is occurring and if sexual violence is being used as a deliberate strategy or is opportunistic—and whether GBV actors have the appropriate level of resources and capacity to respond.

The Quest to Quantify

At the onset of emergencies and subsequent months, members of the media, UN actors, donors and some NGOs may fixate on one question: How many girls and women have been raped or were otherwise subjected to sexual violence?

Prevalence or incidence surveys are not feasible in emergency settings and calculating the prevalence or incidence of sexual violence is a challenge, even in well-resourced settings. These surveys can potentially be more harmful than beneficial as they pose significant safety and ethical risks to women and girls. Prevalence surveys also risk redirecting important human and financial resources away from other priorities, such as improving the quality and accessibility of healthcare.

Having a total number of reported survivors of sexual violence will never provide a complete picture of the scale and scope of sexual violence in emergencies, as hundreds and thousands of women and girls are unable to report incidents of violence, either out of concern for their safety or because they lack access to support and quality care.

The best and most ethical way to collect information on sexual violence is through specialized service providers. By establishing health and psychosocial services and addressing obstacles to these services, survivors of sexual violence can safely receive care without further risk to their safety. Civil society actors play a crucial role in providing confidential and appropriate services to survivors of sexual violence and creating environments where the rights of women and girls are upheld and respected. Humanitarian workers must not wait for data before establishing these services.

IMPORTANT! "GBV is happening everywhere. It is under-reported worldwide, due to fears of stigma or retaliation, limited availability or accessibility of trusted service providers, impunity for perpetrators, and lack of awareness of the benefits of seeking care. Waiting for or seeking population-based data on the true magnitude of GBV should not be a priority in an emergency due to safety and ethical challenges in collecting such data. With this in mind, all humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions … regardless of the presence or absence of concrete 'evidence'."[20]

> **The purpose of assessments is to determine *how* women and girls are at risk for GBV, what interventions will best address the identified problems, and whether GBV actors have the appropriate level of resources and capacity to respond. It is *never* to establish whether or not GBV is occurring.**

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[20] Interagency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*, 2015.

SAFETY AND ETHICS[21]

In many emergencies, ethical and safety considerations may be overlooked when conducting assessments, particularly by agencies or actors who are unfamiliar with GBV programming. This inconsistency often puts women and girls and GBV staff at risk; the safety and security of women and girls should never be trumped by the need to collect and analyze information.

The WHO *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* outline eight essential recommendations to guide any information-gathering exercise related to sexual violence in emergencies.

> *"The highly sensitive nature of sexual violence poses a unique set of challenges for any data gathering activity that touches on this issue. A range of ethical and safety issues must be considered and addressed prior to the commencement of any such inquiry. Failure to do so can result in harm to the physical, psychological and social well-being of those who participate and can even put lives at risk.*
>
> *"It is essential, therefore, to ensure that the case for collecting data is legitimate. Furthermore, when collecting and using information about sexual violence it must be done in such a way so as to avoid further harm to those who are part of the process. This includes not just the victims and survivors and their families and supporters, but also communities, organizations working with survivors, and those involved in gathering the information itself.*
>
> *"Collectively, these recommendations are intended to ensure that the necessary safety and ethical safeguards are in place prior to commencement of any information gathering exercise concerning sexual violence in emergencies."[22]*

A necessary, initial question when considering information collection is whether the information sought is actually required. In some situations, there is a risk that sexual violence is being over-researched and over-assessed. In some cases, this has resulted in potentially avoidable harm to women and girls, while not yielding any new or additional information or understanding about the problem. Given that sexual violence is known to be prevalent in all settings, including in emergencies, a lack of specific data about sexual violence in a specific setting is not sufficient justification in and of itself for the collection of information about sexual violence.

The WHO recommendations are the starting point for any assessment that includes GBV components, and especially for those that are conducted as part of the initial emergency response. They are:

1. The benefits of documenting sexual violence must be greater than the risks to survivors and communities.
2. Information gathering and documentation must be done in the manner that prevents the least risk to survivors/participants, is methodologically sound, and builds upon current experience and good practices.
3. Ensure the availability of minimum services for survivor support before asking any questions about sexual violence in a community.

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[21] Adapted from: World Health Organization, *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, 2007.

[22] World Health Organization, *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, 2007.

4. The safety and security of survivors, respondents, participants, the community and the information collection team is paramount and requires monitoring and attention in emergency settings.
5. Protect the confidentiality of all survivors, respondents, and participants.
6. Each survivor/respondent/participant must give her/his informed consent before participating in the data gathering activity.
7. All team members must be carefully selected and receive relevant and sufficient specialized training and ongoing support.
8. Additional policies, practices, and safeguards must be put into place if children – anyone under the age of 18 – are to be involved in information-gathering.

> IMPORTANT! Assessments and assessment teams must not perpetuate stigma by actively and visibly associating GBV with individuals or groups with whom they meet. All assessment team members must fully understand the ways in which assessments can increase violence against women and girls and must not purposefully target survivors when collecting information from community members.

ETHICAL GUIDELINES FOR COLLECTING INFORMATION ABOUT SEXUAL VIOLENCE INVOLVING CHILDREN & ADOLESCENTS

These guidelines are intended to safeguard children and adolescents and promote ethical practices for gathering information from children and adolescents in emergency contexts. Ultimately, the very first question you will face is: ***Is collecting information about sexual violence towards children an acceptable activity in the first place?***

You should seek specialized technical advice and support from other actors – Child Protection, Health, Protection and others – when ascertaining whether it is acceptable to involve children in inquiries into sexual violence, and if so how this should happen. Given this, you should be familiar not only with the WHO Guidelines, but also the specific criteria for determining acceptability of information gathering involving children and who, aside from GBV technical experts should be included in decision-making process.

Overall, the primary concern in all information-gathering activities must always be the protection of the best interests of children and adolescents. The guidelines outlined here suggest a process for ensuring this.

Determining Acceptability of Information Gathering & Ensuring an Ethical Approach

All actors must take careful consideration in deciding whether or not to include children in information-gathering activities. There must be a ***strong case*** for initiating information-gathering activities, given children's vulnerability. The risks of harm for children are greater than for adults, particularly in the immediate onset of an emergency. Initial information-gathering activities with children and adolescents require an extremely strong justification. This can be assessed based on the following criteria, which must also be upheld throughout the information-gathering process:

- *We have determined that the benefits to gathering information outweigh the risks.*

- *We have put in place sufficient human and financial resources to conduct information gathering in an ethical manner. (See below,* Competencies Required for Child-Specific Skilled Interviewers*.)*

- *We know the information needed cannot be gathered elsewhere. In other words, it does not already exist in older assessments and cannot be gathered accurately by older informants (adults).*

- *We can uphold specific procedures for ensuring children's support and safety throughout the interview process (e.g., consideration of where to interview, what ages are appropriate to interview, appropriate questions to use, etc.).*

- *We can guarantee basic support and care services if a child is found to be in need.*

- *We have considered and sufficiently safeguarded against adverse consequences. We have consulted with community members and parents, guardians or caregivers to anticipate all possible consequences for children involved in the information gathering process.*

- *We have actively sought community and stakeholder concerns, and have consulted community leaders for permission to interview community members about children's protection concerns.*

If you identify any of the following criteria during consultations with other actors, you should advocate strongly **against** collecting information with/for/about children:

- *Children's safety and well-being will be put at risk.*
- *Basic care and support services do not exist for children.*
- *Skilled interviewers are unavailable.*
- *Information can be gathered elsewhere.*

Competencies Required for Child-Specific Skilled Interviewers

Individuals interviewing children about sensitive topics, such as sexual violence, require specialized training. It is unacceptable for untrained interviewers to engage in information collection activities. The specific competencies required for interviewers include:

- *Able to engage with children appropriately, according to age and development levels;*
- *Able to communicate care and comfort and provide basic emotional support if needed;*
- *Able to recognize and respond to a child's needs for follow up;*
- *Able to respond to the discovery of a child in danger;*
- *Abel to identify and properly refer a child in need to basic care and support services;*
- *Understand the circumstances under which confidentiality should be breached;*
- *Understand who can give informed consent when working with children and adolescents;*
- *Understand the important elements of consent to communicate to children.*

Guidelines for Appropriate Ages for Interviewing

Children ages 12 and under should **not** be involved in information gathering about sexual violence during an emergency. Other methods/approaches for gathering information related to sexual violence towards children include use of secondary sources of information (teachers, social service workers, health workers, leaders, concerned parent groups, women's groups, etc.).

Older adolescents (15 and above) may be involved in information-gathering exercises with parental consent if necessary, and if the above criteria are fulfilled. Determining acceptable and appropriate ages when older adolescents may be able to give consent without parental involvement requires understanding of the applicable laws, culture, and context as well as careful evaluation of security and other issues in the setting.

Notes & Reflections

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Burning Questions

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SESSION 4: CARRYING OUT ASSESSMENTS

Learning Objectives:

- Introduce different types of assessments.
- Determine which GBV assessment tools to use in diverse emergency settings.

Designing and carrying-out a GBV assessment requires several fundamental steps:

1. Coordinating with GBV actors and other humanitarian agencies to determine what information exists and if other assessments are planned.

2. Establishing the objectives, parameters and scope of your assessment, including the target population and community.

3. Identifying resources available for your assessment, including human and financial resources as well as the time available for your assessment.

4. And, establishing your methodology, both qualitative and quantitative.

In simple terms, these steps can be summarized as what we already know, what we need to know and how we get this information.

IDENTIFYING THE PURPOSE AND SCOPE OF THE ASSESSMENT

WHAT DO WE ALREADY KNOW?

Before any deployment, GBV staff should gather information to help inform assessments and programming in country. While some background information may be found online—for example from websites like the International Crisis Group, Reliefweb or AlertNet—remember that a great deal of relevant information often remains undocumented, particularly in the early days of an emergency.

An assessment is one of the most important steps in designing programming to safely and appropriately meet the needs of women and girls. In an emergency setting, you may find that many agencies and actors have already carried out some form of assessment related to the well-being of women and girls but that they have only been shared at local working group or cluster meetings.

Do not recreate the wheel! Reach out to other contacts in-country, GBV sub-cluster or working group leads, and other GBV and protection actors to collect information and determine what is already known about violence against women and girls, avoiding duplication and minimizing the number of assessments in a given region or area. In many cases, you will be able to determine which actors are providing GBV-related services on the ground, who has carried out GBV-related assessments and the results of these assessments, and the general patterns and manifestations of violence against women and girls in-country before you even arrive.

WHAT DO WE NEED TO KNOW?

Developing a good assessment tool requires identifying what we **need** to know versus what we **want** to know. It is important to make sure the information you are seeking to collect through an assessment will be used to inform programming and advocacy efforts that result in real change and real support for women and girls.

Emergency response prioritizes women and girls' access to life-saving services, such as healthcare and psychosocial services, and seeks to reduce immediate threats of violence. Depending on the information you have already collected from secondary sources and other GBV actors, you may find you have ample information on available services but limited information on community members' knowledge of these services. Where possible, both qualitative and quantitative information should be collected and analyzed.

It is crucial to identify the scope and objectives of your assessment before you begin. Identify what you need to know and why, ensuring that any information you aim to collect will be used to develop effective interventions.

Delineating the parameters of your assessment also means identifying the target areas and populations you intend to assess. Think carefully about why you are choosing to carry out an assessment in a given community. Has this community already been assessed? Are there higher risks posed to women and girls in this specific area? Have other actors indicated that support for survivors of sexual violence in this community is limited or non-existent? You should be able to justify why your organization is targeting a certain area or population.

Staff should also assess the existing capacity on the ground to address sexual violence. Secondary source research can assist with identifying key actors and government agencies working on sexual violence and this information can be verified through further consultations.

HOW CAN WE GET THIS INFORMATION?

Good, valid, reliable information is the foundation for successful assessments that lead to effective advocacy and programming. Collecting accurate information depends on two key issues: employing the most effective tool and ensuring those identified tools are applied in a systematic and consistent manner.

Determining your assessment methodology first requires an understanding of your existing resources and constraints. Is funding available to cover the costs of staff deployed to carry out the assessment and launch related interventions? Is staff available and trained to carry out assessments? How much time is needed and available to get an adequate understanding of the problem before designing an intervention? While you may feel that time cannot be spared in an emergency or crisis to train locally-based staff in emergency assessment methodology, local staff who speak the same language as the affected communities can collect information that might otherwise be unavailable to international staff.

There are a number of ways in which you can collect information for an assessment, both quantitative and qualitative. As much as possible, GBV staff should strive to collect **secondary source data** and information to limit the amount of time the needs of a given community or population are assessed. In many emergencies, humanitarian agencies send assessment teams to camps and other emergency-affected areas to gather information that may already be known.

On-the-ground reality is often very different from that described in reports and public documents. You should conduct a series of introductory meetings with local and international actors, including key GBV actors and cluster leads. This will allow you to share information about your assessment plans and gather relevant information about existing services, gaps, and risks of violence against women and girls. These meetings can also serve as a means to advocate and educate on GBV.

TYPES OF ASSESSMENTS

There are a variety of assessment methodologies and tools that are available to better understand violence against women and design appropriate interventions to support women and girls. While some assessment tools may be useful in post-conflict or stable settings, these approaches may not be useful or feasible in emergency settings.

As you review this module, keep in mind that not all assessment tools will be appropriate for all settings. Conducting a methodologically- and ethically-sound prevalence survey requires extensive technical and financial resources, for example, and is most often not warranted in an emergency when the priority is to meet the immediate health, psychosocial and safety needs of women and girls. In emergency settings, multi-sectoral and rapid needs assessments are the most common way to collect information safely and quickly.

MULTI-SECTORAL NEEDS ASSESSMENTS

A multi-sectoral needs assessment seeks to ascertain the risks and multiple needs of conflict-affected communities. Different organizations use different tools and approaches to assess the needs of populations in emergency settings. Typically, a team of humanitarian staff with different expertise will lead an initial multi-sectoral assessment when responding to an emergency.

In conducting a multi-sectoral assessment, organizations typically gather information on:

- Water and Sanitation
- Security
- General Protection
- Child Protection
- Population Movements
- Sexual Violence
- Health
- Humanitarian Access

In general, multi-sectoral assessments seek to determine: the nature and scale of a crisis and the needs of a given population; whether a particular organization should intervene and that organization's added value; and the scope and scale of an effective intervention, given existing resources.

GBV technical staff may not always participate in an initial multi-sectoral assessment and in these cases, other emergency staff may collect basic information related to violence against women. This can provide vital information about the risks of violence that women and girls are facing as well as on-the-ground services and programs currently available.

However, it is crucial that all staff members conducting generalized or multi-sectoral rapid assessments that include GBV components understand the ethical and safety concerns surrounding sexual violence information collection and how to mitigate these risks prior to conducting assessments. These staff should also utilize GBV technical support when gathering and analyzing information to ensure that information collected will be used to inform future interventions.

A lack of concrete data regarding sexual violence from a rapid multi-sectoral assessment is to be expected and often warrants a specific GBV assessment. Regardless of the culture, religion or geographic region, sexual violence is significantly underreported and is rarely discussed openly. Rapid multi-sectoral assessments usually cannot provide an accurate reflection of sexual violence occurring in an emergency but proxy indicators can indicate where further investigation is needed. Unlike other

findings from other sectors, an initial rapid assessment is rarely going to immediately provide data to identify gaps related to sexual violence.

It is also possible that the population will not be familiar with the term GBV. If there is little knowledge around violence against women and girls or if the subject is socially taboo, an assessor may unintentionally cause harm to survivors within a community or potentially create a situation that jeopardizes gaining access to data about sexual violence.

RAPID NEEDS ASSESSMENTS

Based on the timeline, GBV and multi-sectoral assessments may be referred to as rapid assessments as they are typically conducted within a few days. Rapid assessments:

The following tools can contribute to **rapid needs assessments**:

- Safety audits
- Service mapping
- Individual interviews
- Focus group discussions

Determining your tool will depend on the specific context, as well as what time and resources are available.

- Are limited in scope and focused primarily on sexual violence, as opposed to the multiple forms of gender-based violence that may exist in any given context

- Are realistic in terms of timing and resources available to collect information

- Adhere to international ethical and safety standards for collecting information on sexual violence during an emergency.

In an emergency, rapid assessments should focus specifically on sexual violence. This includes rape, sexual exploitation, and sexual assault. The exclusion of other forms of GBV, however, does not imply that they do not exist or are not severe. In the early stages of an emergency, sexual violence is the most immediate and life-threatening form of GBV. This includes rape and the exchange of sexual acts for food, services or protection.

Rapid assessments identify problems, gaps, and unmet 'needs' of a population. This can include information about the health, psychosocial and safety needs of women and girls, available medical and psychosocial services, the quality of these services, and general information about security risks women and girls are facing. One immediate output from a rapid GBV assessment is to advocate for and assist with developing preventative measures within the provision of broader humanitarian assistance. Needs assessments also provide GBV actors with necessary information to determine if and how they should respond to the emergency and launch relevant interventions.

In conducting a rapid assessment, staff collects the minimum amount of information needed to launch an emergency response. There may be a great deal of information one would like to know, for example the prevalence of rape, service utilization rates, and cultural beliefs and attitudes about gender and violence against women. However, given the limited time allowed for rapid assessments and the context of the emergency, this information may not be available, may be impossible to collect and may not be relevant. Remember, rapid assessments collect information necessary to launch emergency interventions to meet immediate needs. As time progresses, there may be more opportunities to collect additional information, either through the provision of services or through ongoing discussions with community members.

Organizations used **safety audits** to quickly assess security risks in spontaneous settlements around Port-au-Prince, Haiti, after the 2010 earthquake. In this context, the results of the audits were used to advocate with other clusters for improved lighting, segregation of latrines, and improved accessibility of health services.

In contexts such as Darfur and the Democratic Republic of Congo, safety audits helped identify risks related to the collection of firewood.

A note on safety audits: In emergencies and where camps for displaced populations exist, staff may elect to carry out audits of safety and security. Safety audits are typically carried out in camps or settlements but can be used to assess the safety and security in any geographic location with specific boundaries. The safety audit tool is based on observation alone as a means of assessing risks related to camp layout, resource availability and the provision of humanitarian services and assistance. This includes information about the availability of and risks associated with water and sanitation services, health facilities, NFI distributions, camp security, food distribution and access to fuel.

The result of safety audits may be used to advocate with camp management or NFI clusters or coordinating bodies to improve the layout of camps, the distribution of services, or security within the camp.

GBV actors may also identify actions that can be undertaken immediately to address security concerns.

GBV SITUATIONAL ANALYSES

As an emergency progresses and as time allows, GBV staff may opt to carry out a situational analysis. This is a more in-depth process to collect and analyze both quantitative and qualitative information to develop a broader, deeper and more sophisticated understanding of a problem.

Whereas rapid assessments seek to collect the minimum information needed to launch an appropriate response, situational analyses collect more detailed information related to the underlying socioeconomic, demographic and cultural factors contributing to violence against women and girls in a given country or context. A situational analysis also seeks to more clearly define the context in which violence against women and girls is occurring by research and analyzing a population as well as the cultural, political, legal, physical and socioeconomic environment in which the population lives.

This can include an analysis of quantitative information and indicators including housing conditions, household income and poverty rates, political participation, gender roles in the household, and the availability of social services. Both time-series data—information that shows the extent and direction of changes over time—and cross-sectional information—that which describes various groups within a population—can be used in situational analyses. Qualitative information may also be collected from key groups in the population or other actors including service providers, social scientists, policy analysts, government officials, UN actors and civil society members.

A **situational analysis** is used to collect and analyze complicated and diverse data in order to develop effective action plans. [It] organizes broad categories of data and information [to] enable a systematic investigation of GBV issues and programming.

– Reproductive Health Response in Conflict Consortium, *Gender-Based Violence Tools Manual for Assessment& Program Design, Monitoring & Evaluation in Conflict-Affected Settings*. 2003

In many cases, information needs may be met through secondary sources; where this is not the case, you may elect to carry out focus group discussions or interviews with key groups and actors.

Analyzing information collected means comparing it across a set of norms and standards for services, laws and policies, to identify gaps in service provision, legal systems and structures, and women and girls' access to services, benefits, and opportunities.

The below table provides an overview of basic methods used to gather information and their benefits:

TOOL	METHOD	BENEFITS
SAFETY AUDITS	• Visual observations in visits to emergency-affected areas • Compares conditions against a set of pre-selected indicators	• Provides an opportunity to further identify gaps, risks or problems • Can be used on a regular basis (daily, weekly, etc.) so changes and new risks can be identified
SERVICE MAPPING	• Technical interviews with service providers offering different services, including health, psychosocial, legal, etc. • Compare and contrast responses from different respondents • Participation in coordination meetings and other public fora	• Provides insight into level of services available and accessible to survivors • Provides an opportunity to further identify gaps, risks or problems • Provides an opportunity to verify information from other sources
FOCUS GROUP	• Discussions based on key topics, such as access to healthcare, safety and basic needs • Small groups of people (10-12 people) from similar backgrounds, for example, gender, age, ethnicity or profession • Community mapping can be folded into the focus group, particularly in places with strong visual tradition	• Collects opinions from multiple groups and multiple people • Helps develop a general sense of community perception of key issues of concern
INDIVIDUAL INTERVIEW	• Based on a set of pre-determined questions, typically in-depth or technical in nature • Compare and contrast responses from different respondents	• Allows for technical examination of issues raised in focus group discussions • Provides an opportunity to verify and further identify gaps, risks or problems
RECORD REVIEWS	• Service provider records, statistics or other data and information • Protection monitoring reports in camp-settings	• Provides a sense of issues that are documented or being reported by populations • Provides an opportunity to further identify gaps, risks or problems
REVIEW OF EXISTING DATA	• National statistics offices • Data from camp management, UN agencies, cluster leads	• Provides a description of population • Helps identify vulnerable groups within a population and potential risks of violence

Some methods are more appropriate than others, based on the context, the target group and the information sought. In some cases, focus group discussions may be a useful way to collect information from groups of women and girls, men, community leaders, or staff at a health facility. In other cases, you may opt to conduct one-on-one interviews with key community leaders, service providers, GBV actors or other humanitarian agencies, to explore certain topics in more detail.

While most information collected in a GBV rapid assessment is qualitative, quantitative data may also be useful. In most cases, direct data related to GBV will not be available but other types of quantitative data can tell us more about the situation on the ground in regard to GBV, such as pre-emergency basic health, economic, and demographic information or the number and percentage of facilities providing GBV-related services.

GBV staff should be careful when directly asking women and girls about sexual violence and keep local customs and traditions in mind when broaching the subject with women. In some cases, women may face elevated risks of violence by their partners if they are seen discussing violence with humanitarian workers. Invest the time in training staff and preparing them for an assessment.

There are some general questions and lines of questioning that may lead women and girls to provide information about sexual violence without having to answer questions about their own experiences. Properly sequencing questions can often lead to better information, for example by asking questions generally about health services and safety issues for women. If the women being interviewed are comfortable with the GBV staff they will speak freely of these problems. More often than not, the sex of the interviewer at this point in the assessment makes a critical difference as women and girls are typically more comfortable engaging in conversations regarding sexual violence with other women.

BEFORE YOU ASSESS: CRITICAL CONSIDERATIONS & STEPS!

All assessment templates or generic tools must be adapted to the local context. Information collected before the assessment from partners, project records, other staff and public sources of information can help contextualize assessment tools. However, the extent to which the assessment tools are adjusted to the local context must also be informed by international standards for research on violence against women and girls.

Before carrying out any assessments, staff should ensure that proper permissions are received and should respect any protocols with regard to the collection of information from emergency-affected communities. This may include meeting with and receiving permission from government or local authorities, camp management, or cluster leads, including the camp management and protection clusters and the GBV sub-cluster. Assessment teams should also map out locally available services before carrying out the assessment to ensure that any survivors or participants requiring immediate health, psychosocial or protection assistance can receive these services.

Staff conducting assessments in insecure environments must also be fully briefed on relevant security protocols before carrying out assessment activities. The environments in which organizations operate can be volatile, and the presence of armed actors can increase the likelihood of sporadic fighting. Staff must understand how to react and protect themselves and those they are interviewing if fighting breaks out.

GBV staff conducting focus groups and interviews must properly identify themselves; communities and respondents should be clear about who you are and with whom you work. You should clarify why you are specifically focusing on women and girls and make it clear that respondents are under no obligation

to share information or participate in focus groups or interviews. Reassure respondents that any information collected will not be attributable and will be kept confidential.

Staff must also establish an environment of trust and equality with women and girls in the targeted community and promote a safe and secure environment. GBV staff may approach women as they naturally form small groups, for example while collecting water, preparing food or caring for children or walk on foot through communities and speak with women in their homes. In conducting assessments where women's participation in activities with international NGOs may increase threats or risks of violence by their partners, GBV staff can approach community leaders to request permission to discuss 'women's issues' with the women alone. The intention is not to deceive men in the community but rather frame the discussion in a non-threatening way. Using public health as an entry point has helped staff gather information on violence in conservative communities.

ASSESSMENT CHALLENGES

Focus group discussions in public settings can pose challenges to the safety of women and girls and the validity of the information they provide. Children, youth or men may be curious as to why NGO staff is speaking with women. There are settings where the mere presence of men changes the type of information women provide to NGO staff.

Local NGOs or grassroots organizations may be useful in facilitating or arranging focus groups with women and girls. However, this has the potential to create a bias in the information collected, depending on the political persuasions of these groups, their work with emergency-affected communities, and their perceptions of the emergency and the communities in need.

In other cases, the government or security personnel may not allow access to emergency-affected populations or may only permit access when government representatives accompany assessment teams.

The results of assessments may also increase the risks of violence against women in militarized or insecure environments, particularly if the findings of the assessment implicate or imply that armed groups or government personnel have perpetrated violence against women and girls or other human rights violations. Extreme caution should be taken in these cases to ensure that GBV assessments do not unintentionally increase the risks of violence against women and girls.

In some emergency contexts, regardless of the skill of the GBV staff, it is not safe or not acceptable for women and girls to discuss sexual violence openly and staff may have to rely on other sources of information, such as health information systems or humanitarian service registration statistics. GBV staff must identify innovative ways to 'hear' women and girls' voices and ensure that humanitarian actors are never putting women and girls in unsafe positions.

SESSION 5: INTRODUCING THE PROGRAM MODEL

Learning Objectives:

- Introduce the IRC GBV emergency response program model that guides response to the needs of women and girls in emergencies.

THE BASICS OF PROGRAM DESIGN

Humanitarian actors often undertake activities that aim to address GBV without clearly thinking through the relationship between these specific activities and the overall goal of supporting women and girls. It can be difficult to think beyond project activities, particularly when operating in an emergency. One way to help you think about objectives is to consider the project activities, such as "training teachers and constructing classrooms" or "working with local councils to rebuild water points and markets destroyed in the conflict." Whatever comes to mind for your particular project, ask yourself "why is that important?" And whatever answer you come up with, ask yourself again, "why is that important?" Keep asking "why is that important," and you will begin to articulate your responses in goals and objectives that reach beyond activities.

Improving the quality of life is the point; it is the objective to which this activity contributes. With all GBV activities, it is important to think through the causal relationship that connects project activities with the overall project objective. Thinking though the logic of your activities will improve their impact.

When thinking through program design, you can use the below table as a guide. Each row, or level, represents an important element of the overall program strategy.

PROGRAM STRATEGY	INDICATORS	MEANS OF VERIFICATION	CRITICAL ASSUMPTIONS
Goal: The overall purpose towards which the program contributes. This statement should articulate the durable solution to which the project is contributing.	None	None	None
Objective: The part of the goal that the program will achieve.	Impact indicators	Method of data collection	Assumptions in moving from objective to goal
Outcomes: Changes that the program seeks to achieve. This can include changes in people's knowledge or attitude.	Outcome indicators	Method of data collection	Assumptions in moving from outcomes to objective
Outputs: The goods and services that the program will produce. E.g. number of people trained.	Output indicators	Method of data collection	Assumptions in moving from outputs to

Major Activities: Major tasks carried out by program personnel and partners.	Note: Major inputs go here, not indicators. Major inputs are the major resources needed to carry out the activities.	None	outcomes and/or in moving from major activities to outputs.

NOTE: GUIDANCE ON MONITORING AND EVALUATION

Though emergency settings limit the amount of time available to design and implement program, interventions should always have established indicators and an accurate system of monitoring, review and analysis. Monitoring and evaluation of emergency interventions increases accountability, encourages results-based management, and improves future interventions by identifying and documenting lessons learned.

A logical framework, or logframe, can help ground an organization's response in the goals and objectives of the intervention and prioritize where to direct efforts. Use the logframe to define key indicators to demonstrate performance and show whether or not proposed changes have occurred.

The means of verification lays out how you gather the information necessary to track a particular indicator. Each indicator must have an accompanying means of verification. When working with a logframe, it is important to identify the means of verification at the same time as identifying the indicator. This is because if a suitable method cannot be found the indicator must be abandoned and a new one selected. An indicator without a means of verification signifies that there is no way to collect data on that indicator, which renders the indicator useless.

It is important to consider the time and effort involved in data collection. Some indicators will be tracked frequently throughout the life of the project, through routine monitoring. Other indicators will be tracked through mid-term or end of project evaluations.

Outputs should be monitored relatively frequently. This means you want to choose indicators and means of verification that use a data collection method that is not overly time-consuming or costly. As you move up in complexity to effects and impact/objective levels of the log frame, your indicator and means of verification may involve data collection methods that are more complicated, time-consuming and costly. This is acceptable because in most cases, you are not measuring outcome and impact/objective indicators as frequently as output indicators (with the obvious exception of certain health impact indicators that are monitored frequently).

As you continue, keep in mind that for effective short- and long-term protection from violence for women and girls, interventions must take place at three levels so that structural, systemic and individual protections are institutionalized.[23] These levels are:

- Structural level: preventative measures to ensure rights are recognized and protected (through international, statutory and traditional laws and policies)

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[23] Adapted from A. Jamrozic and L. Nocella, The Sociology of Social Problems: Theoretical Perspectives and Methods of Intervention, Cambridge University Press, 1998.

- Systemic level: systems and strategies to monitor and respond when those rights are breached (statutory and traditional legal/ justice systems, healthcare systems, social welfare systems and community mechanisms)
- Operative level: direct services to meet the needs of women and girls who have been abused

THE GBV EMERGENCY RESPONSE PROGRAM MODEL

Emergency response should prioritize women and girls' access to life-saving services, such as healthcare and psychosocial services, and seek to reduce immediate threats of violence. In some cases, a GBV intervention may not actually be a stand-alone program, but may integrate essential services into existing programs. In other cases, you may support local or national institutions to provide care and assistance to women or girls or provide technical assistance to existing GBV programs that pre-date the emergency.

The following pages outline the IRC program model for responding to GBV in emergencies. This program model, based on years of experience in rapid response to GBV during crisis, is focused on the first 12 weeks of an emergency. This is a critical response window, and is when humanitarian actors most often sideline the needs and considerations of women and girls; however, the guidance provided is also valid for longer-term, protracted, or cyclical emergency contexts.

The IRC program model can be used as a guide in most contexts, but should also be closely examined in light of specific contextual considerations, analysis of needs, and pre-existing services and actors.

WHERE IS ACCESS TO JUSTICE IN THE PROGRAM MODEL?

In the early days of an emergency, staff and funding may be very limited. Allocating these limited resources to activities like an audit of national laws and policies or an assessment of legal services is not appropriate if adequate health and psychosocial services are not available. You can, however, lay the groundwork for improved access to justice by putting in place quality health and psychosocial services, and by establishing a case management structure and referral system. These aspects of emergency programming can help facilitate the process for women and girls who request legal assistance. Staff can provide women with accurate and realistic information about existing services and support and the likely outcomes of legal action to help them make informed decisions about the options before them.

In the early stages of an emergency, it may not be feasible to link women with justice actors—such as the police and courts—in part because justice systems and structures may have disintegrated as a result of the emergency. In these settings, staff may address the issues of impunity through national and international advocacy efforts or may support national efforts to reform or create laws and policies that support the rights of women and girls. Ensuring redress for GBV survivors also includes working to build the capacity of existing national and traditional legal actors to enable them to appropriately carry out their responsibilities.

GENDER-BASED VIOLENCE (GBV) EMERGENCY RESPONSE PROGRAM MODEL

Goal: Women, girls & GBV survivors are protected from harm & supported to recover & thrive.

Survivors of GBV access appropriate services in a safe and timely manner.

Outcome: Survivors of GBV have safe access to health services.[1]
- Carry out service mapping of available GBV-related health services.
- Advocate for action to improve identified gaps in health services.[2]
- Work with health actors to identify and train GBV focal points in all health facilities.
  - Work with health actors to identify confidential spaces within health centers.
  - Train health facility medical and non-medical staff on GBV guiding principles for supporting a survivor and providing safe referrals.

Outcome: Survivors of GBV have access to emergency GBV case management services.
- Identify service providers already providing GBV case management services.
- Train GBV caseworkers in the provision of basic case management.
- Establish case management system, including appropriate intake and consent forms.
  - Ensure safe, confidential storage of all client information.
  - Provide weekly supervision and mentoring to GBV case workers.
  - Identify safe and confidential spaces for the provision of case management.

Outcome: Women, girls, and survivors of GBV have safe entry points to psychosocial services.
- Identify safe spaces through which women, girls and survivors can access basic emotional support, accurate information about services and referral.
- Identify women's groups/networks that can provide survivors with basic emotional support and a safe space through which to assimilate into community activities.
  - Train and mentor psychosocial staff and/or partners.
  - Provide individual and/or group emotional support activities for women & girls.[3]

Outcome: Survivors of GBV safely navigate referral pathways and benefit from well-coordinated services.
- Carry out mapping of available services for survivors of GBV.
- Develop functional referral pathways, with entry points fitted to the needs of different survivors (children, adolescents, adults, survivors with disabilities, etc.).
  - Disseminate information on referral pathways among service providers.
  - Establish and/or advocate for regular meetings between service providers.[4]
  - Provide other sectors with information related to referrals and guiding principles.

Outcome: Communities know the available services and access them.
- Train community outreach teams to disseminate key messages on service availability.
  - Develop & translate clear, simple messages about service availability, and disseminate through relevant means (info boards, info sessions, radio, etc.).

Women and girls face reduced risk of violence.

Outcome: Women and girls access material and cash-based support to help meet immediate needs.
- Understand communities' perceptions of safe entry points for GBV services.[5]
- Advocate lead distribution of material support (dignity kits, solar lights, stoves, etc.).
- Provide cash-based means to help women & girls meet individual & family needs.[6]
- Advocate that all humanitarian service delivery is safe for women & girls.
  - Work with shelter, food, livelihoods and economic recovery actors to monitor impact cash & distribution programs have on women and girls' safety & well-being; ensure mechanisms are in place to identify potential negative consequences.

Outcome: Humanitarian actors across sectors identify and address risks to women & girls.
- Advocate for and participate in inter-sector/cluster coordination on women & girls.
- Lead/support regular safety audits to identify and monitor risks to women & girls.
- Lead/advocate for actions that reduce risks to women & girls in immediate environment (firewood or community patrols, public lighting, shelter & latrine locks).
  - Advocate GBV IWG focal points to share concerns & info at other sectors' meetings.
  - Disseminate GBV action sheets (adapted from IASC) to all humanitarian sectors.
  - Advocate for in-country protocols on the Prevention of Sexual Exploitation & Abuse (PSEA), including clear reporting protocols & training all humanitarian personnel.[7]

Outcome: Communities support women, girls, & survivors of GBV, and promote women's networks and spaces.
- Identify women's groups and/or networks that can provide a safe space for women & girls to share information and experiences.
- Identify a unique physical space that allows women and girls to meet and share.
  - Provide group activities for women & girls through safe spaces / women's groups.
  - Identify avenues in which survivors of GBV can safely assimilate in group and community activities while maintaining the confidentiality of their experience.[8]

Outcome: Communities are aware of risks women & girls face and develop strategies to reduce those risks.
- Conduct mapping exercises to identify safe and unsafe areas for women & girls.
- Work with sectors and community leaders to share information about services.
- Disseminate messages to inform women, girls and the community of risk mitigation measures, safe wood and water collection practices, buddy systems, etc.).
  - Train staff, partners and community volunteers in basic risk assessment and monitoring using safety audits, community mapping or other tools.

Policies, systems, & funding prioritize women, girls & survivors.

Outcome: Decision-makers act to improve the protection of women & girls.

Immediate activities to support the program model:
- Develop clear, targeted recommendations based on assessment and analysis of needs and risks (see immediate Activities, below).
- Disseminate targeted recommendations to specific audiences, including other sectors/clusters, donors and governments.
  - Build inter-agency and cross-sectoral consensus around advocacy messages and strategies where possible and relevant.

Immediate activities to support the program model: ◆ Develop & put in place safety plans for staff, partners & volunteers. ◆ Establish a policy to reinforce the importance of staff self-care & provide concrete options for staff support, including regular debriefing for staff providing services to survivors. ◆ Carry out GBV rapid assessment to identify factors that increase women & girls' vulnerability to violence, gaps in services, and barriers to accessing services. Methods may include safety audits, service mapping, focus group discussions & key informant interviews.

[1] The actions outlined here are tailored for non-health actors whose actions contribute to clinical care for survivors. ◆ [2] This includes the presence of health workers trained in the clinical management of rape & provision of medicines and supplies in health facilities. ◆ [3] In an acute emergency response, individual psychosocial support may only be possible during the initial case management meeting with a survivor. ◆ [4] These meetings are among service providers, to follow up on existing referrals and address challenges to referrals and case management. These are separate from GBV coordination meetings. Information sharing guidelines should be established to ensure meetings are confidential. ◆ [5] This takes place through focus group discussions, community mapping exercises, or other approaches ◆ [6] Such as unconditional cash transfers, cash or food vouchers, or cash for work. ◆ [7] Senior management holds primary responsibility for implementing and overseeing a system to prevent SEA from UN, NGO, and related personnel. For further information and support, see www.iom.int/pseatoolforce. ◆ [8] In this way, GBV survivors do not have to identify as survivors in order to assess support. A survivor may choose not to disclose for many reasons, including safety.

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Notes & Reflections

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SESSION 6: CASE MANAGEMENT

Learning Objectives:

- Understand the key steps of case management in emergency contexts.

A case management approach is useful for clients with complex and multiple needs who access services from a range of service providers, organizations and groups. **Case management** is a collaborative, multidisciplinary process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's needs through communication and available resources to promote quality, effective outcomes.[24]

Unless an organization providing local case management pre-exists the emergency and has not itself suffered significant damage, it is unlikely that you will be able to provide true case management during the acute emergency response period. Your priorities will be focused on establishing minimum essential health and psychosocial services, and you may not be able to train caseworkers and establish a complete case management system. In emergencies characterized by the upheaval of local communities and large population movements, it might also be unlikely that service providers see a survivor more than once. Follow-up may not be realistic or possible.

Despite these challenges, there are several measures you can take to ensure that survivors receive the critical care and information they need, and to set the groundwork for the establishment of case management services once other essential services are in place.

Any training for psychosocial and medical responders should also address the principles of case management, with particular emphasis on empowering the client and informing her of her choices and services available. Staff should understand all five steps of case management, and understand how the first three steps in particular are relevant when providing individual counseling to survivors. (Psychosocial staff are often caseworkers as well as counselors, so should have this background as part of preparedness and regular service delivery.)

Case management in emergencies focuses on the following three steps:

> **IMPORTANT!**
>
> 1. The client is the primary actor in case management.
>
> 2. Action plans are developed in collaboration with the client and must reflect her wishes and choices.
>
> 3. The goal is to empower the client and ensure that she is involved in all aspects of the planning and service delivery.

Assess: Carrying out an assessment involves getting information. Why has the client come for help? What has happened? How does the client see the situation? What needs does the client have? What supports does the client have? Listen to the client's story, help her to identify her needs, and carefully and confidentially document information. Active listening is one of the most powerful elements of psychosocial care.

Plan: What does the client want to happen next? To help a client plan how to meet those needs and solve problems, we give relevant information about available services. We help a client identify her options and help her make informed decisions about what she wants to do.

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[24] Case Management Society of Australia, 1998

Implement the Plan: How can we help a client achieve her goals? This step means putting the plan into action. This involves direct service delivery, referral for services not provided, advocacy on behalf of the client and supporting her throughout the process. The action plan is just a road map. When implementing a plan, consider a car with a driver and a navigator. The client has drawn up a map and is driving the car, determining how fast to go, where to turn and when to stop. The caseworker is the navigator, helping the client maneuver through the steps in her plan or road map.

The following two additional steps are part of the standard case management process in more stable contexts, and case management staff should seek additional support to put these into place, if they are not already doing so before the crisis. These steps may not be feasible in an emergency context.

Follow-up and review: This step includes following-up to make sure the client is getting the help and services she needs to improve her situation and solve her problems. Is the situation better? Has the help been effective? It involves monitoring and evaluating the consequences for the client and identifying barriers to achieving outcomes. In your follow-up, you might identify additional needs and actions points and should therefore plan accordingly with the client. The plan of action should be time-framed and based on the client's needs.

Case closure: This usually happens when the client's needs are met and/or her own support systems are functioning.

CASE MANAGEMENT & PSYCHOSOCIAL SUPPORT

Case management and psychosocial support are two elements of GBV response that are often conflated or confused.

Case management is a process used to assess and meet the immediate needs of survivors related to an incident(s) of violence. Actions are based on fulfilling the short term needs of the survivor (health, emotional support, legal, etc.) and once deemed adequate, the case is closed and the case management process is concluded for that incident and survivor.

Psychosocial support denotes a collection of activities, processes and systems that are focused on the entire individual and their environment and helping them to restore a sense of functioning and self-worth. Related to GBV survivors, psychosocial support seeks to improve a survivor's well-being by:
- Bringing healing to survivors and their families through acceptance;
- Restoring the normalcy and flow of life;
- Protecting survivors from the accumulation of distressful and harmful events;
- Enhancing the capacity of survivors and families to care for their children; and
- Enabling survivors and families to be active agents in rebuilding communities and in actualizing optimistic futures.

Psychosocial support can include many different kinds of activities, including individual and group interactions, as well as interventions including a survivor's family or other individuals. In short, psychosocial support focuses more broadly on the individual whereas case management focuses on the immediate needs related to the incident of violence.

However, case management and psychosocial support for survivors of GBV are very strongly linked: case management can have positive psychosocial outcomes, when it is performed in a way that is supportive of a survivor's emotional well-being and connection with social networks. For example, when a case manager provides emotional support to a survivor through words of understanding and support, helps survivors to learn about violence and its consequences, or helps survivors to cope with the social stigma attached to the violence by linking her with a support group – each of these seeks to improve a survivor's

psychosocial wellbeing. In addition, staff providing case management and psychosocial support are often the same, particularly in emergency contexts.

CASE MANAGEMENT DOCUMENTATION IN EMERGENCIES

When to begin maintaining case files will depend on the specific context and your ability to ensure safe, confidential storage of all client information. As soon as a system is in place, you should introduce a basic intake tool and consent form, accompanied by a more comprehensive case management tool. Where case management services existed prior to the emergency, these service providers should be consulted and should inform any tool development. While emergency responders may need to support case management service providers to cope with increased client loads, their role should be to support and reinforce the quality of services.

Remember – if your organization does not already provide case management services, this training DOES NOT qualify you to begin to do so, in an emergency or otherwise. Please seek additional support if your organization wishes to begin providing case management services.

INDIVIDUAL REFLECTION: WHAT DOES THIS MEAN FOR ME?

Take some time to reflect on and answer the following questions.

Does my organization already provide Case Management services? If yes, how can I make sure my services are adapted to the emergency context?

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If no, what is my role in relation to Case Management (e.g. as an entry point/connector, sharing relevant information in communities, making referrals, working together with case management agencies or organizations, etc.)?

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Are there any risks for me as an individual and for my organization in taking these steps? How can I manage them?

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Notes & Reflections

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SESSION 7: PSYCHOSOCIAL SUPPORT

Learning Objectives:

- Understand the psychosocial impact of GBV.
- Identify the most appropriate psychosocial approaches in emergency settings.

THE PSYCHOSOCIAL IMPACT OF GBV

GBV shatters trust, destroys communities, diminishes opportunities for personal development, and has a deep impact on the well-being of women and girls. Psychological consequences of GBV include fear, shame, anxiety, and suicidal ideation. Incidents of GBV can also lead survivors to withdraw from day-to-day activities and social support, making recovery and the resumption of 'normal' functioning more challenging.

Often, an accumulation of violent or traumatic events affects an individual's ability to function, both as an individual and within her family, community, and society. Violence or trauma related to emergencies – such as forced displacement, witnessing violence or surviving an armed attack – can severely impact the well-being of women and girls; acts of sexual violence can result in even more psychological distress and social harm as local systems, services and networks which previously existed disintegrate. In addition, women or girls may have experienced other forms of violence before the onset of the emergency which can impact their ability to manage the consequences of the new incidents of violence related to the emergency.

Psychological Consequences of GBV

Post-traumatic stress
Insecurity
Depression
Anger
Anxiety
Fear
Self-hate
Shame
Self-blame
Mental illness
Suicidal thoughts and/or attempts

The social effects of conflict include altered family relationships and community networks, and economic status. Conflicts or natural disasters can lead to increased death, separation of families, experiencing or witnessing physical and sexual violence, the breakdown of family and community networks, damaged human values and practices, and environmental destruction.

UNDERSTANDING PSYCHOSOCIAL PROGRAMMING

Psychosocial refers to the dynamic relationship between psychological and social effects of a traumatic event or violence on an individual. Both the psychological and social effects of emergencies continually influence each other.

PSYCHO-SOCIAL

Humanitarian agencies have come to prefer the term psychosocial well-being over narrower concepts such as mental health, as 'psychosocial' points explicitly to social and cultural influences, as well as psychological influences, on well-being.
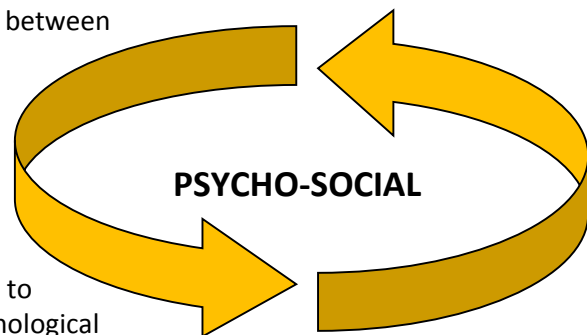
The psychological effects of conflict affect an individual's different levels of functioning, including:

- Cognitive, those perceptions and memory that serve as a basis for thoughts and learning;

- Affective or emotional; and

- Behavioral

The psychosocial needs of a GBV survivor are determined by the nature and extent of emotional, psychological, and social harm, that is, the extent of suffering and the resulting level of dysfunction.

Psychosocial assistance to a GBV survivor is built on an understanding of the survivor's unique needs, not on a predetermined formula for psychosocial intervention. It requires assessing the psychosocial functioning of a survivor: her unmet needs, her personal strengths, and her abilities. Some survivors need a great deal of help; others need only reassurance and a little information.

CULTURAL RELATIVISM

Often when issues related to the unequal status of women and girls and sexual violence are raised in a community, debates regarding cultural relativism can emerge. When GBV staff initiate these discussions, it is critical that the role of humanitarian actors is clearly articulated to colleagues, communities and all stakeholders.

The psychosocial needs of survivors are specific to the context and culture, as well as to the individual's experience and reality. Humanitarian actors should not 'impose' a psychosocial intervention on communities but should design and implement a strategy in concert with communities themselves.

APPROACHES TO PSYCHOSOCIAL SUPPORT

Psychological and social consequences of violence that go unaddressed often have long-term negative implications at the individual, family and community levels. Yet, psychosocial programming has been typically overlooked as a priority intervention in emergencies as its outputs are often less tangible than other programs, such as health, water sanitation or food and non-food item distribution. Thus, humanitarian actors often prioritize other responses in the midst of the competing priorities in an emergency.

In recent years, the need for such interventions is now less disputed than before and there is increasing consensus that humanitarian actors should implement psychosocial programs at the outset of emergencies. However, this consensus has not led to consistent or standardized approaches towards addressing the psychosocial needs of women and girls. Some organizations follow a clinical model; that is, they see psychosocial interventions as responding to the individual needs of those who have suffered from trauma.

The IRC, however – along with many others – understands psychosocial support within a community-based model, where interventions focus on strengthening community resources and establishing or re-establishing coping strategies. Community-based models begin with the assumption that in emergencies, the needs of individuals cannot be separated from the family and/or community of which they are a part. It recognizes that the psychosocial well-being of an individual is influenced by individual, community and environmental resources.

In addition, it is being increasingly recognized that psychosocial interventions in emergency contexts can provide opportunities not only for restoration but also for transformation – that is, women and girls can take advantage of changes in existing community systems and mechanisms to transform their role, and that psychosocial support can play an important role in this process.

The consequences of events such as conflict, mass displacement and natural disasters are diverse and impact the well-being of community over many years. They can disrupt or diminish the physical, material and economic resources of a community and erode psychosocial well-being.

Interventions that target an individual survivor's psychosocial well-being are typically implemented in combination with social integration activities in order to decrease stigma to survivors. These interventions provide an additional entry point in the community for survivors, provide support for survivors who do not require more intensive support, and provide an opportunity for survivors to gain access to skills and knowledge-building activities that may not otherwise be available to them.

Psychosocial interventions in emergencies should address the consequences of sexual violence and promote:

- **Healing** at an individual, family, and community levels by rebuilding trust and coping mechanisms.

- **Empowerment** by realistically and safely working to increase women's role in decision-making and their access to economic opportunities.

- **Acceptance** by ensuring survivors and their children are included and supported by their communities.

The diagram[25] on the following page provides a visual demonstration of types of psychosocial interventions that can be applied in different social spheres, all of which contribute to the ultimate goals of healing, empowerment and acceptance.
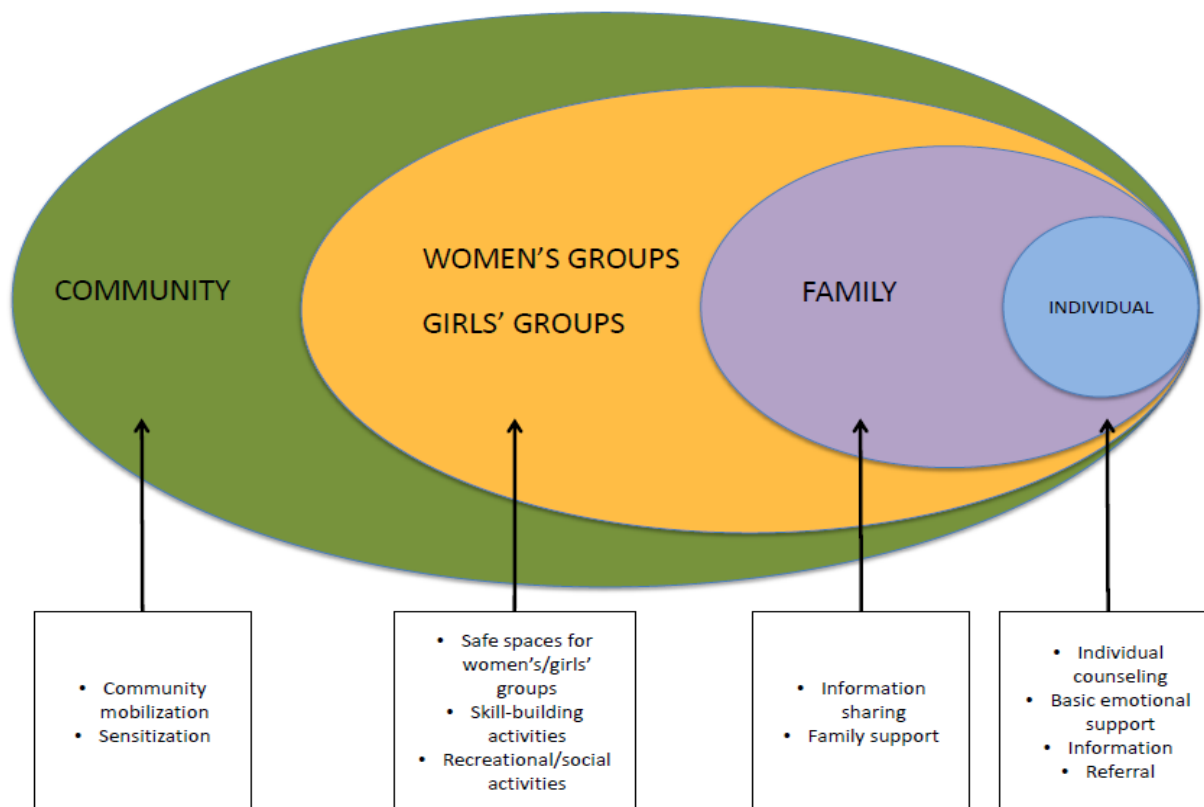
In emergency settings, GBV providers empower survivors of sexual violence by providing them with information to help them make decisions. GBV providers also empower women and girls through skill-building sessions and information sessions.

GBV actors can strengthen community and individual by facilitating social cohesion in the following ways:

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[25] International Rescue Committee, 2010

- Empowering women and girls and reducing their vulnerability
- Promoting acceptance and community support for survivors of sexual violence
- Helping women and girls to overcome shame and stigma and help them access healthcare
- Supporting survivors to play a productive part of the family and community and ultimately resume normal life

Keep in mind there may be some factors in a person's life that might help them to deal with violence and trauma (mediating factors) and there may be aspects of a person's life that actually make the trauma worse without outside intervention (exacerbating factors).

MEDIATING FACTORS	EXACERBATING FACTORS
- If she has community and personal support - If she receives responsible and appropriate support from authorities - If there are precautions taken to prevent it happening again - If there is a safe environment to rest and recover - If she has good physical and mental health - If she feels she coped well - If she has positive self-esteem - If she has an empowered view of herself as a woman	- If it happens on top of previous trauma - If there is no safe place to go to - If there is a lack of understanding and support - If there was more than one perpetrator - If she knew or trusted the perpetrator - If she already felt bad about herself - If she is unable to acknowledge or talk about the incident - If she has physical or mental illness or disability - If there is a risk of pregnancy or contracting an STI or HIV/AIDS

Resilience refers to the capacity to do well when faced with difficult circumstances. This includes resistance against destruction, the capacity to protect one's own integrity under pressure and the ability to construct something positive in spite of difficult circumstances. Psychosocial interventions seek to build upon an individual's resilience.

How is resilience supported? What enables people to stay resilient in the face of such difficult circumstances?

Resilience is fostered in human beings in a number of ways:

- Through the experience of empathy, care and respect for one another in a family
- By acquiring relevant knowledge and skills to understand and deal with difficult situations
- Observing good role models who cope successfully with difficulties and maintain an attitude of hope and purpose when facing difficulties
- Having access to systems of knowledge, ideologies or beliefs that give meaning to complex and difficult situations

COUNSELING

Counseling is an effective way of empowering clients by giving them knowledge about their choices and helping them to see how their personal experience relates to gender inequality within society. Women and girls who have suffered sexual violence need support that is geared toward building trust, connections, and understanding; they need to be empowered.[26]

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[26] K. Watterson, Women in Prison: Inside the Concrete Womb; Northeastern University Press, Boston, 1996.

Counseling is a helping relationship aimed at enabling a client to explore a personal problem, giving the client increased awareness of choices they have in dealing with the problem, and assisting her or him to make an informed decision about what to do about the problem.[27] Counselling is an information exchange process, with the additional component of sharing feelings and emotions that the client finds difficult or disturbing. Such feelings act as constraints to functioning, which the client is not able to resolve alone or within usual social relationships.[28]

Helping a client to make informed decisions is empowering (she has control over her choices), respectful (her opinions and judgments are valuable) and responsible (she must live with her decisions and their consequences and is accountable for her own life and choices).

SAFE SPACES FOR WOMEN

Establishing women's community centers or other spaces for women helps improve women and girls' access to services and provides a safe place for them to gather and socialize. Women's centers can be used to host a variety of activities and services, including:

- Individual counseling and emotional support for survivors of sexual violence, to address their needs;
- Discussion and information-sharing sessions on specific topics relevant to women and girls, such as health and sanitation, violence or childcare;
- Skill- and knowledge-building activities, including literacy and numeracy, health education, or sewing classes; and
- Recreational activities such as sports, dancing, drama, arts and crafts, or story-telling.

In some contexts, centers may already exist but in many emergencies, they do not. In the early days of an emergency, it may be difficult to establish permanent or temporary structures to house safe spaces for women. However, as time progresses, thought should be given as to how to establish temporary safe spaces in emergency settings and how to transition these spaces into more sustainable structures once the situation stabilizes.

WOMEN'S GROUPS & GIRLS' GROUPS

Informal groups within communities usually exist long before humanitarian actors step into action during a crisis. Sometimes these groups continue to function throughout an emergency but often, communities are displaced and new groups may form organically. In many emergencies, female community leaders, traditional birth attendants, or midwives take on the role of mobilizing and supporting women and girls.

In emergencies, GBV staff holds structured and informal information sessions with women and girl's groups on topics such as reproductive health, safety, childcare and meeting basic needs. Female representatives from the community or staff from organizations working in the same camps or communities can often facilitate women and girls' groups.

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[27] UNHCR and GRT, *Psychosocial counseling and social work with clients and their families in the Somali Context: A Facilitator's Guide*. 2009.
[28] UNHCR and GRT, *Psychosocial counseling and social work with clients and their families in the Somali Context: A Facilitator's Guide*. 2009.

SKILL-BUILDING & SOCIAL ACTIVITIES

After the initial stages of an emergency have passed, GBV staff can work with women's and girl's groups to provide skill-building activities, such as literacy and numeracy classes, and culturally-appropriate social activities to women and girls.

Skill-building and social activities serve to:

- Reduce stigma attached to survivor-only services or interventions;
- Increase access to skill-building and support activities for survivors to promote self-sufficiency and empowerment to survivors;
- Provide an additional entry point for survivors to receive services and information at their own pace.
- Provide an outlet for group emotional and healing activities for survivors that may not require more individualized or intensive support.

Skill-building activities for women and girls' groups provide a safe space for women to socialize, offer a sense of routine or normalcy in turbulent settings, and help to restore confidence. These activities also promote healing, empowerment and acceptance.

Establishing social activities in emergency settings can be challenging. In some instances, donors and senior management may seek after skill-building activities as 'tangible' elements of GBV programs, despite their appropriateness to the context. In other cases, women themselves may request such activities, as they believe the activities will help them improve their access to economic opportunities. Chronic displacement and insecurity may also pose risks to longer-term activities but women themselves may still opt for them. For example, in North Kivu, women's groups successfully worked together on collective agricultural plots and, despite the risk of persistent displacement and the challenges posed by land ownership, were able to raise and sell crops for profit.

GBV staff should be clear about the goals and anticipated outputs of social activities when working with women to avoid perpetuating false expectations among women and girls participating in these activities.

Skill-building and social activities are sometimes called socioeconomic or income-generating activities. Typically, however, the primary objective of these activities in emergency settings has been psychosocial not economic. When including skill-building and social activities in an emergency response, make sure staff is clear in the program design about the anticipated impact of these activities.

While the economic disadvantages for women and girls have long been recognized as key elements of vulnerability, emergencies are challenging environments in which to establish income-generating activities. The priority in an emergency is to make sure that women and girls have access to lifesaving support, such as healthcare, psychosocial support and interventions to improve safety and security. As a situation stabilizes, opportunities to establish longer-term microeconomic activities, such as village savings and loans activities (VSLA), may arise.

COMMUNITY LEADERS & STRUCTURES

Community leaders, particularly female traditional healers such as traditional birth attendants, can play an important and powerful role in healing. Community leaders often yield high levels of power within communities. Sometimes this power is applied in positive ways to promote the health and well-being of women and girls and other times this power is abused and exposes women and girls to greater risks of violence.

DESIGNING A PSYCHOSOCIAL INTERVENTION

Psychosocial responses should be sustainable, community-based strategies that do not inflict further harm on the survivor or community. Remember that there is no one reaction or response to sexual violence; every survivor will respond differently. However, there are common psychological and social consequences of sexual violence that we can anticipate and be prepared to address.

The places where emergencies occur may have different concepts of self and community than others. Understanding the different cultural concepts of self and community is key to understanding appropriate methods of healing for survivors in any one particular community. For example, responses of individual counseling may not be appropriate if the concept of self and process of healing is strongly tied to the community and more centered on family. Successful psychosocial interventions will ultimately provide a survivor with what she needs to regain control over her life; what that actually means will differ from one community to the next.

Donor priorities and request for proposals often drive decisions about whether and how to intervene. In the face of considerable pressure and time constraints, GBV staff must carefully think through the objectives of psychosocial interventions and how to achieve these objectives.

Humanitarian actors cannot generalize people's reactions to the experiences they have endured; not all survivors of sexual violence want or need services. Interventions should seek to bring resources and assistance to communities to empower survivors to care for themselves and to provide leadership within their communities to safely and appropriately address the needs of survivors.

GBV staff must set realistic goals for psychosocial interventions in both emergency and post-emergency settings. Psychosocial interventions are not only about feeling better but also about functioning better. IRC strives to help survivors reach a place where they are functioning within their communities while remaining realistic about the extent of care we can provide.

Remember, stand-alone psychosocial programs may not be well-accepted if communities feel that their basic needs are not secured; it is often difficult to convince communities (and service providers) of the value of psychosocial programming in the immediate onset of an emergency. In an emergency, women and girls may be preoccupied with meeting basic needs of others before they are ready to address their own psychosocial needs. This is not to say, however, that psychosocial programming should wait until other needs have been met; firstly, it is rare that all other needs will be met rapidly, and secondly, psychosocial support is both necessary as an emergency response intervention in its own right, as well as supportive of other forms of recovery.

Participation & Sustainability

Community participation is key to designing and implementing a sustainable psychosocial intervention. Effective psychosocial interventions:

- Build a sense of local ownership and self-reliance;
- Enable collective planning and action that includes highly vulnerable people;
- Include beneficiary perspectives in defining positive and negative consequences of interventions, including children and youth;
- Strengthen local skills and social institutions that enable local communities to meet the psychosocial needs of its members.

GBV staff must be sure to incorporate strategies to ensure the sustainability of interventions, even in the middle of an emergency. Sustainability of a program to address the psychosocial needs of survivors is reliant on the support and active participation of the community. Community-based programming ensures that the women, girls, men and boys of a community are central to efforts to address GBV.

Ultimately, it is their issue to address and the role of the GBV staff is to lend human and financial resources to build the capacity of the community to be better positioned to address GBV.

Training

Psychosocial interventions are typically implemented by paraprofessionals who may have had only one or two weeks of training and yet are asked to handle difficult situations and cases.

In addition, training can impose outside ideas and tools in ways that silence local understandings and fail to learn from local culture, practices and resources.

Effective programs should:

- Regard training as an on-going process with regular support and supervision;
- Help trainees to understand limits of their knowledge and to seek assistance in handling especially complex situations;
- Tailor training to meet the specific roles and responsibilities of the participants;
- Create spaces for mutual learning to discuss strengths/weaknesses, and the potential to blend Western and local approaches.

GBV staff should ensure that any staff deployed to address the needs of conflict-affected or disaster-affected populations receive appropriate training to carry out their work. Trainings and on-the-job supervision should continue throughout the emergency and daily or periodic debriefs should be conducted with psychosocial staff or caseworkers to provide technical assistance with identified cases while also providing emotional support to staff working in challenging and insecure environments.

INDIVIDUAL REFLECTION: WHAT DOES THIS MEAN FOR ME?

Take some time to reflect on and answer the following questions.

Does my organization already provide psychosocial support in some way? If yes, how can I make sure my services are adapted to the emergency context?

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If no, what is my role in relation to psychosocial support (e.g. can my activities be adapted to have psychosocial benefits? Can I serve as an entry point/connector, or share relevant information in communities, make referrals, work together with psychosocial support agencies or organizations, etc.)?

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Are there any risks for me as an individual and/or for my organization in taking these steps? How can I manage them?

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SESSION 8: HEALTH RESPONSE
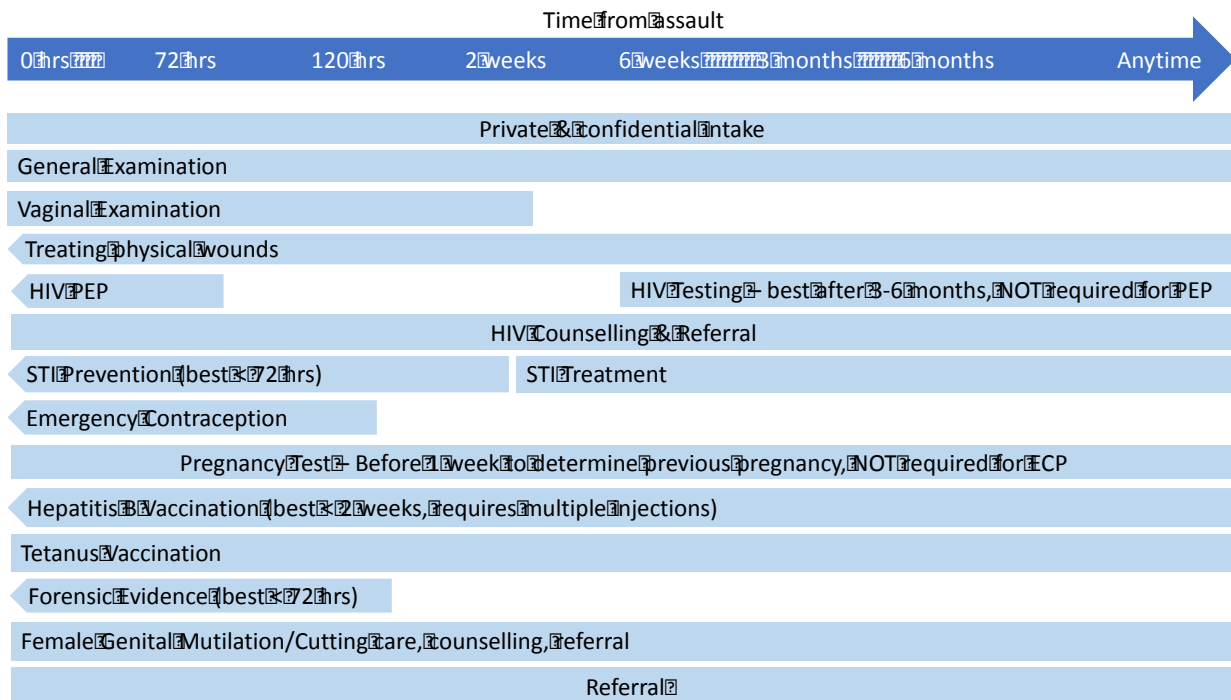
Learning Objectives:

- Identify healthcare priorities when launching a GBV-related response in an emergency setting.
- Recognize the appropriate roles of GBV and Health personnel in health response for adult, adolescent and child survivors.

It is widely recognized that GBV is an international public health issue, and can result in serious injury, illness or death. GBV can contribute to unintended pregnancy, complications of pregnancy and childbirth, maternal mortality, unsafe abortion, HIV infection, child and infant mortality and a host of other adverse outcomes. Violence against women also undermines efforts to improve child, family, and community health and reduce the spread of HIV/AIDS. In fact, the World Bank estimates that violence against women kills and harms as many women of reproductive age as cancer and is a greater cause of illness than traffic accidents and malaria combined.[29]

Despite these facts, adequate, appropriate, and comprehensive GBV prevention and response efforts are lacking in most countries.

The following timeline provides an overview of key healthcare interventions for survivors of (sexual) violence. These interventions are explained in more detail below.

Time from assault							
0 hrs	72 hrs	120 hrs	2 weeks	6 weeks	3 months	6 months	Anytime

Private & confidential intake							
General Examination							
Vaginal Examination							
Treating physical wounds							
HIV PEP				HIV Testing – best after 3-6 months, NOT required for PEP			
HIV Counselling & Referral							
STI Prevention (best < 72 hrs)		STI Treatment					
Emergency Contraception							
Pregnancy Test – Before 1 week to determine previous pregnancy, NOT required for ECP							
Hepatitis B Vaccination (best < 2 weeks, requires multiple injections)							
Tetanus Vaccination							
Forensic Evidence (best < 72 hrs)							
Female Genital Mutilation/Cutting care, counselling, referral							
Referral							

MINIMUM INITIAL SERVICE PACKAGE

The health consequences of GBV are a cause of major morbidity and mortality for girls and women in emergencies and ensuring survivors have access to quality health services is a priority in emergencies. However, there is a tendency to overlook essential sexual and reproductive health interventions in the early days of an emergency.

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[29] Mirsky, J., *Beyond Victims and Villains: Addressing Sexual Violence in the Education Sector*, The Panos Institute, 2003.

The Minimum Initial Service Package (MISP) for Reproductive Health is a priority set of life-saving activities to be implemented at the onset of every humanitarian crisis. When implemented at the onset of an emergency, the MISP saves lives and prevents illness, especially among women and girls. The MISP prevents excess maternal and neonatal mortality and morbidity, reduces HIV transmission, prevents and manages the consequences of sexual violence, and includes planning for the provision of comprehensive reproductive health services.

Implementing the MISP is not optional:

It is an international standard of care that should be implemented at the onset of every emergency.

The MISP is not just an assortment of equipment and supplies; it is a set of internationally accepted minimum standards for treatment and care that must be implemented in a coordinated manner by appropriately trained staff at the beginning of a crisis. It can be implemented without an initial needs assessment. Data on sexual violence, HIV and other sexual and reproductive health issues are not required to implement the MISP.

Who is responsible for implementing the MISP?

Humanitarian workers are responsible for ensuring that MISP priority activities are implemented. MISP activities are not limited to reproductive health staff or even the general health sector. The MISP cuts across all sectors; this includes food security, water and sanitation services, and shelter.

The MISP is a standard in the 2011 revision of the *Sphere Humanitarian Charter and Minimum Standards in Disaster Response*. This serves as recognition that women and girls suffer from unnecessary and excess death and disability when basic and priority reproductive health services are not established for weeks or months into an emergency.[30]

OBJECTIVES & ACTIVITIES OF THE MISP

1. Identify an organization(s) and individual(s) to facilitate the **coordination** and **implementation** of the MISP by:
   - Ensuring the overall reproductive health coordinator is in place and functioning under the health coordination team;
   - Ensuring reproductive health focal points in camps and implementing agencies are in place;
   - Making available material for implementing the MISP and ensuring its use.

2. **Prevent sexual violence** and provide appropriate assistance to survivors by:
   - Ensuring systems are in place to protect displaced populations, particularly women and girls, from sexual violence;
   - Ensuring medical services, including psychosocial support, are available for survivors of sexual violence.

3. **Reduce the transmission of HIV** by:
   - Enforcing respect for universal precautions;
   - Guaranteeing the availability of free condoms;
   - Ensuring that blood for transfusion is safe.

4. **Prevent excess maternal and neonatal mortality and morbidity** by:

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[30] Women's Commission for Refugee Women and Children, *MISP Fact Sheet*, 2006.

- Providing clean delivery kits to all visibly pregnant women and birth attendants to promote clean home deliveries;
- Providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility;
- Initiating the establishment of a referral system to manage obstetric emergencies.

5. Plan for the **provision of comprehensive reproductive health services**, integrated into primary healthcare, as the situation permits by:

- Collecting basic background information;
- Identifying sites for future delivery of comprehensive reproductive health services;
- Assessing staff and identifying training protocols.

SEXUAL VIOLENCE WITHIN THE MISP

In 2005, the Inter-Agency Working Group (IAWG) for Reproductive Health completed an evaluation of reproductive health responses in humanitarian crises, comparing existing reproductive health responses in emergencies with those implemented 10 years prior. In 1995, responses to address the health needs of survivors of sexual violence were largely absent in emergencies. In 2005, the IAWG concluded that while there was an increased response in all of the priority interventions outlined within the MISP; the area that has seen the least progress was sexual violence.

> ### Get Certified
>
> Visit the Women's Refugee Commission's website to take the Women's Commission's MISP Distance learning module and become **certified in the MISP.** Participants who complete the online post-test with a score of 80 percent or higher receive a certificate of completion from the Women's Refugee Commission. The course can be found at www.womensrefugeecommission.org

The MISP recommends several key actions to prevent and manage the consequences of sexual violence. Those specifically related to the provision of health services include:

- Ensure a standard medical response to sexual violence survivors, including the option of emergency contraception, preventative treatments for STIs, post-exposure prophylaxis for prevention of transmission of HIV, and tetanus and hepatitis B vaccinations and wound care as appropriate.
- Ensure privacy and confidentiality of the survivor.
- Ensure the presence of same-sex, same-language health worker or chaperone and, if the survivor wishes, a friend or family member, present for any medical examination.

Implementing the MISP is a component of the minimum prevention and response standards outlined in the IASC *Guidelines for Integrating GBV Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery.*

HEALTH RESPONSE IN THE IASC GBV GUIDELINES

Functioning and accessible health services make a significant difference in women and girls' ability to reduce health risks, and promote the well-being of themselves and their families.

> *Health services are often the first—and sometimes, the only—point of contact for survivors seeking assistance for gender-based violence (GBV). In order to facilitate care, survivors must*

have safe access to health facilities (e.g. safe transit to/from facilities; adequate lighting at facilities; non-stigmatizing and confidential entry points for services; no-cost services; etc.). It is also critical that health providers working in emergencies are equipped to offer non-discriminatory, quality health services for survivors.

Many survivors will not disclose violence to a health-care provider (or any other provider) due to fear of repercussions, social stigma, rejection from partners/families and other reasons. If health-care providers are not well trained, they may not be able to detect the indicators of violence. Survivors may be inadvertently discouraged from asking for help for GBV-related health problems. This can occur if the provider does not ask the right questions; if communication materials in the facility do not make clear the types of services that are available, and that they are available for all; or if the provider makes remarks or in some other way implies that the disclosure of GBV will not be met with respect, sympathy and confidentiality.[31]

The IASC GBV Guidelines outline actions that apply throughout the program cycle to organizations implementing health programs, including primary health care; and specify the importance of appointing GBV focal points from the health sector to participate in GBV coordination. **Key actions related to ensuring access to basic health services are extremely relevant for GBV staff, who should work closely with health actors and support the establishment of services, and any related advocacy.** These actions are:

ASSESSMENT, ANALYSIS & PLANNING

- Promote the active participation of women, girls and other at-risk groups in all health assessment processes
- Investigate cultural and community perceptions, norms and practices related to GBV and GBV-related health services
- Assess the safety and accessibility of existing GBV-related health services
- Assess the quality of existing GBV-related health services
- Assess awareness of *specialized* (clinical) staff in the provision of targeted care for survivors
- Assess awareness of *all* health personnel on basic issues related to gender, GBV, women's/human rights, social exclusion and sexuality
- Investigate national and local laws related to GBV that might affect the provision of GBV-related health services
- With the leadership/involvement of the Ministry of Health, assess whether existing national policies and protocols related to the clinical care and referral of GBV are in line with international standards
- Review existing/proposed health-related community outreach material to ensure it includes basic information about GBV

RESOURCE MOBILIZATION

- Develop proposals for GBV-related health programming that reflect awareness of GBV risks for the

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[31] **Inter-Agency Standing Committee. 2015.** *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery.*

affected population and strategies for health sector prevention and response

- Pre-position trained staff and appropriate supplies to implement clinical care for GBV survivors in a variety of health delivery systems

  Prepare and provide trainings for government, health facility administrators and staff, and community health workers (including traditional birth attendants and traditional healers) on sexual assault-related protocols

IMPLEMENTATION

- Involve women, adolescent girls and other at-risk groups in the design and delivery of health programming
- Increase the accessibility of health and reproductive health facilities that integrate GBV-related services
- Implement strategies that maximize the quality of survivor care at health facilities
- Enhance the capacity of health providers to deliver quality care to survivors through training, support and supervision
- Implement all health programs within the framework of sustainability beyond the initial crisis stage
- Develop and/or standardize protocols and policies for GBV-related health programming that ensure confidential, compassionate and quality care of survivors and referral pathways for multi-sectoral support
- Advocate for the reform of national and local laws and policies that hinder survivors or those at risk of GBV from accessing quality health care and other services, and allocate funding for sustainability
- Ensure that health programs sharing information about reports of GBV within the health sector or with partners in the larger humanitarian community abide by safety and ethical standards
- Incorporate GBV messages into health-related community outreach and awareness-raising activities

COORDINATION

- Undertake coordination with other sectors to address GBV risks and ensure protection for women, girls and other at-risk groups
- Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a health focal point to regularly participate in GBV coordination meetings

MONITORING AND EVALUATION

- Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability and other relevant vulnerability factors—to monitor GBV risk-reduction activities throughout the program cycle
- Evaluate GBV risk-reduction activities by measuring program outcomes (including potential adverse effects) and using the data to inform decision-making and ensure accountability

CLINICAL CARE OF SEXUAL ASSAULT SURVIVORS

Seeking healthcare is very difficult for many rape survivors; in seeking support, survivors are acknowledging that they have experienced physical and/or emotional harm and need assistance. It is critical that health staff, as well as GBV staff, acknowledge and recognize this by always following the basic principles of care and by respecting rights of the survivor.

The clinical management of rape is a component and priority area of emergency reproductive health response. This is a component of primary healthcare and, as such, is not an optional service provided by health teams providing primary healthcare services.

As a priority response, the clinical management of rape should be in place, whether survivors of sexual violence have sought health services or not. This includes having a site-specific protocol for the clinical management of rape, appropriate training for health staff, appropriate drugs, supplies and equipment as outlined in the World Health Organization's 2004 Guidelines for the *Clinical Management of Rape Survivors*.

Rapid responses in emergencies usually leave little time for writing site-specific protocols among many other competing health priorities. IRC has developed a generic protocol to help guide field staff on how to support rape survivors and advocate for better quality care and support. Key elements of this protocol are outlined here:

BASICS

Basic Principles of Care and Rights

Survivors may react in any number of ways to rape and their responses will likely change over time. Nonjudgmental, compassionate care is essential to the healing process and the absence of this can have long lasting effects upon the survivor's mental and emotional state. Furthermore, inappropriate health responses have the potential to re-traumatize survivors, creating a situation where humanitarian actors are actively contributing to further harming survivors.

Survivors have a **right to dignity**. This right has been violated by the attacker and must be emphasized and reaffirmed by all health service providers. In the context of healthcare provision, the right to dignity means:

The right to health: Survivors of rape and other forms of sexual violence have a right to good quality health services, including reproductive healthcare, to manage the physical and psychological consequences of the attack, including prevention and management of pregnancy and sexually transmitted infections (STIs).

It is critical that health services do not re-victimize rape survivors. There is never any excuse for failing to address the mental, physical and emotional health needs of a rape survivor. The protocols should be followed as closely as possible, but the absence of certain supplies or medications does not justify poor care.

The right to non-discrimination: Laws, policies, and practices related to health services should not discriminate against a person who has been raped on any grounds, including race, sex, religion, color, national or social origin, age, or marital status. For example, providers should not deny services to women belonging to a particular ethnic group or because they are unmarried or underage. In cases where the laws of the host country do discriminate, staff should advocate with local organizations and the government for legal reform while doing their best to meet the needs of survivors without putting themselves at risk. Health services must also be provided in a language the survivor understands well.

The right to self-determination: Providers should not force or pressure survivors to have any examination or treatment against their will. Decisions about receiving healthcare and treatment, for example, emergency contraception, are personal decisions that can only be made by the survivor herself. In this context, it is essential that survivors receive appropriate information to allow them to make informed choices. Survivors also have a right to decide whether, and by whom, they want to be accompanied when they receive information, are examined or obtain other services. These choices must be respected by healthcare providers.

The right to information: Information should be given to each client in an individualized way so that she is able to make an informed choice. The survivor needs to know what is going on in her body, what kind

of examination will be performed and why, and what the effects of prescribed medications will be. For example, if a woman is pregnant as a result of rape, the health provider should discuss with her all the options legally available to her—for example, abortion, keeping the child, or adoption. If the individual provider is not willing to discuss the full range of legal options, another healthcare provider should be called to do so.

The right to privacy: Conditions should be created to ensure privacy for people who have been sexually abused. Other than an individual accompanying the survivor at her request, only people whose involvement is necessary in order to deliver medical care should be present during the examination and medical treatment. To the extent possible, other providers, like laboratory staff, should be brought to her so that she does not have to move to receive services.

The right to confidentiality: All medical and health status information related to survivors should be kept confidential and private, including from members of their family, unless the survivor is a minor. Health staff may disclose information about the health of the survivor only to people who need to be involved in the medical examination and treatment, or with the express consent of the survivor. If someone is being charged in the case, the relevant information from the examination will need to be conveyed to the police or other authorities, but in a limited way.

Objectives of the Clinical Consultation

The objectives of the clinical management of rape survivors are:

- To identify and treat injuries and medical complications of rape;
- To organize referral to other relevant services, including psychosocial, protection, and legal services;
- To collect forensic evidence for legal purposes.

It is not the responsibility of the healthcare provider to determine whether a person has been raped. That is a legal determination. The healthcare provider's responsibility is to provide appropriate care, record the details of the history, provide a physical examination, and, with the client's consent, collect any forensic evidence that might be needed in a subsequent legal action.
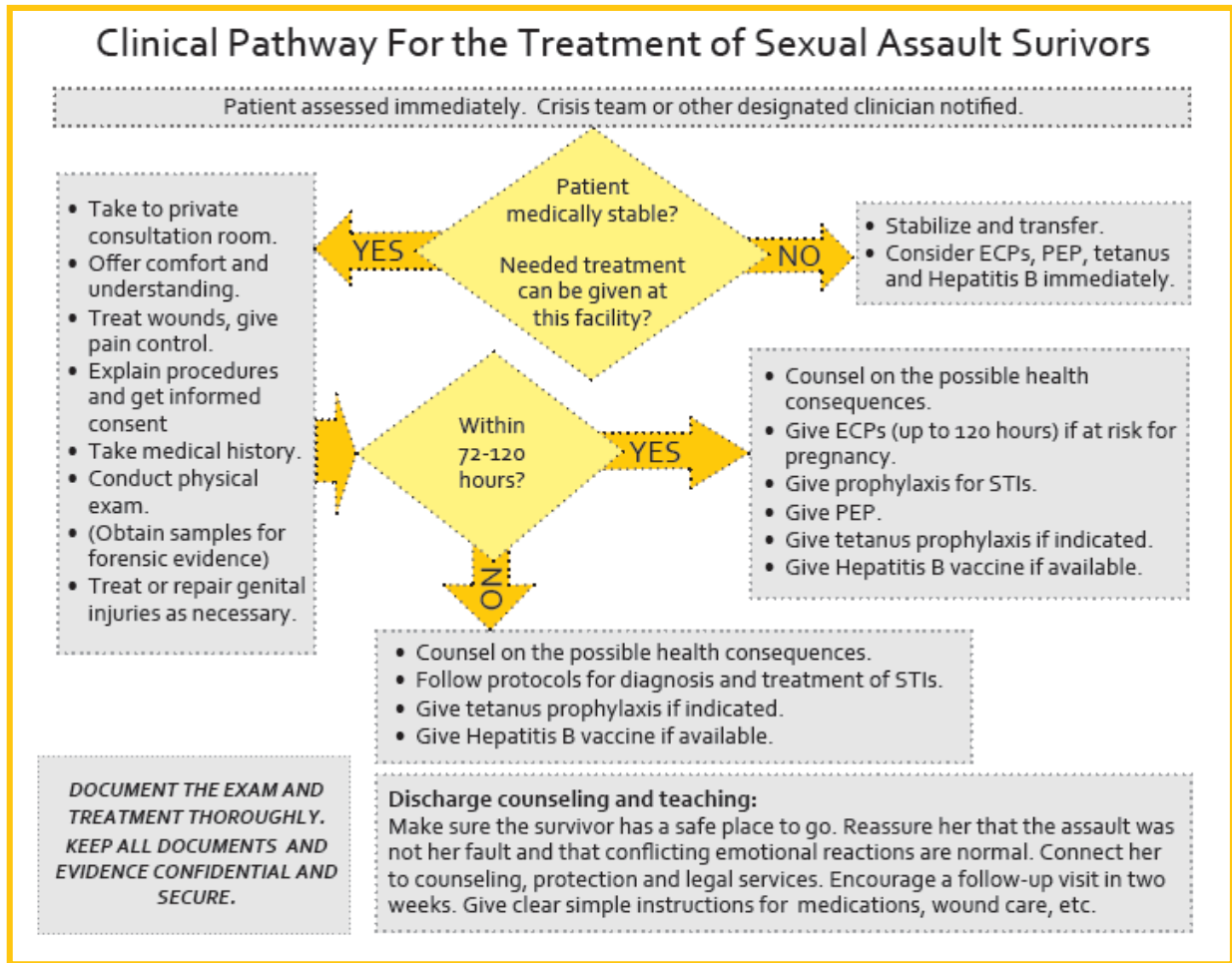
Response Plan for Survivors of Rape

In addition to a locally-adapted protocol, perhaps the most important thing health staff can to do is to prepare for the treatment of survivors of sexual violence. There needs to be a clear understanding that all rape survivors will be seen immediately. A designated individual should be made responsible for ensuring that the health facility is prepared to receive survivors and respond according to the guidelines at any time. Some programs have trained sexual assault response teams to handle these situations. This may not be possible in all settings, but in every case, an appropriately trained and prepared individual should be available at all times. Contact information for that individual should be posted where all staff can find it. There should be a designated and prepared place with adequate supplies so that an interview and exam can be performed without having to move a survivor between rooms. A separate room for both visual and audio privacy is preferable, but a curtained area with good light and easy access to a latrine will suffice.

The responsibility of the health clinic is to provide quality healthcare and ensure that the survivor has access to the best possible legal and psychosocial services. The best resources may be available through referral to another agency or organization. Resources for counseling and legal assistance need to be contacted in advance and a system put in place to assure good communication and coordination between service providers and proper follow-up. This may involve periodic meetings or case management reviews. In particular, careful consideration needs to be given to the security of a rape survivor who does not have a safe place to go.

Clinical Pathway & Checklist for Clinical Management

The clinical pathway for the treatment of survivors of sexual assault is a graphic representation of the treatment paths available to survivors who report to health facilities with different symptoms at various times following the incident. The pathway on the following page shows the steps that all healthcare providers should follow in the management of sexual assault survivors.

Clinical Pathway For the Treatment of Sexual Assault Surivors

Patient assessed immediately. Crisis team or other designated clinician notified.

Patient medically stable?

Needed treatment can be given at this facility?

YES
- Take to private consultation room.
- Offer comfort and understanding.
- Treat wounds, give pain control.
- Explain procedures and get informed consent
- Take medical history.
- Conduct physical exam.
- (Obtain samples for forensic evidence)
- Treat or repair genital injuries as necessary.

NO
- Stabilize and transfer.
- Consider ECPs, PEP, tetanus and Hepatitis B immediately.

Within 72-120 hours?

YES
- Counsel on the possible health consequences.
- Give ECPs (up to 120 hours) if at risk for pregnancy.
- Give prophylaxis for STIs.
- Give PEP.
- Give tetanus prophylaxis if indicated.
- Give Hepatitis B vaccine if available.

NO
- Counsel on the possible health consequences.
- Follow protocols for diagnosis and treatment of STIs.
- Give tetanus prophylaxis if indicated.
- Give Hepatitis B vaccine if available.

DOCUMENT THE EXAM AND TREATMENT THOROUGHLY. KEEP ALL DOCUMENTS AND EVIDENCE CONFIDENTIAL AND SECURE.

Discharge counseling and teaching:
Make sure the survivor has a safe place to go. Reassure her that the assault was not her fault and that conflicting emotional reactions are normal. Connect her to counseling, protection and legal services. Encourage a follow-up visit in two weeks. Give clear simple instructions for medications, wound care, etc.

A checklist for clinical management is included in the World Health Organization's *Clinical Management for Rape Survivors* as well as IRC's *Clinical Care for Sexual Assault Survivors.* The checklist for clinical management includes a list of resources and equipment necessary, such as drugs, staff, health facility setting, equipment, and other supplies.

CARE OF THE PATIENT

Receiving the Patient & Initial Assessment

Survivors should be treated at all times in accordance with the principles of human dignity outlined above, the most important being respect, compassion, and confidentiality. All staff of the facility should be trained to respond immediately to any individual who reports being raped or who appears to have suffered any form of violence.

Staff should be sensitized to the needs of all survivors of GBV and informed of the policies spelled out in the established protocol. Attitudes that view survivors of rape as shamed or defiled or that blame the victim for the assault need to be addressed, but may take time to eradicate. It must be made clear that all staff is expected to treat survivors with compassion and respect in accord with the protocol.

The first concern is for survivors' physical well-being. An individual who requires emergency care should immediately be treated or referred as appropriate. In this case, consideration should be given to aspects of the post-rape treatment that are time sensitive, such as emergency contraception, STI prevention, and post-exposure prophylaxis (PEP) for HIV/AIDS.

Once a survivor is identified and determined to be in stable condition, she should immediately be taken to a private place where the history and the examination can be done. If the person initially receiving the survivor is not specifically trained to provide clinical care to a rape survivor, a trained clinician should be notified and attend to her immediately. A compassionate staff member should stay with the survivor until the trained provider arrives. A female clinician is preferable and where one is not available, a female chaperone should be present during the exam.

As few people as possible should be involved in the process. The staff member escorting her to the private consultation room should introduce herself, offer reassurance and explain briefly that she will be seen by a trained clinician who will ask her questions and examine her. Staff should answer any questions she has and make it clear that the whole process is entirely voluntary. Staff should ask a survivor to agree to each step in the process of her care and let her know that she may say 'no' to any procedure or ask to stop at any point in time.

Obtaining Informed Consent & History

The provider who will perform the examination should review the procedure with the survivor, and parent or guardian if she is a minor, in language she can understand and ask for her consent for the history, the physical exam, the pelvic exam and specimen collection as appropriate. With children, it can be helpful to use a doll to demonstrate prior to performing the actual exam. The survivor can refuse any part of the exam that she wishes; never force a child or any survivor to undergo an examination. A consent form should be completed at this time with the survivor's signature or fingerprint.

A detailed history is helpful in identifying possible sites of injury, including internal injuries, but the survivor should not be forced to talk. Not all persons will want or be able to talk about the assault. Providers should listen and record the story in the words of the survivor. Providers must also reassure a survivor that nothing she says will be made public unless she chooses to have it released, for example if she takes legal action. Providers should ask clarifying questions as necessary after the survivor finishes her story.

The history should include the following components:

- A description of the incident (when, where, use or threat of violence or weapon, penetration)
- Did the survivor know the perpetrator previously? Are his whereabouts known?
- What the survivor did after the incident (bathed, changed clothes, urinated, cleaned teeth, etc.)
- Menstrual/obstetric history to determine pregnancy status/risk
- Medications, allergies, existing health problems
- Vaccination status (tetanus, Hepatitis B)
- HIV status (if known)

Physical Examination

Even after the survivor has consented to the exam, the provider must explain each step as she goes along and give the survivor an opportunity to ask questions. The exam should never be hurried and the survivor must never be asked to undress or uncover completely.

Prior to the more detailed physical examination, the provider should observe and record the general appearance of the survivor and take note of her mental and emotional state. Examinations should begin with a check of the patient's vital signs, including pulse rate and blood pressure; this will appear routine and may help to calm the patient's anxiety. Particular care should be exercised with the genital and pelvic exam. A pelvic exam should be performed *only if indicated*; for example, if there is vaginal bleeding, discharge, or suspected pregnancy, or if forensic evidence is being collected.

Investigations

In many cases, no laboratory or diagnostic tests will be required. Injuries and symptoms should be evaluated as they would in any other case, while maintaining privacy and confidentiality. If trained counselors are available, an HIV test may be offered. However, a positive result would represent prior HIV infection and the absence of an HIV test should in *no way* prevent a provider from offering PEP. The same is true for pregnancy testing, which will only reveal pre-existing pregnancy. A positive pregnancy test will eliminate the need for emergency contraceptive pills (ECP) and affect the choice of medications prescribed.

Investigations may include the following:

- Urinalysis for urinary symptoms
- Pregnancy testing
- Blood tests for syphilis and/or HIV
- X-rays for injuries

Prescribing Treatment

The specific treatment regimen will depend on local protocols, the availability of medications, disease prevalence in the population and the circumstances of the patient. Note that there is no medical reason for withholding any of the following treatments from children, although some of the doses may need to be adjusted depending on weight.

Survivors seen **within 72 hours** who have experienced penetration should be offered PEP for HIV and prophylaxis against the most prevalent STIs, such as syphilis, gonorrhea and Chlamydia. Depending on the context, metronidazole for trichomoniasis and Hepatitis B vaccine may also be given. The Hepatitis B vaccine is effective up to **two weeks** after exposure.

HIV testing is not necessary prior to prescribing PEP and a survivor who cannot or does not wish to be tested should still be offered PEP if indicated. However, for survivors who are HIV positive, there is no benefit from using PEP. An HIV positive survivor should be given counseling and referral information just as any other HIV positive person.

ECP can be effective **up to 120 hours or 5 days** after an incident, but is more effective if given earlier. The progestin-only ECP regimen has the fewest side effects. If a progestin-only regimen is not available, oral contraceptive pills containing both estrogen and a progestin can be used. A pregnancy test is not required before dispensing ECP.

Survivors with open wounds should be given tetanus toxoid if there is any doubt as to their immunization status. If they have not previously been vaccinated, they should be advised to finish the course for a total of two doses.

The Medical Certificate

> **The quest for justice and the fight against impunity should never create obstacles to other lifesaving care.**

Medical care of a survivor of rape includes preparing a medical certificate. This is a legal requirement in most countries and forms should be obtained from local legal authorities. The medical certificate constitutes an element of proof and is often the only evidence available to prosecute an incident of sexual violence, apart from the survivor's own story. It is the responsibility of the healthcare provider who examines the survivor to make sure such a certificate is completed and is kept confidential. The healthcare provider should provide one copy to the survivor and keep one copy locked away with the survivor's file, in order to be able to certify the authenticity of the document supplied by the survivor in a court if requested. The survivor has the sole right to decide whether and when to use this document.

In some countries, healthcare providers and others have prioritized the provision of a medical certificate above the delivery of quality medical care. In these countries, survivors may be required to report cases to the police to acquire a medical certificate before receiving healthcare. This prevents women and girls who wish only to receive healthcare from accessing healthcare and support.

Release of Information

The survivor should be made aware of what information will be released and to whom. Anonymous information regarding the location and nature of the attack can be passed on to protection staff so that action may be taken to prevent future attacks against others. Any information that could be used to identify the survivor may only be released with her consent. The IRC protocol on the clinical management of rape includes sample "release of information" forms.

Remember, the information collected belongs to the client, not to the service provider. It is up to the client to decide when, where and how information about any information should be released or shared. She must fully understand and voluntarily agree to share information and, in order to give informed consent, must:

- Have all information about the agreement and its consequences;
- Be over the age of 18;
- Be mentally sound enough to understand the agreement and the consequences;
- Have equal power in the relationship.

If she does not wish to share any information about her case with anyone, you may ***not*** share her information.

Counseling & Follow-up of the Patient

In addition to receiving information about her treatment, a survivor will also need to hear some other important and compassionate messages and must feel that she is believed and supported. An individual who has just suffered an attack may not be able to absorb everything she is told, but a calm approach, simple statements and repetition will help.

COLLECTING FORENSIC EVIDENCE

Forensic evidence may be collected to help the survivor pursue legal redress if she wishes and if it is feasible. The survivor may choose not to have evidence collected. Respect her choice.

Only qualified and trained health workers should collect evidence and only after review of the pertinent local laws and procedures. In many countries only registered doctors are allowed to testify in court.

Before collecting forensic evidence, health workers must determine whether forensic evidence can be processed and safely stored, and whether police and local authorities are able to perform the relevant tests. Information that cannot be processed or that will not be used **should not be collected**.

GBV AND HEALTH: WHO DOES WHAT?

It is the ultimate responsibility of health actors to ensure that health staff is trained and health facilities are equipped to provide care to survivors. This includes having a clinical management of rape protocol in place. It is not the responsibility of the GBV team.

> Healthcare providers must understand that it is not their responsibility to determine whether a person has been raped. **That is a legal determination.**

It is the role of GBV staff to provide support to the health actors in sensitizing medical and non-medical personnel to the needs of survivors, and promoting compassionate care. GBV staff also facilitates coordination with health and other sectors to ensure survivors receive all needed services. GBV staff *does not* provide any direct health services, procure or dispense drugs, or supervise health staff.

Both GBV and health teams should integrate messages regarding the adverse health impact of sexual violence in their outreach to communities. This includes working with local health workers and community leaders to inform the community about the urgency of and the procedure for referring survivors of sexual violence. Health and GBV staff should also work in concert to ensure that all actors on the ground are informed of existing national guidelines and protocols for the clinical management of rape, to ensure that all actors are providing appropriate health responses to survivors of rape.

HEALTHCARE PROVIDERS	GBV WORKERS
• Provide appropriate healthcare • Record the details of the history, the physical examination, and other relevant information • Collect any forensic evidence that might be needed in a subsequent legal action (with the patient's consent)	• Advocate to ensure an adequate health response is in place • Provide technical support, as needed, including training on psychosocial support and care for survivors • Work with health team to ensure follow-up and referral of cases

BOTH HEALTHCARE & GBV ACTORS

• Work with communities to increase awareness about the availability of services
• Ensure ethical, safe, and appropriate data collection methods are in place

INDIVIDUAL REFLECTION: WHAT DOES THIS MEAN FOR ME?

Take some time to reflect on and answer the following questions.

Does my organization already interact with healthcare systems in some way? If yes, how can I make sure my services are adapted to the emergency context?

_____

_____

If no, what is my role in relation to healthcare (e.g. Can I serve as an entry point/connector, or share relevant information in communities, make referrals, work together with healthcare agencies or organizations, etc.)?

_____

_____

Are there any risks for me as an individual and/or for my organization in taking these steps? How can I manage them?

_____

_____

Notes & Reflections

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_____

_____

_____

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_____

Burning Questions

_____

_____

_____

SESSION 9: REFERRAL SYSTEMS

Learning Objectives:

- Examine different models of referral systems.
- Discuss the importance of referral systems in emergency contexts.

Survivors of GBV have multiple needs, and coordination amongst service providers is crucial to meeting those needs. GBV actors may discuss the need to improve coordination at site-specific levels but many fail to think through the most effective ways to do so. A case management approach and context-specific referral systems are both useful ways to coordinate service delivery and facilitate survivors' access to services. Service delivery coordination varies from site to site, based on which actors are present and their understanding of what a referral system should look like. In this module, we will examine various referral system models, and explore the elements necessary to effectively implement a referral system for survivors during the early days of a humanitarian crisis.

Regardless of the number of cases being reported, GBV actors must establish functional referrals systems. GBV referral systems aim to improve timely access to quality services for survivors of GBV. In an emergency and during periods where services are not yet available or are starting, establishing a functional referral system is crucial and can help survivors negotiate the services available to meet their multiple needs. The goal of referral systems is not to increase the number of cases referred but to improve the quality and timeliness of care received.

The lead coordinating body is responsible for ensuring that the referral system functions. This means establishing and supporting links between service providers, scheduling regular meetings to discuss any problems with the system, and developing and updating referral forms and a directory of locally available service providers, with input from all service providers involved. The lead coordinating agency must dedicate sufficient human resources to manage the referral system. In an emergency context, the role of coordinating site-specific referral systems may be assumed by a non-service delivery agency (e.g. a UN agency), or an international NGO where these UN agencies are not operational or present.

STEPS TO DEVELOPING A REFERRAL SYSTEM[32]

The four steps to establishing a functional referral network are:
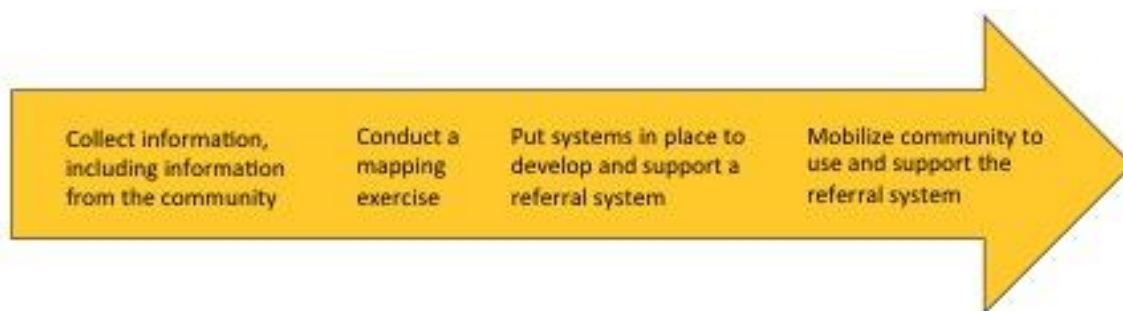
1. Collecting information about the services available in a community; this may be done as part of a rapid or preliminary assessment;

2. Conducting a mapping of these existing services, including where services are available and who is providing them;

3. Establishing a system to ensure that service providers are able to effectively and safely refer clients for additional support beyond their capacity;

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[32] Adapted from Family Health International, "Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings."

4. Mobilize the community to use and support the referral system.

During a rapid assessment, GBV staff should meet with communities to identify where and how women and girls access assistance and identify any key barriers to accessing quality care, particularly at local health facilities. Using this information, GBV staff must then map available services. This means identifying actors providing quality GBV-related services, including post-rape care, counseling or basic emotional support, and other health and social services. These services may be provided by international or national NGOs, government structures or community-based actors, such as traditional birth attendants. In mapping these services, GBV staff must ensure that the services provided are of quality and survivor-centered. For example, while many communities may refer GBV cases to local traditional birth attendants for medical care, GBV staff should verify the quality of this support and ensure that it prioritizes the well-being and safety of survivors before including them in any referral system.

Establishing a functional referral system requires the following actions:

- Identifying a lead coordinating agency and focal points within each service delivery agency in the system
- Agreeing upon roles and responsibilities of each entity in the network
- Sensitizing staff in service delivery agencies in the network
- Agreeing upon guidelines to maintain confidentiality and shared confidentiality within the referral system
- Establishing agreed-upon mechanisms for referrals and documentation of the referral process
- Training all relevant staff on the referral system, procedures and tools and distributing these tools.
- Establishing a system to elicit regular feedback and analyze the effectiveness of the mechanism

Once a functional referral system is established, GBV actors must mobilize community members to use and support the system. All members of the community and service providers should be familiarized with the referral system and knowledgeable about the services provided by any actor to whom they refer a survivor. The referral system should be written and translated into local languages and into a child-friendly—pictorial if possible—and easy-to-understand version. Information about the referral system should then be disseminated throughout the community so that as many people as possible are aware of the process. GBV actors should undertake community mobilization and promotional and public awareness activities to build demand for services and seek the support of local leaders to use their influence to increase community support for the referral system.

How Do We Know It's Working?

Referral systems should facilitate survivors' timely access to services, while at the same time confidentiality is maintained at all times. Key factors that improve a referral system's functionality include:

- Service providers are available to cover urgent survivor needs and a plan exists for a course of action to address any gaps in service provision in the system
- An organization is identified as the central coordinating body for the network
- Each service delivery agency in the system has staff dedicated to ensure that survivors referred for treatment receive timely and appropriate care
- Service providers in the referral system meet regularly
- A directory of services and organizations within the defined area exists
- A standardized referral form is in use among all service delivery agencies in the network
- Referrals among organizations in the system are traceable and their outcomes monitored

- Referrals are documented at both the referral and receiving points and referring agencies receive feedback when survivors receive services
- Gaps in services can be identified and steps can be taken to address gaps
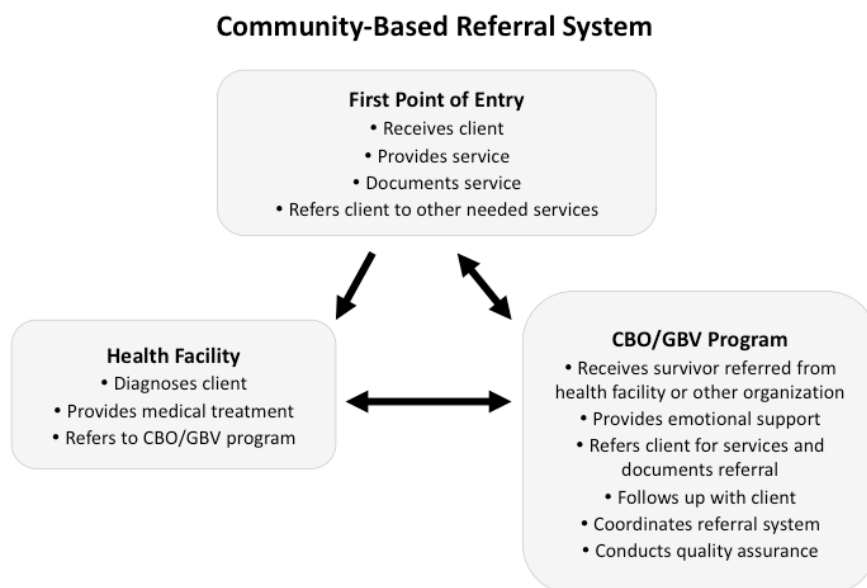
Monitoring & Evaluating a Referral Network

- Actors should develop a mechanism to monitor and evaluate response actions and the effectiveness of reporting and referral systems. Monitoring the referral network is key to ensuring it is consistently functioning appropriately and needs are being met.
- Some examples of indicators to monitor the effectiveness of referral systems include:
- Total number of referrals made
- Number of referrals made to which services
- Number or percent of referral services completed
- Number or percent of clients who reported their needs were met
- Number of follow-up referrals made
- Number or percent of clients who report satisfaction with referral process
- Referral systems must be designed to allow consistent, standardized methods of monitoring. This includes developing and implementing specific tools that help to facilitate the delivery of quality services through the referral process, such as a directory of services, referral forms, client tracking forms and referral registers.

EXAMPLES OF REFERRAL SYSTEMS
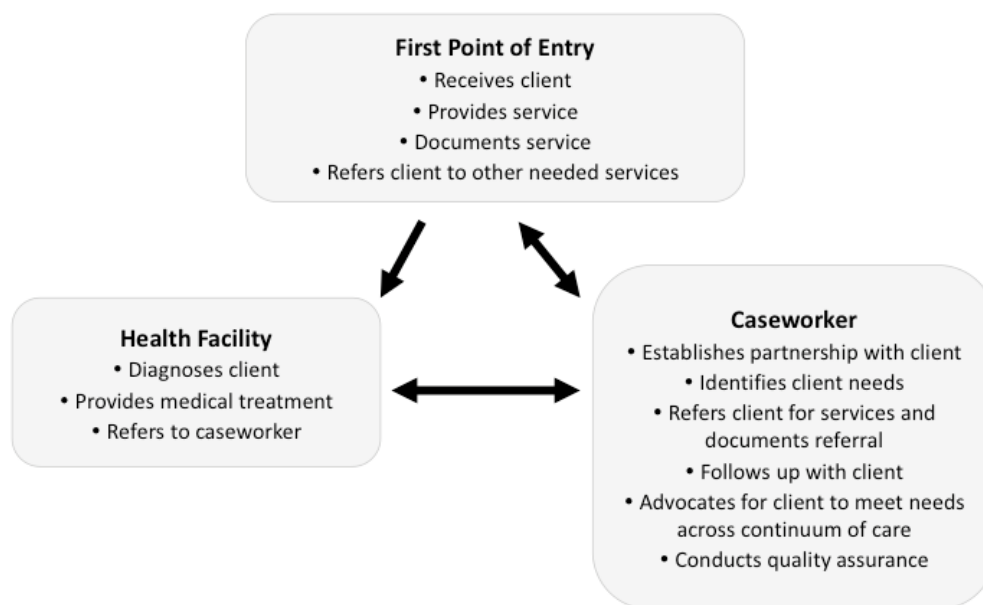
COMMUNITY-BASED REFERRAL SYSTEMS

In some settings, it may be possible and more appropriate to have women's groups serve as the central coordinating entity of a referral system. Staff can train volunteers from women's groups to serve as volunteer psychosocial focal points. These focal points know of services available in the community, how to access these services and when survivors should access these services, to obtain the best quality care possible.
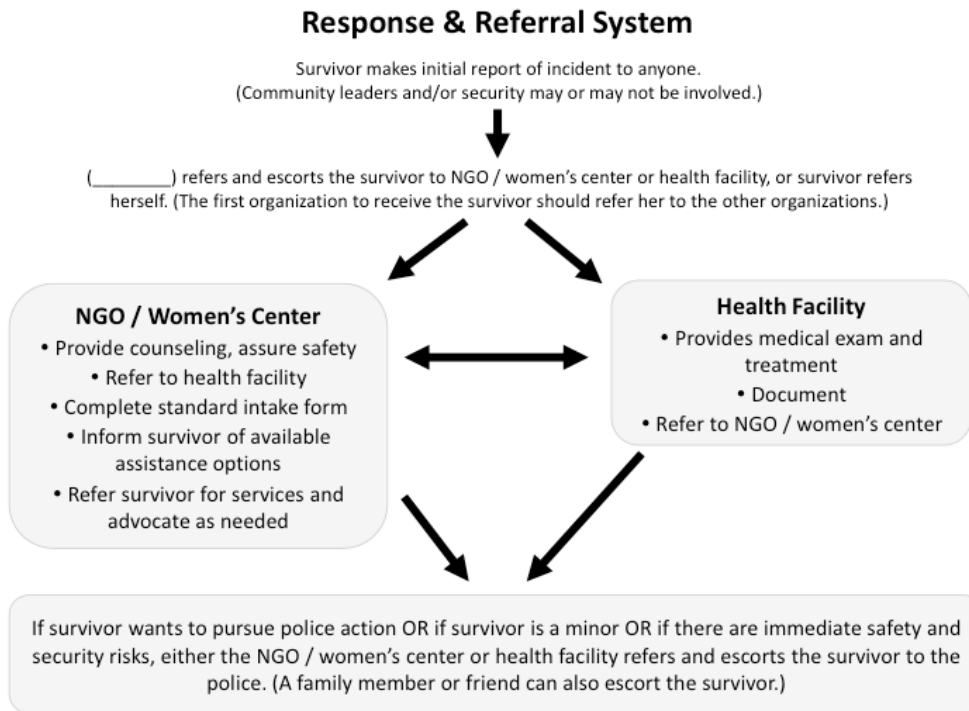
Community-Based Referral System

First Point of Entry
- Receives client
- Provides service
- Documents service
- Refers client to other needed services

Health Facility
- Diagnoses client
- Provides medical treatment
- Refers to CBO/GBV program

CBO/GBV Program
- Receives survivor referred from health facility or other organization
- Provides emotional support
- Refers client for services and documents referral
- Follows up with client
- Coordinates referral system
- Conducts quality assurance

CASE MANAGEMENT-BASED REFERRAL SYSTEMS

Where case management services exist, caseworkers work with survivors to develop a plan for immediate support and ensure that they access services. Caseworkers play an advocacy role to ensure survivors receive needed services, monitoring the provision of services and following-up with the survivor throughout the process. A case management-based referral system allows survivors to be active participants in defining their needs and deciding what options best meet those needs.

Case Management Referral System

First Point of Entry
- Receives client
- Provides service
- Documents service
- Refers client to other needed services

Health Facility
- Diagnoses client
- Provides medical treatment
- Refers to caseworker

Caseworker
- Establishes partnership with client
- Identifies client needs
- Refers client for services and documents referral
- Follows up with client
- Advocates for client to meet needs across continuum of care
- Conducts quality assurance

All of these models have their merits; GBV staff must understand how they translate in emergency settings where humanitarian actors are trying to coordinate to address the immediate needs of survivors. On the next page is an incident reporting and referral standard model developed by UNHCR and outlined within the IASC GBV Guidelines.

Response & Referral System

Survivor makes initial report of incident to anyone.
(Community leaders and/or security may or may not be involved.)

(_____) refers and escorts the survivor to NGO / women's center or health facility, or survivor refers herself. (The first organization to receive the survivor should refer her to the other organizations.)

NGO / Women's Center
- Provide counseling, assure safety
- Refer to health facility
- Complete standard intake form
- Inform survivor of available assistance options
- Refer survivor for services and advocate as needed

Health Facility
- Provides medical exam and treatment
- Document
- Refer to NGO / women's center

If survivor wants to pursue police action OR if survivor is a minor OR if there are immediate safety and security risks, either the NGO / women's center or health facility refers and escorts the survivor to the police. (A family member or friend can also escort the survivor.)

While this model is important, it might not be feasible in an emergency setting. It's important always to remember – particularly in the acute response and the start-up phase of a GBV program – that referral systems must be viewed from a response perspective and not from an incident reporting perspective alone.

INDIVIDUAL REFLECTION: WHAT DOES THIS MEAN FOR ME?

Take some time to reflect on and answer the following questions.

Does my organization already interact with a GBV referral system in some way?

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How would this change in an emergency? Can I serve as an entry point? Can I provide information to survivors? Should I be coordinating with other agencies/organizations?

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Are there any risks for me as an individual and/or for my organization in taking these steps? How can I manage them?

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Notes & Reflections

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Burning Questions

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SESSION 10: COMMUNITY OUTREACH

Learning Objectives:

- Discuss key messages and outreach mechanisms when raising awareness with the community about GBV during an acute emergency.

COMMUNITY OUTREACH OBJECTIVES

In an emergency, community information-sharing is not about changing community norms or preventing violence more globally. Information sharing in this context is about ensuring access to services as quickly and safely as possible, and reducing the risks that women and girls face.

KEY TOPICS

Sexual Violence - During the acute emergency, sexual violence tends to be reported more and has the high potential for life-saving support especially if they are able to get to a health clinic where staff are trained in the clinical care of sexual assault within the critical window.

Access to services (especially life-saving health services) - Survivors need to know where to find help. Services - especially health services - are time-sensitive and we want survivors to get the best package of services that they can.

Activities that can help reduce women and girls' risk of violence - Provide ways in which the community can mobilize and prevent risks to GBV

APPROACHES

What are the different community outreach methods that you have used in your work?

- Mass Campaigns
- Wandering loudspeakers
- Dissemination of BCC materials – posters, pamphlets, radio, Billboards
- Theater Troupes
- Trainings / workshops (15-30 people)
- Meetings (15-50 people)
- Small Group Discussions- tea talks, coffee discussions (5-10 people)
- Door to door (one-on-one discussions, 1-3 people)
- Quick Chats

What outreach approaches are more likely used at the onset of an emergency?

- Wandering loudspeakers
- Dissemination of BCC materials – posters, pamphlets, radio, Billboards
- Meetings (15-50 people)
- Informal Small Group Discussions (5-10 people)

EFFECTIVE MESSAGES

The following are key attributes to a messaging that will make community outreach messages better understood and more effective:

- Clear – keep the wording and meaning of the message simple, and make images large, simple, and culturally appropriate

- Action oriented – how is the message helping the community/women and girls/survivors know what to do to help themselves
- Specific – details are instructive.
- Positive – illustrate positive action and attitudes. Don't patronize or vilify. Negative portrayals do not work; people rarely see themselves as the problem, and nobody likes to be preached at. Instead, model positive behaviors that they can follow.
- In particular, images of violence should ***not*** be used in community outreach messaging. Using images of violence can serve to normalize the violence rather than showing people what not to do, and may also trigger negative or traumatic memories for survivors.
- Messages should be designed to reach the most people as possible. Take into consideration the overall literacy rate.
- Safety is an essential element to consider in designing community outreach/awareness-raising messages and methods. In some cases, it may be safer to adapt your messaging to talk to small groups of women rather than conduct blanket community-level awareness-raising campaigns. In other situations, the opposite may be true. You will to discuss this with staff teams and women and girls to ensure no additional risks are created.

Where possible, prepare messages, outlines or templates for community outreach work in advance of a crisis. These can then be adapted if a crisis occurs, but the process will be much shorter and less time-consuming. While it is ideal to have images that are culturally similar to the community, during the acute phase of an emergency it is ok to use pictures that give correct information even if they don't exactly represent the affected community (keeping account of major cultural taboos). When the emergency stabilizes and you have more time to make an accurate representation of the community, you'll have time to improve the message; however, during the acute phase it is better to make sure good information is shared even if it is not visually correct.

CONSIDERATIONS IN COMMUNITY OUTREACH

What should staff and supervisors should be concerned about when doing outreach about GBV?
- Safety (of women and girls, and of staff):
    - o When sexual violence is used as a weapon to humiliate the population, the belligerents will rarely be accepting of discussions around GBV..
    - o Consult with women and girls to find out what is safe
    - o People lose trust during crises, and families may not appreciate if a woman talks to a stranger, especially if they males. Just talking to a stranger can sometimes lead to confinement or physical violence.
- Cultural attitudes towards different types of GBV
- Respecting people's time - women and girls (especially single female headed households) may be too busy to meet and go to find information or join information meetings.
- It is extremely important to be careful with the kind of messaging that is used. Avoid messages that place the blame – even in an understated or hidden way - on women and girls for the violence they experience.

INDIVIDUAL REFLECTION: WHAT DOES THIS MEAN FOR ME?

Take some time to reflect on and answer the following questions.

Does my organization already share information about GBV services or risk reduction? If yes, how will we need to adapt our messages or methods for a crisis context?

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Are there any risks for me as an individual and/or for my organization in doing this? How can I manage them?

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Notes & Reflections

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Burning Questions

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SESSION 11: REDUCING RISKS FOR WOMEN AND GIRLS IN EMERGENCIES

Learning Objectives:

- Examine approaches to mitigating risks and meeting women and girls' basic needs in emergencies.
- Introduce response and preparedness discussions that are tailored to specific contextual considerations.
- Identify how emergency contexts increase risks of sexual exploitation and abuse, and understand the appropriate response from the humanitarian community.

In emergencies, women and girls face a host of safety and security risks linked to displacement. Many of these risks, when identified, can be safely and quickly addressed by humanitarian actors. However, humanitarian agencies may unintentionally increase these risks through assistance programs and services designed to improve efficiency without properly identifying and addressing the needs of women and children and the potential obstacles they may face in accessing services safely.

STRATEGIES TO REDUCE SAFETY & SECURITY RISKS

INVOLVING WOMEN & GIRLS IN PLANNING & DECISION-MAKING[33]

To fully address the safety and security concerns of women and girls, they themselves must participate in planning protection and assistance activities. Programs that are not planned in consultation with women and girls, nor implemented with their participation, often increase the risks they face. Since a large proportion of refugees are women, who are often solely responsible for their dependent children, it is essential that they be involved in the planning and delivery of assistance activities if these are to be properly focused on their needs. In Pakistan, civil engineers developed a water-trucking program to supply a large refugee camp with access to clean water. The location of the trucks and water distribution points were determined based on existing infrastructure and roads and did not incorporate the views and concerns of women and girls. As a result, many women later told aid agencies that these water points were completely inaccessible to them as they required women and girls to cross large portions of the camp unaccompanied, exposing them to threats of harassment and violence.

Camp management committees and other decision-making bodies should have equal participation from both women and men to ensure that the needs of women are identified and met.

CAMP DESIGN & LAYOUT[34]

Many cases of sexual violence can be prevented if there is safe planning of sites where displaced populations live, and if shelters are safe and meet internationally agreed-upon standards. Provision of appropriate and safe shelter is one means of strengthening protection.

There must be strong coordination among organizations and active involvement of communities, especially women, to ensure security-focused and gender-sensitive shelter arrangements during an emergency. Organizations working to provide shelter must be involved in assessment, monitoring, and coordination of prevention and response to sexual violence.

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[33] Adapted from UNHCR, *Guidelines on the Protection of Refugee Women.* Geneva: UNHCR, 1991.

[34] Adapted from IASC, *Guidelines for GBV Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, 2005.

Select sites that allow sufficient shelter space for the population and that do not pose additional security and protection risks, such as proximity to international borders, frontlines and other high-risk areas, including the local environment.

CAMP SECURITY & PATROLS

The police, camp security personnel, community security groups, or military personnel may address security and safety concerns. These actors need to be identified and have clearly delineated responsibilities. All security groups, particularly those assisting survivors of GBV, must uphold human rights in their work and should be trained on prevention of GBV and women's rights.

In some emergency settings, displaced populations may establish camp security groups or neighborhood watch teams. These groups must recognize that they are not a military or police force and care should be taken to ensure that they do not assume the responsibilities of security or military personnel, such as levying fines or punishments.

Security and safety actors also play a role in prevention activities by communicating current security risks and issues present in the camp or location to all members of the community. Security and safety actors may also devise creative security solutions to address identified problems, such as fencing, lighting, or placing locks on latrines.

GBV actors must carefully consider the role of security forces in camp settings. In some cases, increased patrols by UN peacekeeping forces may decrease general lawlessness and improve communities' sense of security but in other settings an increase of peacekeepers may increase the presence of other armed actors or increase the militarization of the camps. Any military personnel carrying out patrols must be unarmed and adhere to international best practices and guidelines in peacekeeping and civilian protection.

IMPROVING ACCESS TO RESOURCES

In North Kivu in 2008, hundreds of thousands of Congolese citizens were displaced by fighting between government armed forces and rebel groups. In a matter of days, previously established IDP camps were teeming with newly displaced, many of them women and children, and existing services and resources for the displaced were stretched to capacity. These camps were located meters from the frontline between government armed forces and rebel groups and many women and girls reported that they were crossing the frontline every day to return to their fields and the surrounding forests to harvest crops and collect firewood. Many women who undertook these journeys were raped or harassed but they felt they had few other options as they needed firewood to cook and care for their families and rations in the camps were limited.

In many cases, humanitarian agencies can improve women and girls' immediate safety and security by providing assistance to meet their basic needs. Special consideration should be given to ensure that risks associated with fuel collection and other activities that involve movement in insecure or volatile areas and identified and properly addressed. For example, in North Kivu, IRC distributed firewood to displaced women and girls to help reduce their trips outside the camp and their exposure to potential threats and violence.

MEETING THE BASIC NEEDS OF WOMEN AND GIRLS

The distribution of non-food items (NFI) is not only a protection strategy but also an effective way to meet women's basic needs in the early days of an emergency. In areas where clean water and bathing shelters are scarce, women and girls may suffer higher rates of vaginal infections if they are forced to

bathe in their clothing or have few places to wash clothing. In the early days of an emergency, organizations can distribute sanitary kits to women of reproductive age to meet women's sanitary needs, help restore dignity and promote basic hygiene and health. These kits typically contain sanitary materials, soap, a bathing bucket and clean underwear. Access to sanitary materials also allows women and girls to resume daily activities outside the home, such as collecting water and food or attending school. Limited access to sanitary materials has been shown to impact girls' school attendance rates.[35]

To ensure that women and girls have access to distributions of humanitarian goods, actors may also elect to distribute ID cards, registration cards or distribution vouchers, plastic sheeting, food and other humanitarian materials through female heads of households to ensure that items are equitably distributed in affected communities.

In some cases, this has unintentionally increased violence against women and girls. For example, in one country, food distribution cards were distributed to female heads of household on the assumption that women would more equitably distribute food amongst family members than male heads of household. Pregnant and lactating women were given additional rations to meet their increased caloric needs. This unintentionally increased violence against women and they reported higher levels of unwanted pregnancies as their partners were forcing them to become pregnant to obtain additional rations. Humanitarian actors must think through the consequences of distributions to ensure that they do not increase the risks of violence women and girls face.

PREVENTING SEXUAL EXPLOITATION & ABUSE

Sexual exploitation and abuse (SEA) by humanitarian actors is a tragic yet common phenomenon in emergency settings. From Bosnia to DRC, Cambodia to West Africa, there have been numerous reports of violence and sexual exploitation of women and children in emergencies by UN peacekeepers and other humanitarian actors. Sexual exploitation represents a fundamental abuse of power and a violation of human rights standards, creating anger and resentment towards the international community and a major breech of the mandates and ethical framework that humanitarian actors agree to operate within.

In January 2002, the international media broke a story based on a joint Save the Children/UNHCR assessment of sexual exploitation of women and children by humanitarian workers in refugee camps in Sierra Leone, Guinea and Liberia. It alleged that perpetrators were employed by a number of organizations, including NGOs, UN agencies, the government, and international peacekeepers.

In some cases, humanitarian workers were reported to be exchanging humanitarian assistance and services—like food, health, or education—for sexual favors. Many NGOs, government, military and UN bodies were named in the report.

The subsequent attention the media has given to sexual exploitation pushed organizations to address sexual exploitation and increase understanding and awareness of the problem. Codes of conduct, stronger performance standards, staff-trainings and better reporting systems were established. The Secretary-General of the United Nations issued a bulletin on sexual exploitation, which stresses that exploitation "violates universally recognized international legal norms and standards and has always been unacceptable behavior and prohibited conduct for United Nations staff."[36]

However, despite these efforts, the problem still persists. In most every conflict setting around the world, sexual exploitation is a serious issue that affects girls and women most severely. Some examples of sexual exploitation include:

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[35] Inter-Agency Network on Education in Emergencies, *Gender Responsive School Sanitation, Health and Hygiene*, May 2009.
[36] Special Measure for Protection from Sexual Exploitation and Sexual Abuse, 2003, ST/SGB/2003/13.

- A humanitarian worker requiring a sexual act in exchange for material assistance, favors, or privileges
- A teacher requiring a sexual act in exchange for a passing grade or admission to class
- A refugee leader requiring a sexual act in exchange for favors or privileges
- A soldier or security officer requiring a sexual act in exchange for safe passage or protection
- An NGO driver requiring a sexual act in exchange for a ride

Sexual exploitation remains under-reported due to secrecy, feelings of shame and inadequate documentation. In certain cases, survivors will not report because they cannot afford to lose the benefits they are receiving. Yet many people know it happens every day. Even staff that are not abusive are often reluctant to speak out against colleagues who are involved in abusive, illegal behavior, contributing to a 'conspiracy of silence'.37

Statistically speaking, sexual exploitation may not seem to be a priority issues as the vast majority of humanitarian staff are not abusers and exploiters. However, sexual exploitation is a serious issue that warrants a comparable response as it affects displaced and conflict-affected communities, humanitarian organizations and the humanitarian community, at large. Sexual exploitation represents a failure in our duty of care and to uphold basic rights.

Key Concepts in Sexual Exploitation

> **Sexual exploitation** is exchanging money, shelter, food or other goods for sex or sexual favors from someone in a vulnerable position.
>
> **Sexual abuse** is threatening or forcing someone to have sex or provide sexual favors under unequal or forced conditions.

Sexual exploitation is a form of sexual violence and involves the use and abuse of power and vulnerability. Perpetrators of sexual exploitation exploit unequal power relationships through the use of physical force or other means of coercion—for example, threats, promise of food or services, withholding aid, giving preferential treatment—to obtain sexual acts from a more vulnerable person.

Exploitation generally refers to someone in a position of power using someone less powerful for financial or social gain or personal pleasure. In addition to sexual exploitation, natural disasters and emergencies can increase the likelihood or severity of other types of exploitation, for example, economic exploitation such as indentured servitude or forced labor.

Women and children may be asked by humanitarian workers, incentive workers or camp leaders to pay for ID cards, registration for a distribution or camp residency, or humanitarian goods. Child-headed households are also particularly vulnerable as they face risks of exploitation by displaced adults or neighbors as well as humanitarian workers.

Contributing Factors

A number of factors in emergencies and natural disasters can increase the risk or severity of abuse of power or exploitation. Some include:

- Lack of economic opportunity
- Scarcity of supplies and dependence on service providers

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37 Handrahan, Lori, "Gender, Identity, Power and Post-Conflict Reconstruction," *Security Dialogue,* Vol. 35, No. 4, December (2004), p.435-436.

- Being vulnerable in other ways, such as separated from your family, acting as head of your household or having a physical or mental disability
- Inadequate laws
- Weak reporting or investigation protocols or limited oversight mechanisms
- Corruption and impunity from prosecution
- Breakdown in social protection mechanisms

Consent

Many survivors of sexual exploitation have explained that they understood what they were doing and that they consented to have sex in order to get money or food. They also stated that even though they did not feel right doing it, they had little option to do otherwise and felt that they had no other choice. It is important to remember that true consent never exists unless there is a valid alternative choice; where an individual either does not understand their options or does not have other options, they cannot be said to provide informed consent to an act.

SEXUAL EXPLOITATION & THE UN

In late 2004, the international media broke a story about the sexual exploitation of women and children in eastern DRC, reportedly perpetrated by some of those mandated to protect and help them. Members of the United Nations Organization Mission in the DRC (MONUC) were accused of exploiting Congolese women and girls and refugees living in Congo.

Sexual exploitation by UN staff is prohibited and violates UN principles and several UN Secretary-General Bulletins. The Secretary-General's 2003 bulletin, Special Measures for Protection from Sexual Exploitation and Sexual Abuse, defines exploitation as:

Any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including but not limited to profiting monetarily, socially or politically from the sexual exploitation of another and the exchange of goods or services for sexual acts, both of which are strictly prohibited conduct for UN personnel.38

This bulletin also outlines six core principles which all UN staff—civilian and military—are obliged to adhere. The core principles apply to all UN staff without exception.

In 2006, the General Assembly adopted a resolution recommending the adoption of a UN-wide approach to assisting 'victims' of sexual exploitation committed by both UN staff and UN-related personnel. The resolution outlined the UN's commitment to providing assistance and support to 'complainants,' 'victims,' and children born as a result of sexual exploitation and abuse by UN staff or related personnel.

The nature of such assistance ranges from basic emergency assistance, including medical and psychosocial support, to more comprehensive support such as educational opportunities or skills training and financial support. In cases where the alleged act of sexual exploitation and abuse also constitutes a crime, the UN has committed to assist 'victims' to pursue their case with the national authorities, should they so wish. The resolution also notes that where 'credible evidence' exists that a child has been fathered as result of alleged sexual exploitation or abuse by a UN staff member or related personnel, the UN will assist the child, or his/her mother or guardian, in pursuing a claim to establish paternity or obtain child support.

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[38] United Nations, *Secretary-General's Bulletin: Special measures for protection from sexual exploitation and sexual abuse (ST/SGB/2003/13)*. New York: UN, 2003.

PREVENTING SEA

Humanitarian agencies can take steps to reduce and prevent incidents of sexual exploitation, both organizationally and programmatically. Organizationally, senior management can send a strong message about the organization's commitment to preventing sexual exploitation, ensure that all staff understand and have signed codes of conduct, and develop a country action plan to prevent and respond to incidents of sexual exploitation.

From a programmatic perspective, staff can conduct risk assessments to identify risks of exploitation within programs and adopt actions to reduce these risks. Organizations can also ensure that communities understand their entitlements, the objectives of the organization's programs, and the organization's code of conduct.

Notes & Reflections

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Burning Questions

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SESSION 12: RESPONDING TO OTHER FORMS OF GBV IN EMERGENCIES

Learning Objectives:

- Understand potential responses to other forms of GBV in emergencies

OTHER FORMS OF GBV

Although much GBV prevention and response work in emergencies focuses on sexual violence, this is not the only kind of violence that women and girls experience. Emergencies exacerbate all forms of violence for a variety of reasons.

Early/forced Marriage: Economic hardship may lead families to force their daughters to get married earlier so they are no longer a financial burden on the family (note that this is not the same for boys). Many families will also try to 'protect' their daughters from other forms of violence by marrying them.

Domestic Violence/Intimate Partner Violence: Intimate partner violence runs the whole gamut of violence from sexual through physical and economic to emotional/psychological violence. All of these forms of IPV can be exacerbated in crises, during which men may use higher levels of stress & hardship as excuses to take out their anger and frustration on their wives (note that this does not excuse the violence, which is still a choice on the part of the perpetrator). Women may also lose the social networks and coping mechanisms that they have used to mitigate the violence in the past, leading to increased repercussions.

Sexual Exploitation/Trafficking/Forced Prostitution: When economic systems break down in crises, traditional income-generating activities may no longer be available, leaving women and girls more vulnerable to exploitation in its various forms.

It is important to note that many forms of violence, including intimate partner violence, may include – or be expressions of – sexual violence. For example, although we use the term early/forced marriage in talking about the phenomenon of girls being forced to marry much older men, one of the key kinds of violence occurring in such a situation is rape.

APPROACHES

Issues such as early/forced marriage are complex and difficult to address, even in stable contexts where programming is established and can operate over a longer period. Therefore, it is important to recognize that they cannot always be 'solved' – especially in emergencies. Our focus will most often be on mitigating the immediate consequences or preventing further harm.

Mitigating immediate consequences: While it may seem that early and forced marriage are very different issues to sexual violence perpetrated by an armed actor, for example, the consequence can look very much the same. Girls who are forced to marry at a young age may experience significant physical trauma from sexual intercourse and require health care, for example. Survivors of intimate partner violence will require psychosocial support to recover from their experiences. Case management, psychosocial support and healthcare services are therefore just as important for cases of early marriage or IPV as for other forms of sexual violence.

Preventing further harm: The other key aspect when dealing with such issues is to take steps to avoid further traumatization for the survivor, including by trying to mitigate immediate risk (how can you help a survivor to make her situation safer, are there places she can go or others who can help her) and by

identifying individuals who can advocate on her behalf (e.g. can community leaders work with the families to try to delay marriage, is there some way in which the family can access economic resources that would reduce the need to focus on the marriage of their daughter, etc.). In situations of sexual exploitation, preventing further harm also involves reporting the perpetrator to the appropriate reporting mechanisms (refer to Session 11: Risk Reduction and Annex 3: Additional Resources for further information on this).

Advocacy: Issues such as early marriage are very closely intertwined with social and religious norms, which makes them complex and difficult to address. In emergency situations, we do not have the time or resources to address change of social norms on a broad scale; however, we can interact with local religious and community leaders to try to improve the situation for individuals, and to try to reduce risks for women and girls more generally.

RECOGNIZING OUR LIMITS

It may not be possible to provide a response to **all** GBV cases, particularly in the acute stage of an emergency – this means both that the caseload may be overwhelming and require prioritization of cases where lifesaving care is possible, and also that response to some more complex cases may not be feasible in an emergency (although this will of course depend on the context and the stage of the emergency).

One of the key complicating factors in dealing with intimate partner violence, for example, is that in many cases the violence is likely ongoing, and therefore the survivor will continue to experience trauma even as services are provided.

This is difficult to manage when we are interacting with survivors, because we want to make things better for them. It is important to recognize that we can most likely not 'solve' the problem, but that even the small act of listening to and believing a survivor when she shares her experience can have a significant positive impact on her life. Be guided by what the survivor wants and needs from you.

INDIVIDUAL REFLECTION: WHAT DOES THIS MEAN FOR ME?

Take some time to reflect on and answer the following questions.

Does my organization already support survivors of these forms of violence in some way? If yes, how can I make sure my services are adapted to the emergency context?

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If no, what is my role in relation to these forms of violence (e.g. can my activities be adapted to support the specifically? Can I serve as an entry point/connector, or share relevant information in communities, make referrals, work together with case management or psychosocial support agencies or organizations, etc.)?

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Are there any risks for me as an individual and/or for my organization in taking these steps? How can I manage them?

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Notes & Reflections

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SESSION 13: INFORMATION MANAGEMENT & SHARING

Learning Objectives:

- Review the principles of good information management and discuss how to ensure safe and ethical information management and sharing in an emergency setting.

Currently, the management of GBV information, especially in emergencies, is characterized by a lack of consistency and standards in how and what information is collected. As we discuss information, it is

important to consider how and why we use information and, in particular, how to adhere to ethical principles in data collection. An emergency situation is no justification for not maintaining ethical standards. In this session, we will discuss concrete, practical approaches for maintaining electronic and written documentation safely and securely.

WHY COLLECT INFORMATION?

Given that sexual violence is known to be prevalent in all settings, including in emergencies, a lack of specific data about sexual violence is never sufficient justification in and of itself for the collection of information about sexual violence, much less sharing collected information with others.

GBV programs collect a wide variety of information for various purposes. GBV actors may collect information on trainings and awareness-raising sessions, the effectiveness of referrals and referral systems, and incident-related data, including incident types, perpetrator information, and survivor information.

Often, insecurity in emergencies limits access to communities and the time in which to implement services. Rapid response interventions measure whether services are in place and accessible, but not necessarily service utilization rates. GBV actors can begin to establish systems to capture data to reflect service utilization rates but must recognize that the analysis of this data may occur later, after the early stages of an emergency have passed.

Humanitarian agencies and GBV actors need to be smarter about how they collect and use information. Sound qualitative and quantitative GBV data gathering systems established at the outset of an emergency response aids in effective programming, advocacy and fundraising. Program information may be used to raise awareness amongst donors, UN agencies and other international actors about gaps in services and the manifestation of violence against women and girls. It may also be used to improve the quality and delivery of services, collecting data for evidence-based decision-making in programs, advocacy and coordination

In Sierra Leone, IRC GBV staff analyzed incident data received in Freetown and determined that a majority of the child sexual abuse cases they received were perpetrated by co-habitants or landlords. This was linked, in part, to patterns of resettlement as children were often left at home alone, living near or with other returnees, and without the networks of protection previously afforded to them before the conflict. IRC used this information to raise awareness about the risks children faced in an effort to prevent future abuse.

DESIGNING EFFECTIVE & SAFE INFORMATION MANAGEMENT SYSTEMS[39]

Good information management systems are simple, flexible, reliable, useful, sustainable and timely. We need standard indicators and standard methods of data collection to immediately put in place during an acute emergency for GBV to consistently monitor, review and analyze data and trends.

SECURITY & CONFIDENTIALITY

All program data containing information on clients should be collected and stored in adherence to international best practices and standards that prioritize confidentiality and the safety and security of clients.

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[39] IASC, *Guidelines for GBV Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*. Geneva: IASC, 2005.

Maintaining confidential databases or sensitive information of any kind requires considerable investment in both technology and personal discipline. In the absence of specific information storage systems and staff vetting processes, we must assume our data is not secure and may be subject to unauthorized access and dissemination.

With this in mind, the following are recommended procedures. These are mostly common sense and if implemented can reduce the risk of unauthorized access to sensitive information:

Maintaining Hard Copies

1. Only print information if it is absolutely necessary. Promote a paper-free working environment to reduce the amount of information that is printed. In most cases, social workers will not have access to computers or hand-held data devices and thus will be using paper forms to document cases. If information is printed, register each copy and track it (apply a serial number and maintain a spreadsheet). Ensure readers are aware that they are accountable for the documents.

2. Destroy all printed material when it is no longer needed. Do this by shredding or burning (if safe to do so) followed by pulping. Pulping means adding water to shredded paper or ashes to further destroy any remaining material. This usually renders the information completely unreadable.

3. Store printed material in a safe or other secure container and limit access to the combination or keys.

Maintaining Soft (Electronic) Copies

1. Do not email information unless absolutely necessary. When you do send an email, include instructions for the recipients so that they are aware the information in the email and its attached files is sensitive. This may include caveats such as "Limited Distribution: Do not disseminate this email or attachments without permission from…"

2. Store electronic data on a single computer or removable storage media, for example a flash drive, and keep only limited backup copies.

3. Secure backup copies in a locked safe or room or keep flash drives with you at all times.

4. Access to information should be controlled. This includes establishing chains of control for all staff accessing or using client information and limiting access to computers used to store confidential data.

5. Information stored electronically should be password protected. Use a series of passwords to reach each level of information. Maintain security by ensuring that each user knows only the passwords to access the information for which s/he has legitimate need.

6. Use identifiers to mask personal identities. A system of codes to identify a client can be assigned identifying numbers, or other codes such as using certain letters from a client's last name. Only the person entering the information initially into the computer and assigning the identifier should know the identity of the client.

DATA COLLECTION CHALLENGES IN EMERGENCIES

Often in emergency settings, UN agencies and GBV actors will focus on calculating the prevalence of violence. However, this may not be the most appropriate use of resources in emergency settings. GBV staff can facilitate the creation of systems to collect information that will improve service delivery and prevention efforts.

INTER-AGENCY CHALLENGES

Different GBV actors use different incident definitions. This poses a challenge to inter-agency data and information sharing, particularly in fora where coordinating bodies are attempting to triangulate or aggregate information. Agencies also employ different methods of collecting data. This limits GBV actors' ability to compare data, monitor trends, and provide appropriate follow up.

In a number of emergency settings, as well as post-conflict and stable settings, GBV actors fail to establish protocols for information sharing, preventing actors from standardizing information movement across sectors, the aims for using information and secure data management systems.

In addition, UN actors may be collecting information for UN-centered monitoring systems, such as the Monitoring and Reporting Mechanism linked to Security Council Resolution 1612. This data may not be used to improve support and care for survivors of sexual violence and care should be taken to ensure that any data or information provided is anonymized and that service providers have access to compiled reports and analyses to improve service availability.

Good Practice in Information Management

The Gender Based Violence Information Management System (GBVIMS) was created to promote and protect the safety, respect and dignity and consent of GBV survivors. The GBVIMS User Guide provides examples of good practice in GBV information management, and key points for GBV actors involved in information management. Essential points are included here.

GBV individual case data should not be gathered in situations where services to survivors are not available; services must be available to GBV survivors if data is going to be gathered from them.

GBV survivors' confidentiality must be protected, and survivors must formally consent for their information to be shared: Sharing GBV information may draw unwanted attention to survivors, programs, agencies or communities. You must ensure, therefore, that all shared information protects the identity of all involved and ensures client confidentiality. This means that no information is shared that could be used to identify the survivor or anyone else involved (e.g. the alleged perpetrator, the family and community of the survivor, the service provider, etc.).

GBV intake forms should not be shared outside of the context of referral: Service providers are often asked to share an unnecessary level of detail regarding their clientele. For example, service providers are often requested to share the initial intake and assessment form (sometimes referred to as an incident report form) with the agency responsible for GBV coordination – for data collection purposes, but client files should never be shared outside the realm of a referral (so as to avoid having the survivor repeat her story and history) and without the client's written informed consent. Otherwise, only quantified and de-identified (or "anonymized") data should be shared. This is first and foremost an issue of ethics; there are also potential safety and security ramifications associated with sharing an inappropriate level of data.

GBV data should be kept securely in locked cabinets, with passwords to protect files and only shared on a need-to-know basis: Organizations providing services for GBV survivors are aware of the sensitive nature of the data they collect. The persistent threat of retribution is a global reality for GBV survivors, GBV staff and organizations that implement GBV programming in all phases of humanitarian response. The sensitive nature of GBV data and the potential harm that could happen if the data were misused makes it extremely important for service providers to store data in a manner that ensures the safety of the survivor, the community and those collecting the data.

GBV information sharing protocols or agreements should be in place between organizations that share GBV data, which explains how data is shared with whom, and for what purposes: Organizations collecting data often fail to decide what data is actually needed at what level, for what purposes and how it will be used *before* they start sharing it. Similarly, organizations requesting information be shared with

them often fail to clarify and communicate to others what specific data they need, for what purposes and how it will be used *before* they request it. An **information sharing protocol** is a set of guidelines for organizations to follow during the information sharing process. The ISP should set clear guidelines for any sharing of GBV incident information and to protect survivors while promoting improved GBV coordination. It is essential that only the appropriate level of data is shared and that the purpose for sharing the data is explicitly stated. Clients' control over their data must be respected.

Trust and a spirit of collaboration are essential to facilitating information-sharing amongst organizations: The process of developing an ISP will need to **engage all relevant actors** and is equally as important as the final document produced. There has been a tendency for information sharing to be a one-way street, typically with service providers sharing data with agencies tasked with consolidating data. Service providers often share their data without receiving any information as to how the data was used or with whom it was shared. Participating organizations may never see the compiled data, which means that they lose the opportunity to learn or further inform their programming. One-way information sharing can act as a disincentive for organizations to share information.

INTER-AGENCY INFORMATION SHARING

Coordination bodies may require sharing data and findings. However, how and when this information is shared will depend on the context. GBV actors must think carefully about the reasons why information is shared and the process through which this might occur. All too often, there is an automatic assumption that information on sexual violence is necessary regardless of the role of the agency or actor. If agencies are trying to provide high-quality programming that maintains the safety and security of survivors to a reasonable degree, this extends to information sharing. Survivor-centered decision-making for action is key to answering how information is shared.

Organizations may share aggregate and anonymized information with other partners through an inter-agency meeting or group and according to specified information-sharing protocol. In some cases, organizations may not share any information with external actors, if doing so might jeopardize the safety and security of the women and girls with whom the organization works or if jeopardizes the organization's operational presence. This might be particularly true in countries where the host government is unsupportive of GBV programming or using GBV as a deliberate military strategy in a conflict to control, humiliate or eliminate a population.

All information shared with external sources or outside of regular protocol should have specific purposes for sharing with a third party. Coordination often requires sharing data and findings. Any data shared among agencies should be coded with no identifying information included and specific agreed-upon protocols should be in place for all relevant operational actors, detailing the purpose of information-sharing, protocols and chains of communication, minimum safety procedures, and staff training requirements.

Consistent and agreed-upon approaches among different operational actors must be established to ensure standard safety and confidential practices in terms of any level of information collection and sharing involving GBV survivors.

When disseminating or discussing information, ask yourself the following:

- Who needs to know about this issue?
- Why does this person need to know?
- How this information will be shared and used?
- What are the possible risks to our organization or client if we share this information?

If you cannot adequately answer these questions, you must reconsider your decision to share this information.

INDIVIDUAL REFLECTION: WHAT DOES THIS MEAN FOR ME?

Take some time to reflect on and answer the following questions.

Does my organization already collect, receive or use individual GBV survivor data? If yes, how will I keep this data safe in an emergency? How will I store and/or destroy data to make sure it is protected?

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What steps do I need to take to do the above?

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Are there any risks for me as an individual and/or for my organization in taking these steps? How can I manage them?

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Notes & Reflections

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SESSION 14: COORDINATION & ADVOCACY IN EMERGENCIES

Learning Objectives:

- Understand how to leverage resources and support for women and girls and GBV programming in emergencies.
- Understand the importance of effective coordination and how to interact with the relevant systems

This session discusses some of the challenges in coordinating and advocating for programs and funding that address GBV in emergencies. The session addresses coordination, advocacy and fundraising together because the three are very closely linked, and all are in service of ensuring that resources, support and programming are used effectively for women and girls; however, there is a strong focus on advocacy as this is a common thread throughout GBV work and is integral to every level of intervention—structural, systemic, operative—when addressing sexual violence in emergencies.

WHAT IS COORDINATION?

Coordination consists of groups, systems or mechanisms that organize humanitarian actors and interventions to ensure that assistance is delivered in an effective and efficient way. This includes mapping interventions, strategic planning, managing information, mobilizing resources, ensuring accountability, avoiding duplication and filling gaps.

Coordination is an important element of humanitarian work. In some contexts, formal 'Cluster' systems are active. Clusters are formalized groups of humanitarian actors (both UN & non-UN) in each of the main sectors of humanitarian action (e.g. water and sanitation, health, protection, nutrition, etc. The heads of each cluster, and their responsibilities, are standardized.
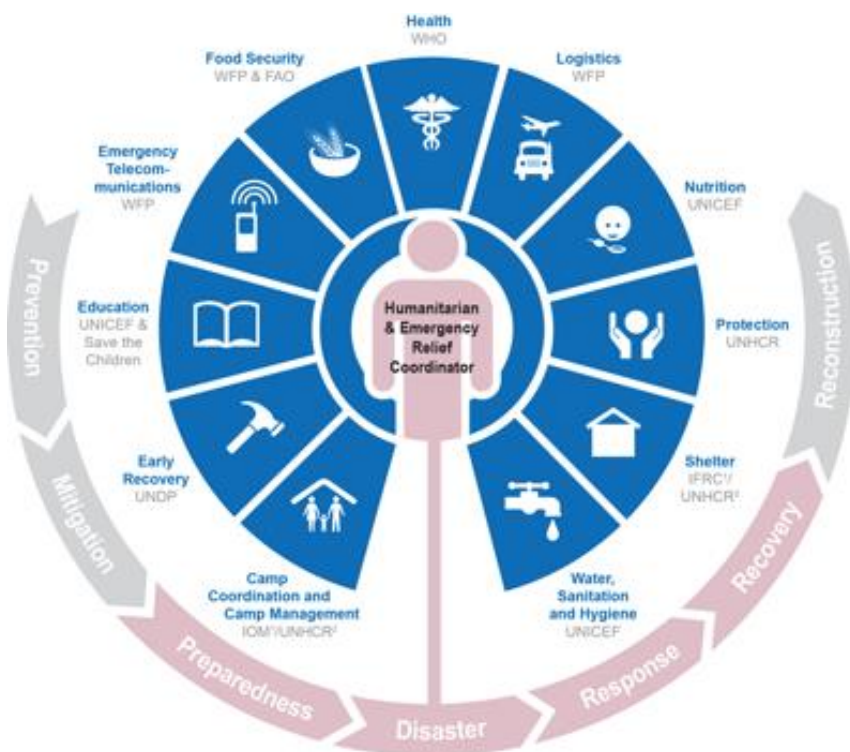
GBV work is generally coordinated through the Protection Cluster or sub-groups within this known as GBV sub-clusters or GBV working groups. At the global level, GBV coordination is led by what is known as the GBV Area of Responsibility, within the Global Protection Cluster.

Formal coordination mechanisms such as the cluster system are important and should be kept informed of assessments, activities and plans so that they can understand and coordinate gaps in programming. However, these formal systems do not always reach the most community-based, grassroots levels – and coordination still needs to happen at those levels. Even where formal coordination bodies do not exist, 'coordination' itself can still happen – organizations or agencies in the same area can still meet bilaterally or convene meetings amongst each other.

Coordination systems can allow you to understand what is happening and where, where the gaps are and where your organization can most effectively intervene. It also helps you to avoid duplicating what others are already doing. Importantly, coordination systems are a good forum to raise issues that you want other organizations to address – for example, if organizations are not responding to the needs of women and girls, or if you notice gaps in the field that need to be addressed.

WHAT IS ADVOCACY?

Advocacy is a key element of emergency work and, in particular, for humanitarian staff working on sexual violence issues. But what is advocacy? What makes someone an advocate? And, how does advocacy work most effectively for GBV programming in emergency settings?

Different groups use the term advocacy in multiple ways in emergency settings. Some groups may use the term to refer to a formal campaign or strategy while others might simply use the term to refer to an action taken.

In fact, advocacy is an active effort to effect social change. This can be aimed at protecting someone's rights or aimed at advancing an idea. Advocacy efforts can be led by people or for people at the community, district, national or international level. It is important to remember that powerful advocacy activities are most often initiated by those who have been affected by the issue themselves.

Advocacy is "the deliberate and strategic use of information – by individuals or groups of individuals – to bring about change. Advocacy work includes employing strategies to influence decision makers and policies, to changing attitudes, power relations, social relations and institutional functioning to improve the situation for groups of individuals who share similar problems."[40]

Advocacy activities and strategies can aim to:

- Change a decision maker's understanding of a problem or issue
- Change the way decisions are made or change the decision-making process
- Influence the choices that a decision-maker considers and makes

In emergency settings, GBV staff might advocate collectively to a UN agency or peacekeeping mission to improve the protection of displaced women and girls. The GBV sub-cluster or working group in a particular country might advocate with government authorities to change national law or policies. Or, a grassroots women's group might take concerns about access to healthcare to their village council or local authorities.

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[40] Adapted from AWID, 2001 and FCR, 2003

Advocacy is different from awareness-raising. A key difference is that advocacy is direct, targeted action aimed at influential people intending to alter a specific issue. Awareness-raising increases public knowledge and perception on a specific issue. While advocacy does raise awareness, awareness-raising is not necessarily advocacy.

TYPE OF APPROACH	AIM	TARGET GROUPS
Community Mobilization	Raise awareness, empower communities, build community capacity to address the problem	General public, specific groups of people
Information, Education, Communication	Raise awareness, change behavior	General public, specific groups of people
Advocacy	Raise awareness, impact decision and policymaking to change the social environment	Specific groups of influential people

WHERE DOES ADVOCACY TAKE PLACE?

Advocacy is a powerful tool to help meet the needs and fulfill the rights of women and girls in emergencies and can be undertaken at all levels: at the grassroots or local levels, the district or national levels, and the regional or international levels.

At the Local Level: This type of advocacy seeks to directly address the needs of and support affected communities and involves working closely with local decision makers. Depending on the setting, local decision makers may include service providers, refugee or IDP camp management, community leaders, other humanitarian staff, coordinating bodies, local government leaders, security personnel or civil society organizations.

At the District or National Levels: This type of advocacy seeks to change the systems in place to support women and girls in emergencies. Key targets might include district-level or national-level government officials, national-level coordinating bodies, donors based in-country, or national-level offices of humanitarian agencies.

At the International Level: Advocacy at the international level seeks to mobilize resources, increase awareness of an emergency and make structural-level changes to improve support for women and girls. Decision makers at this level might include UN staff in New York or Geneva, international governmental aid agencies, regional coordination bodies, and other international coalitions, alliances and NGOs.

Examples of advocacy include:

LOCAL LEVEL

Working with local leaders to gain support for sexual violence programming and to encourage them to take specific actions to help women and girls in their community access to services related to sexual violence.

NATIONAL LEVEL

Meeting with health actors to standardize treatment for rape survivors by adapting and implementing a national protocol for the clinical management of rape.

INTERNATIONAL LEVEL

Meeting with private or government donors to keep them informed of the needs of women and girls in a specific country and ensure that funding for GBV programming remains a priority.

HUMANITARIAN ORGANIZATIONS AND ADVOCACY[41]

Humanitarian organizations are often uniquely placed to give voice to the people with whom we work; often we offer insights or perspectives that no one else is able to provide. For many staff, advocacy is already a daily part of our jobs, whether we give it that name or not. When we talk about our work to policymakers in government or journalists or public audiences, we are contributing to the organization's advocacy efforts.

Advocacy should be rooted in the 'field,' whether the field is a refugee camp in Kenya or the streets of Miami. When we talk to legislators, donor representatives, journalists, and government advisors who assess and shape policy in the countries in which we work, we can provide rare and valuable insights to important issues.

Humanitarian organizations can advocate on behalf of refugees, displaced people, asylees, asylum seekers, returnees, other victims of war and persecution, and those in need, whose voices, would not be heard without our help. We do this on our own and with other organizations. We may also speak up on behalf of IRC staff or other humanitarian organizations by seeking better security measures or conditions for our work.

Humanitarian organization's advocacy goals can include:

- Improved protection of and delivery of aid to refugees, IDPs, asylum seekers, and returnees;
- Improved humanitarian and human rights policy and practice;
- Adequate resources for victims of war and persecution;
- Unhindered access to humanitarian assistance for populations in need;
- The preservation of the United States as a sanctuary for the persecuted, and a working and robust US refugee resettlement program.

Humanitarian organizations should consider several factors before developing an advocacy position:

- The relevancy to the organization's mission
- The potential impact for the communities in which we work
- Organization field staff security and operational presence

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[41] Adapted from IRC and the Women's Commission for Refugee Women & Children, *Advocacy Handbook*. New York, 2008.

- The resources, time and expertise required to adequately address the issue
- Whether the issue is so controversial that it might compromise staff ability to fulfill the mission in the future or, in other words, whether the costs outweigh the benefits

Addressing sexual violence in our advocacy and policy work requires sensitivity and careful planning. There are times when governments, political leaders, UN agencies and others will find certain advocacy positions objectionable. The safety of staff and the communities with whom we work will always be of paramount concern.

DESIGNING AN ADVOCACY STRATEGY

Advocacy strategies differ, depending on the context in which you are operating. The basic steps in designing an advocacy strategy are outlined below. Based on the specific context and the identified needs, an advocacy strategy may not necessarily include all of these steps or address the elements in any particular order.

In emergencies, the needs of women and girls can change rapidly as the political or security situation changes. The key stakeholders and events around which strategies are formulated are not fixed, especially within conflict and displacement scenarios. The objectives of your advocacy might change then as well.

IDENTIFY A CLEAR PROBLEM THAT CAN BE RESOLVED THROUGH ACTION

A problem is any situation that creates difficulty or hardship for an individual or group. In identifying the problem, consider the following questions:

- What problems do women face in the community?
- What is the greatest priority for women?
- Why is this a problem?
- What needs to be done to address this problem and help women or survivors?
- What solution is the most likely to succeed?

Begin with an identifiable problem that you want to change. You must understand all aspects of this problem. An effective advocacy strategy focuses on a well-defined problem that can be addressed and resolved. After deciding which problem will be addressed, investigate and collect information about the problem and the extent of the problem.

Remember, international laws, standards and guidelines can be used as a platform for advocacy, as discussed earlier. For example, the IASC GBV Guidelines can serve as a tool to encourage other coordinating bodies groups—such as health, protection, and camp management—to address aspects of sexual within their planned activities.

IDENTIFY THE DESIRED GOAL OR RESULT

What do you want to achieve? In order to identify a feasible goal, you must be thoroughly familiar with the problem and conduct thorough research on the issue.

Explore the costs or benefits associated with that result. Who will benefit from this result? Does anyone in the community stand to lose anything from this result? What will this result cost and who will have to pay this cost?

Consider all types of costs, not just financial. This might include security, health or emotional costs. For example, will a particular group of women face elevated risks of violence from their husbands after the result is achieved? Are there unintentional costs to achieving this result?

Also, consider which elements of your goal are negotiable and which elements are non-negotiable. Are there some specific results which you would be willing to abandon to achieve other results? In some cases, you might find that the only way to achieve the non-negotiable elements of your goal is by making concessions on others.

IDENTIFY 'GATEKEEPERS'

Gatekeepers are individuals, organizations or institutions that make decisions or influence or control the decision-making process. Identifying gatekeepers is a crucial part of designing an effective strategy as they can either help bring about the change you seek or create obstacles to change.

When identifying the gatekeepers, consider the following questions:

- Who makes the decisions that will help you achieve your goal?
- Who influences the gatekeeper and how he or she makes decisions?
- What can the gatekeeper do to help you? What is the gatekeeper unable to do to help you?
- What motivates the gatekeeper to help or not help you?

Make sure you fully understand the role of the gatekeeper and the benefits and limitations of their support. Learn as much as you can about the gatekeeper before arranging a meeting. Is the gatekeeper sympathetic to your issue? Does he or she need to be won over? Identifying and applauding the gatekeeper's accomplishments in the community can help to build good relationships.

Keep in mind that gatekeepers might not understand the issues as well as you do. Therefore, you must be able to communicate the desired change clearly, explain why the specific change is required, and respond to questions or proposals that conflict with your desired outcome.

A component of successful advocacy is forming professionally rapport with gatekeepers. In this regard, meetings should not be seen as a one-off event but part of an on-going relationship.

DESIGN YOUR STRATEGY & PLAN OF ACTION

You now have the information you need to define an advocacy strategy and plan of action to achieve your goal. Your advocacy strategy should include the following information:

Goal: What is your desired goal or outcome

Targets: Which 'gatekeepers' will you target in your advocacy strategy and why? What actions can they take to help move you toward your goal?

How: How will you influence the decisions or actions of these gatekeepers? If you provide them information, what information will you give to them and how will you share it with them? How will you motivate them to act?

Decide how public your actions will be: very public or private, behind closed doors? What types of low-profile, medium-profile and high-profile actions you will take and when?

If it is determined that an advocacy strategy or message jeopardizes the safety of IRC's programs, staff or the communities in which we work, a less-public approach can be pursued. This is sometimes referred to as 'backdoor advocacy.'

Backdoor advocacy can include:

- Sharing information with advocacy based organizations
- Sharing information with coordination groups, consortiums, alliances
- Sharing information with media or donors in a confidential manner

You may choose to talk to journalists off the record or work behind the scenes with human rights organizations, grassroots movements, or think tanks. By using these methods, you can highlight key issues of concern without increasing risks to safety, service delivery or operational presence.[42]

Some examples of actions you might take include:

LOW-PROFILE ACTIONS	MEDIUM-PROFILE ACTIONS	HIGH-PROFILE ACTIONS
• Quiet negotiation with 'gatekeepers' • Share information informally with 'gatekeepers' • Ongoing meetings with allies and 'gatekeepers'	• Continue negotiation with 'gatekeepers' • Meet other officials from the government, UN and NGOs • Launch public education and awareness activities • Participate and raise the issue in community meetings • Form alliances with other groups and organizations	• Write letters to key officials from the government, UN and NGOs • Public criticism • Write letters or articles for the newspaper or radio • Hold public rallies or marches • Testifying before government or multi-lateral bodies and panels

By whom: Assign actions and decide who will do what. This includes actions that allies or other like-minded groups or organizations can take as well as your own staff or group members.

Some of the most powerful advocacy activities are driven by those directly affected by the problem. While women and girls survive brutal acts of sexual violence during emergencies, they are also powerful advocates in these environments as we have seen in countless countries. It is vital to remember that women and girls are not only survivors of sexual violence, but also a powerful force for change. As security permits, staff should identify ways to support the advocacy efforts of grassroots women's organizations.

> **ALWAYS** evaluate the activities you are planning to undertake to make sure they do not endanger you or anyone else in the community. Evaluate the proposed actions for potential negative repercussions.

When: When will you undertake your actions? Identify strategic times for action, for example when a problem is first brought to light or when groups are meeting to address the problem. You must also know when gatekeepers make decisions, how long those decision-making processes take and when to expect the results from these decisions.

How much: What resources will you need to implement this strategy? What human resources, financial resources, tools, and partners will be required to implement your plan? What resources are needed to realize your goal?

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[42] Adapted from IRC and the Women's Commission for Refugee Women & Children, *Advocacy Handbook*. New York, 2008.

BUILD ALLIANCES AND RELATIONSHIPS FOR SUPPORT

Identify allies in the community as well as potential opponents. Remember, you may be trying to change systems, policies or practices which have been in place for many years and thus you may face great opposition. Building alliances with other like-minded groups can help influence gatekeepers and decision makers.

Identify NGOs or other groups in other communities that have undertaken similar advocacy. Have other organizations tried to address this problem before? What strategies worked and which strategies did not work? These groups can provide valuable information about their experiences and may be able to help influence the change.

IMPLEMENT AND MONITOR YOUR STRATEGY AND PLAN OF ACTION

As you implement your strategy and plan of action, review and adjust your actions as necessary. If some actions do not work, figure out why and learn which actions work best. Adapt your plan as you implement it, always taking into account the risks associated with these actions.

ADVOCACY IN EMERGENCIES

At the onset of emergencies, advocacy positions and strategies can be very useful to leverage support for the organization's interventions, improve funding for sexual violence programming, and ensure that the needs and rights of women and girls are accounted for in emergency efforts.

However, advocacy in emergencies can be challenging as staff must consider how to most effectively and safely undertake advocacy activities without jeopardizing the safety of women and girls, their communities and organization staff. When working in hostile environments, GBV staff must collaborate with in-country senior management to assess the safety and security of staff and beneficiaries and determine appropriate and feasible levels of advocacy.

Often, a humanitarian response organization's priority in hostile environments is to maintain life-saving operations and ensure services continue to meet the needs of the most vulnerable. In these types of environments, safety and security risks may require GBV staff to use alternative means of persuasion and influence to address sexual violence.

Some examples include:

- **Sharing information or forming strategic partnerships with trusted advocacy organizations to channel sensitive in-country information to the international arena.** Information and insight from operational agencies, like the IRC, is highly often valued by advocacy organizations and these actors are often better-placed to speak loudly and publicly on sensitive issues.

- **Sharing information with on-the-ground coordination groups, consortiums and alliances**. This can occur through coordination bodies or other partnerships with groups that have common ideals, mandates or desired outcomes. An alliance where no one organization is publically identified in publically-released information provides a good 'shield' for operational agencies.

- **Confidentially providing journalists with accurate information about GBV** during an emergency. This can be an effective way to raise international awareness about the needs and rights of women and girls in an emergency. However, staff must abide by IRC's guidelines on working with the media and liaise with senior management in-country when doing so.

- **Educating international donor organizations**. Providing recommendations on how and where donor funds can be most effective provides an ability to respond effectively to an emergency. In

addition, donor agencies operate in top-level spheres of influences, often out of reach of most humanitarian aid agencies. Therefore, information provided to donors can have direct influence at the highest international decision-making levels

Notes & Reflections

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SESSION 15: EMERGENCY PREPAREDNESS

Learning Objectives:

- • Understand the purpose of preparedness and the tasks that can enhance readiness

Emergency Preparedness aims to establish a standing capacity to respond to a range of different situations that may affect a country or region by putting in place a broad set of preparedness measures[43]. This process allows us to be ready to deal with uncertainty and quickly adapt when the situation around us is changing rapidly. It's about being proactive and planning for potential situations that may occur. Being prepared will help ensure that the emergency intervention starts immediately and service delivery is of good quality.

Preparedness for gender-based violence in emergencies relies on actions from a variety of people who have different levels of association to your work. Because so many different people can enable better preparedness, on the surface preparedness can seem overwhelming. It is important to be strategic about how to do preparedness.

There are different layers of preparedness to focus your time and energy. These layers depend on your influence to get specific preparedness tasks done. Think of it like a beam of light from a flashlight – things that are closer to the flashlight beam are easier to see. People who are closer to your project are going to be easier to influence when prioritizing tasks that can help your project be better prepared and ready for an emergency. In the first layer, your organization, you have the most control on which tasks can be done using the resources and time that you have at hand.

Other tasks are going to have varying degrees of support from other actors. Your ability to get those tasks done will depend on your leverage with those other individuals, be it people from other organizations who prioritize GBV response, senior management, operations and other sectors within your organization, or the greater humanitarian community. Work to build understanding and buy-in from key figures in advance – particularly those with the power and resources to make essential decisions when a crisis occurs. During an emergency, time and resources are in short supply and priorities need to be made.

Preparedness does not have to be done all at once. Spread out the tasks; do one or two tasks per week over a period of time. It is better to be partially prepared than not prepared at all because you kept pushing off all the little tasks as a "preparedness activity". Since there is rarely enough time to do preparedness tasks, it's best to start with those tasks that you and your team will have the most influence getting done.

PREPAREDNESS TOOLS

A variety of tools exist to support your preparedness planning. Within the emergency response and preparedness package you will find templates for preparedness plans, contingency plans (including scenario development), a communication and responsibilities matrix and a deployment materials

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[43] https://interagencystandingcommittee.org/system/files/legacy_files/

checklist. These should be reviewed and adapted to your context before use. Additional resources can also be found in Annex 3.

- **Preparedness Plan Template –** The preparedness plan template outlined below is designed to support your reflection during the training on the actions that are most likely for you and your organization in an emergency, according to your current interventions and organizational strengths.
- **Scenario Development** – Guidance to identify the most likely scenarios in your context. The questions to guide your scenario development are included in the second tab of the same Preparedness Plan Template spreadsheet.
- **Communication & Responsibilities Matrix for Key Individuals at the Advent of an Emergency** - This is a simple map that outlines who should be contacting who and what their responsibilities are when a crisis occurs. It makes sure that the lines of communications are clear and that people know what to do when needed.
- **Emergency Deployment Tool Kit / Materials Check-List** - This is a list of the materials that a response team would need if they have to deploy into a crisis situation. It lists the types and quantity of the materials needed and who is responsible to have them packed and ready.

What Does This Mean for Me?

	Existing interventions/activities	What needs to change for emergencies	Risks for women, girls, survivors, staff
Case Management			
Psychosocial Support			

Healthcare			
Referral Systems			

Community Outreach			
Information Management & Sharing			
Coordination, Advocacy, Fundraising			

ANNEXES

ANNEX 1: KEY TERMS

Advocacy	The deliberate and strategic use of information—initiated by individuals or groups of individuals—to bring about change. Advocacy work includes employing strategies to influence decision-makers and policies, to changing attitudes, power relations, social relations and institutional functioning to improve the situation for groups of individuals who share similar problems.
Assessment	An assessment is a process undertaken to collect and analyze information in order to better understand a particular issue. In humanitarian settings, NGOs and UN agencies often carry out assessments to identify community needs and gaps in coordination and then use this information to design effective interventions.
Case Management	A collaborative, multidisciplinary process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's needs through communication and available resources to promote quality, effective outcomes
Emergency	Any situation in which the life or well-being of civilians affected by natural disaster, conflict or both has been or will be threatened unless immediate and appropriate action is taken, and which demands an extraordinary response and exceptional measures.
Gender-Based Violence	An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. The term *gender-based violence* highlights the gender dimension of these types of acts; or in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. GBV can be sexual, physical, psychological and economic in nature, and includes acts, attempted or threatened, committed with force, manipulation, or coercion and without the informed consent of the survivor.
Natural Disaster	The consequences of events triggered by such natural hazards as earthquakes, volcanic eruptions, landslides, tsunamis, floods and drought that overwhelm local response capacity. Such disasters seriously disrupt the functioning of a community or a society causing widespread human, material, economic or environmental losses, which exceed the ability of the affected community or society to cope by using its own resources
Preparedness vs. Contingency Planning	Preparedness planning is a process designed to establish a standing capacity to respond to a range of different situations that may affect a country or region by putting in place a broad set of preparedness measures, while contingency planning involves developing strategies, arrangements and procedures to address the humanitarian needs of those adversely affected by specific crises.
Rape	Non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.
Sexual Assault	Any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing,

	fondling, or touching of genitalia and buttocks. This incident type does not include rape, i.e., where penetration has occurred.
Sexual Exploitation	The sexual coercion and manipulation (includes all types of sexual acts) by a person in a position of power providing any type of assistance in exchange for sexual acts. In these situations, the survivor believes she or he has no other choice than to comply.
Sexual Violence	Any sexual act (or attempt to obtain a sexual act), unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.

ANNEX 2: ACRONYMS

DRC	Democratic Republic of Congo
ECP	Emergency Contraception Pills
GBV	Gender-Based Violence
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
IRC	International Rescue Committee
MISP	Minimum Initial Service Package
MRM	Monitoring and Reporting Mechanism
NGO	Non-Governmental Organization
OCHA	UN Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the High Commissioner for Human Rights
PEP	Post-Exposure Prophylaxis
PSEA	Prevention of Sexual Exploitation and Abuse
PTSD	Post-Traumatic Stress Disorder
RHRC	Reproductive Health Response in Conflict Consortium
SEA	Sexual Exploitation and Abuse
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organization

ANNEX 3: ADDITIONAL RESOURCES

Gender-Based Violence

- Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, IASC (gbvguidelines.org)

- Managing Gender-Based Violence Programmes in Emergencies, UNFPA, https://extranet.unfpa.org/Apps/GBVinEmergencies/index.html.

- Managing Gender-Based Violence Programmes in Emergencies E-learning Companion Guide, http://www.unfpa.org/publications/managing-gender-based-violence-programmes-emergencies (available in Arabic).

- Core Concepts in GBV: Facilitator Manual, International Rescue Committee, (http://gbvresponders.org/response/core-concepts/).

- Various GBV resources, guidelines & tools, Gender-Based Violence Area of Responsibility (gbvaor.net)

- Various GBV resources, including prevention, service provision, empowerment adolescent girls, disability inclusion, and emergency response, IRC (gbvresponders.org).

Emergencies & Humanitarian Standards

- ALERT Emergency Preparedness Platform (http://www.alertpreparedness.org/)
- Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response (http://www.sphereproject.org/handbook/)
- Core Humanitarian Standards (https://corehumanitarianstandard.org/the-standard)
- Protection Mainstreaming guidance & tools, Global Protection Cluster (http://www.globalprotectioncluster.org/en/areas-of-responsibility/protection-mainstreaming.html)
- Contingency planning and humanitarian action: A review of practice, Humanitarian Practice Network (ODI), 2007 (https://www.files.ethz.ch/isn/93866/networkpaper059.pdf)

Case Management & Psychosocial Support

- Caring for Child Survivors Implementation Guidelines, UNICEF & IRC (http://www.unicef.org/pacificislands/IRC_CCSGuide_FullGuide_lowres.pdf)

- IASC Guidelines on Mental Health & Psychosocial Support in Emergency Settings, Inter-Agency Standing Committee, 2007 (http://interagencystandingcommittee.org/system/files/guidelines_iasc_mental _health_psychosocial_with_index.pdf)

- Lilleston, Pamela et al. *Reaching Refugee Survivors of Gender-Based Violence: Evaluation of a Mobile Approach to Service Delivery in Lebanon.*

Health Response to Sexual Violence

- Clinical Care for Sexual Assault Survivors: A Multimedia Training Tool, International Rescue Committee (http://gbvresponders.org/response/clinical-care-sexual-assault-survivors/)
- Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons. Revised Edition. World Health Organization, 2004 (http://apps.who.int/iris/bitstream/10665/43117/1/924159263X.pdf)

- Minimum Initial Service Package for Reproductive Health in Crisis Situations: A Distance Learning Module, Women's Refugee Commission, Revised 2011 (http://iawg.net/minimum-initial-service-package/)

Prevention of Sexual Exploitation and Abuse

- Taskforce on the Prevention of Sexual Exploitation and Abuse, United Nations (pseataskforce.org)

- Report the Abuse, (www.reporttheabuse.org).

- Best Practice Guide: Inter-Agency Community-Based Complaints Mechanisms, Inter-agency Standing Committee, 2016 (http://interagencystandingcommittee.org/system/files/cbcm_best_practice_guide.pdf)

Disability Inclusion

- GBV and Disability Toolkit, WRC & IRC (gbvresponders.org)

- Working with Persons with Disabilities in Forced Displacement – Need to Know Guidance Series, UNHCR (www.refworld.org/docid/4e6072b22.html)

Safe Spaces

- Women and Girls Safe Spaces: A guidance note based on lessons learned from the Syrian Crisis, UNFPA (http://www.unfpa.org/resources/women-girls-safe-spaces-guidance-note-based-lessons-learned-syrian-crisis)

- Girl-Centered Program Design: A Toolkit to Develop, Strengthen & Expand Adolescent Girls Programs, Population Council (http://www.popcouncil.org/research/girl-centered-program-design-a-toolkit-to-develop-strengthen-and-expand-ado)

Monitoring and Evaluation, Information Management & Sharing

- Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies, WHO (http://www.who.int/hac/techguidance/pht/SGBV/en/)

- Gender-Based Violence Information Management System (gbvims.org)