Gender-Based Violence

Emerging Issues in Programs Serving Displaced Populations

Beth Vann

Reproductive Health for Refugees Consortium

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GBV Global Technical Support Project

JSI Research and Training Institute
on behalf of the
Reproductive Health for Refugees Consortium

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The Global GBV Technical Support Project provides technical assistance and training to UN agencies, international and national nongovernmental organizations, host governments, and displaced communities. The project seeks to strengthen prevention and response to gender-based violence by facilitating the development of effective program strategies with populations affected by armed conflict. It is led by JSI Research and Training Institute in collaboration with the Reproductive Health for Refugees Consortium. The activities are financed by the United States Department of State under the authority of the Migration and Refugee Assistance Act of 1962, as amended.

The Reproductive Health for Refugees Consortium (RHRC), formed in 1995, works to increase access to a range of quality, voluntary reproductive health services for populations affected by armed conflict. Each member brings unique strengths; collaboration has provided RHRC with numerous multidisciplinary skills and technical capabilities, as well as a broad field base. The members of the RHRC are the American Refugee Committee, CARE, Columbia University's Heilbrunn Center for Population and Family Health, International Rescue Committee, JSI Research and Training Institute, Marie Stopes International, and Women's Commission for Refugee Women and Children.

JSI Research and Training Institute is an affiliate of John Snow, Incorporated and provides a range of research and consulting services in the health care and service sectors. JSI, whose mission is to improve the health and well-being of people around the world, has worked in more than 80 countries. Its headquarters are in Boston, Massachusetts; other U.S. offices are in Washington, D.C., Concord, New Hampshire, and Denver, Colorado. JSI also maintains offices in more than 20 countries throughout the developing world.

Beth Vann MSW, the Global GBV Technical Advisor, specializes in projects that address violence against women in populations affected by armed conflict. Since 1998, her work has focused on GBV technical advising, training, and research with displaced communities, NGOs, UN agencies, and host governments. Ms. Vann has 20 years of experience in development and management of health and social services programs, and has worked in 12 countries. She holds a master's degree in social work and a bachelor's degree in psychology.

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PREFACE

Acronyms are both the shorthand and the lifeblood of the international community, and gender-based violence programs are certainly no exception. The terms—and abbreviations—that we use for the issues we address change over time as we revise our understanding of these concerns.

In the early years, we in the international community were addressing *sexual violence* through *victims of violence* programs in refugee settings. Over time, we realized the importance of recognizing and highlighting the strength and resilience of victims of violence. Before long, we were calling them "survivors." The word "victim" connotes powerlessness and stigma, the very outcomes that all projects are trying to prevent. Projects formerly known as VOV became projects for *survivors of violence*.

SV, VOV

SOV

Along the way, we realized that SV was too narrow a term because it did not cover issues of domestic violence, various harmful traditional practices, and other related problems. At the same time, we were discovering a new language that included gender equality, gender equity, gender mainstreaming, and gender in development. Thus, SV became *sexual and gender-based violence*.

SGBV

Meanwhile, WHO was studying *violence against women* and UNFPA was writing about *gender-based violence*.

VAW, GBV

In 2001, members of the RHRC were debating the use of SGBV. The term was deemed redundant and confusing because it implies that sexual violence is not gender-based violence, and vice versa. The group agreed that, in fact, sexual violence is one form of gender-based violence, not separate. The consortium therefore decided that SGBV would henceforth be known as GBV.

As of this writing, the UNHCR uses SGBV, WHO has VAW, and UNFPA uses GBV.

In early 2002, when a scandal broke in West Africa concerning sexual exploitation of young refugee females at the hands of workers in humanitarian organizations, some organizations attempted to establish the term, *sexual and gender-based violence and exploitation*. The use of SGBVE demonstrates a disconnect—a mistaken belief that somehow sexual exploitation is not a form of sexual and gender-based violence. The SGBVE term was mostly short-lived, but it provides a perfect example of how little is truly understood about what we mean when we say SGBV or SGBVE or GBV or VAW.

SGBVE

This publication uses the term GBV. We believe the term clearly and simply frames the central issues of gender underlying all forms of violence that GBV programs seek to address. In framing these as gender issues, GBV programs therefore must include women, men, girls, and boys—and address societal issues of gender, equality, and power. Additional considerations relevant to individual settings, such as age, ethnicity, education, and socioeconomic status are also included by implication.

This book is a compendium of key lessons learned during my five years working with GBV programs in 12 countries;* it is designed to be read and used by staff and volunteers who work to protect displaced populations—from high level policymakers to field-based workers. I hope the issues, observations, and challenges identified here and the ideas presented will not only add to the collective knowledge on GBV but also motivate humanitarian aid organizations to strengthen their collaborative efforts to prevent and respond to GBV.

*Angola, Bosnia (Serb Republic), Eritrea, Guinea, Kenya, Liberia, Serbia, Sierra Leone, Tajikistan, Tanzania, Thailand, Zambia.

Part 1, Emerging Standards, describes the evolution of GBV programs serving populations affected by armed conflict. Chapter 2 is a brief description of the current recommended model for integrating GBV prevention and response into the work of all humanitarian actors. Chapter 3 describes the most common challenges to GBV prevention and response efforts, and outlines solutions that are described further in other chapters. Chapter 4 is an analysis of the key challenges organizations face at policymaking levels as they attempt to integrate GBV action into their work; it includes recommendations for resolving those challenges.

Part 2, Common Issues, Practical Solutions, is an analysis of the seven most common problem areas for GBV programs in the field. Each chapter describes an issue, analyzes the reasons behind the difficulties, and offers suggestions for resolving these problem areas in programming.

Part 3, Varied Programs, Shared Challenges, contains summaries of the seven GBV programs that I visited most recently, and their needs for technical assistance. With its pending, fledgling, or established GBV program, each profile is a microcosm of the status of the approximately 13 comprehensive GBV programs around the world serving populations affected by armed conflict. Each profile briefly discusses the reason for the displaced population situation in that country, the GBV-related issues, and technical assistance that I provided during the field trips. The TA in each country emerged from a consultative and participatory process involving all stakeholders. In most cases, the interagency GBV team received technical assistance and training; often, this included facilitating program planning with the team. Most country teams developed specific plans for establishing and/or strengthening GBV programs.

Appendix A is a list of recommended resource materials relevant to GBV programming in populations affected by armed conflict.

Appendix B is a sample interagency procedure manual for GBV prevention and response. The manual, which can be revised and adapted for use in any setting, specifies the procedures and agreements for interagency coordination, collaboration, and communication. The first such manual was produced by the interagency GBV team in Tanzania in 2000. Since that time, it has been revised and is being considered for use in a number of countries. As with many components of GBV programs that serve displaced populations, the concept of a procedure manual is in its infancy. As interagency action is increasingly refined and understood over time, with ongoing program development and continuing lessons learned, tools such as this manual will evolve and change.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ARC	American Refugee Committee
BBC	Burma Border Consortium *or* British Broadcasting Corp.
BPRM	Bureau of Population, Refugees, and Migration (U.S. State Department)
CCSDPT	Committee for Coordination of Services to Displaced Persons in Thailand
CDC	Centers for Disease Control
COERR	Catholic Office for Emergency Relief and Refugees
CSI	Community Safety Initiative
DFID	Department for International Development (United Kingdom)
DV	domestic violence
FAWE	Forum of African Women Educationalists
FGM	female genital mutilation, also known as female genital cutting
GBV	gender-based violence
GBV TA	gender-based violence technical advisor or technical assistance
HIV	human immunodeficiency virus
ICRC	International Committee of the Red Cross
IDP	internally displaced person
IEC	information, education, and communication
IMC	International Medical Corps
IRC	International Rescue Committee
KWO	Karen Women's Organization
M&E	monitoring and evaluation
NGO	nongovernmental organization
NUEW	National Union for Eritrean Women
NUEYS	National Union for Eritrean Youth and Students
OSCE	Organization for Security and Cooperation in Europe
PLA	participatory learning and action
PRA	participatory rural/rapid appraisal
RH	reproductive health
RCH	reproductive and children's health
RHRC	Reproductive Health for Refugees Consortium
RTG	Royal Thai Government
RUF	Revolutionary United Front (Sierra Leone)
SCF	Save the Children Fund
SGBV	sexual and gender-based violence
SLA	Sierra Leone Army
SOV	survivor of violence

STI	sexually transmitted infection, also called sexually transmitted disease
SV	sexual violence
TA	technical advisor; technical assistance
TBA	traditional birth attendant
TOT	trainer of trainers, training of trainers
TSZ	temporary security zone (Eritrea-Ethiopia border area)
UAC	unaccompanied child(ren)
UN	United Nations
UNAMSIL	UN Assistance Mission in Sierra Leone
UNDP	UN Development Program
UNDPKO	UN Department of Peacekeeping Operations
UNFPA	UN Population Fund
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
UNIFEM	UN Development Fund for Women
UNOCHA	UN Office for Coordination of Humanitarian Assistance
USAID	US Agency for International Development
VAW	violence against women
VOV	victim of violence
WFP	World Food Program
WHO	World Health Organization
YWCA	Young Women's Christian Association

Contents

Tables

Figures

Part 1

Emerging Standards

CHAPTER 1

A Brief History of GBV Programming

Gender-based violence (GBV) is a serious international public health issue; adequate, appropriate, and comprehensive prevention and response strategies are lacking in most countries world wide. The situation is especially problematic in refugee and displaced population settings that arise out of conflict, for it is here that women and children comprise the greatest numbers and are the most vulnerable to exploitation, violence, and abuse. This chapter is an overview of efforts to address GBV in populations affected by armed conflict.

Sexual violence perpetrated by wartime combatants is an age-old phenomenon. Today, however, there is also evidence of sexual exploitation, domestic violence, and other forms of GBV in populations affected by armed conflict.* Although few hard numbers are available, news of the toll wrought is increasingly surfacing not only in anecdotal evidence—reports from victims, health-care professionals, and compatriots—but from the studies now being conducted by WHO, RHRC, CDC, and others to identify the magnitude and depth of the problem in some settings.

Addressing GBV among displaced populations has become an increasingly high priority over the past 15 years, coinciding with the growing world wide attention to human rights and women's rights. The United Nations High Commissioner for Refugees (UNHCR), mandated to protect and assist refugees world wide, is the designated leader for efforts to address GBV among refugee populations. Since the early 1990s, UNHCR and its NGO partners have been implementing comprehensive GBV programs to address violence against women and children.

We have learned that the most promising prevention and response strategies require integrated and coordinated action by multiple actors from the displaced community, international humanitarian aid organizations (international NGOs and UN agencies), national NGOs, and host governments.

The key sectors, or functional areas, that must be involved are the health, psychosocial, security, and legal justice systems (both formal and informal). To achieve integrated action, there must be collaboration, coordination, communication, technical training, and high-level support and commitment between and within all these participants.

This is not a simple task.

THE STATE OF THE ART

Early GBV programs were generally small in scope and focused on sexual violence, with services provided through separate or *vertical* systems that were either scaled back or eliminated within a year or two

*Populations affected by armed conflict include refugees, internally displaced persons, returnees, and those who live in conflict or postconflict settings. The term "displaced populations," as used in this book, includes all of these groups.

when the special funds were spent. The only documentation of the experience was usually in internal reports with limited distribution.

The first major document on the issue, *Sexual Violence Against Refugees: Guidelines on Prevention and Response,* came out in 1995. It was UNHCR's first attempt to establish comprehensive and specific standards for GBV prevention and response in refugee settings.

The RHRC's 2002 publication If Not Now, When? *includes a detailed history and analysis of the various factors that contributed to the development of GBV prevention and response in refugee settings as a specialized area of attention.*

That same year, the RHRC was formed. One of its objectives is to help integrate reproductive health services into refugee settings world wide; GBV is a reproductive health concern. Advocacy and technical support rendered by the Consortium, combined with members' GBV field programs, added momentum to efforts by UNHCR and others to push GBV among displaced populations onto the world agenda.

An injection of funds from the UN Foundation provided support for monumental leaps in GBV program development. In October 1998, the foundation awarded $1.65 million to UNHCR to strengthen its efforts (and those of other humanitarian actors) to prevent GBV in five countries in sub-Saharan Africa—Kenya, Tanzania, Guinea, Sierra Leone, and Liberia—and to put into place services that respond compassionately to survivors. It marked the first time that funds were targeted for coordinated interagency development of comprehensive multisectoral GBV services that were to be implemented by well-trained and well-equipped staff.

The knowledge base of multisectoral GBV programming in displaced population settings grew exponentially with the UNHCR/UN Foundation programs. Multisectoral and interagency GBV programming became the expected norm. By the start of the new millennium, UNHCR and NGOs were developing more comprehensive programs tied into multiple sectors of action. Initiatives in many countries included health care, emotional support, social reintegration, and, often, police and legal intervention. Field programs were addressing a range of GBV, including domestic violence, incest, and a variety of harmful traditional practices. Prevention strategies were launched, which included displaced community involvement in changing cultural beliefs and practices about women's rights.

At an international conference in 2001 hosted by UNCHR to bring together multisectoral GBV actors from displaced population settings world wide, participants developed a set of minimum standards and recommendations for continued development of these important programs. Participants called for revision and expansion of UNHCR's 1995 Guidelines. Among other recommendations, they urged all organizations to establish codes of conduct for staff. Conference participants identified that some national and international aid staff—sometimes including high-level managers—have been known to exploit the people who were to be the beneficiaries of their work.

NEW OPPORTUNITIES

Ironically, in early 2002, the international media broke a story about sexual exploitation of women and children in refugee camps in West Africa, reportedly perpetrated by some of the people charged to protect them. Organizations identified in the report included NGOs, UN agencies, the government, and international peacekeepers.

Humanitarian aid workers did not find the allegations surprising, but the public was shocked. The resulting scandal and ensuing attention propelled UN agencies and NGOs into action. Codes of conduct, stronger performance standards, better reporting systems, and gender-awareness training for staff are either in progress or already underway. At the same time, GBV programming has become a topic of great interest, and more

NGO and UNHCR country offices are requesting resource materials and technical support in this matter.

Published resource materials, best-practice recommendations, guidelines, and field tools for designing and managing GBV prevention and response are emerging as the pool of knowledge and experience grows. Unfortunately, materials specific to displaced populations are sometimes difficult to identify and obtain, especially by field programs in countries with limited access to the Internet. Because the field is so new and materials are evolving, even those that are available may be redundant or out of date. Many personnel who work in *emergency* programs are not familiar with *development* organizations and development projects, and do not have access to the wisdom already gained in GBV programming in the development field. Thus, it is difficult for many organizations to find and use appropriate materials and tools for developing quality GBV programs.

As of mid-2002, two key documents, together, summarize the current recommended standards for GBV programming with displaced populations:

- *Sexual Violence Against Refugees: Guidelines on Prevention and Response*. UNHCR, Geneva, 1995.
- *Prevention and Response to Sexual and Gender-Based Violence in Refugee Situations: Interagency Lessons Learned Conference Proceedings*. UNHCR, Geneva, 2001.

Two important new resource documents are in press. UNHCR and the RHRC are developing materials that should complement each other and provide clear and comprehensive guidance on the current state of knowledge for developing field programs to address GBV.

UNHCR is preparing a revised and updated version of its 1995 *Guidelines*. The new version includes minimum standards for prevention and response action, roles and responsibilities of specific staff and sectoral areas in refugee and displaced population settings, as well as new recommended forms, checklists, and monitoring and evaluation tools.

The RHRC is finalizing a *GBV Tools Manual*. The manual will include forms and guides for conducting situational analyses, prevalence surveys, focus groups, developing monitoring and evaluation, recruiting staff, and other essential components for GBV prevention and response programs.

Each resource will be available for Internet download and as hard copy from the relevant organizations. Appendix A is a list of resource materials and ordering information.

CHAPTER 2

The GBV Program Model Today

This chapter discusses the model that is now recommended by UNHCR and GBV experts for integrated, inter-agency prevention and response to GBV in communities affected by armed conflict.

Prevention and response to GBV requires three interrelated sets of activities: prevention, response (survivor assistance), and coordination, all involving women and men, adults and children from the displaced community, and staff in NGOs, UN agencies, and host government authorities.

However, before we can successfully develop prevention and response strategies, we need a clear understanding of exactly what it is we are protecting people from. At present, there is no single definition that is clear, specific, limited, and well *understood*, *agreed upon*, and *used* by all concerned. The term *gender-based violence* is a phrase to describe a group of concepts. If we are to understand the problems of GBV, we must understand the concepts and issues surrounding its meaning.

DELINEATING THE PROBLEM

Gender

In the 1990s, *gender issues* entered the radar screen of the international community. GBV experts believe that framing issues in terms of *gender* rather than *women* is an effective means of involving both women and men in resolving the societal issues that create inequalities based on gender.

The meaning of the word *gender* in the English language has evolved in the past 10–15 years. The word *sex* refers to the biological differences between males and females. *Gender* has come to mean the cultural and societal differences between males and females; for example, female and male responsibilities, expectations, privileges, rights, limitations, opportunities, and access to services.

The English word *gender* does not translate directly into most other languages. The direct translation is usually the word for *sex* (biological differences) and does not convey the conceptual underpinnings of the term. In each setting, GBV programs must work with the community to find words in their language that convey the true meaning of the words and concepts surrounding GBV.

Power

Gender has everything to do with power. Violence against women is a manifestation of historically unequal power relationships between men

and women, a crucial social mechanism by which women remain in a subordinate position compared with men.

Violence and Use of Force

Some staff interpret the word *violence* to mean exclusively physical or sexual aggression that results in physical harm. In the context of GBV, however, violence also means using some type of force—not necessarily physical—to force someone to do something. Violence can include emotional or psychological force (e.g., coercion, threats, manipulation, verbal abuse), social force (e.g., stigma, rejection, isolation, discrimination), economic force (e.g., denying access to food, shelter, livelihood, employment, money), and political force (e.g., differential access to protections and opportunities, discriminatory laws and practices). Violence also includes any threat of all these acts, either direct or implied.

Injury and Harm

Physical or sexual harm are most commonly associated with GBV. There are many other types of injury, however, and these include emotional, psychological, social, and economic damage. Any of these can lead to the ultimate harmful consequence, death. Harm is often subjectively defined, and each survivor is different in the extent of harm she or he feels.

Consent

For the purposes of this Declaration, the term "violence against women" means 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.

—UN General Assembly Declaration on the Elimination of Violence against Women, 1993

The absence of informed consent is another element in the definition of GBV. Informed consent occurs when someone fully understands the consequences of a decision and consents freely and without any force.

It is further assumed that children (under age 18*) are unable to fully understand and make informed choices about such issues as genital cutting (FGM), and marriage.

"She didn't say no" is a common defense for acts of GBV. In many cases, she might say "yes" or would not say "no" because she feels threatened and fears for her safety, her social status, or her life.

Human Rights

Acts of violence against women and girls violate a number of principles enshrined in international and regional human rights instruments, including the right to life, equality, security of person, equal protection under the law, and freedom from torture and other cruel, inhumane, or degrading treatment.

GBV

GBV, then, encompasses a range of acts of violence committed against females because they are females and against males because they are males, based on how a particular society assigns and views roles and expectations for these people. It includes sexual violence, intimate partner or spouse abuse (domestic violence), emotional and psychological abuse, sex trafficking, forced prostitution, sexual exploitation, sexual harassment, harmful traditional practices (e.g., FGM, forced marriage, infanticide of girl children), and discriminatory practices based on gender.

DEFINING AND TARGETING GBV PROGRAMS

GBV includes a wide range of acts and can be an overwhelming and all-inclusive program area. One of the greatest challenges for actors in the field

*UN Convention on the Rights of the Child, 1989.

is to set priorities and target specific types of GBV rather than trying to address the entire range of abuses women and children suffer. The types, risks, magnitude, and lethality of GBV vary in different communities and settings. The interagency team must first understand GBV in the setting. Situation analyses and assessments are discussed in Chapter 7, Monitoring and Evaluating Programs.

The recommended strategies described below draw from lessons learned in displaced settings, specifically, and from the extensive body of knowledge world wide about strategies to address GBV in nonconflict settings.

COORDINATING ACTIVITIES

No one sector, organization, or discipline has sole responsibility for preventing and responding to GBV. Everyone must work together to understand GBV and design strategies to address it. Most important, the term *everyone* includes the displaced communities; without active community involvement, GBV intervention cannot be fully successful. Given the multisectoral and interagency nature of GBV prevention and response, there is a need for coordination and leadership: a lead agency. In some settings, UNHCR leads the efforts; in other settings, an NGO with special funding for a GBV program provides the capacity for the high levels of activity needed for this coordination and leadership.

The design, monitoring, and evaluation of interagency and multisectoral action must be a coordinated effort. Some key components for coordination must be established and agreed upon by all actors, including the following:

- Community participation in all stages of program design and implementation;
- Guiding principles for how everyone will maximize confidentiality, survivor respect, and safety;
- Systems for receiving and documenting GBV incident reports;
- Referral mechanisms between and among organizations;
- Systems for information sharing, problem solving, and coordination;
- Continuous monitoring and evaluation to guide action in both prevention and response.

RESOURCES

The Interagency Guidelines for Prevention and Response to SGBV, *Geneva (in press) provide detailed guidance on how to establish interagency coordination teams.*

Appendix B, a Sample Draft Manual of Interagency Procedures and Practices *that can be adapted for use in any setting, describes mechanisms for program design and coordination in more detail.*

PREVENTING GBV

Prevention consists of reducing or eliminating the root causes of GBV and the situation-specific factors that contribute to, perpetuate, or increase the risk of GBV. Prevention activities target potential victims and potential perpetrators in terms of both their behavior and their environment.

Root Causes and Contributing Factors

GBV, which at its core is the abuse of power, is rooted in gender inequality and discrimination. Preventing GBV involves influencing changes in knowledge, attitudes, and behavior among women and men, young and old, displaced and helper, concerning issues of gender and power.

Populations fleeing conflict experience a breakdown in traditional family and community support systems. Families separate. Women, separated from their husbands and extended families, raise children alone, often without job skills or means for generating income. Children separated from parents or other family often have no trusted adult to protect them. In the land of refuge, women and children face the same risks as they did in their land of origin and during flight—and some new ones,

too. With food and shelter provided by humanitarian organizations, men in the community may feel powerless and confused by the loss of their traditional role as the family's provider and protector. This environment, arising out of national or civil conflict and marked by poverty and dependence, contributes to GBV, although the root causes go much deeper.

Thorough Assessment

Understanding the causes and contributing factors of GBV in a community begins with a situation analysis that identifies the following components of the environment:

- The demographic composition (age and sex) of the population;
- The social and cultural norms for gender expectations, use of power, and decision making in the community;
- The family and community systems for protection that were in place before, and are in place now;
- The groups and individuals at risk of GBV; the extent and types of GBV that occur; and community attitudes and beliefs about GBV, including how the community defines GBV;
- The knowledge, attitudes, and behavior of people in positions of power in the community and in assistance organizations;
- The physical environment, site layout, and access to services and facilities;
- The formal and informal systems for law and administration of justice.

Prevention Strategies

The key to GBV prevention is education.

With a solid understanding of the community-in-need and its environment, the interagency team can target prevention activities to potential perpetrators, potential survivors, and the people who assist both groups.

Historically, efforts to address GBV have focused on empowering women because they are the majority of potential survivors. This focus is important, but, on its own, it ignores the other half of the abuse equation, namely, the perpetrator. Lessons learned world wide have broadened understanding of the dynamics of GBV; a central activity in prevention now is working with children and with men and encouraging men to work with men.

Prevention includes activities that address both the root causes and the contributing factors, such as—

- Educating about gender, power, human rights, and GBV, using a variety of participatory methods that promote discussion and reflection about attitudes and beliefs, and ultimately lead to changes in behavior. This effort is often called *awareness raising* and includes many different types of activities targeting all the demographic groups within the refugee and aid communities. Education can empower potential victims and change the attitudes and behavior of potential perpetrators and the community-at-large that may be perpetuating GBV through silent acceptance of abusive behavior and blaming the victim.
- Educating potential survivors about where to go for help if they are victimized by GBV, and what help would be available.
- Promoting changes in national and traditional laws and practices to bring about stronger protection of the human rights of women and children. It may include education and advocacy with displaced leaders and advocating with government lawmakers through partnership with national human rights NGOs.

- Establishing and enforcing standards of behavior for humanitarian aid staff, such as codes of conduct, accountability systems, and consequences for violations.
- Educating and problem solving with humanitarian aid staff about GBV risks in the setting, and the types, places, and circumstances under which GBV occurs.

RESPONDING TO GBV

GBV response comprises a group of comprehensive services for survivors that reduce the harmful after-effects of GBV and prevent further trauma and harm. However, help cannot be mustered until an incident has been reported and the survivor has requested assistance. Response, therefore, begins with establishing assistance services and building trust in the community that appropriate and useful help is available.

Building and maintaining trust in the response services requires adherence to three fundamental guiding principles for all who assist survivors: (1) ensuring the survivor's safety, (2) protecting the survivor's confidentiality, and (3) respecting the survivor's dignity, choices, and rights.

A number of potential outcomes and after-effects with all types of GBV result in some predictable survivor needs. Failure to understand and appropriately address survivor needs can have fatal consequences. GBV survivor needs for assistance can be generally categorized into four areas, or sectors. Specific types of GBV carry with them some differences in after-effects and survivor needs. These differences must be well understood; services must be designed accordingly.

Minimum response action from each of the four sectors is described below.

- Community/social services:
  - Community education—targeting the community, UN and NGO staff, local government authorities—for protection awareness, rights awareness, and knowledge of available assistance;
  - Outreach and identification of survivors; designated place(s) where survivors can go to receive assistance without stigma;
  - Counseling (i.e., short-term listening and emotional support) for survivors and families;
  - Advocacy and assistance for survivors with health care, security and legal justice systems, and other needed services;
  - Group activities—including income generation and microcredit projects—for survivors and other vulnerable women that focus on building support networks, reintegration into communities, confidence building, skill building, and promotion of economic empowerment.
- Health clinic or hospital:
  - Outreach and identification of survivors;
  - Examination and treatment by trained staff using appropriate protocols and with adequate equipment, supplies, medicines: treat injury, prevent unwanted pregnancy, treat/prevent STIs, assess mental trauma;
  - Medical evidence documentation for legal proceedings, as requested and required;
  - Follow-up care and treatment;
  - Referral (and transport) to appropriate levels of care;
  - Collaboration and coordination with traditional healing practitioners.

Reducing GBV Risk—

- *Engage more women refugees in food and other distributions.*
- *Increase the presence and visibility of trained UNHCR staff and security personnel.*
- *Install lighting, fencing, and other deterrent systems in high-risk areas.*
- *Balance the number of men and women employed by all organizations in the setting.*

- Security and police:
  - Appropriately trained, competent, and adequately equipped police force;
  - Presence of police/security workers, especially after dark and in high risk areas;
  - Analysis of incident data and communication with all actors and community of security risks and issues;
  - Creative security solutions to address identified problems (e.g., fencing, lighting, use of radios);
  - Strategies and options for immediate protection of survivors (e.g., relocation, "protection" area in a camp, safe houses).
- Legal justice system:
  - Nondiscriminatory laws and practices that protect human rights;
  - Court system with adequate training and capacity to adjudicate cases appropriately and timely.

The designated lead agency documents GBV incidents on standard report forms using standard terms and definitions; compiles data; shares information; and coordinates as described above.

All actors in all organizations engaged in response must have sufficient capacity to provide the response services needed by any individual survivor. For this reason, a large part of the work in a GBV program is building the capacity of the responders. There are usually needs for training; developing clear and consistent protocols, procedures, and policies for actions to be taken; and materials and equipment to do the job.

When GBV programs are starting up, for the first year or two, the designated lead agency is responsible for working with the organizations in each sector to ensure proper training and development of procedures and protocols. The lead agency also convenes meetings and leads the interagency action to develop and improve response systems, including those described in the above section, Coordinating Activities.

CHAPTER 3

Emerging Issues in GBV Programming

World wide, efforts to end GBV require a slow, steady process to chip away at the conditions, beliefs, and attitudes that perpetuate the problem. In displaced settings, a number of specific conditions unique to the population and the environment contribute to the challenges of addressing GBV. Despite these differences in detail, there are common conditions and issues across field sites, countries, and regions of the world; these are discussed in this chapter.

Whether in flight from a developing or industrialized country or settled in a camp, settlement, or urban setting, the greatest numbers of displaced populations are women and children. They are the most vulnerable to exploitation, abuse, and other types of violence simply by virtue of their gender, age, and status in society.

COMMON CONDITIONS

Risks to women and children emerge before they reach a place of refuge, for example—

- Rape and sexual abuse are often used as a weapon of war;
- Sex can be demanded in exchange for safe passage;
- Children can get lost or separated from families. Women and children travel without male protection.

Displaced populations bring to their place of refuge the attitudes, beliefs, and practices of their own society. The type and extent of GBV in their home community will probably continue or increase in the refugee setting. Unfortunately, there is a lack of baseline data on the prevalence of different types of GBV in most of the countries experiencing armed conflict.

A person's legal status, or lack of legal status, can also play into the GBV scenario. Not everyone in exile is recognized as a refugee or an internally displaced person. Refugees receive aid from humanitarian organizations, and IDPs are entitled to their government's help. Without either designation, displaced populations do not have access to the protection and assistance available to others.

People experience multiple losses when they flee from conflict and take refuge in a camp, village, or urban setting. Family members may die or disappear; personal belongings and property can be lost or stolen; dignity and independence are stripped away. The loss of family and social supports can lead to a breakdown of social behavioral controls. The loss of the traditional male role—to provide for and protect his family—can erode the traditional power base in a community.

Refugees and IDPs, especially in the early stages of a crisis, are dependent on humanitarian aid for basic survival—security, food, and shelter. This dependence and powerlessness, compounded for women and children,

makes them extremely vulnerable to abuses of power and exploitation. They perceive they have no choice; it is either acquiesce or do without basic assistance.

Assistance and Services

Domestic violence and other forms of GBV escalate in times of extreme stress. The dependence, poverty, and fear—the stress—among displaced populations sometimes lasts for years.

A gender imbalance among aid workers, supervisors, managers, and administrators is common in humanitarian settings. Although the situation is changing and there are notable exceptions, men generally make up the majority of people who plan, implement, and manage humanitarian assistance with varying degrees of participation from women.

Male viewpoints, of course, do not always take women's needs into account. For example, it is generally men who design and build latrines; world wide, latrines do not consistently lock from the inside. Yet latrine areas are notorious for being high-risk areas for rape.

The assistance available to refugees and IDPs varies greatly across settings. Most refugee camps offer certain minimum services, such as health care, shelter, and food. For IDPs, however, there are often no services at all, because of the insecurity in combat zones. Health care in refugee camps varies depending on the stage of emergency, level of donor funds, and the capacity and preferences of the organization offering the service. Equipment and medication for post rape medical management may or may not be available, and health staff may or may not be trained in post rape management.

Security and safety for refugees and IDPs is normally the responsibility of the government in the host country. In most countries of refuge, the government police and judicial systems lack the capacity to fully meet their responsibilities in relatively normal times, let alone in the presence of refugees and IDPs. Many police posts around refugee camps do not even have paper and pens to take notes when someone reports an incident to them.

The Local Environment

It is common practice to consult with the displaced communities when planning and implementing humanitarian aid. Most leaders are men, and finding women who are willing and able to participate as truly equal partners and decision makers is difficult.

Refugee camps are often in isolated rural areas that lack adequate infrastructure, such as decent roads, reliable electricity, and telephone lines. Camps may be located in lawless areas where police presence is limited and security is a constant problem.

Establishing sufficient protection for the displaced in urban settings is even more challenging than in camps or settlements, especially if the displaced population is made up of "illegals." Urban settings can allow them to be invisible and anonymous, but if a problem arises, these people have little recourse with local police and other authorities.

Additionally, international aid for the displaced sometimes has the side effect of making the refugees a little better off than the citizens. Perceptions among nearby communities that refugees and IDPs receive preference can lead to rage and sometimes retaliation. There have been confirmed reports of gang rape of refugee women committed by local men resentful of the nearby refugee community.

COMMON ISSUES

Just as the circumstances that give root to and sustain GBV are both the same and different from country to country, so are the issues, challenges, and obstacles that limit efforts to address GBV.

Understanding GBV

Many people who work in displaced settings and lead refugee programs have little understanding of the issues and concepts surrounding gender, power, abuse of power, and GBV. They are usually unaware of the roles and responsibilities they should assume to prevent and respond to GBV and are unfamiliar with the written materials that specifically address GBV in conflict settings. Although it is well known that rape is a weapon of war and GBV is a problem for displaced populations, only a few international humanitarian organizations are taking comprehensive action to address it. The situation is changing in light of the early 2002 findings in a report from Save the Children-UK and UNHCR about sexual exploitation and abuse perpetrated by workers in humanitarian aid organizations and by international peacekeepers.

The public scandal and embarrassment resulting from that report is benefiting refugee women and children. Many organizations that had not previously concerned themselves with GBV are now motivated to do so.

The new interest and urgency for action offers an unparalleled opportunity to build a broader understanding of the problem and to establish comprehensive, interagency, multisectoral action for preventing and responding to all forms of GBV in displaced populations.

Community-Based, Interagency, Multisectoral Integrated Action

GBV is a problem, not a sector. Deeply rooted in cultural beliefs and practices, this complex problem requires complex action rendered by many different sectors. At some field sites, these complexities are acknowledged and a comprehensive, community-based, interagency GBV program is underway with the goal of achieving integrated and sustainable action from all humanitarian actors. At other sites, GBV is considered to be a social services problem; organizations that do not provide psychosocial programs pay little attention to the problems. In this latter case, community services and health workers handle GBV incidents ad hoc, overseen by the UNHCR Community Services Officer (if there is such a post) with occasional assistance from Protection or Field Officers; there is no interagency planning or action to comprehensively prevent and respond to GBV.

In countries where NGOs are implementing special vertical GBV programs, high levels of resources are available for rapid multisectoral GBV program start-up. But vertical programs can have drawbacks. They are generally not integrated into the existing systems (e.g., health care, psychosocial services, security, and legal justice). Coordination, communication, and collaboration across sectors and organizations are often limited because a vertical structure, by definition, does not need such mechanisms. In addition, vertical programs usually are not grassroots efforts that emanate from within the refugee community, but from the NGO implementing the program. Thus, to achieve integration and subsequent sustainability, vertical GBV programs must progress from work conducted mainly by NGO staff to integrated action by all organizations in the setting, with strong community leadership and participation and interagency, multisectoral coordination.

There are countries without an established vertical GBV program or a designated GBV Coordinator trying to integrate GBV prevention and response into existing programs and services. Such countries need high-level attention and support, as well as a variety of training and technical assistance resources to build capacity to lead the process among key stakeholders.

COMMON NEEDS

Despite the differences between the various systems in place for addressing GBV around the world, the same general needs exist at field sites. The seven initial activities described below can build a firm foundation for integrated, interagency, multisectoral, community-based GBV prevention and response.

- Basic training to raise awareness and understanding among humanitarian staff and leaders about concepts and issues of gender, power, and GBV.
- Training in the roles and responsibilities of the four key sectors and all relevant NGOs, UNHCR, refugees, and government ministries for prevention and response to GBV. This includes understanding and agreeing to guiding principles for all actors, including how to ensure confidentiality and empower survivors. It also includes clarifying GBV-related duties and accountability standards for all staff.
- Training in specific sectoral skills and tasks for preventing and responding to GBV (e.g., counseling skills for counselors, participatory methods for community educators and animators, post rape management for health care workers, and police procedures and proper application of relevant laws by police and courts).
- Facilitating interagency and intersectoral planning for site wide action in both prevention and response.
- Facilitating the development of interagency systems for incident reporting, documentation, referrals, information sharing, monitoring and evaluation, and coordination.
- Providing technical support for designing, monitoring, and evaluating GBV programs.
- Training and technical assistance for promoting community participation and fostering sustainability.

COMMON SOLUTIONS

Based on the observations and lessons of the GBV Technical Support Project, it is clear that certain elements must come into play if appropriate, compassionate, multisectoral prevention and response to GBV is to become the norm, specifically—

- Multisectoral and interagency country teams that understand GBV, develop a coordinated vision and plan for prevention and response action, and oversee ongoing coordination and program development;
- Interagency teams that use agreed-on and accepted procedures, protocols, and guidelines;
- Consistent and effective data collection, analysis, and monitoring and evaluation systems;
- Information-sharing and support networks for GBV program leaders world wide.
- Access to resource and best practice materials, including new information available in newsletters, journal articles, and reports that disseminate best practices, lessons, innovations, and other practical tools for this relatively new area of humanitarian aid.

CHAPTER 4

Mainstreaming GBV Programs

Today's concept for a GBV program is a move from the stand-alone project to one in which GBV prevention and response is fully integrated and mainstreamed into the work of all humanitarian actors. This chapter describes the issues on the road to integration and mainstreaming and suggests some actions to take along the way.

Effective prevention and response to GBV depends on multisectoral interorganizational collaboration, integrated action, and active community participation. But sometimes, these objectives seem overwhelming and almost impossible to attain.

When discussing the idea of integration and the interagency collaboration necessary to achieve it, several GBV program coordinators and consultants have expressed frustration over what they see as a lack of shared philosophical and theoretical foundations for their programs. Counteracting this situation requires taking the critical step of establishing a vision at organizational levels in NGOs and in UNHCR. A shared vision could clarify integration and mainstreaming from the beginning and guide goal setting, action, as well as daily decision making in the field. Some would argue that this kind of visioning and planning is unrealistic in an emergency humanitarian situation. On the other hand, without it, the roles, responsibilities, and action steps are unclear to all involved.

Emergency conditions and staffing limitations can short-circuit the development of coordinated visioning and planning. And, since some NGO programs to address GBV in conflict-affected populations are new vertical programs, funded outside UNHCR, coordinated planning with UNHCR at the site often occurs only after the program is already underway. Meanwhile, precious time may be lost (and GBV survivors suffer additional harm) due to the lack of well-planned and coordinated efforts undertaken by all stakeholders, many of whom have key roles and responsibilities in assisting survivors.

TWO TYPICAL SCENARIOS

A snapshot of what is happening at some sites may offer insight into the need for organizational understanding, visioning, and planning for GBV programs. The boxes on the following pages describe scenarios in two typical countries.

The scenarios described in Countries A and B are real. It is common for interagency collaboration and planning not to be built into programs from the outset. A lot of time is spent later trying to catch up—to educate, engage, and work with key stakeholders and actors while simultaneously pulling together ad hoc responses to ever-increasing requests from the community for assistance. But GBV issues and problems are too big for one sector, one organization, or one person. Interagency collaboration

Country A

The First Year

A nongovernmental organization writes a proposal to launch a new project concerning issues of "sexual and gender-based violence in the refugee population," into its health programs. It will be a new, separate, vertical project using donor funds that will not come through the UNHCR. The NGO hires a GBV Program Coordinator who, in turn, hires refugee and national staff to serve as GBV counselors and community educators. The GBV staff begin raising awareness about gender equality, human rights, and GBV.

This NGO is not UNHCR's implementing partner for either GBV or community services. UNHCR staff do not understand the new program and are not well informed about UNHCR'S GBV guidelines and recommended strategies for prevention and response.

It takes months to meet the many stakeholders and to discuss this GBV program. No one understands exactly what the GBV program is about, which sector coordination group the program belongs to, or how to support the work.

The GBV program is subsequently placed under the health interagency coordination group. The coordinator seeks one-on-one meetings with staff from other sectors to establish coordinated action, but busy staff, unaware of the nature of the GBV program, do not deem these discussions to be of high priority.

As the program gets underway, refugees begin reporting domestic violence and a few sexual abuse cases to the GBV counselors. Health, security, and other needs become apparent, including tangible roles and tasks for UNHCR Protection Officers to perform. The GBV program coordinator and staff scramble to obtain individual assistance for each case while simultaneously attempting to develop a response system among the relevant organizations. The coordinator finds less and less time to pursue interagency coordination and communication.

The GBV program is perceived by all as a health project only. The country director and heads of offices are unaware of the high-level attention and interaction needed across organizations and sectors. The country director requests reports containing information similar to that for the NGO's other programs: financials, number of staff, vehicles in working order, inventory, refugee population, number of program activities, number of refugees attending program activities, number of GBV incident reports received, and so forth.

A Year or Two Later

The GBV coordinator is burned out. She is perceived as confrontational and argumentative and her contract is not renewed. A new coordinator arrives. She brings a completely different set of skills, experience, interests, and what appears to be an injection of optimism and energy into the work.

The new coordinator spends more time than her predecessor developing interagency and multisectoral action and coordination, leaving the GBV staff to operate with minimal supervision or ongoing training. Frustrated about the high number of domestic violence reports that keep coming in, many staff try to solve these difficult and complex cases themselves. Some of them counsel survivors to be more obedient in order to avoid the violence. Staff also start confronting violent husbands in an attempt to convince them to stop the battering. They describe these interventions as "counseling," that is, helping the family to overcome its problems.

One day, an angry husband burns down a GBV refugee staff member's house. A few weeks later, another angry husband stabs a GBV refugee staff member with a knife.

and planning at the start would establish a sense of shared ownership of the GBV program that in turn would build understanding and appropriate action for the multisectoral and interagency roles and responsibilities.

Most programs are initiated and led by humanitarian organizations, with minimal community involvement from the beginning. If community members do not understand the program, they cannot participate fully and support the work of the refugee staff. In the context of GBV, misunderstanding

Country B

The First Year

In a long-standing refugee setting, with a fairly stable population and occasional small refugee influxes, UNHCR's implementing partner for community services is a national NGO. One year, UNHCR added a small amount of funds to its contract with the community services NGO, which expanded the counseling and skills-training programs to include targeting survivors of GBV. The focus is on rape and sexual exploitation, but other forms of GBV could be covered if survivors come forward.

There is a six-month lag in implementing this program expansion because of various delays in obtaining signatures and the first cash installment. By Month 7, GBV refugee staff are hired and they receive three days of training in counseling skills. Over the next two months, posters are produced and distributed throughout the camps and the NGO begins awareness-raising groups in the community with refugee women. By Month 9, survivors are reporting some cases to the NGO (mostly domestic violence). UNHCR community services monitors the program; Field and Protection Officers are generally aware of some of the activities. The GBV program is considered by all to be a community services function.

In Month 11, parents of a four-year-old girl report that a neighbor raped their daughter. The NGO community services program manager immediately contacts the police, field assistant, community services assistant, and health clinic medical officer. With no coordinated response system in place, the program manager spends all of her time over five days on this case, moving from office to office to share information and advocate for needed action. After four months and myriad delays, the case comes to trial. The judge dismisses the case because the victim cannot remember the details and is terrified, unprepared, and unable to testify. Medical evidence is incomplete, the examining doctor has since left the country, and no documentation is available except the police report. The accused returns to the camp.

A Year Later

The program now offers training for health workers and police. Interagency procedures and coordination mechanisms are in the early stages of development. Community services staff are trained in documentation and emergency response procedures; they provide counseling and advocacy with GBV survivors as well as education and awareness raising in the refugee community. The UNHCR community services officer monitors GBV incident reports, following up and referring to protection officers and others as needed. Community education has expanded to include refugee leaders and schools. The majority of incidents reported are domestic violence, with occasional reports of rape and rare reports of sexual abuse or exploitation, or both. In the coming year, the community services officer hopes to begin training and awareness raising about GBV with all humanitarian aid organizations, including all UNHCR staff. UNHCR, however, facing budget cuts, must reduce the community services program, and the post for an expatriate community services officer in this field office will soon be removed. Over the next year, the tenuous systems for the GBV program break down without ongoing attention and support.

can lead to more violence and can present dangers to the staff. An interagency team that fully understands the issues and the program would engage community interest, support, and action from the beginning and avoid many of the problems experienced by Countries A and B.

FINDING SOME COMMON DENOMINATORS

In a perfect world, leaders who plan complex programs such as GBV, would, at the outset, understand and agree on the nucleus of the problems they are addressing. The common view expressed in GBV literature is that GBV springs from the subordinate position of females, an unequal power dynamic from which discrimination, abuse, and other types of gendered violence flow. But leaders of humanitarian agencies and staff do not universally understand or share this opinion. Furthermore, some who don't subscribe to

this opinion are actually taking advantage of the vulnerability and disempowerment of women and children. It is not possible to develop a comprehensive way to go forward if the planners and players do not agree on the nature of the problem. But if there is at least common agreement that some types of GBV are occurring and causing serious harm, it may be enough to begin moving ahead. Over time, broader understanding and agreement about the full range of GBV issues can grow. (Attitudes and behavior of all staff, all levels, is discussed further in Chapter 6, Building Human Resources.)

If you can do SGBV [programs], you can do anything. SGBV has it all: protection, international law, national law, culture and values, social services, health, coordination, emergency relief, development, field, security, water and sanitation, food, staff performance, leadership, training, logistics. Everything. No wonder we're tired!

—UNHCR Protection Officer, 2000

In any case, if serious harm is occurring, then response is needed—assistance to address survivor needs. And identifying and removing the factors that contribute to these occurrences requires preventative action.

Thus an array of multisectoral and interagency prevention and response action to GBV is needed. But how much—or how little—must be determined by the unique needs in each individual setting. Who this multisectoral action will involve, how it will take place, and how it will ultimately be mainstreamed must also be determined in each setting, based at least partly on the resources available.

Experiences in the field suggest that in the early stages of a refugee program, immediate tasks be undertaken first to ensure at least emergency care for GBV survivors. As the situation moves from "emergency" to "care and maintenance," the focus turns to long-term planning and sustainability. In these later stages, prevention and response to GBV is more akin to development programs than emergency relief, building the capacity of the community to help itself, rather than turning to others for help. Table 4–1 at the close of this chapter shows a sample plan for such a gradual and systematic transition. With appropriate resource allocations, the end result can be the mainstreaming of GBV prevention and response into all activities in the setting.

Another consideration in establishing a GBV program is to remain focused on the achievable. With GBV endemic in its various forms around the world, it is unrealistic to think we can eliminate GBV in displaced populations. Longstanding cultural beliefs and corresponding behavior do not change quickly. And, nearly always, funding in refugee settings is reduced over time, necessitating reductions in programs and services.

Overall, a GBV program could be viewed as a range of activities that build the capacity of multiple organizations, individuals, and groups to prevent GBV and provide assistance to survivors. Primary activities involve training, facilitation, and appropriate leadership to influence change in knowledge, attitude, and behavior of humanitarian staff, host country authorities, and the community. The program might also provide direct, specialized, vertical services to survivors, such as counseling, advocacy, and health care until those responsible for those services are capable of providing them. Even if direct services are part of the program, all organizations must share the view that integrated services are the ultimate goal, and that capacity building is the path to achieving that goal.

GBV PLACEMENT IN AN ORGANIZATIONAL SYSTEM

The placement of a GBV program in an organization will directly affect the program's success: different types and levels of support and attention will drive the selection and prioritization of goals, objectives, and activities.

One important GBV program activity is advocacy with donors, governments, UNHCR, and NGOs to establish interagency services, obtain additional staff, more funds, or other support to ensure adequate survivor assistance in the future absence of vertical services and special GBV funds. GBV program coordinators are uniquely qualified for such advocacy because they fully

understand the situation. Often, however, the GBV program is placed in a disadvantageous sectoral or organizational position in the setting, which limits the GBV program coordinator's visibility, credibility, and success with advocacy efforts.

Exactly where GBV programs belong in humanitarian organizations is a matter of some debate. Some find GBV too touchy-feely, and want it subsumed under the psychosocial sector, frequently perceived as a nebulous and all-encompassing realm of difficult but not life-threatening problems. Unfortunately, and largely due to this perception of what a social service program actually entails, psychosocial programs are often underfunded and among the first to be reduced when funds are tight.

Others believe GBV belongs to the health sector, specifically under reproductive health. And indeed, advocates for reproductive health were among the first to bring attention to the problems of GBV in refugee settings. In many field sites, RH is the only assistance available to GBV survivors. Certainly, health is an important element in addressing GBV and includes a wide array of relevant activities and concerns. But it is only one element and some GBV programs placed in the health sector are limited by the focus and boundaries of that health program.

Police often view GBV as a law enforcement issue exclusively. Clearly, this is an incomplete appraisal of the problem: many types of life-threatening GBV are not considered criminal acts in any number of countries.

There is also considerable belief that the larger umbrella of protection is where a GBV program belongs, and that UNHCR protection officers should oversee all matters concerning GBV. Steering a GBV program in this direction has proved problematic in some sites because UNHCR staffing and funding levels can be unreliable and insufficient.

In reality, GBV belongs in all of the above domains, and more. GBV, like HIV/AIDS and child protection, is a problem, not a sector. It is a cross-cutting issue, needing attention from all sectors, all organizations, all projects.

Meanwhile, and until the day when these cross-cutting protection issues are fully integrated into the work of all staff, all projects, all sectors, there is a need for special leadership and concentrated attention. Careful consideration is necessary when deciding where to place them within an organization so that they get the required attention, support, and resources, and engage in all necessary activities unimpeded by sectoral or bureaucratic constraints.

MOVING FROM VERTICAL TO MAINSTREAM PROGRAMS

Some NGOs have established direct, specialized, and vertical GBV services, such as counseling, health care, and legal advising, the most needed and least available services for survivors.

The leaders must ask themselves how they can provide the necessary direct services and simultaneously build the capacity of others (refugees and IDPs, UNHCR, NGOs, and local authorities) to do the work. What is the long-term plan? Should we continue to provide these direct, vertical services for as long as the refugees and IDPs remain? Or should we be developing a phase-out plan for ourselves and these vertical services?

Ultimately, the GBV program should be broadened from the original vertically oriented program and eventually integrated into the mainstream of refugee assistance, and, in so doing, made sustainable.

Integrating GBV prevention and response into everyone's work and the day-to-day actions of displaced communities requires certain levels of capacity (knowledge and skills) and tangible resources (e.g., people, equipment).

Learning from Development Programs

Even in emergencies, the goals and strategies of most GBV programs are closer to development projects than classic emergency humanitarian aid (although the debate about emergency vs. development philosophies and practices is a continuing one). A wealth of knowledge from GBV programs in development settings can be applied to emergency humanitarian relief settings. Appendix A contains a list of recommended resources and contacts.

The interagency team must understand the exact nature of mainstreaming and corresponding capacity-building and integration plans at the beginning stages of program design.

GBV work is multisectoral, interorganizational, and complicated. Start-up GBV programs require attention and coordination. But no one in the country had been given this responsibility and the time to perform as required. As a result, tasks fell behind, confusion began to grow, and the overall program lacked attention, analysis, and development. A lesson learned is that an overall coordinator, with a clear work plan and benchmarks, should be hired for future complex, interagency program startup.

—GBV consultant report, 1999

Integration plans must include a hard look at potential capacities. For example, in many cases, the setting is a war-torn country with economic and infrastructure problems. It may be unrealistic to expect full integration of all services and all sectors to address GBV at the same high levels of care available through a vertical program. Integration may require some compromises.

In nonconflict settings around the world, development programs are working with governments and national NGOs to build capacity and provide basic GBV services. In emergency relief settings, it might prove effective to promote these kinds of partnerships between the two (government and NGOs) so that their combined efforts can provide a fuller array of GBV prevention and response action.

INVOLVING THE COMMUNITY

Another critical central element for GBV program success that must be understood by the entire interagency team is the active engagement and leadership of the community. Without this participation, there will be no incident reports, no clients, no comprehensive response, and only limited prevention. This community involvement is substantially different from the classical activity of humanitarian aid workers distributing goods and services donated by outsiders to beneficiaries. The term *beneficiary* implies a powerless recipient of services and care. Theoretically, there are no beneficiaries in GBV programs—only participants.

GBV initiatives are founded on the principle that the refugees and IDPs are to be leading the effort. Humanitarian staff in health, psychosocial, security, and legal justice sectors are there to support and assist the refugees in establishing systems for GBV prevention and response. This is no small undertaking and one that takes time, especially given the wide cultural diversity involved in defining GBV, grappling with attitudes about gender, and a host of other related considerations. This community development requires leadership to conduct training, build capacity, build coalitions, supervise, and support. Perhaps most importantly, it requires time.

—GBV consultant report, 2000

Social services programs of all types and development projects world wide have long known that, while *doing for* is in many respects easier than *doing with* or *teaching how to do yourself*, doing for is not sustainable. It does nothing to address the factors perpetuating the problem and does not build the community's capacity to help itself.

Broaching the subject of GBV, gaining community support, and enlisting active participation, require knowledge of, and skill with, participatory methods for community development. These tasks involve patience, carefully considered action, and time.

Although some refugees and IDPs spend many years in camps, sooner or later they will return home and integrate into the local community, or resettle in another country. They will take with them new knowledge, attitudes, and behaviors learned while displaced. The displaced setting is a golden opportunity for influencing change, decreasing GBV incidents, and increasing the chance that a GBV survivor will be assisted and not blamed in the future community.

THE LONG AND BUMPY ROAD TO INTEGRATION AND MAINSTREAMING

Moving from conceptual to concrete integrated action requires interagency planning based on a full understanding of the problem, the issues unique to the setting, the potential capacity of organizations, individuals, and groups, and the need to move gradually, step by step, adding elements over time. Table 4–1 is a sample plan for a gradual and systematic integration of GBV prevention and response action into the larger scope of humanitarian aid and host government ministries.

It is also important that GBV program goals and objectives remain seated in reality. Prevention and response to GBV is neither easy nor perfect even in the most highly developed and wealthiest countries. This does not imply,

however, that we should be complacent and accept the unacceptable. Rather, it is incumbent upon us to accept what is feasible and to be creative while striving to influence change in attitudes, knowledge, and behavior. Interagency teams can succeed in these efforts if they take the time to develop some key elements that will guide them, as listed below:

- A clear understanding of GBV;
- A shared vision of GBV prevention and response in the setting;
- Intersectoral and interorganizational ownership of the GBV program;
- High level organizational support;
- Active community involvement;
- Planning for long-term integration and sustainability.

As time goes by, I am learning that true community participation in and ownership of the GBV program is much, much harder than it looks (unless we are doing it incorrectly, which may well be possible!). I would say that, even if you work on it from the very beginning, it would take about two to three years to have the community begin to truly assume responsibility for the program's activities. The first year is spent simply raising awareness and persuading them to think of GBV as a problem worth their time and energy. Maybe mine is a particularly difficult country, because it lacks much outside support and investment from donors and other assisting agencies. I don't know because this is the first country in which I have been doing this kind of work. At any rate, we are trying, but it is really, really, really hard.

—A GBV program coordinator, 2002

Table 4–1

Sample Plan for Gradual and Systematic Integration of GBV Prevention and Response

	Immediate Emergency Situation *In First 3 Months*	**Fairly Stable Settings, Year 1–2** *Add These Components…*	**Stable Settings, Longer term** *Add These Components…*
Refugee community education	One-time orientation for new arrivals with continuing information through community leaders: ■ What to do, where to go for help after a GBV incident ■ Rights, benefits, entitlements as refugees	At least one-time training for all; posters/other materials posted in key locations at the site: ■ What to do, where to go for help if you know of a GBV incident ■ Human rights, GBV	Variety of ongoing activities targeting specific groups (e.g., women, men, youth, children) with the goal of attitude and behavior change: ■ Examining gender norms in the culture ■ Preventing/stopping GBV Community education is led by trained and qualified refugee volunteers with material support from a designated organization.
Refugee community mobilization		■ Identify interested community members; mobilize them to conduct awareness-raising and encourage survivors to come forward for help ■ Women's center or other safe space for drop-in incident reports	Over time, these groups become well trained and autonomous, with periodic meetings organized by a designated organization in the setting: ■ Crisis response teams ■ Men's groups engaged in prevention and working with men ■ Women's groups engaged in prevention and working with women and children survivors ■ Youth counselors, peer educators ■ School programs about GBV
Work with local community (host country)		■ Local population has access to primary and reproductive health services at refugee health clinic	■ Drama and other presentations that describe refugee life ■ Include local women in survivor services, such as support groups
Humanitarian aid staff education	■ Standards of behavior and/or code of conduct, sanctions, reporting system	■ Gender ■ Human rights, GBV ■ Guiding principles for response to survivors (confidentiality, respect, safety)	■ Integration: preventing GBV through your sector's work

Table 4–1 (*continued*)

	Immediate Emergency Situation *In First 3 Months*	**Fairly Stable Settings, Year 1-2** *Add These Components…*	**Stable Settings, Longer term** *Add These Components…*
Interagency, interdisciplinary, multisectoral coordination	■ System for emergency reporting, referrals, documentation, survivor assistance and security	■ Incident report and case outcome data collected, compiled, disseminated; used for planning by multisectoral actors ■ Written procedures for reporting, documentation, roles and responsibilities of all key actors, referral systems ■ Procedures incorporate the guiding principles of confidentiality, respect, safety ■ Regular planning–coordination–information sharing meetings at camp, field, national levels	■ Integration: Special GBV procedures are incorporated into other procedures and policies within each organization ■ UNHCR takes the lead to organize periodic reviews and revisions to procedures
Health	■ Medical exam, treatment, follow-up post rape/sexual abuse ■ Documentation ■ Simple M&E indicator	■ Established protocols for post rape examination, treatment, and follow-up care ■ Documentation ■ Expanded M&E indicator(s)	■ Med exam, treatment, follow-up for all types of GBV occurring in the setting ■ Active screening for GBV of all female patients ■ Expanded indicators for all types of GBV interventions at health clinic ■ Community health workers, TBAs, traditional healers conducting awareness-raising in community, finding and assisting survivors
Psychosocial	■ Community Services and/or Health staff providing immediate emotional support, information, advocacy for survivors ■ Documentation of incident reports ■ M&E indicators for emergency response and outcomes	■ Expanded initial support to include informing survivor about all options and potential outcomes for response services ■ Differential response for different types of GBV occurring ■ Survivor empowerment through skills training and income generation activities ■ M&E indicators for response and prevention activities and outcomes	■ Separate or specialized GBV refugee and national staff/volunteers in the Community Services organization who provide emotional support, referrals, advocacy with survivors ■ Documentation system for incident reporting and follow-up ■ Microcredit/loan programs ■ Women/survivor support groups ■ Specialized counseling for extremely traumatized individuals ■ Specialized children's counselors

Table 4–1 (*continued*)

	Immediate Emergency Situation *In First 3 Months*	**Fairly Stable Settings, Year 1–2** *Add These Components…*	**Stable Settings, Longer term** *Add These Components…*
Security	■ Emergency response to incidents ■ Investigation and arrest; law enforcement ■ Survivor security and protection ■ UNHCR monitoring and advocacy	■ Private interview space in police post ■ Temporary placement, relocation options for survivors ■ M&E indicators	■ Training by police for police in appropriate response; repeated regularly for in-coming replacements
Legal justice	■ UNHCR monitoring and advocacy	Informal: ■ Leaders/elders manage only "less severe" cases, as defined and agreed with host country and UNHCR ■ M&E indicators Formal: ■ Refugee cases handled like all others by national justice system ■ UNHCR —System for notice of refugee cases scheduled in court —Information, support, assistance, advocacy for survivor/witnesses through all stages of process —M&E indicators	Informal: ■ Training for leaders in human rights, gender equality; they set standards for decision making that incorporate these principles Formal: ■ Training programs for judiciary in GBV guiding principles, relevant laws, and so forth ■ National lawyers on contract for survivor/witness assistance, advocacy, support through all stages of police and judicial process

Note.
For each item listed, human resources are needed. Human resources will require orientation, training, material support, and careful supervision. Planning and timelines should consider the human resources available for your setting, including literacy and English skills. Chapter 6, Building Human Resources, describes these and other personnel considerations in greater detail.

Part 2

Common Issues, Practical Solutions

CHAPTER 5

Finding and Keeping GBV Leaders

Integrating GBV prevention and response into every sector's work requires a lead GBV coordinator. This chapter discusses the responsibilities, qualifications, and qualities of effective GBV coordinators.

Integrating every facet of GBV prevention and response into the work of all actors and all sectors in a refugee setting requires a leader: someone who is both a technical expert and facilitator, the one person in the setting—perhaps in the country—devoting 100 percent of her work mobilizing refugee and humanitarian aid communities to the cause she represents.

In a growing number of countries, this coordinator is an employee of an international nongovernmental organization with separate GBV program funding. Sometimes, the coordinator is a consultant on a temporary contract to UNCHR. In many places, there is no designated post for a GBV program coordinator, and there is no one available who possesses both the necessary time and expertise to perform the work. In such cases, GBV efforts move very slowly.

A DAY IN THE EARLY FIELD LIFE OF A GBV PROGRAM COORDINATOR

You have funding for one year. Recruiting, hiring, and getting yourself to your field base took nearly two months. As quickly as humanly possible, you orient yourself to the setting; begin a situation analysis; become familiar with the project proposal (written by someone else); order your desk, chair, computer, and filing cabinet; begin meeting everyone in UNHCR, the host government authorities, refugee leaders, and relevant NGOs; and find staff to work in the refugee sites you cover.

Your program covers a wide geographic area with multiple camps; driving on unpaved roads to a camp can take more than two hours. You are lucky in your country; there is a vehicle you can use every day.

It is now the fifth month and the project proposal you inherited seems overly ambitious. How can you possibly "reduce the incidence of GBV" in your setting by the end of the year?

Somehow, you manage to hire 30 national and refugee women and men who know basic English, can read and write, and seem to be respected in their communities. Your country director and headquarters expect outcomes measured in numbers.

Here it is the end of sixth month, time to write next year's proposal, and you have only begun to educate the staff: "What is gender? What are human rights?" You have five months left to raise community awareness and get multisectoral, integrated, interagency, coordinated response services in place among health, police, and UNHCR staff. Next month, your donor will visit, you are expected to demonstrate some results, and your desk has not yet arrived.

The most important facet of the GBV coordinator's work is to build coordination, collaboration, and communication between and among humanitarian staff and displaced communities. This part of the program coordinator's work helps develop a program tailored to the unique needs of that particular displaced community and the resources available in the country. To this end, the tasks are as follows:

- Consult, advise, train, and mobilize all stakeholders, all sectors and all organizations in GBV efforts at all levels.
- Lead and facilitate resolution of problems that arise in interagency planning and action.
- Supervise and manage any specific GBV staff and volunteers who work in the community and confront sensitive, difficult issues face to face.
- Oversee all facets of GBV program design, planning, development, implementation, management, monitoring and evaluation.

The goal is to build GBV capacity in everyone and develop mainstreamed systems so that a special GBV program is no longer necessary.

In essence, when a GBV coordinator succeeds, she has worked herself out of a job.

On one level, the coordinator's workload appears to be no more difficult than most other jobs in a displaced setting. What compounds the GBV coordinator's job is the need to move among different sectors and deal with entrenched attitudes of both colleagues and clients, simultaneously. And all of this has to be accomplished in a society where discussion of sex and sexual relations are exceptionally sensitive, embarrassing, and perhaps even taboo.

JOB RESPONSIBILITIES

As with all jobs, the GBV coordinator will find her own way and select her priorities after a period of orientation and learning, and even as she starts to work. A clear vision for the program, along with realistic goals and specific objectives, will help her build an effective program. So will adequate support from all levels of administration right from the start.

A sample, detailed job description appears at the end of this chapter. Stripping away the details reveals that the one essential responsibility of the GBV coordinator is to build capacity in everyone living and working in the refugee setting. The GBV coordinator must mobilize all actors to influence change in knowledge, attitudes, and behavior among all staff and community members.

Staff and refugees alike have various and conflicting views about what GBV really is.

GBV is a complex issue deeply rooted in individual and cultural values, beliefs, and long-standing practices. Staff and refugees alike have various and conflicting views about what it really constitutes. Understanding these takes time and considerable effort. Designing and implementing strategies to change these views requires a GBV coordinator with time and proper qualifications.

QUALIFICATIONS

We know that people working in harrowing situations need support or they will burn out. Turnover has been fairly high in GBV programs, a reflection of the constant and daily frustrations of the work.

GBV strategies are crosscutting, interagency, multisectoral, and interdisciplinary, and many stakeholders must commit themselves to the program if success is to be achieved. Involvement at and support from every level—from the field to the highest levels of the bureaucracy—is critical to a GBV coordinator's capacity to keep going in the face of obstacles and setbacks.

Agreeing on a common vision and on the work needed to achieve that vision determines the qualities demanded of the GBV coordinator.

Most GBV coordinators are women, and the majority of GBV survivors coming forward for help will probably be women. Some unusually complex cases require the GBV coordinator's direct involvement, and it is difficult, if not impossible, for a man to provide the counseling and emotional support needed. Also, issues of gender inequality, oppression, and sexual violation are best understood by the oppressed.

Certainly, there are men who are sensitive and aware of these issues, and indeed there are a few men serving in this job. However, some people would argue that because they have not experienced or been vulnerable to the same violations as women, men cannot fully understand the problem. Others would say that a man can understand the attitudes and behaviors of the oppressor in ways a woman cannot.

They want me to go to another country. But my plan is to run as if my hair were aflame. I need a serious break.

—A GBV coordinator, 2001

Taking all of this into account, however, we recommend, with no hesitation or apology, that the GBV coordinator be a woman. The best scenario is to have both: one woman and one man, but budgets will usually not allow for two coordinators.

RECOMMENDED CHARACTERISTICS

Although small in number, well-qualified, effective, and creative GBV coordinators are at work in displaced settings around the world; some of their qualities and skills have been identified and appear below. These attributes should be taken into account during the recruitment process.

Personality Traits

Some essential personality traits are needed. Among the most important are the following:

A GBV coordinator is

- *A facilitator*
- *A negotiator*
- *A consensus builder*
- *A teacher*
- *A diplomat*
- *An advocate*
- *An advisor*

- Diplomacy combined with assertiveness—an ability, frequently inherent, to confront and discuss contentious and sensitive issues with respect, care, and tenacity.
- Creativity and a sense of humor—the ability to step outside chaos and see it, reframe it, and then find strengths on which to build; and the ability to see how ludicrous human behavior can be. The dark humor found among humanitarian workers serves them well as a coping mechanism amidst tragedy.
- Trustworthiness—the ability to display empathy, warmth, genuineness, and integrity. Gaining the trust of the people she works with will enable the GBV coordinator to discuss and influence cultural beliefs, attitudes, and behavior. Often, simply by virtue of her reputation for integrity, the coordinator also becomes the sounding board and informal counselor for national and expatriate staff on topics unrelated to the GBV program.

Necessary Experience

Solid skills and experience in key areas are invaluable, including—

- Thorough awareness and knowledge of gender issues and GBV; commitment to gender equality;
- Knowledge of sexual and reproductive health;
- Knowledge, skill, and experience in participatory methods for community development and mobilization;
- Skills and experience in group facilitation;

- Thorough understanding of the principles of counseling in its many forms; solid counseling skills and experience;
- Dynamic training skills;
- Sound supervisory skills; and
- Experience in program management, at least one year in an NGO, with a pragmatic understanding of the project cycle and the ability to develop, manage, monitor, and evaluate programs.

Education and Professional Orientation

Educational background and related professional values, ethics, and interests must match the skills required to achieve success.

Most people drawn to GBV work are sensitive and caring, and many come from the fields of social work or public health. These professions are well suited to the interactive nature of the coordinator's work. Both are oriented to the benefits of collaboration and partnerships, which guide the professional to facilitate multisectoral, interdisciplinary, and interagency action. Each profession also offers ongoing support through continuing education, guidance for ethical issues, and a network of colleagues all over the world.

Social workers usually have clinical skills in counseling, making them better able to train and supervise those who provide direct psychosocial services to survivors. Public health workers have a strong health orientation, which may be needed in some settings.

Social Work

The social work profession promotes social change, problem solving in human relationships, and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

*Social work in its various forms addresses the multiple, complex transactions between people and their environments. Its mission is to enable all people to develop their full potential, enrich their lives, and prevent dysfunction. Professional social work is focused on problem solving and change. As such, social workers are change agents in society and in the lives of the individuals, families, and communities they serve. Social work is an interrelated system of values, theory, and practice.**

Public Health

"The mission of public health is to "fulfill society's interest in assuring conditions in which people can be healthy." (Institute of Medicine, Committee for the Study of the Future of Public Health, Division of Health Care Services. 1988. The Future of Public Health. *National Academy Press, Washington, DC).*

Public health carries out its mission through organized, interdisciplinary efforts that address the physical, mental, and environmental health concerns of communities and populations at risk for disease and injury. Its mission is achieved through the application of health promotion and disease prevention technologies and interventions designed to improve and enhance quality of life. Health promotion and disease prevention technologies encompass a broad array of functions and expertise.†

*International Federation of Social Workers Web Site <www.ifsw.org>

†Association of Schools of Public Health Web Site <www.asph.org>

FINDING GBV COORDINATORS

Finding qualified candidates has been difficult for some organizations. It is important to look in the right places: battered women's shelters, rape counseling services, professional social work and public health associations and educational institutions, and the host of GBV programs in the Americas, Africa, Asia, and Europe.

KEEPING GBV COORDINATORS

With a greater understanding of the GBV coordinator's job, organizations are better able to understand and provide the support and assistance needed to achieve both program results and job satisfaction. Staff turnover is expensive and exhausting; it impedes progress. GBV fieldwork is difficult and demanding; staff desperately need support and camaraderie, which will prevent burnout and reduce turnover. Better staff training and stronger support networks will also bring a widening pool of experienced and skilled GBV resource people to the work. The responsibilities of other players, as suggested, could serve as a guide to support the GBV coordinator's work.

Heads of Offices and Country Directors

The head of office, as the primary liaison with other organizations, has a key role in supporting the GBV program. The following suggested actions will assist the GBV coordinator:

- Carefully consider organizational placement and oversight of GBV within the country program structure to ensure the issue receives maximum support and attention.
- Keep up to date on GBV activities, successes, and problems. Receive and review reports with GBV data, trends, analysis of GBV prevention and response activities, successes, and problems.
- Meet with the GBV coordinator regularly; listen carefully and provide needed support and assistance.
- Engage the active participation of UN agencies, refugees, NGOs, and the host government.
- Provide high-level advocacy and support with other organizations; assist in problem solving; advocate for adequate resources.
- Collaborate with colleagues in other organizations to ensure interagency planning and attention to GBV. Maximize use of available resources. Share information, successes and challenges.
- Identify and obtain resources to support GBV activities, including funding, as well as technical and other support.
- Budget for and encourage GBV coordinator attendance and participation at international and regional conferences and training events.

Leaders and Staff at Headquarters

Headquarters staff members also have a central role in organizational support for the GBV program and the coordinator's work. For example—

- Taking into account the need for appropriate organizational placement and technical support mechanisms for GBV; and
- Participating in developing, planning, and advocating for the integration of GBV into all sectors within both the organization and the larger international humanitarian aid community.

PROFESSIONAL DEVELOPMENT AND SUPPORT NETWORKS

The GBV Coordinator also has a responsibility to establish continuing education, support, and information-sharing networks for herself. Some examples include the following:

- Establish and maintain contact with GBV colleagues and peers in the country, the region, and throughout the world.
- Attend at least one international conference each year.
- Visit GBV programs in nearby countries.
- Actively seek resource and reference materials; establish a system for identifying and obtaining new materials.

SAMPLE JOB DESCRIPTION

Gender-Based Violence (GBV) Program Coordinator
(Expatriate or National)

Responsibilities

Refugee Staff and Volunteers

- Draft job descriptions for refugee staff and volunteers.
- Recruit, hire, and supervise refugee staff and volunteers.
- Develop training curriculum in collaboration with identified training organizations.
- Arrange for staff and volunteer orientation, training, and refresher courses.
- Develop and implement strategies for volunteer retention and recognition.
- Provide ongoing supervision and staff management to ensure high-quality services.

Refugee Community Mobilization

- Using participatory methods, engage refugee leaders and other refugee groups and individuals in active participation with all phases of program planning, development, and implementation.
- Organize and facilitate monthly camp-level discussion and coordination meetings to build refugee capacity and strengthen community-based prevention and response to GBV.

Multisectoral and Interagency Program Development and Coordination

- Establish close working relationships with NGOs, host government agencies, and UNHCR in the setting; meet regularly with individuals and groups from these organizations.
- Organize and facilitate regular (monthly) coordination meetings with these organizations at field and national levels.
- Lead the effort to develop a multisectoral and interagency prevention and response system to include referral and reporting mechanisms, information sharing, coordination, and monitoring/evaluation. Establish written guidelines and procedures.
- Working closely with partner organizations and training resources, facilitate and organize training workshops for skill building, sensitization, and capacity building of all humanitarian workers for appropriate prevention and response to GBV. Includes specific and targeting response training with health center, police, host country judiciary and other authorities, community services, UNHCR, and others.
- Arrange for comprehensive and progressive gender-awareness training workshops with all staff within this organization. Liaise closely with other organizations to encourage similar training in all organizations operating in the setting.

Program Monitoring and Evaluation

- Conduct a situation analysis of GBV in the setting. Using participatory methods, collect data and information from multiple sources among refugees, NGOs, host government, and UN agencies.
- Revise the GBV Incident Report Form and GBV definitions as needed for the setting. Train partner organizations in use of this form.
- Maintain awareness of all GBV cases reported in the setting through immediate review of Incident Report Forms and regular meetings with field staff and volunteers.
- As needed for difficult or complex cases, provide direct advocacy and assistance.
- Collect, compile, and analyze GBV report data monthly.
- Collect and compile program activity information, evaluating progress toward achievement of program outcomes.
- Develop monthly report formats that capture relevant information and support the analysis and evaluation of program progress.
- Develop and monitor outcome indicators; share this information with others and use it for ongoing program design.

Administrative and Miscellaneous Duties

- Maintain awareness of budget and expenditures in order to manage the program within budget.
- Write monthly work plans, reports, and other reports as needed or requested.
- Develop program proposals.
- Identify assistance needs and gaps in the setting; keep country director informed with observations and recommendations.
- Other duties as required.

Personal and Professional Qualifications

- University degree in social work or other social sciences, public health, community health, or related field.
- Thorough awareness and knowledge of gender issues and GBV. Commitment to gender equality.
- Knowledge of reproductive health issues.
- Knowledge, skill, and experience in participatory methods for community development and mobilization.
- Group facilitation skills and experience.
- Counseling skills and experience.
- Training skills; at least one year of training experience.
- One year of experience in program management in an NGO; humanitarian setting preferred.
- Experience working with refugees preferred.
- Diplomacy and assertiveness; the ability to confront and discuss sensitive issues with respect and care.

CHAPTER 6

Building Human Resources

Human resources are the critical tools in all GBV programs. This chapter discusses ways to find, train, and support staff, and how to retain staff in sufficient numbers and the right mix.

Without an adequate number of properly trained, skilled, motivated, and supported staff, the many sectors and organizations involved in GBV work cannot achieve their short-term objectives and long-term goals: preventing and responding to GBV. A large part of building this staff capacity is addressing knowledge, attitudes, and behavior about gender and power. We must also ensure that staff who work in GBV programs include representatives from the displaced communities, the host government, UNHCR, and relevant NGOs.

WHO WILL DO THE WORK?

Four sectors and a large variety of skilled staff should be involved in GBV prevention and response.

The four key sectors, or functional areas, for GBV response services are health, psychosocial, security, and legal justice. Following is a sample array of actors who may be involved in varying degrees in this work.

- **Health**: Doctors, nurses, midwives, traditional birth attendants, community health workers, traditional health practitioners, health managers, administrators, coordinators, health ministry officials.
- **Psychosocial**: Community volunteers, community services workers, teachers, refugee groups, skills-training and income-generation program staff, social services and welfare ministry officials.
- **Security**: Police, security forces, security officers, field officers, protection officers, security workers, community leaders.
- **Legal Justice**: Traditional tribunals, community leaders and elders, protection officers, judges and other officers of the court, legislators and lawmakers, NGOs and advocacy groups working to improve national laws and policies related to gender and GBV.

Mainstreaming or integrating the services of special programs such as GBV requires adequate staff. If vacancies are not filled, or if GBV project staff must fill in for positions eliminated in other projects, then services to displaced populations can be severely affected.

Sound interagency planning is essential. But if leadership positions in a key sector or organization are not filled, there is no one available to develop the necessary integrated GBV action.

DEVELOPING A MULTIDIMENSIONAL PROGRAM

In the initial phase of designing a GBV prevention and response program, an interagency team must clarify roles and identify the types of core staff available from the displaced, national, and international communities who will be engaging in direct survivor response services and leading prevention activities. Once trained, core staff will train others, thus gradually expanding the pool of human resources and integrating GBV into the work of all sectors and all staff.

Developing integrated actions to address GBV takes time.

The core staff usually includes most of the UNHCR staff; refugee and national GBV counselors and/or community services workers; managers and interested staff from the health facility, psychosocial programs, security, and legal justice system; and interested and committed staff from other sectors and organizations at the site.

BUILDING STAFF CAPACITY

GBV understanding, attitudes, skills, and abilities evolve over time. Training and supervision must continue to guide and support staff progress and the evolution of the program. Building this capacity calls for three general activities, described in detail below.

1. Build skills required to accomplish job duties through training and continuing refresher training.
2. Influence change in staff attitudes and behavior by raising awareness and understanding of GBV and instituting systems for staff accountability.
3. Supervise staff through careful monitoring, support, mentoring, coaching, and guidance. These activities are especially important for staff and volunteers who provide counseling and emotional support to survivors.

Training Staff

RESOURCES

The revised Interagency Guidelines for Prevention and Response to SGBV *(in press) contains recommended standards for prevention and response action, sector by sector.*

The Reproductive Health for Refugees Consortium Web site (<www.rhrc.org>) has an extensive list of GBV resources and links to training materials for each of the four key sectors.

UNHCR, WHO, UNFPA, Oxfam, and Save the Children have all developed training manuals, how-to guides, and other resources on gender, violence, mental health, and protection of women and children.

GBV training for staff from all sectors should cover the program's guiding principles and the standards drawn from them. Training should also cover all activities, including reporting and referral procedures established by the interagency team.

Few detailed training manuals tailored to GBV programs in displaced communities have been published. The existing publications are difficult to find. Most GBV coordinators develop their own manuals with help from existing materials, or they contract with outside trainers to develop materials and conduct the training. Building networks of GBV staff regionally and globally would reduce the need to start from scratch (as discussed in Chapter 4, Mainstreaming GBV Programs). GBV coordinators can share the various unpublished training manuals and materials that have been developed for another country's use and adapt them to their country.

Psychosocial staff usually require a broader range of training than staff in other sectors. Counselors in particular perform a wide range of work in both prevention and response. They may be part of a vertical GBV program, or they may be community services workers or other staff employed in community services or other psychosocial projects.

These counselors provide some type of counseling for survivors of many different types of GBV. (The counselor's role is defined in Chapter 9, Defining Counseling.) They also may be the people who work directly with the community to promote change in knowledge, attitudes, and behavior.

CASE STUDY

An international NGO obtained 12 months of funding to develop multisectoral response to GBV and mobilize IDP communities in the country to engage in prevention activities. The new program coordinator was to hire and train a small number of IDPs to establish volunteer groups to conduct these activities.

Three major languages are spoken in this county. It is difficult to find someone in the community who speaks more than two fluently. Program implementation was delayed 6 months while the GBV coordinator scoured the country for appropriate staff. By Month 12, the coordinator realized that she could have communicated the staffing challenges more clearly to the donor. She would then have been in a position to negotiate some changes in program strategies that would more closely match the resources available (e.g., that staffing plans seek part-time rather than full-time staff with a mix of languages, hire translators, and revise activities to accommodate the slower pace required for multiple translations).

If she had done this at first, the activities could have started much earlier.

Raising Awareness and Influencing Behavior Change

Refugee, national, and international staff bring to their jobs beliefs and attitudes that influence their behavior, including the willingness and ability to carry out job functions. In most cultures around the world, women exist in an unequal and subordinate position in relation to men. These cultural beliefs are held by humanitarian staff; of course there are wide variances across cultures.

Before staff can even hope to raise awareness and influence change in others, they must identify their own attitudes and practices and learn about issues of gender and changing norms. This task requires the same kinds of strategies used in working with the larger community, that is, facilitating an exploration of cultural views that then moves on to an examination of personal views.

The process is gradual. It typically begins with a discussion about women's and men's roles, human rights, and concepts of power and equality. Eventually, staff develop a thorough understanding of GBV that will enable them to perform their duties and responsibilities, including identifying and eliminating any of their own behaviors that may contribute to the GBV problems in the setting.

GBV experts are optimistic that enforceable—and enforced—codes of conduct, combined with training and awareness raising will have a significant impact on the actions and accountability of all humanitarian aid staff.

Staff behavior can also be greatly influenced by organization wide and site wide expectations, rules, regulations, policies, and consequences. Since the recent sexual exploitation scandal in West Africa,* codes of conduct are being established in virtually every displaced setting. As shameful and embarrassing as it may be to acknowledge, some humanitarian aid workers are among the perpetrators of GBV and other humanitarian aid workers are aware of these GBV incidents but keep silent.

However, a code of conduct is effective only if accompanied by procedures for staff accountability, including reporting mechanisms and consequences—and if the code of conduct is enforced. If leaders, managers, supervisors, and peers at all levels and in all organizations fully understand this problem and deem it unacceptable, real progress can be made toward preventing GBV.

Supervising and Monitoring Staff

Job descriptions, performance standards, and systems for accountability are crucial for appropriate supervision; that is, ongoing training, support, coaching, mentoring, and guidance. Social services programs demand close

*The findings in West Africa are discussed in Chapter 1, A Brief History of GBV Programming.

supervision, and this is especially true for GBV programs. The work is emotionally demanding, often unpopular to undertake, and frequently round-the-clock. Furthermore, it can be dangerous. Many people drawn to GBV counseling work are passionate and dedicated, and develop strong emotional attachments to the issue and to the clients. Supervisors must be alert to workers who take it upon themselves to solve and fix problems themselves, *doing for* rather than *doing with*. Such an approach runs contrary to the goal of empowering survivors to make their own decisions and building the community's capacity to help itself.

When asked about their objective with a particular client, GBV workers commonly answer, "We try to resolve the case." They are sincere in their wish to make the problem stop, but the fact is that survivors must resolve their own situation with support, information, and advocacy from the worker. Their problems are not *ours* to own or to fix. (See Chapter 9, Defining Counseling, for further discussion of these issues.)

Good supervision includes frequent coaching, mentoring, teaching, and guidance. A GBV supervisor should feel comfortable supervising people of different cultures, be assertive in addressing staff issues, and have training in recognizing the symptoms of burnout.

Secondary trauma and burnout are common among social service workers world wide. The best strategy for dealing with burnout is to prevent it. Frequent and regular supervision is one form of prevention. GBV coordinators in many settings monitor supervision needs through frequent visits to field sites. The range of supervision methods in use includes the following techniques:

- Individual discussions with each staff member: asking questions, listening, observing, advising, teaching, coaching, and mentoring.
- Facilitated debriefing sessions after particularly difficult or frustrating cases.
- Regularly scheduled staff meetings that include informal discussions and continuing education.
- Specific and enforced policies and procedures that ensure staff security and set professional boundaries.
- Performance review and feedback every three months or at least annually.
- Modeling of professional behavior and effective problem solving.
- Organized sports and competitions.
- Work and on-call schedules rotated to accommodate 24-hour, 7-day emergency availability and ensure time off.

By acknowledging that human resources are the critical tools for addressing GBV, the leaders of a GBV program can build skills, influence behavior changes, and institute supervisory mechanisms, all essential to develop and support human resources.

CASE STUDY

The GBV program in one country operates in the capital city and at two field sites at opposite ends of the country, entailing a two-day trip from a field site to the main office. The expatriate GBV coordinator and two national assistants have coordinated a monthly travel schedule that allows one of them to be present for support and supervision at each field site for a few weeks every month.

Each staff member travels one week of every month, taking the office laptop computer along so that work can continue from the field. Training and refresher workshops are scheduled to coincide with these field visits, with the visiting supervisor facilitating the training.

Table 6–1. Guide for Training and Capacity Building with GBV Program Staff

No. of Days *(Approx.)*	Topic	Notes and Ideas: Who and How to Train	Training Objectives/Post-Test Ideas (*By the end of the training, participants will be able to …*)
2	Gender	*Oxfam Gender Training Manual*: lots of ideas, clear guidance for conducting these workshops and sessions	■ Describe the importance of understanding the concepts of gender when doing GBV work ■ Understand their own gender roles and gender in their community ■ Describe how issues of gender perpetuate GBV ■ Describe the concept of gender in their mother tongue, without using the word "gender"
½	Concepts of power and abuse of power, vulnerability and lack of choice, different types of violence	In addition to gender, these concepts are the foundation for understanding GBV	■ Identify four characteristics each of people in the community who have power and those who do not ■ Describe four different types of violence
½	Human rights	What they are, international documents, and so forth UNHCR Protection Officer	■ Answer, "What is a human right?" ■ Identify and describe five human rights relevant to GBV ■ Identify relevant human rights instruments/ documents
½	Rape, sexual assault, abuse, including child sexual abuse	Detailed description, outcomes/after-effects, survivor needs Special needs of children, incest cases	■ Identify three reasons for fatal outcomes post rape ■ Identify two psychological after-effects and describe survivor needs in relation to them ■ Identify two health outcomes and describe survivor needs ■ Describe one emotional after-effect of incest
½	Sexual exploitation, trafficking, other such abuses	Detailed description, outcomes/after-effects and survivor needs Codes of conduct for humanitarian staff, power/abuse relationships, what to do if the perpetrator is someone in power or high position	■ Identify two psychological after-effects and describe survivor needs in relation to them ■ Identify two health outcomes and describe survivor needs ■ Describe codes of conduct and other staff performance guides in the setting ■ Describe procedure for reporting sexual exploitation and protecting the reporter
1	Domestic violence	Detailed description, cycle of violence, outcomes/after-effects, survivor needs, challenges and frustrations of working with battered women The client is the victim, not the perpetrator. DV intervention in our setting is not mediation or family counseling Very real safety threats for GBV workers in these cases	■ Identify two psychological after-effects and describe survivor needs in relation to them ■ Identify two health outcomes and describe survivor needs ■ Identify two potential threats to personal safety and how to avoid them when working with DV cases ■ Identify two goals of counseling DV survivors ■ Identify one positive and one negative potential action on the part of police and justice system in response to DV cases
½	Harmful traditional practices	These practices in the setting Detailed description, outcomes/after-effects, needs of survivors	■ Identify two harmful traditional practices in the community ■ Identify two health outcomes of these and describe survivor needs
½	Discrimination and psychological/social abuse	Detailed description, outcomes/after-effects, needs of survivors	■ Give two examples of social abuse and describe survivor needs

Table 6–1. (*continued*)

No. of Days (Approx.)	Topic	Notes and Ideas: Who and How to Train	Training Objectives/Post-Test Ideas (*By the end of the training, participants will be able to …*)
½	Summary of all after-effects	Common consequences organized into the four sectors, linking potential after-effects to possible survivor needs and possible response action Special emphasis on "Blaming the victim"	■ Identify four health and four psychosocial potential after-effects that most forms of GBV have in common ■ Define "blaming the victim" and describe three ways it can result in further harm and trauma ■ Describe how to apply understanding of after-effects to choose action to assist a survivor
½	Causes and contributing factors	Review of all different types of GBV and the causes and factors that perpetuate /influence types and extent of GBV in any setting. Includes— *Oxfam Gender Training Manual:* gender issues *UNHCR Guidelines:* access to services and programs in the setting, risk factors in conflict and refugee settings	■ Describe how issues of gender in the community perpetuate GBV ■ Identify five potential causes or contributing factors to watch for in this setting
¼	Overview of prevention and response	Brief summary of four sectors— What is prevention, what is response?	■ Describe the steps involved in assisting a GBV survivor (response) ■ Identify four primary sectors/actors who might assist a survivor
½	Health response	Actions needed: Who are the actors in your setting; what are the training and sensitization needs? Protocols, procedures needed	■ Identify four roles/responsibilities of health actors for response
3	Emotional/ psychological/social response	Actions needed: emotional support, skills training, income generation, support groups, and so forth Who are the actors (community services, others)? What are the training and sensitization needs of actors? Focus on community-based services (provided by community, rather than humanitarian aid organizations) and active listening skills, teaching, and practice GBV staff members are NOT therapists, advisors, or family mediators. Clearly define our role to provide listening and emotional support, and information about survivor choices for assistance.	■ Identify four roles/responsibilities of psychosocial actors for response ■ Describe the difference between active listening and advising ■ Demonstrate emotional support and active listening through role-play in three different types of GBV cases ■ Demonstrate the ability to interview a GBV survivor, gather information, assess emotional status, and provide emotional support, all through role play
1	Security and justice response	Actions needed: Who are the actors? What are the training and sensitization needs? Summary of relevant national laws, police and court procedures by someone from police and/or courts. Maybe also UNHCR has a national lawyer on staff who can do all or part of this training.	■ Identify two roles/responsibilities of the police in GBV response ■ Demonstrate general understanding of relevant laws (specify in each setting) ■ Identify three survivor advocacy needs when facing the legal justice system ■ Identify three roles of UNHCR when GBV cases are reported to the police
1	Guiding principles	Confidentiality: discuss in detail how to ensure respect for survivor choices and for survivor dignity; Safety and security of survivor	■ Identify the three primary guiding principles ■ Describe three ways to guard confidentiality ■ Describe three ways to respect the survivor ■ Describe three actions to ensure survivor security ■ Describe three actions to ensure security

Table 6–1. (*continued*)

No. of Days (Approx.)	Topic	Notes and Ideas: Who and How to Train	Training Objectives/Post-Test Ideas (*By the end of the training, participants will be able to …*)
2	Receiving reports, referral procedures, coordination	Incident Report Form training (one full day at least) Procedure for Incident Report: what to do with completed form Working with community to establish report/referral center (e.g., drop-in center, health center, police) Emergency response setup, including procedures for night referrals Consent for release of information; confidentiality procedures Interagency coordination needs; how to establish and maintain Current situation with interagency procedure manual and information sharing	■ Demonstrate ability to complete Incident Report Form correctly ■ Describe the procedure for emergency response and reporting a GBV incident (e.g., during the day, at night) ■ Identify five stakeholders who will need to be included in the GBV coordination team at camp level
1	Situation analysis	Present information from situation analysis in the setting Discussion of trainees' knowledge of GBV in the setting	■ Describe the community's definitions and views about GBV
2	Training	Methods and techniques; do's and don'ts; practice	
1	IEC and behavior change	What it is, importance of targeted and clear IEC; overview of designing IEC, involving community; testing, implementing, revising, monitoring/evaluating effects of IEC involving men	■ Identify four steps to develop IEC materials ■ Describe the importance of targeted IEC ■ Identify two methods to evaluate effects of IEC
½–1	Staff roles and limitations	Detailed interagency, intersectoral staff roles and responsibilities Detailed discussion of GBV staff job descriptions, roles, expectations, limitations, tasks. Includes discussion of staff safety and security	■ (need to develop in each setting)
1	Administrative topics	Work plans, weekly objectives/plans Reports—weekly, monthly Coordination Supervision	■ (need to develop in each setting)
5	Participatory methods for assessment, community mobilization (e.g., PRA, PLA)	Approximately one week in the classroom, one week of field practice and classroom follow-up/review	■ (need to develop, based on training curriculum)

Table 6–1. (*continued*)

No. of Days *(Approx.)*	Topic	Notes and Ideas: Who and How to Train	Training Objectives/Post-Test Ideas (*By the end of the training, participants will be able to …*)
5	Participatory methods Practice	Ideas for this practice Divide into four subgroups, for example —Design two sensitization/IEC activities —Select and refine three PRA methods for use in GBV work with community —Write three role plays/dramas —Draft awareness-raising session targeting men After two days, each subgroup presents /conducts its activity with the whole group (group acts as "participants") Feedback, discussion, revisions Each participant receives the revised activity plans in writing.	■ Demonstrate ability to use participatory methods for continuing assessment, community education, and prevention

SUMMARY

Approx. total

30 days

Training to be spread over a three- to six-month period.

On completion of training, participants will be considered prepared for the job if …

- Staff will successfully pass posttraining test(s) covering all training topics and will demonstrate achievement of training objectives for each topic
- Staff will be able to describe the relationship between gender, power, and GBV
- Staff will be able to complete Incident Report Form correctly
- Staff will be able to develop weekly and monthly work plans, document their work, and write reports and compile data correctly—as required by the program.
- Staff will be able to conduct participatory activities
- Staff will be ready to finalize their first IEC materials and begin community sensitization.

Notes.

This is a ***working draft***, intended only as a ***guide.*** GBV Coordinators in multiple settings contributed to this draft, which is a best-case scenario. Often, field sites to not have sufficient resources or time to conduct this training. Each must determine its own priorities for staff development.

The training is to be conducted over three to six months after hiring GBV staff, depending on the program activity schedule. Some topics can be grouped together; others are clearly distinct.

The assumption is that "GBV staff" duties include the following: (1) interviewing GBV survivors; (2) providing emotional support and crisis counseling; (3) providing referrals, advocacy, and case management; and (4) providing community development activities for awareness raising and prevention of GBV.

CHAPTER 7

Monitoring and Evaluating Programs

GBV programs must demonstrate that GBV is serious and life-threatening, and that the programs are proving effective in addressing the problem. Coming up with sound evidence is the subject of this chapter.

Gender-based violence kills. In some sites, there are rumors that survivors of GBV are committing suicide; there are also rumors of GBV victims being killed by their assailants. But GBV programs lack the capacity to capture and verify this information. There are many humanitarian actors who believe GBV programs are somewhat of a luxury, not a necessity. When resources become limited and budgets are cut, programs that are not deemed life saving or otherwise essential face reduction or elimination. This is the fate that the early Victims of Violence program (the GBV program predecessor) suffered, and there is no reason to believe that it will not happen again.

Unfortunately, monitoring and evaluation (M&E) is one of the weakest areas in most GBV programs. Yet without effective M&E, GBV programs lack information necessary to guide ongoing design, revision, and improvements. Monitoring and evaluation of GBV programs must be improved before time and circumstances divert the world's attention away from the problem. For the past few years, and certainly at present in the wake of the West Africa "sexploitation" scandal, GBV programs have become popular. But although they are now a cause-célèbre, interest will diminish without proof of program effectiveness.

M&E DEMANDS TIME AND RESOURCES

Funding for GBV should not be reduced for lack of budget; it should be reduced only after the desired program outcomes are achieved: integrated action by a multisectoral team working together with the community.

Despite the complexity of the multisectoral, interagency, and interdisciplinary activities that a GBV program demands, monitoring and evaluating a program is not as complex as one would imagine at first glance. Neither is it a simple procedure.

Some activities are specific, and meaningful outcomes are easily monitored and measured (e.g., the numbers of rape cases seen at the health clinic in three days, in time to avoid unwanted pregnancy). Other activities are more difficult to quantify (e.g., the outcome of counseling or achievements in changing male behavior).

GBV programs must establish thoughtful and effective monitoring and evaluation systems. It does require time, but it can be kept simple and efficient by following the maxim: Keep It Simple, but Systematic (KISS).

The lack of a clear vision for the GBV program and realistic, specific program goals and objectives make M&E more difficult. In other words, if GBV programs lack clarity about where they are going, how will they know if they have arrived?

Many program coordinators lack expertise and confidence in designing the M&E needed for interagency and intersectoral GBV action, and will continue to conduct weak M&E if their concerns are not resolved. They need skills training, support, continuing education, and access to resource materials.*

Monitoring and evaluation is the process through which we gain information on program activities and achievements in order to make decisions to improve them.

—Therese McGinn and Roger Vaughn†

In field sites everywhere, there never seems to be enough time to complete the enormous amount of work that needs to be done. Nevertheless, M&E is a bona fide program activity, not a luxury to be undertaken if there is more time.

All program coordinators must plan for and manage the time necessary to incorporate systematic M&E activities into every GBV program. For the program to measure true progress, all key GBV staff (i.e., more than just the GBV staff employed by the designated lead agency) must compile information, analyze it, review it, think about it, and use it for planning and guiding the work.

INCORPORATING M&E INTO PROGRAM DESIGN

Monitoring and evaluation is a systematic process. It should be incorporated into a GBV program during the planning phase and continue throughout the program cycle (Figure 7–1). Continuing and systematic M&E will provide the most meaningful information.

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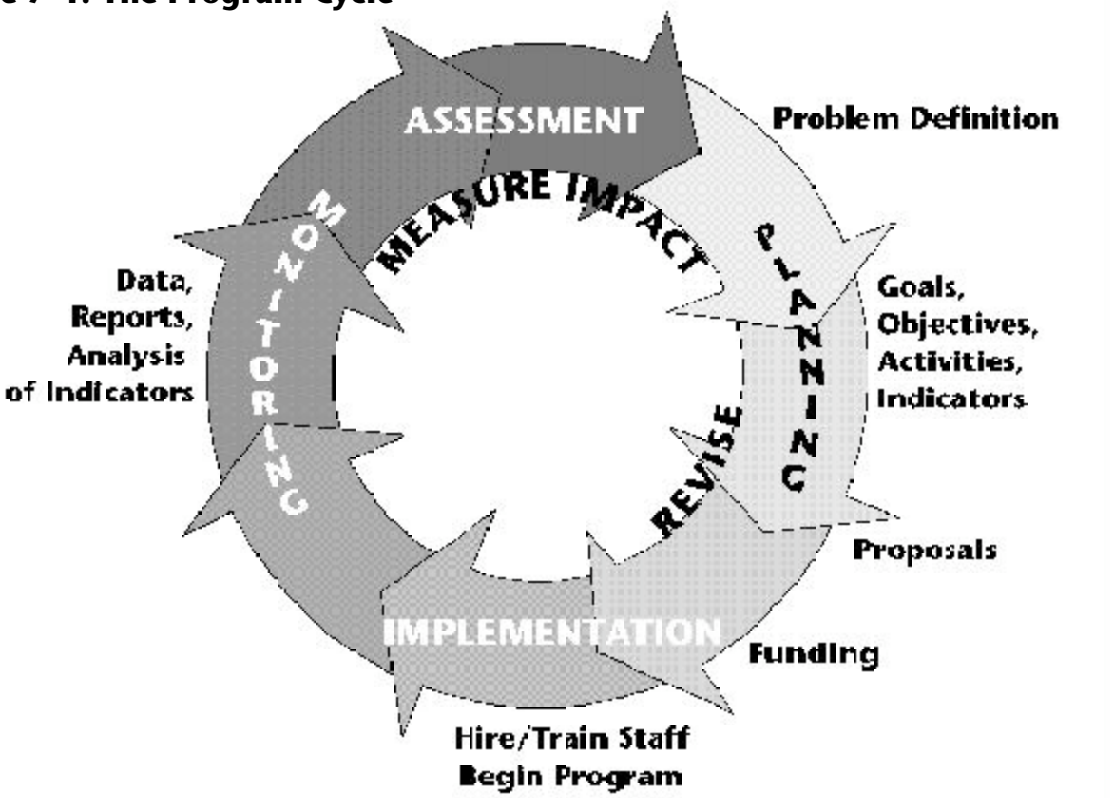
*Chapter 6, Building Human Resources, covers this topic more thoroughly.

†*The Causal Pathway,* (unpublished) is a process for program design, monitoring, and evaluation. This chapter draws heavily from it. *The Causal Pathway* was developed by Therese McGinn and Roger Vaughn, Heilbrunn Department of Population and Family Health, Columbia University, New York City.

Figure 7–1. The Program Cycle



Needs Assessment

The needs-assessment phase of the program cycle marks the beginning of the M&E process. For GBV programs, two generally accepted methods are used in this phase: the situation analysis and the prevalence survey.

Situation Analysis

The situation analysis is a comprehensive review of the situation at hand, giving the interagency team an understanding of the strengths and weaknesses of services currently available and the needs in the target population. It also provides a beginning understanding of the types and extent of GBV occurring in the setting.

M&E is occurring in limited fashion at some GBV sites. However, nowhere is it far enough advanced to document, with any certainty, if a multisectoral GBV program is consistently effective or providing high-quality services.

A situation analysis should include an examination of the following information:

- Type and extent of GBV taking place.
- Formal and informal community systems for conflict resolution and leadership.
- Attitudes, knowledge, and behavior of the community, host government staff, and humanitarian aid staff (especially in key response organizations) regarding gender, human rights, power, and GBV.
- Ability of the community, host government staff, and humanitarian aid staff to meet survivor needs with the services available (e.g., staffing, protocols, and equipment).
- Training for the community, host government staff, and humanitarian aid staff to meet survivor needs.
- Mechanisms for interagency and interdisciplinary coordination.
- Extent (and effectiveness) of interagency and interdisciplinary communication and collaboration.
- Perpetuating factors in the setting that contribute to incidents of GBV and prevention activities already underway, including staffing and training.

Prevalence Surveys

Many NGOs considering the addition of a GBV program to their portfolio believe that they must first survey the women and children in the population to quantify the prevalence of GBV and gather baseline data. But a survey is probably not necessary in the early phases. Building in-depth knowledge of survivor needs and community attitudes is a process that occurs over time.

A survey may also be inappropriate because the risks might outweigh the benefits. GBV is a hidden problem, and a number of ethical and safety concerns must be taken into account before any surveys are conducted. If survivors self-report and no services are in place to assist them, the survey may do more harm than good, opening emotional wounds that cannot be closed without follow-up support. More important, surveys may endanger a survivor: if the perpetrator knows she is a survey respondent, he may retaliate; security systems may be inadequate to protect her.

Because various types of GBV occur in every conflict and nearly every culture, it is safe to assume at the outset of any GBV program that there are GBV survivors with unmet needs in displaced populations. The situation analysis will provide enough information to get the program started without endangering either survivors or the viability of the GBV program. Surveys may be useful, and necessary, for program development after support services are ready to step in.

Problem Definition

A thorough needs assessment will likely reveal a fairly long list of problems related to prevention of and response to GBV. Table 7–1 is a rough list of the problems compiled at one field site and gleaned from a discussion of the site's situation analysis.

For GBV programs to be manageable and effective, it is crucial to clearly define the problems to be addressed. The interagency team, including all stakeholders in the community, must be involved in defining the problems to be addressed and selecting priorities.

Objectives and Goals

The muddy and all-encompassing nature of the objectives, goals, and plans in many GBV programs has led to M&E that lacks focus. This makes it nearly impossible for a GBV program coordinator to know whether a program is achieving results. For example, a few years ago, a goal in a typical GBV program proposal for a 12-month program was "Reduce GBV in the refugee community." GBV is a multidimensional and long-standing problem in communities, and it is not realistic to assume that a program can actually reduce GBV in only 12 months.

In the past year or two, more realistic program goals have been emerging. Some GBV programs include goals such as "Improving the health and psychosocial status of GBV survivors" or "Increasing the capacity of service providers to address survivor needs." The complex nature of GBV requires intervention over a period of years, and these programs are more akin to development projects than to emergency relief. It is useful, therefore, to first

Table 7–1. GBV Problems Identified at a Single Site Through Situation Analysis, by Sector

Health

- Domestic violence involving physical injury reportedly occurs.
- Unwanted pregnancies post rape are common.
- STD/AIDS transmission and infection are likely outcomes of rape.
- Most survivors do not seek health care after an incident.
- Survivors minimize the effects and details of GBV.
- Lack of forensic evidence contributes to dismissal of criminal cases.
- Health center doctors refuse to testify in court.

Psychosocial

- Community believes wife-beating is a socially acceptable practice.
- Survivors do not feel safe enough—physically, emotionally, or socially—to report GBV incidents.
- High rates of wartime sexual violence, perpetrated by combatants, are suspected among displaced populations.
- Male-dominated leadership demonstrates low levels of understanding or respect for human rights of women.
- Few survivors participate in skills training and income-generation programs. Many survivors fear the stigma of being associated with GBV.
- Skills training and income-generation programs lack resources.

Security

- Police lack awareness of national laws prohibiting GBV crimes.
- Police lack procedures for investigating GBV reports and interviewing victims.
- Lawlessness and lack of security presence is observed in camp.
- Camp-based security workers are all male.
- GBV survivors do not report such crimes to police.

Legal Justice

- UNHCR Protection Officers and Assistants are all male.
- UNCHR and NGOs lack awareness of national laws and procedures covering GBV crimes.
- GBV cases filed in court in preceding year were dismissed for lack of evidence or lack of witness presence.

establish long-term goals (e.g., integration), and describe the outcomes expected after two to five years of program activities. The objectives for each 12-month period can then be specified to accommodate funding cycles and build on progress made in the previous 12 months.‡

Indicators

Indicators are the measures used to monitor program activities and measure progress. Given the sectors, organizations, disciplines, and their myriad activities, it is easy to select too many indicators, thus creating an unwieldy M&E process. GBV program designers should, therefore, select the few key indicators that will enable M&E of the activities and outputs deemed most central and important to the program's objectives.

There are two different types of indicators that are most relevant for GBV programs:

- **Output indicators**—a measure of the number of activities and services provided by the GBV program and their quality. They can be especially useful for M&E during the first year or two of a program, when the program focuses on capacity-building activities and M&E measures progress in achieving objectives as indicated by the number of activities and outputs.
- **Effect Indicators**—a measure of the changes in level of knowledge, attitudes, skills, intentions, and behaviors of the community. Achieving such significant changes (e.g., "reduced incidence of GBV") takes years, spanning the entire life of the GBV program.

Defining Acceptable Results

Each GBV program must define its own acceptable results, that is, the results measured by the indicators that reveal whether a GBV program has met its goals and objectives. Defining acceptable results will follow easily if goals and objectives are thoughtfully considered, realistic, attainable, specific, and measurable.

INFORMATION NEEDED TO MONITOR INDICATORS

The second step in the M&E process is to define the information needed to monitor the indicators. Indicators and measurements for M&E of any program are only as effective as the information collected.

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‡Chapter 4, Mainstreaming GBV Programs, describes the gradual progression toward integration.

CASE STUDY

After three months of mass information campaigns in the community, GBV survivors in one program started coming forward to report GBV incidents and seek assistance. However, health, psychosocial, security, and legal justice staff had not yet received GBV training or orientation.

Three survivors of child sexual abuse went through the hospital, police, and court systems without assistance or advocacy. The health examinations and court appearances traumatized the children. In the end, two of the three cases were dismissed for lack of evidence.

These three children were harmed by their experiences; it would have been better if their cases had not been reported. Nevertheless, the country director of the NGO starting this GBV program believes that the program is successful. The director's indicator of success is the number of reports; not the quality of service received.

Many assumptions about determining results that meet GBV program objectives and goals are made during program design, and must be well understood by program planners. For example, indicators that count the number of staff training sessions and awareness-raising activities will not reveal whether health staff have absorbed the requisite knowledge and skills and know how to use them to deal swiftly and effectively with a GBV incident. Instead, the indicator must be a measure for the knowledge and skills they actually attain; post-test results are one possible measurement.

GBV program design must include careful consideration of the kinds of information, both quantitative and qualitative, needed for monitoring and evaluation. Information needed to monitor program indicators is only part of what is necessary for effective M&E. Ongoing assessment of needs, knowledge, attitudes, and behavior is necessary to guide program activities and enable evaluation of program effectiveness.

The information required for M&E involves much more than the number and type of incidents. For example, individual GBV survivors will have different needs; contributing or perpetuating factors, will vary depending on the type of GBV the survivor experiences.

If M&E is the path to understanding program actions, then the interagency team, led by the GBV coordinator, needs a great deal of information.

RESOURCES

M&E tools from UNHCR and RHRC include a situation analysis guide, sample indicators for prevention and response, a recommended incident report form, and sample tracking forms for compiling incident report details.

Interagency Guidelines for Prevention and Response to SGBV *and RHRC's* GBV Tools Manual *are in press.*

Quantitative Incident Report Data

Incident and follow-up data should provide detailed information about the types and characteristics of GBV occurring as well as the outcomes of services provided. Programs should compile the following data for each type of GBV, without revealing any identifying information:

- Demographic data for survivors;
- Demographic data for perpetrators;
- Data about the incident location, day, time, and so forth;
- Number of days between the incident and the report;
- Survivor needs according to the assessment completed at the time the incident was reported, usually by a refugee or IDP counselor; and
- Services available and provided, including outcomes:
  - Psychosocial services (e.g., number of counseling sessions, number and type of referrals for skills training, income generation, support groups, and outcomes of the referrals)
  - Health treatment and outcomes
  - Police (e.g., number of arrests made, length of time between police report and arrest)
  - Formal justice system (e.g., number of case postponements, acquittals, and convictions; time period between arrest and final judgment)
  - Traditional justice system (e.g., number of cases heard and case outcomes)

Qualitative Incident Data

GBV is always underreported, and GBV program coordinators can assume that reported incidents represent only a small percentage of what is actually occurring in the community. One more challenge is to find a way to regularly and systematically gather, compile, and analyze qualitative information about unreported incidents as well as knowledge, attitudes, and behavior

concerning gender, power, and GBV. Gathering qualitative information requires participatory methods such as—

- Focus groups;
- Refugee or IDP GBV advisory groups consisting of comunity members; and
- Informal discussions with individuals in the community, observations, and transect walks through the setting.

Information from Counterparts

GBV is a problem, not a sector, and information must be gleaned from a number of sources and sectors, not just from GBV program staff and their activity notes. GBV programs have many counterparts in displaced settings, each with information relevant to GBV. Some examples of organizations and individuals that may be counterparts are the following:

- Unaccompanied children's programs,
- Child protection programs,
- Children's psychosocial programs,
- HIV/AIDS prevention programs,
- Health clinics,
- Schools and training programs, and
- Traditional healers and traditional birth attendants.

These groups and individuals can be sources of information and analysis of trends in the community. The information they provide can indicate needs, problems, issues, and successes related to GBV. Relevant information might be found in—

- Activities similar to those in the GBV program that provide insight into knowledge and attitudes in the community and might present an opportunity for partnership and coordination (e.g., dramas, peer education, and training workshops);
- Problems reported that indicate GBV risk among its participants; or
- Involvement of females and males in its programs and services, especially those conducted in schools.

Staff Supervision and Evaluation

Monitoring and evaluation of program staff and volunteers is also part of M&E. Regular observations of staff, and discussions with them, along with written performance evaluations, will reveal issues, challenges, and successes that can help in the design of staff training and support systems.

MONITORING TOOLS

Standard tools, forms, and report formats for M&E must be designed to gather, compile, and report on the requisite information from multiple sources. A typical M&E kit includes the following report tools, and use of these forms and tools must be incorporated into the training:

- Incident report forms;
- Incident report follow-up and case management forms;
- Staff training records, attendance sheets, post-test results, and performance evaluations;

- Community education records, attendance sheets, follow-up interview results;
- Program narrative and data reporting (summary) forms;
- Tracking sheets and log books; and
- Monthly report forms.

ANALYSIS OF DATA

Gathering, compiling, and reviewing information is only half of the M&E process. Analyzing and using the information is the reason for M&E. Data collected, shared appropriately, and analyzed properly help GBV programs draw conclusions about the nature and extent of the problem, the quality and effectiveness of services, and the effectiveness of program activities.

Good analysis requires time to think about and discuss the information. GBV staff meetings and interagency team meetings present a good opportunity to discuss, debate, analyze, and draw conclusions for action.

STRENGTHENING M&E

For valid reasons, M&E for GBV programs in refugee settings has been limited. The interactive and multisectoral nature of GBV program activities is one factor. There has also been a lack of resource materials to support effective M&E for GBV programs. Efforts have been underway for the past year to develop useful guidance and tools for M&E in GBV programs. A number of new M&E tools have been developed and field tested. They will offer GBV leaders and interagency teams concrete assistance for developing systematic and effective M&E to suit the needs of each unique setting. Over time, GBV programs will be able to demonstrate both the extent of the problem and the effectiveness of program activities.

CHAPTER 8

Using Data to Identify and Solve Problems

Collecting, compiling, and analyzing data about GBV is a key element in program monitoring and evaluation. Although data collection and analysis is one of the weakest areas in GBV programs, there is some data available; this chapter describes and analyzes the data gathered by the GBV Technical Support Project. This chapter also discusses the data problems identified in the field and recommends strategies to strengthen the use of data for program monitoring and evaluation.

One task of the GBV Technical Support Project is to collect and compile GBV incident report data from multiple field sites. The initial plan was for the GBV Technical Advisor to gather data reports during field visits and compile the information for analysis. The results were expected to increase understanding of the types and extent of GBV reported in the field and to serve as a start for global comparisons of GBV among displaced populations. This task proved to be nearly impossible.

FINDING DATA

Obtaining data and reports was the first challenge. The GBV TA found that none of the headquarters of organizations that serve refugees had one place where GBV incident report data was maintained and used to guide program planning and development. Some data and reports were kept in country offices or field offices of some GBV programs and were available from the GBV program coordinator. Sometimes refugee staff kept detailed notebooks about GBV incidents and the GBV TA could obtain some data by perusing these records. One cumulative data report covering one year and one country was obtained from UNHCR headquarters in Geneva. In all, the GBV TA collected one set of data from each of four GBV program sites.

A Problem of Definition

Comparison of the data was difficult because definitions of the different types of GBV vary from country to country and even from field site to field site within a country. *Sexual harassment* in one site might be *sexual abuse* or *sexual exploitation* in another. In the two years since the UNHCR highlighted these problems in *How-To Guide: Monitoring and Evaluation of SGBV Programmes, Kigoma and Ngara, Tanzania*, the problem of definition has not been resolved.

Inconsistent Data Collection, Compilation, and Use

Another problem was the inconsistency in forms and formats that field sites use to document incidents. The report from the 2001 SGBV Lessons Learned Conference in Geneva* recommended a universal Incident

**Prevention and Response to Sexual and Gender-Based Violence in Refugee Settings: Interagency Lessons Learned Conference Proceedings*, Geneva: UNHCR, 2001.

Report Form, but its use is not universal. Some sites do not document GBV incidents on the Incident Report Form; others complete Incident Report Forms only for rape and sexual assault. Some sites document certain types of GBV incidents in log books, which do not contain the same detailed information called for by the Incident Report Forms.

The data currently collected do not reflect all incidents reported and lack consistent demographic and situational information.

Data compilation itself is scarce, spotty, or nonexistent. Many sites lack monthly data reports on the number and type of incidents. Some sites compile data in great detail from time to time, but do not have systematic methods for data compilation; therefore, the compilation is extremely time-consuming and occurs only intermittently. Others collect data, but have not yet developed systems for compilation and analysis. One site had a collection of incident reports spanning almost three years, but they remained unused in a file drawer.

GBV staff are generally aware of the types and extent of GBV incidents being reported, but have very few, if any, hard numbers with which to monitor and evaluate their work. GBV programs seem to be guided by qualitative, subjective information and impressions. Although qualitative information is perfectly acceptable, most programs did not have consistent systems for collecting, compiling, and analyzing it.

Even with the limitations and challenges of finding incident report data, some of the collected numbers and reports proved useful. The following sections discuss three different sets of information:

1. GBV program data from four sites, collected by the GBV Technical Support Project during 2001–2002;
2. A child sexual abuse incident analysis report from Tanzania, 2000;
3. Detailed incident data from Tanzania, 1999–2000.

Each set of data yields different information that can be used for analysis and program guidance. The tables and figures demonstrate fairly simple ways to compile, analyze, and use data for M&E in GBV programs. They also indicate the potential of proper M&E and data analysis for program planning and design.

GBV INCIDENT DATA FROM FOUR COUNTRIES, 2001–2002

Table 8–1 describes the data available–or not available–during GBV Technical Support Project field visits in 2001–2002. As indicated, sets of data were obtained from Guinea, Sierra Leone, Tanzania,† and Zambia. The data do not cover the same months and same years; different countries use different definitions of incidents.

In most locations, the numbers available were cumulative rather than monthly. Table 8–2 shows the raw data collected. The last rows at the bottom of the table indicate the average number of reports during a one-month period in each country. This allows for some comparisons across countries and sites.

Population sizes in the program sites ranged from approximately 1,500 to more than 70,000. No population figures were provided for calculating reporting rates, so comparison of data within a single country or across different countries is limited. Population data would allow for calculation of the reporting rate per 10,000 population in each site—a rate comparable across sites and countries.

†Data from Tanzania were obtained from UNHCR for the purpose of demonstrating comparisons across four countries.

Table 8–1. GBV Incident Data Obtained by GBV Technical Advisor, 2001–2002

Country	GBV Program Initiated	Time Period and Type of Data Collected from the Site	Notes
Angola	Not yet	No data available	Program not yet in place
Eritrea	2001	No data available	Reporting system not yet in place
Guinea	1999	Cumulative totals for six sites during the period August–September 2001 (No monthly figures available)	System for documenting and compiling incident reports is still in progress; data are not compiled monthly or on a regular schedule. Data here are from one available report that compiled rape, sexual assault, and domestic violence reports for refugees during a two-month period and differentiated between adult and child rape survivors. The report also showed the health and legal justice follow-up provided. It was an excellent effort to compile information for program planning. It was, however, labor intensive and is therefore done infrequently.
Serbia	N/A	No data gathered	Database pending under Network of Trust project; will not be exclusively refugees and IDPs.
Sierra Leone	1998	July 2002 report for all five sites Includes Incident Reports in July and year-to-date cumulative totals	Recently developed a comprehensive format that summarizes GBV reports, health and legal justice outcomes. For refugees, IDPs, and local citizens. The data do not yet include details and demographic information about survivors, perpetrators, and circumstances surrounding the incidents.
Tanzania	1997	2001 cumulative totals for each of 11 sites(No monthly figures available)	Although Tanzania was not included in the GBV TA site visits, the year-end 2001 cumulative report was obtained from UNHCR. In Tanzania, GBV data for refugees are compiled and reported monthly, giving total numbers of GBV reports, by type and by site or camp.
Thailand	Not yet	No data available	Program not yet in place
Zambia	2001	Cumulative totals for one camp during the period May–July 2002 (No monthly figures were available)	Program is still in early stages. Reporting systems are in early design phases. Data were available for refugees and came only from GBV staff notes that included a wide range of community services problems, from public fighting to witchcraft. Data included here are only those reports most likely to be GBV cases.

Figure 8–1 shows the average number of all types of GBV reported during one month in one country. Again, it must be noted that data for the same month of the same year were not available from all sites. Given the differences from country to country and camp to camp in population and the length of time a program has been in place, a cross-country comparison is somewhat akin to comparing apples and fish. Nevertheless, the figure presents an estimate of GBV incidents reported in each country. If documentation and reporting were consistent across countries and camps, such a figure could raise questions that could be useful for M&E.

For example, why do Tanzania and Guinea report more GBV than Sierra Leone and Zambia? One possible answer is the length of time GBV programs have been operational in these countries. In Sierra Leone and Zambia, many sites are just beginning GBV programming, services are not yet fully in place, and communities are not yet well informed about help available; therefore, fewer reports would be received.

Table 8–2. Reported Incidents of GBV Gathered for Four Countries, by Country and Site, 2001–2002

Location	Time Period	Rape After Arrival (Adult and Child)	Rape Before Arrival (Adult and Child)	Rape of Child (Under 18 Years)	Rape of Adult (18 Years and Older)	Total Rape
Guinea						
Kountaya Camp	Aug–Sept 2001	0	8	4	0	12
Telikoro Camp	Aug–Sept 2001	0	21	0	0	21
Boreah Camp	Aug–Sept 2001	0	11	0	0	11
Sembakounya Camp	Aug–Sept 2001	0	4	2	0	6
Kouankan Camp	Aug–Sept 2001	0	0	0	0	0
Nzerekore town[a]	Aug–Sept 2001	0	5	2	0	7
All 6 locations	*Aug–Sept 2001*	*0*	*49*	*8*	*0*	*57*
Sierra Leone[b]						
Bo	July 2002	—	—	—	—	1
Gerihun	July 2002	—	—	—	—	3
Kenema	July 2002	—	—	—	—	5
Kono	July 2002	—	—	—	—	9
Pujehun	July 2002	—	—	—	—	4
All 5 locations	*Jan–July 2002*	—	—	—	—	*59*
Tanzania[c]						
Lugufu Camp	Jan–Dec 2001	25	0	—	—	25
Mtabila Camp	Jan–Dec 2001	34	0	—	—	34
Muyovosi Camp	Jan–Dec 2001	15	0	—	—	15
Nyarugusu Camp	Jan–Dec 2001	32	0	—	—	32
Mtendeli Camp	Jan–Dec 2001	32	7	—	—	39
Karago Camp	Jan–Dec 2001	38	13	—	—	51
Nduta Camp	Jan–Dec 2001	23	6	—	—	29
Kanembwa Camp	Jan–Dec 2001	22	1	—	—	23
Mkugwa Camp	Jan–Dec 2001	0	0	—	—	0
Lukole A Camp	Jan–Dec 2001	51	0	—	—	51
Lukole B Camp	Jan–Dec 2001	21	0	—	—	21
All 11 locations	*Jan–Dec 2001*	*293*	*27*	—	—	*320*
Zambia[d]						
Nangweshi Camp	May–July 2002	1	0	0	0	1
AVERAGE REPORTS PER MONTH						
Guinea total all 6 sites	2001	0	23.5	3.5	0	27
Sierra Leone total all 5 sites	2002	—	—	—	—	22
Tanzania total all 11 sites	2001	24.4	2.3	0	0	26.7
Zambia total 1 site	2002	0.3	0	0	0	0.3

Notes.
— Not available.
[a]Data covers two areas within the town with high refugee populations. During this time period, Guinea did not count data on early or forced marriages.
[b]Category for rape includes both child and adult survivors. Data include refugees, IDPs, and citizens.
[c]Tanzania is the only country here with data compiled for the specific category of "sexual harassment." It was defined as unwanted sexual bothering of someone for sexual purposes or using sexual acts, words, sounds, or implications. May include low-level physical contact, such as touching; can include threats of a sexual nature.
Notes (*continued*).

Table 8–2. *(continued)*

Location	Time Period	Attempted Rape	Domestic Violence	Early or Forced Marriage	Sexual Harassment	Other GBV	Total Reports
Guinea							
Kountaya Camp	Aug–Sept 2001	1	24	—	—	—	37
Telikoro Camp	Aug–Sept 2001	3	22	—	—	—	46
Boreah Camp	Aug–Sept 2001	0	5	—	—	—	16
Sembakounya Camp	Aug–Sept 2001	0	59	—	—	—	65
Kouankan Camp	Aug–Sept 2001	0	24	—	—	—	24
Nzerekore town[a]	Aug–Sept 2001	3	87	—	—	—	97
All 6 locations	*Aug–Sept 2001*	*7*	*221*	—	—	—	*285*
Sierra Leone[b]							
Bo	July 2002	0	0	0	—	0	1
Gerihun	July 2002	0	2	0	—	0	5
Kenema	July 2002	0	19	1	—	0	25
Kono	July 2002	1	5	3	—	0	18
Pujehun	July 2002	0	3	1	—	0	8
All 5 locations	*Jan–July 2002*	*4*	*80*	*4*	—	*2*	*149*
Tanzania[c]							
Lugufu Camp	Jan–Dec 2001	11	286	99	108	—	529
Mtabila Camp	Jan–Dec 2001	10	93	10	6	—	153
Muyovosi Camp	Jan–Dec 2001	4	104	3	1	—	127
Nyarugusu Camp	Jan–Dec 2001	4	70	14	4	—	124
Mtendeli Camp	Jan–Dec 2001	7	95	24	23	—	188
Karago Camp	Jan–Dec 2001	3	138	7	15	—	214
Nduta Camp	Jan–Dec 2001	9	129	9	5	—	181
Kanembwa Camp	Jan–Dec 2001	4	61	13	0	—	101
Mkugwa Camp	Jan–Dec 2001	3	80	1	28	—	112
Lukole A Camp	Jan–Dec 2001	3	903	6	1	—	964
Lukole B Camp	Jan–Dec 2001	0	510	5	0	—	536
All 11 locations	*Jan–Dec 2001*	*58*	*2,469*	*191*	*191*	—	*3,229*
Zambia[d]							
Nangweshi Camp	May–July 2002	0	15	1	0	*7*	24
AVERAGE REPORTS PER MONTH							
Guinea total all 6 sites	2001	3.5	110.5	0	0	0	141
Sierra Leone total all 5 sites	2002	1	*29*	5	0	0	57
Tanzania total all 11 sites	2001	4.8	205.8	15.9	15.9	0	269.1
Zambia total 1 site	2002	0	5	0.3	0	2.3	*7.9*

[d]The definitions used for rape and attempted rape are unclear. Incidents classified in Zambia camp records as "marital conflict" were classified here as "domestic violence" (a category that did not exist in the camp records). "Other GBV" includes cases classified as "unwanted pregnancy"; staff explained that these are often due to sexual exploitation and are usually unmarried women 16 to 22 years old, although it is likely that some are not GBV cases.

Figure 8–1. Average Number of GBV Reports in One Month, by Country

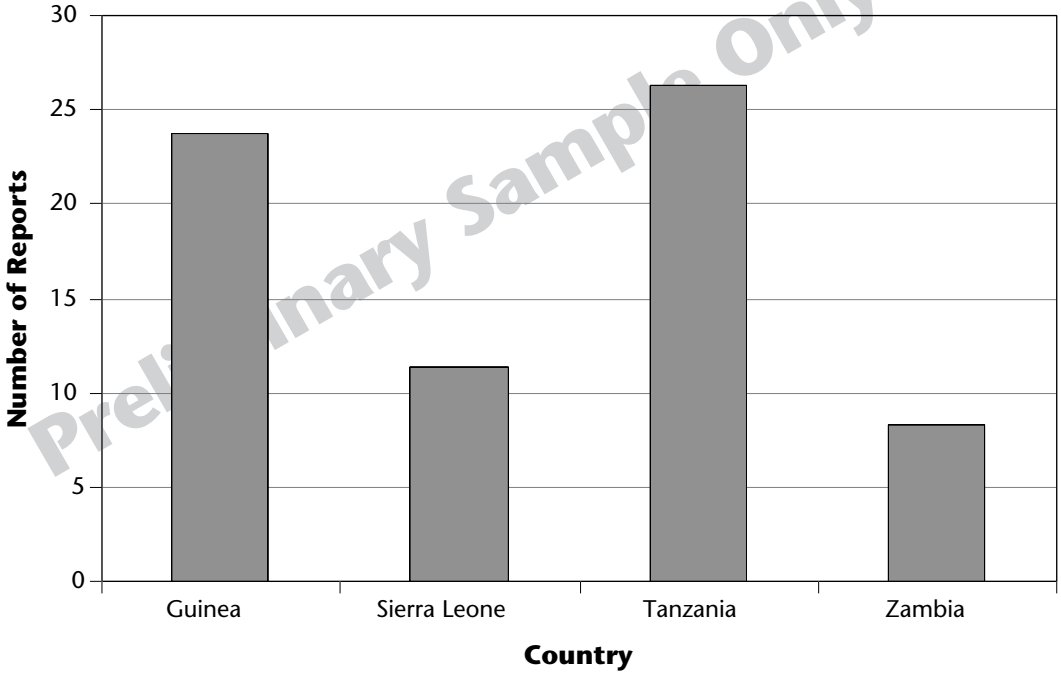


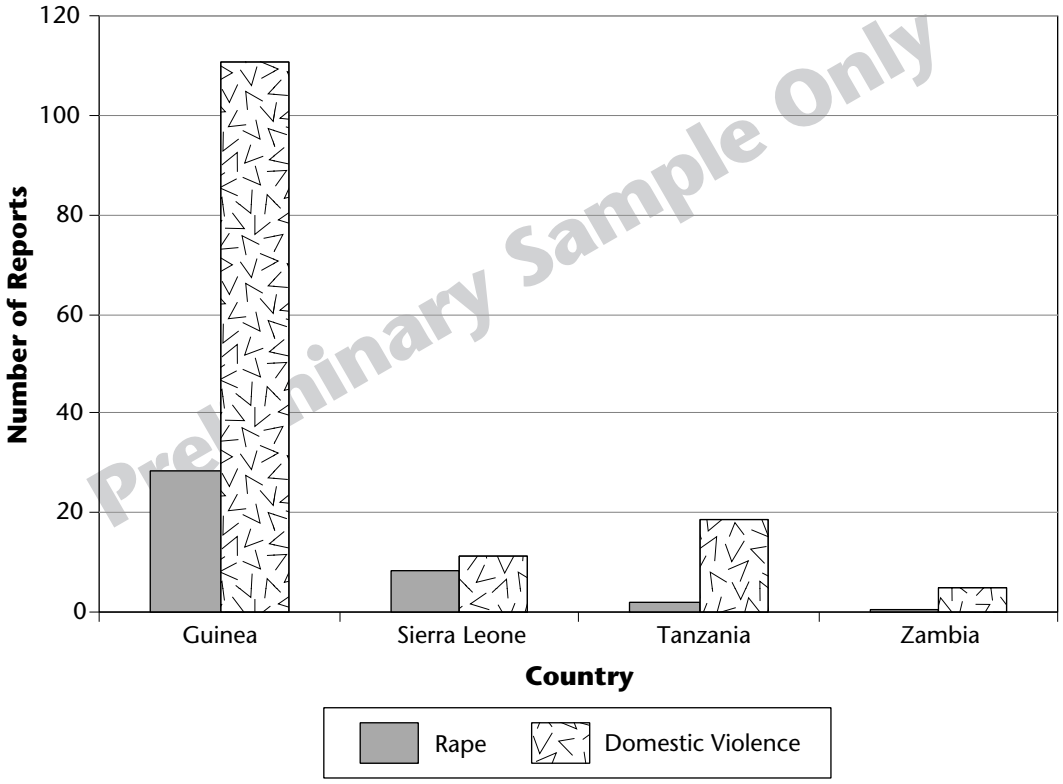
Figure 8–2 compares the number of reported rapes to the number of reports of domestic violence. Here, too, consistent documentation and reporting could raise useful questions. For example, given the close living environments in many sites, is domestic violence less hidden than rape? Or is it more acceptable to report domestic violence and seek assistance than to report rape? The low numbers for reported rapes could indicate that GBV programs need to do more outreach and community education to address the significant shame and social stigma attached to rape, thus encouraging survivors to report this type of crime.

PROMISING SYSTEMS IN SIERRA LEONE AND TANZANIA

Of all the data reviewed, the systems in Sierra Leone and Tanzania have the potential to yield the most useful data. Sierra Leone's monthly data report was revised mid-year 2002. It now includes numbers and types of incidents reported in each field site as well as follow-up and outcome data about health and legal justice interventions. Over time, this information will reveal trends and permit analysis that can guide program development. Sierra Leone is also designing a system to compile detailed data from Incident Report Forms so that they can monitor demographic and other information. This system will enable Sierra Leone's program staff to better understand who the survivors and perpetrators are and the nature of predisposing or contributing factors to the incidents, and thereby to design more targeted prevention and community education activities.

Tanzania developed its system in 2000, collecting and compiling incident data from all camps. UNHCR Community Services and Protection staff gather data reports from NGOs that provide GBV services in the camps and compile a country wide report of the types and numbers of

Figure 8–2. Comparison of Rape and Domestic Violence Reports in One Month, by Country



GBV reported each month. Tanzania also established detailed tracking sheets on which each NGO compiles demographic information and details about GBV reports. Since the GBV TA was unable to obtain copies, it was not clear whether NGOs were, indeed, tracking or compiling these details.

TANZANIA CHILD SEXUAL ABUSE DATA, 2000

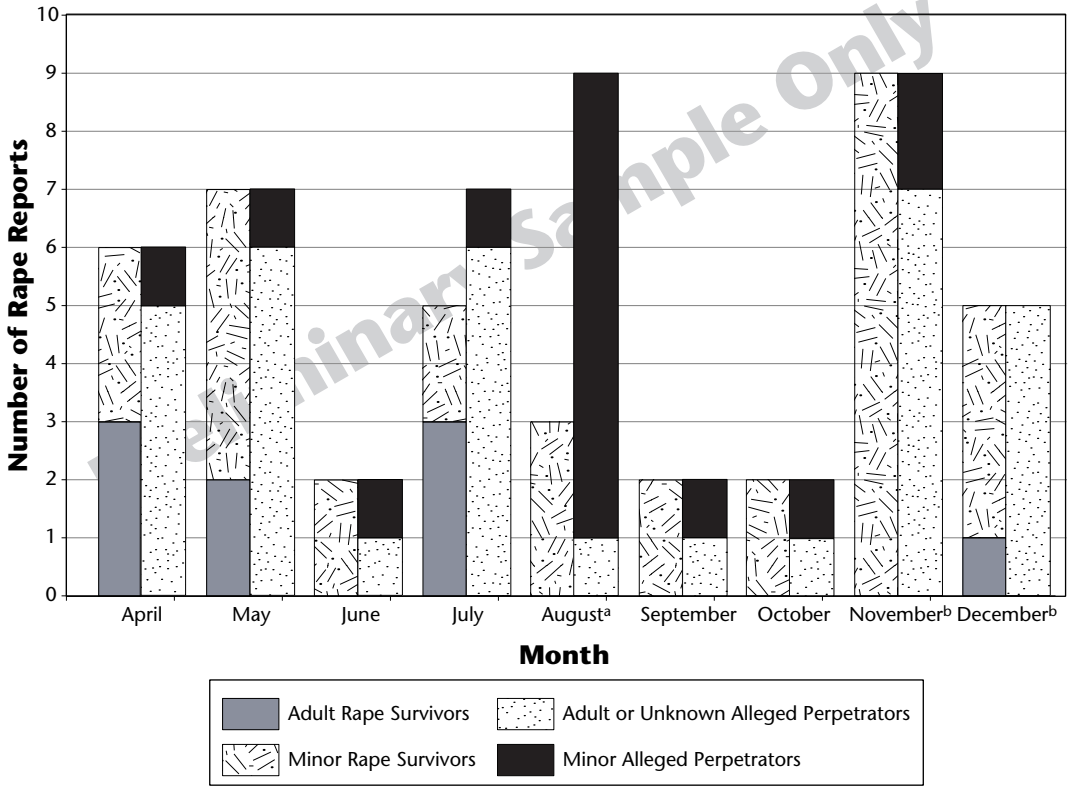
One interesting outcome of Tanzania's data collection system is that, in late 2000, UNHCR and NGOs in three camps "discovered" the problem of child sexual abuse (Figure 8–3). After compiling case details and reviewing the data collected on incident reports, the organizations were able to identify similarities between camps vis-à-vis the causes and predisposing factors leading to child sexual abuse, and go on to develop prevention activities. Although no follow-up report was available, the initial data collection and compilation provides an example of how to use data to guide program activities.

The Tanzania team compiled information from details in Incident Report Forms as shown in Figures 8–3 and 8–4. The team went on to compare the data with qualitative information that might be relevant about events and activities gathered from the camps, and then discuss the findings with community members.

After data review and discussions with the community, the Tanzania team made some conclusions about factors that seem to contribute to sexual abuse of children. These are summarized in Table 8–3.

The UNHCR, NGO, and refugee team then developed a list of recommendations for action to address the identified factors. It will be interesting to learn the outcomes of action taken and to see a repeat analysis of child sexual abuse incident reports. A follow-up report was not available at this time.

Figure 8–3. Rape Reports in Kasulu Camps, Tanzania, by Month, April to December 2000



Notes.

[a]In August, two incidents were each allegedly perpetrated by groups of four boys, six to nine years old.

[b]Between the end of October to early November, NGOs conducted mass public awareness campaigns about child sexual abuse in these camps. Reports for November and December were for incidents that occurred prior to these months; the increase in reported incidents is probably due to the increased public awareness.

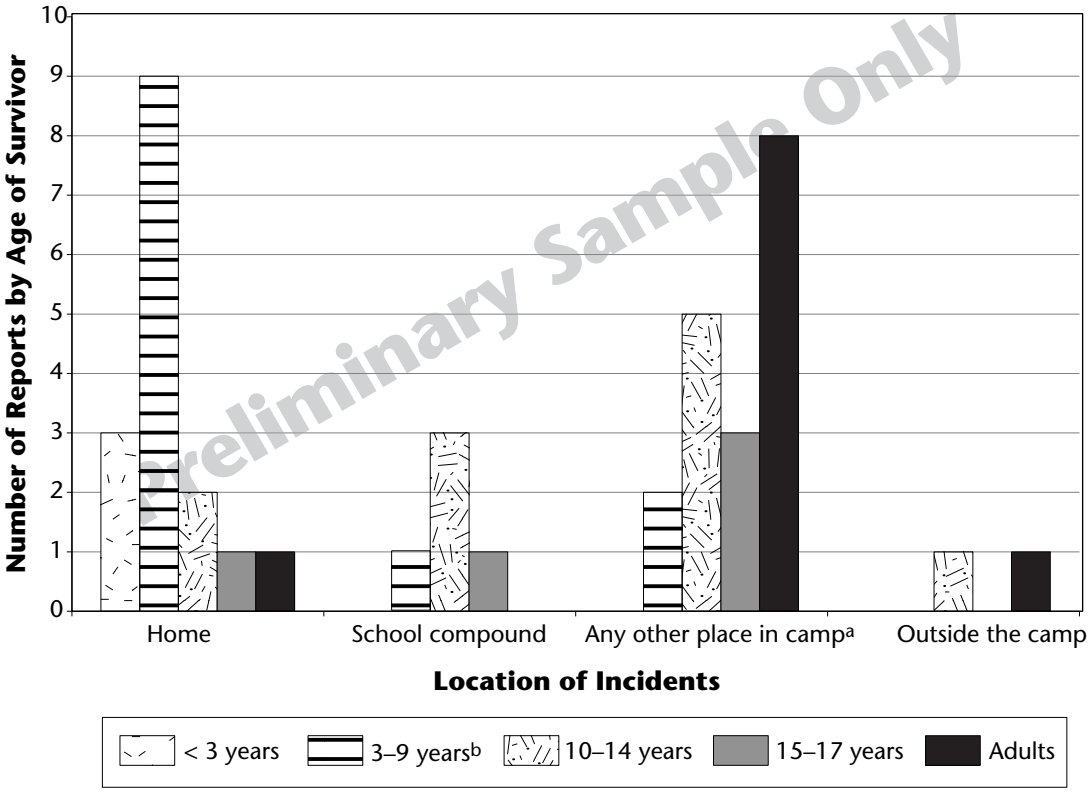
TANZANIA GBV INCIDENT REPORT DATA DETAILS, 1999–2000

The third set of information was the only detailed site wide GBV incident data analysis available; it was gathered and compiled by the GBV Technical Advisor in 2000. Data were gathered from Incident Report Forms and entered into a Microsoft Excel spreadsheet. The raw data was then used to create tables, charts, and graphs, using Excel Wizards and other functions. The result is a collection of simple analyses that could be replicated in any field site and yield a greater understanding of GBV for monitoring and evaluating progress and guiding strategies for preventing and responding to GBV.

Source, Methodology, Quality of Data

The data were obtained from Incident Report Forms on file with the International Rescue Committee in Kibondo, Tanzania. When a survivor reported a GBV incident, a refugee counselor in IRC's GBV program completed a standard Incident Report Form in Swahili. The form collected demographic data on both the survivor and perpetrator (if known), details about the incident, and notations of initial referrals and immediate interventions by health, protection, police, community leaders, and other actors. The forms include only information available at the time they were completed (the time of the survivor's initial report), and do not provide details of later follow-up actions and outcomes.

Figure 8–4. Rape Reports in Kasulu Camps, Tanzania, by Survivor Age and Incident Location



Notes.

[a]"Any other place in camp" was usually neighbor, relative, or friend's house.

[b]Most incidents with children under age 10 occurred when they were alone at home.

In Kibondo in 2000, an IRC refugee supervisor reviewed all incident reports on file that were received during the six-month period from August 1999 through January 2000. The supervisor transferred the data onto a spreadsheet; a clerk later entered the data into an Excel spreadsheet.

Many fields on the incident reports were incomplete. Therefore, the data analysis here is limited; conclusions must be considered preliminary and used only as examples. There were inconsistencies in the designation of the type of incident reported. For each report, the narrative description was reviewed to confirm proper classification and many were reclassified.

Analysis

The following tables and figures demonstrate useful visual presentations that can be achieved with data collection, compilation, and analysis. It is important to note, however, that the validity of the data presented here is questionable because of the limitations described above. Therefore, they should be viewed as samples of what can be done, *not* as hard numbers.

Number of Reports and Report Rates

Table 8–4 shows the reporting rate per 10,000 population for rape and attempted rape, assault (intimate partner physical abuse), and the totals of all types of GBV reported. The rates are indicated for four camps (Kanembwa, Mkugwa, Mtendeli, and Nduta) for each month in the six-month

Table 8–3. Possible Contributing Factors for Child Sexual Abuse in Tanzania

Age Group	Possible Contributing Factors
Under 10 years	■ Children are left alone at home when parents leave to fetch water or firewood, visit market, church, food distribution centers, or to visit relatives and friends. ■ Children are left with entrusting relatives, neighbors, or friends. ■ Children are hungry or not properly fed; people use food to entice them. ■ Children at this age are curious. When parents and children share a bedroom, children have the opportunity to observe their parents having sex, thus exposing them to the practice. ■ Myths: for example, some witch doctors tell men that if they insert a penis into a child's vagina, it will brighten their lucky star for wealth and fortune. ■ Traditional practices create communication gaps between children and parents (e.g., not talking about sex).
11 to 14 years	All of the above factors, plus ■ Adult men take advantage of attractive and sexually active young adolescent girls. ■ Children are exposed to sexual video shows and magazines. ■ Girls who live with single parents and unaccompanied minors are at greater risk. ■ Survivors lack information about reproduction and reproductive health. ■ Gender expectations and limitations, such as the lack of decision-making power among females, increase the risk for this age group.
15 to 17 years	All of the above factors, plus ■ Poverty: some males perceive that lack of money or status will prevent them from having an adult girlfriend or sexual partner. ■ There is a real threat that if the victim tells anyone, she will be viewed as guilty and will be punished. ■ People believe that young girls are free of STDs and HIV/AIDS. ■ Girls are easily tricked with promises and gifts. ■ Young girls are sent alone to fetch water or firewood. ■ Poverty and sexual exploitation: people exchange sex for money, clothing, food, and alcohol.

period. Calculating the reporting rate per 10,000 population allows for better comparison of numbers across sites, taking into account the population differences. The calculation requires knowing the population and the number of reports during the designated time period. For this reason, it is important that all sites obtain population figures for each GBV program site every month.

Table 8–4 shows the dramatic differences between camps for reported GBV incidents. An effective M&E strategy would be to determine the reasons for the wide variance. For example, the GBV coordinator could examine whether documentation is collected more consistently and thoroughly in some camps. She could also look at differences in awareness-raising and outreach activities or cultural and societal differences between camps. Such an M&E exercise conducted every month, would be useful to monitor changes over time and to continually probe the reasons for the fluctuations month-to-month and camp-to-camp. For example, the report rate of rape and attempted rape in Nduta camp increased from 0.20 per 10,000 to 1.49 during these six months. Calculating the report rate for the months following this six-month snapshot will show whether rapes and attempted rapes are increasing and will raise questions about why they are increasing.

Incident Details

The data below take data analysis and its usefulness for M&E one step further. By examining the details surrounding GBV incidents, the GBV program coordinator can tailor prevention and response strategies to address GBV within particular sites. By following up with more M&E after changes are made within individual camps, the GBV program coordinator

Table 8–4. GBV Reporting Rates in Four Camps, Tanzania, August 1999–January 2000

Month	Camp	Report Rates: Rape and Attempt Per 10,000	Report Rates: Assault Per 10,000	Total All GBV Reports Per 10,000
January 2000	Mtendeli	1.26	1.89	**4.21**
January 2000	Kanembwa	—	—	—
January 2000	Nduta	0.20	0.20	**0.40**
January 2000	Mkugwa	—	—	—
December 1999	Mtendeli	—	2.30	**2.93**
December 1999	Kanembwa	0.57	1.72	**2.30**
December 1999	Nduta	0.41	0.20	**0.61**
December 1999	Mkugwa	1.00	1.92	**5.76**
November 1999	Mtendeli	1.45	1.56	**2.45**
November 1999	Kanembwa	1.73	1.16	**4.05**
November 1999	Nduta	—	0.67	**0.67**
November 1999	Mkugwa	—	—	**16.30**
October 1999	Mtendeli	1.50	1.76	**2.77**
October 1999	Kanembwa	0.58	7.53	**8.69**
October 1999	Nduta	0.22	0.45	**0.67**
October 1999	Mkugwa	—	—	—
September 1999	Mtendeli	0.55	6.34	**6.89**
September 1999	Kanembwa	1.76	1.76	**4.11**
September 1999	Nduta	1.23	1.23	**2.45**
September 1999	Mkugwa	8.00	—	**8.00**
August 1999	Mtendeli	1.07	4.70	**6.20**
August 1999	Kanembwa	1.71	2.85	**4.55**
August 1999	Nduta	1.49	0.74	**1.72**
August 1999	Mkugwa	—	8.00	**8.00**

Note. — Not available

Figure 8–5. Percentage of All Types of GBV Incident Reports by Time of Day, Mtendeli Camp, Tanzania, 1999–2000

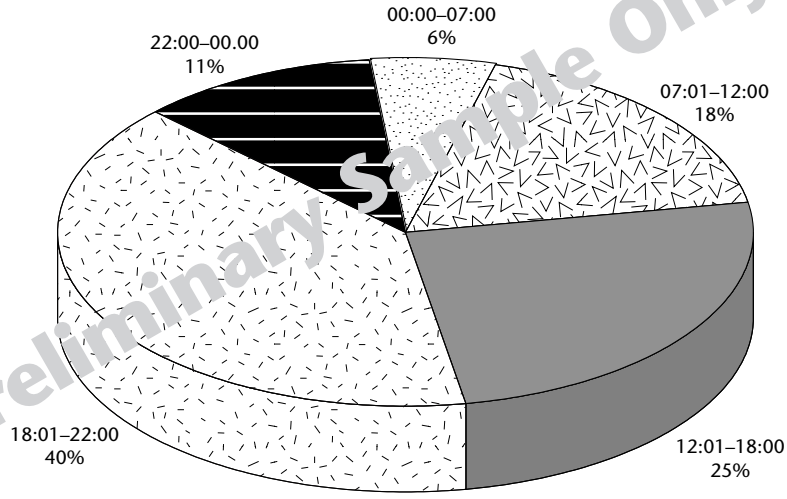
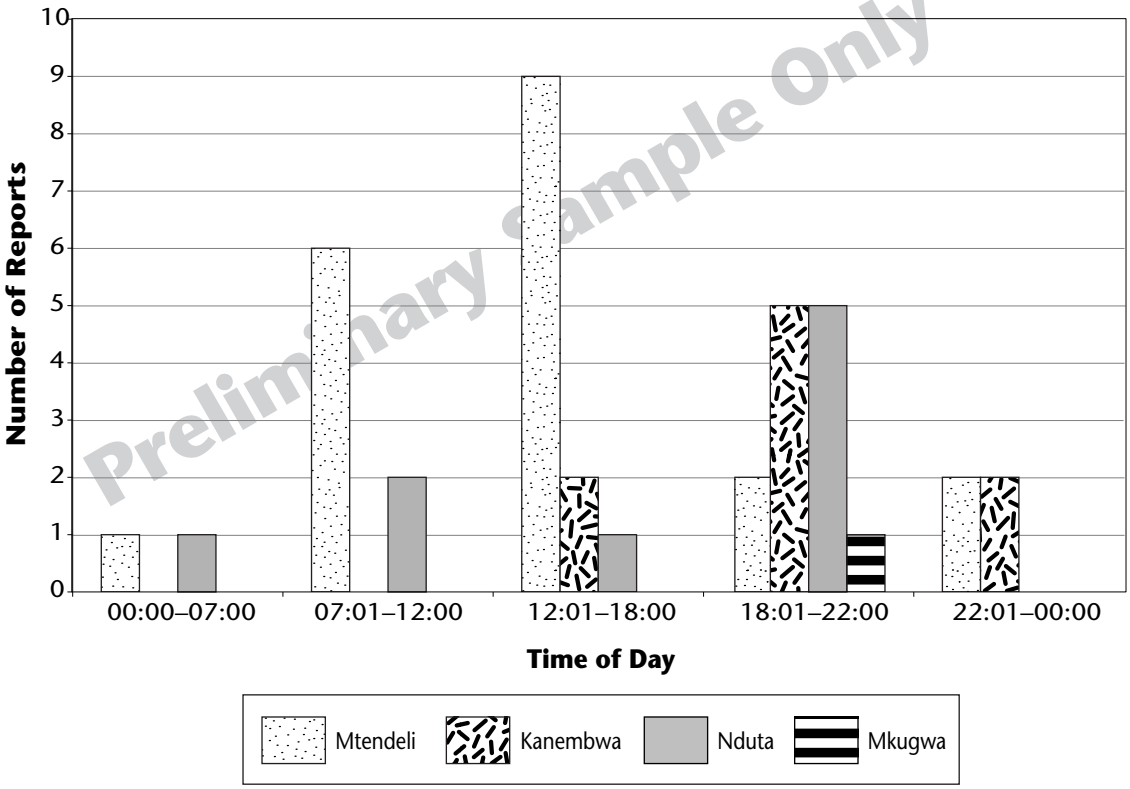


Figure 8–6. Rape Reports in Four Camps by Time of Incident, Tanzania, 1999–2000



could then apply what works in one camp to another camp. Thus, the data become useful to more than one setting.

Time of Day of the Incident

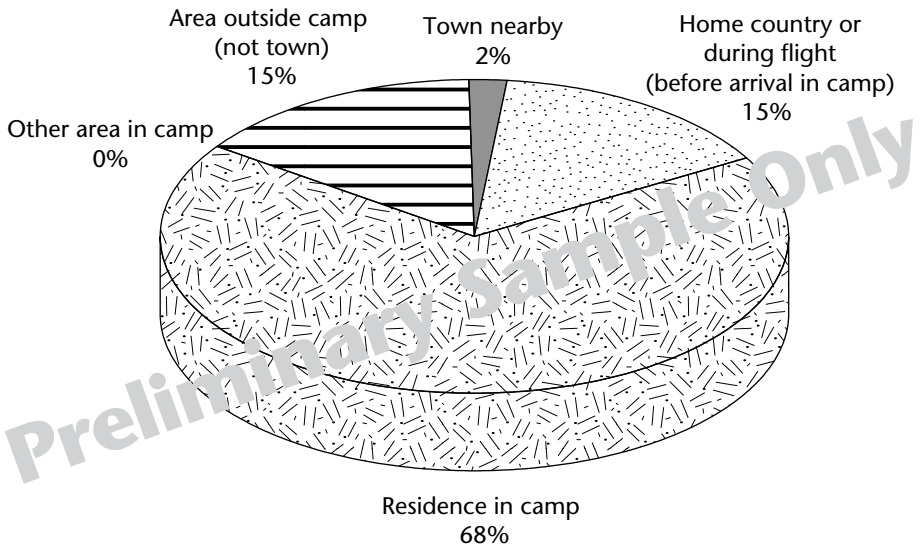
Effective prevention strategies require an understanding of the causes and contributing factors to GBV incidents. Figure 8–5, a sample pie chart, examines one possible contributing factor: the time of day an incident occurs. This pie chart was developed from *all* reported incidents during the six-month period in Mtendeli Camp. A surprising factor was that nearly half (43 percent) of all incidents occurred during daylight hours, from 07:00 to 18:00. Is this particular time period significant? And, given that the other 57 percent of incidents reported occurred at night, the GBV team might want to consider lighting or other possible prevention strategies.

Another figure examines the significance of the time of day for reports of *only rape* in all four camps. Figure 8–6 shows that in Mtendeli, the majority of rapes reported occurred during daylight hours. The GBV coordinator could check data to learn where the incidents occurred; this information might help the team understand why higher numbers of rape occur during daylight hours when the perpetrator could be seen.

Location of the Incident

A few simple keystrokes in Excel reveal important information about the locations of rapes reported in all four camps for the entire six-month period. Figure 8–7 demonstrates that the greatest majority of reported rapes occurred in residential areas of the camps, not outside while survivors collected firewood, as is commonly believed. This information could be

Figure 8–7. Percentage of Reported Rapes in Four Camps During Six Months, by Location, Tanzania, 1999–2000



essential for designing prevention strategies. Although many programs claim that distributing firewood is the primary way to prevent rape in displaced settings, the numbers in this table seem to dispute that claim, at least for these camps during this time period. For effective M&E, a GBV coordinator could develop a figure like this one for each camp. GBV staff might gather more information about exact locations, that is, whether the rape occurred in the survivor's house or elsewhere.

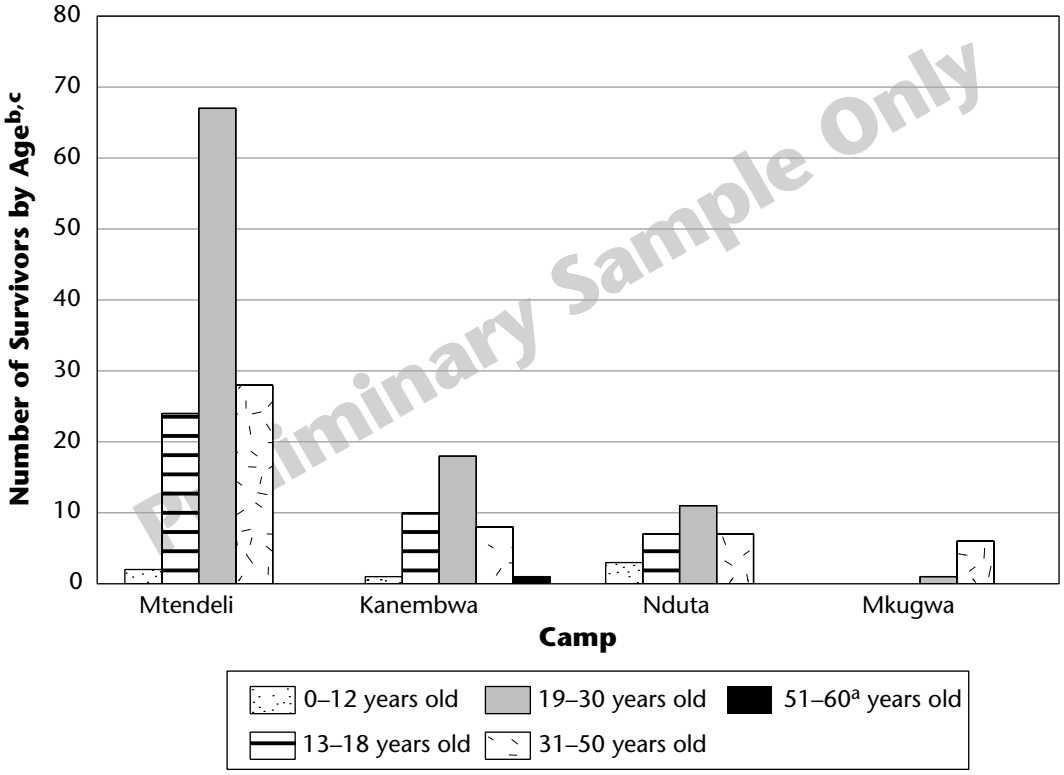
Survivor Age

The age of survivors is essential information for GBV programs. Figure 8–8 clearly shows that the majority of victims reporting GBV incidents are women aged 19 to 30. The GBV program coordinator could use this information to institute an assessment of the characteristics or behaviors of this age group that result in a higher number of rape reports. For example, survivors of this age may be more likely to report incidents than younger or older survivors. If the data truly reflect actual incidents within the age group, and bearing in mind that not all GBV survivors report all incidents that occur, the GBV program could target this vulnerable group with community-awareness campaigns.

Perpetrator Relationship to the Survivor

An analysis of the perpetrator's relationship to the survivor in Figure 8–9 shows that the majority of perpetrators are husbands. Interestingly, the data here show similarities to the data in Figure 8–2 and Table 8–2, which demonstrated the higher number of reports of domestic violence compared to other types of GBV in four countries in 2001–2002. If the GBV program

Figure 8–8. Reports of GBV in Four Camps During Six Months, by Age of Survivor, Tanzania, 1999–2000



Notes.

[a]There were no reported survivors over age 60 during this time period.

[b]The total number of incidents in all four camps was 186; the total number of survivors was 194. This discrepancy between numbers is another example of the problems and limitations of the data.

[c]A few reported incidents included multiple survivors, ages 13 to 60.

coordinator were to disseminate the information from Figure 8–9 in the community, it might promote stronger campaigns to prevent domestic violence and perhaps lead to stronger social sanctions against the perpetrators. The GBV program coordinator could also examine the perpetrator's relationship to the survivor only for incidents of rape, discovering information that could help with rape prevention.

Time Between an Incident and a Call for Help

All the incident reports compiled for this data analysis included notations of the date of incident and the date the GBV counselor received the incident report from the survivor. Figure 8–10 shows that most rape survivors report an incident within three days; this is a good thing because prompt health care could have been provided. Because many fields on the Incident Report Forms used for this analysis were left blank, the data do not show whether survivors received health care when they reported the incident to the GBV counselor. Numbers such as these would be useful to the GBV coordinator who could assess whether survivors are receiving prompt, adequate health care and other appropriate services.

For example, the GBV team could develop community awareness campaigns that target potential rape survivors. The campaigns could communicate the importance of prompt health examinations and treatment after

Figure 8–9. GBV Incidents in Four Camps During Six Months, by Perpetrator's Relationship to Survivor, Tanzania, 1999–2000

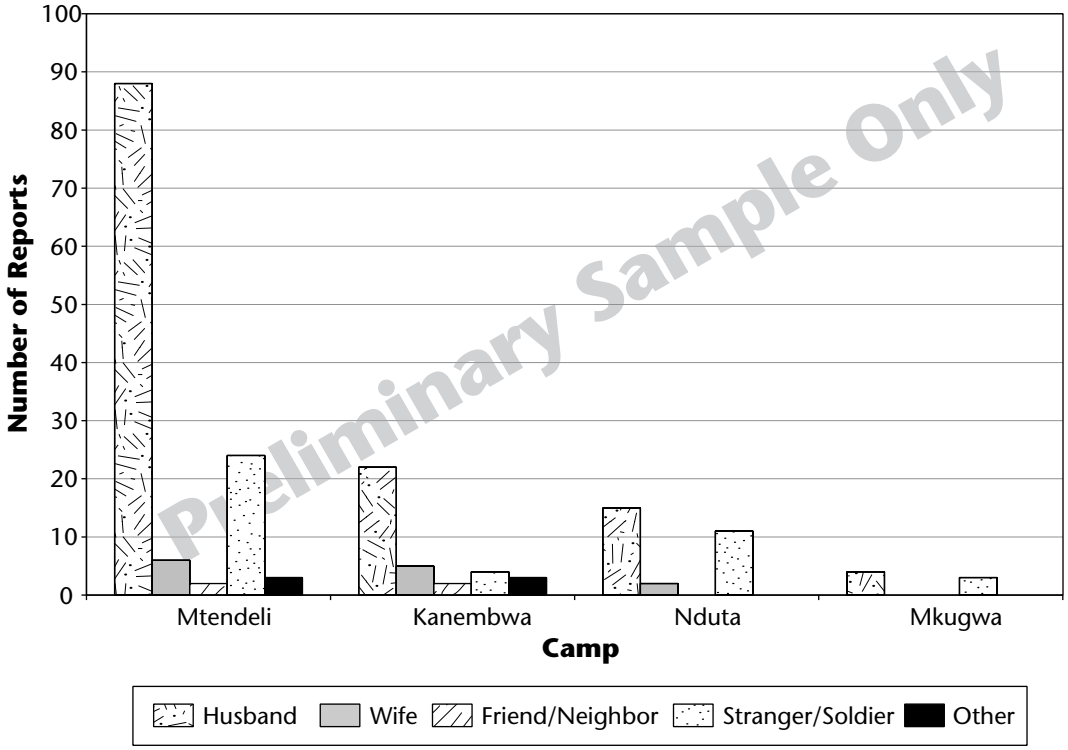
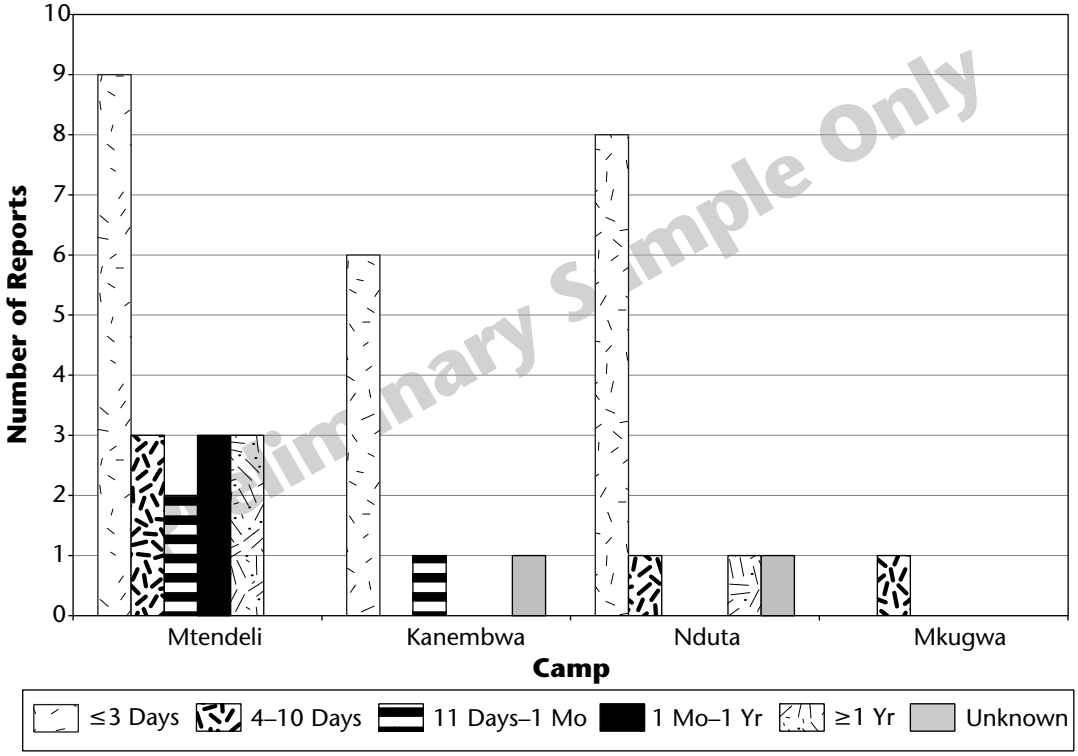


Figure 8–10. Rape Reports in Four Camps During Six Months, by Time Between Incident and Report to GBV Program, Tanzania, 1999–2000



rape occurs. This kind of targeted approach for potential survivors is possible when Incident Report Forms include demographic data about survivors and information is gathered, compiled, and analyzed. As a further use for M&E, the GBV program coordinator could conduct a more in-depth analysis of the cases who report *after* three days; this information could be used for community awareness campaigns or other strategies to promote quicker reporting by more survivors.

IMPROVING DATA COLLECTION AND ANALYSIS

The challenge for instituting and improving data collection and analysis is analogous to monitoring and evaluation. Both these areas are often difficult for humanitarian workers, who are already pressed by lack of time and resources. Nevertheless, GBV programs need more and better information to understand GBV in the setting where it occurs and to target program activities.

Staff in all GBV field programs can, and should, take immediate steps to improve collection and use of quantitative data, as follows:

The new GBV Tools Manual *from the Reproductive Health for Refugees Consortium (in press) will include specific GBV definitions and terms recommended for consistent use at all sites. Over time, with consistent definitions and data collection, information can be gathered and compared globally. This will build a greater understanding of GBV in populations affected by armed conflict and can guide development of GBV prevention and response programs.*

1. All staff should use a standard Incident Report Form. Supervisors should properly train and supervise staff in its use and ensure that all fields on the form are completed.
2. The interagency team should establish common, consistent definitions for the various types of GBV occurring in the setting. Supervisors should train and supervise staff to appropriately classify and define incidents reported to them.
3. GBV coordinators should develop and use tracking and compilation forms (computerized or handwritten) to compile details for incidents, follow-up, and case outcomes.
4. The GBV program coordinator should review compiled data and discuss them with staff and the interagency GBV team to analyze trends, ask questions, and learn about issues that need further probing through qualitative methods.

The investment in time and resources for proper data collection, analysis, and monitoring and evaluation will lead to valuable guidance for GBV programs. The end result could be a reduction in GBV and improvement in the lives of displaced people—the payoff that makes M&E and data analysis worthwhile investments.

CHAPTER 9

Defining Counseling

GBV counseling can help victims become survivors and regain control over their lives. This chapter describes some of the do's and don'ts inherent in GBV survivor counseling.

The most frequent request from staff who provide psychosocial services to GBV survivors is for counseling training. They say, "We want to learn how to solve GBV cases," but this simple request is actually an indication of many questions that lie underneath: How can we convince a survivor to come forward and tell us her story? How can we stop long-standing marital conflicts? How do we keep families together and also stop the violence? What should we say to make her feel better?

These questions reflect the challenges and frustrations of this work. Addressing these questions and supporting counselors in their efforts to help survivors, requires more than training alone. GBV programs must clearly understand and define counseling in the setting, incorporating survivor needs, various types of counseling, community norms and beliefs, and traditional counselors that may already exist in the community.

WHAT IS COUNSELING?

The term *counseling* abounds in multiple meanings, definitions, styles, and connotations. There are variances even within the classic helping professions of psychology, social work, psychiatry, and theology. However, counseling, in one form or another, probably exists in all cultures.

A counselor is—

- *An advisor*
- *A guide*
- *A confidante*
- *An advocate*
- *A teacher*
- *A mentor*
- *A director*
- *An instructor*

In GBV counseling, an effective counselor is a trusted confidante who listens, reassures, and accepts the survivor; guides her in exploring options and deciding what, if any, action she wishes to take; and advocates for her if she needs and requests such assistance.

Empowerment and confidentiality are the key concepts in GBV counseling. Establishing effective counseling services requires a thorough understanding of the specific community as well as the spectrum of GBV counseling methods and challenges.

Here are some facts to keep in mind:

- Many victims of domestic violence want someone to tell the abuser to stop, but this intervention is inappropriate for a GBV counselor to undertake.
- GBV counselors do not necessarily know what is right for the survivor; one solution does not fit all individuals.
- GBV counseling will not solve the survivor's problems; rather, it should facilitate the client's own decision-making processes.

- GBV counseling is not the same as mediation and conflict resolution.
- GBV counselors must remain safe and secure. Working with perpetrators is risky and requires special planning and consideration.
- GBV counseling can be extremely rewarding; it can also be intensely frustrating with no sense of "finish."

Table 6–1, a suggested training plan for GBV program staff at the end of Chapter 6, Building Human Resources, includes training topics and learning objectives.

Counseling usually calls for providing emotional support and dealing with issues of economic empowerment and social reintegration that can reduce risk and vulnerability for GBV. Unfortunately, even counselors who have had the requisite training (and most have not) lack clear guidance to what they should and should not do. Current GBV counselor training tends to focus on learning active listening skills and leaves the aims, purposes, and limitations of such counseling unclear. Defining and clarifying the counseling component of the GBV program is a companion issue to that of defining and building the capacity of the GBV staff. A discussion of staff training and supervision appears in Chapter 6, Building Human Resources.

THE COUNSELORS: ISSUES AND CHALLENGES

Most GBV counselors are members of the community and carry with them community attitudes, values, and beliefs about gender relations, conflict, and problem solving.

Experience in identifying and dealing with the psychosocial problems of refugees (including posttraumatic stress disorders) is limited. Any program dealing with mental health must be community based with the refugees themselves playing a major role. The program must be based on a solid knowledge and understanding of the refugees' cultural background and integrated with the other services provided to refugees, and, from the outset, its long-term sustainability must be ensured.

—The UNHCR Handbook for Emergencies (Geneva: UNHCR, Second Edition)

In many settings, after receiving as little as five days of training in human rights, gender and GBV issues, and counseling skills, counselors go straight to work with survivors. New counselors who come on board after the program has started are often trained on the job, with only a slightly more experienced staff counselor at their side. The training cycle is sometimes repeated if a large number of new staff is brought in at once. Continuing education is intermittent and often set aside due to the large number of administrative and documentation issues that must be addressed at staff gatherings. Also, organizational understanding and commitment to the GBV program (as discussed in Chapter 4, Mainstreaming GBV Programs) will affect staff capacity building in that there may be insufficient funds and time allotted for staff training, supervision, and continuing education.

In most GBV programs, refugee staff duties and responsibilities include both counseling of individual survivors (response) and leading participatory learning activities with the larger community (prevention). This dual role can be very challenging for some staff members. Some people who may be gifted counselors are not effective community mobilizers, and vice versa. Additionally, there is a significant psychological toll levied on counselors over time. Counselors' frustrations in not being able to solve GBV cases will often take them out of a supportive role and into a stronger advice-giving role, which negates the idea of empowerment. Counselors should help to guide survivors to decisions, not make those decisions for them and not tell them what to do.

Counselors can help survivors, or can inadvertently harm them with ill-informed good intentions and even perpetuate GBV. This can happen if the purposes and limitations of counseling are not clearly understood, if the training program does not deal with all the ramifications of GBV and counseling, and if supervision is not vigilant. The case study on the next page is an unfortunately common illustration of what can happen if counselors lack a clear purpose and vigilant supervision.

Most displaced women regard domestic violence as their most overwhelming GBV problem. Once aware of the concepts of human rights and gender equality through the GBV program, they want the abuse to stop. And they

want someone to tell the abuser to stop. Counselors untrained in such intervention do not know how to respond.

Over time, the counselors become frustrated over their inability to solve the cases that come to them. Without adequate training and careful supervision, many counselors succumb to deep-seated societal norms about GBV and apply them in their work with survivors, especially in domestic violence cases. The counselor calls the husband in, and in an attempt to mediate the case, typically advises him to stop hitting his wife and advises the wife to be more obedient.

This kind of action is potentially dangerous to the counselor and harmful to the survivor. There are reports of abusive husbands physically attacking GBV staff. There are also rumors of women committing suicide after reporting domestic violence and being told to be more obedient. Unfortunately, incidents such as these have not been documented or included in program data.

Training and supervision of GBV counselors must continuously address these attitudes and beliefs. Gender awareness, commitment to gender equality, and understanding of the endemic and complex issues inherent in GBV builds over time. It requires repeated discussions, vigilant guidance, and careful supervision.

GBV programs can avoid these challenges by addressing these fundamental questions in the design phase:

- How do we define counseling in the individual setting?
- What are the purposes of the counseling we will provide in this setting?
- Who are potential counselors?
- What do the counselors need to work effectively?

To answer these questions, program designers must understand the community. Programs should incorporate the following features:

- Culturally appropriate interventions, including existing traditional practices, for emotional support and healing after traumatic events.
- Survivor needs, both immediate and long term.
- The qualities, skills, and knowledge base of potential counselors, that is, the human resources in the community.

Accepted methods for emotional healing in communities can include the following:

- *Ceremonies*
- *Rituals*
- *Rites*
- *Western psychotherapy*
- *Art and play therapy*

CASE STUDY

I heard a lot of opinions that made me question staff's understanding of and commitment to their work…. A more important issue was how GBV staff also shared the exact normative factors that contribute to high rates of rape and domestic violence, and impunity of perpetrators. Domestic violence occurred because wives did not want to obey, I was told, and so the role of the counselors would often be to "help her to accept." Rape, likewise, happened because the women were not careful enough or because women wore provocative clothing.

—A consultant on temporary assignment with a GBV program in Africa, 2002

COMMUNITY NORMS AND TRADITIONAL COUNSELING METHODS

Methods for emotional support and healing after a traumatic event differ among cultures, societies, regions, and countries. The practices range from ceremonies and rituals to "western" psychotherapy.

GBV program planning must include an assessment of traditional, customary, and accepted methods for healing trauma in the community being served. Indeed, the community may already have a valued form of counseling in place.

Belief, faith, trust, and respect are central to healing. To a great extent, the benefit of any emotional-psychological healing practice is directly related to a personal conviction that the practice is valuable and effective.

Refugees from urban areas in the former Yugoslavia, for example, may believe in the value of individual talk therapy with a professional psychotherapist. In contrast, rural Sierra Leoneans may have faith in traditional healers and group ceremonies. Rwandans may seek advice from trusted elders. And, the religious in any country may find comfort in their spiritual and religious practices and beliefs.

RESOURCES

Mental Health of Refugees *(Geneva: WHO/UNHCR, 1996) includes a discussion about traditional practices and healers, guidance on how to recognize and build cooperation with traditional practitioners, and how to deal with dangerous traditional practices.*

Individual personal preference will vary. Not all Sierra Leoneans believe in traditional healing; not all Yugoslavs have faith in psychotherapy; not all Rwandans respect the advice of elders; not all Catholics believe that prayer will heal them. In other words, not all GBV survivors want or need the same type of counseling. Indeed, some may not want—or need—any counseling at all.

Any customary practices that are not harmful or dangerous should be incorporated into the GBV program's plan for psychosocial assistance. Ceremonies and rituals can have especially great value for survivors, and there may be ways to adapt existing practices to specifically address GBV issues.

Western talk-therapy models of counseling are unfamiliar to clients in most displaced communities, and the appropriateness of using this type of service should be carefully examined.

Also, systems already in place for resolution of conflict should be taken into account. The norm may be for elders or other community leaders to hear and adjudicate cases of rape, domestic violence, forced marriage, and other forms of GBV. Adjudication usually includes advising (a form of counseling) both the perpetrator and the victim, and defining a course of action.†

NEEDS-BASED ASSISTANCE

There is a difference between psychosocial *need* and psychosocial *assistance*. The terms are often confused but, in fact, one should build upon the other.

Psychosocial needs of a GBV survivor are determined by the nature and extent of emotional, psychological, and social trauma, 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 some formulaic intervention. It requires an assessment of psychosocial functioning: unmet needs, personal strengths, and abilities. Some survivors need a great deal of help. Others need only reassurance and a little information.

†These traditional courts and tribunals are discussed in greater detail in Chapter 11, Partnering with Traditional Leaders.

There are certain predictable emotional, psychological, and social after-effects associated with different types of GBV. Table 9–1 includes a brief list of the most common after-effects of GBV and examples of possible interventions. It can serve as a rough guide to the realm of psychosocial counseling with GBV survivors.

The GBV counselor must be trained and carefully supervised if she is to conduct an assessment and, together with the survivor, develop a plan to address the survivor's needs. An effective plan should include an array of actions and services to reduce suffering and to increase functioning. In addition to counseling, the plan may also include help in the following areas:

- Social and economic empowerment through skills training, income generation, and loan programs.
- Social reintegration through group activities.
- Social acceptance through supportive community attitudes.

THE COUNSELORS: QUALITIES, SKILLS, KNOWLEDGE

Counseling and other assistance can be rendered to the survivor by family members, religious leaders, police officers, doctors, and a host of others in the community, as well as by GBV counselors.

Counselors might be—

- *GBV staff*
- *Elders*
- *Traditional healers*
- *Peers*
- *Religious leaders*
- *Mental health counselors*

The person the survivor tells her story to could be anyone in the community; frequently it is someone with no special knowledge or expertise in GBV counseling. At the least, that person can provide—

- A supportive, nonjudgmental attitude.
- Encouragement to talk about the incident, without pressure to reveal more than she is ready to reveal.
- Reassurance that the incident was not her fault.
- Encouragement to seek medical care and psychosocial assistance and an escort to these services.
- Maintenance of trust by keeping the matter confidential.

An objective of most GBV programs is to ensure that these minimal responses are available in the community. Two separate, but related activities can help make this possible:

Establish Specialized GBV Counseling Services

Counselors may be either staff in a vertical GBV program or community development workers employed in an integrated community services program. A counselor's basic job is to provide confidential, individual survivor counseling. But counselors can also lead support groups, train GBV sectoral actors in appropriate responses, and serve as community educators and animators. These extended responsibilities ultimately help develop the community's own response and prevention activities.

The roles and responsibilities of GBV counselors must be clear, and all must have appropriate training and supervision. This can be accomplished by developing appropriate job descriptions for staff and defining program policies and procedures that describe purposes and methods for the different activities.

Build the Knowledge and Capacity of Community Members to Provide the Minimum Responses

A variety of participatory methods are needed to educate and mobilize the community to the cause. Eventually the community will acquire the knowledge base needed to be able to hear a survivor's story and provide the minimum responses described earlier.

The majority of GBV incidents are concealed from everyone, even from the family. Stepping forward to be counted is remarkable and brave; it is a statement of extreme trust in the person in whom the victim confides. A survivor will report a GBV incident to someone trusted, someone perceived as being able to provide help.

If the custom in the community is to seek counsel and advice from elders or religious leaders, then GBV programs should make a concerted effort to incorporate them into the counseling services. Engaging traditional counselors as partners, and including them in training and discussion or supervision sessions may be effective strategies. Survivors go to these people for help, and GBV programs must support them as they work to address survivor needs.

Conversely, if traditional counseling and advising is part of cultural practice, the GBV counselors must be able to differentiate between various types of counseling. If the cultural norm is for the traditional counselors to give advice and instruct people in what to do, GBV counselors from the community will probably have difficulty understanding other types of counseling. Supervision and training must take this situation into account.

PURPOSES AND TYPES OF COUNSELING

In any setting, choosing which types of counseling to provide is contingent on customary practices and the resources available for training and ongoing supervision. Issues of sustainability must also be considered when selecting the types of counseling to be used and selecting the counseling staff.

A description of the most common types of counseling‡ follows.

Crisis Counseling

All counseling rest on three basic elements: respect, confidentiality, and empowerment. Counselor training must include in-depth analysis of each element so that counselors thoroughly understand and consistently incorporate them into their work.

A personal crisis is what happens to the inner state of a person reacting to stress when his or her normal coping mechanisms are not working. A crisis is usually precipitated by a threatening situation. The threat might be physical or psychological, or both. As a result, a person may become psychologically paralyzed and feel he or she is losing control. He or she may experience confusion, increased emotional intensity, cognition disturbance (especially problem-solving ability), and distorted thinking (e.g., believing that things will never get better).

Crisis counseling concentrates on helping a person at the time of crisis and for a short follow-up period. (Crisis theory suggests that a crisis usually lasts from four to six weeks.) The counselor may have to spend a great deal of time with a client during the first few days, or at the most, weeks. But, this intensive counseling should not go on for more than a few weeks. After this period, the counselor should see less and less of the client to allow the normal support mechanisms, both internal and external, to take over. This strategy reduces the risk of dependency and helps the client regain control over her or his life.

Crisis counseling involves—

- Active listening.
- Encouraging the client to verbalize feelings and fears resulting from the crisis.
- Accepting the fears and other emotions as being genuine for the client.

‡These descriptions draw from the work of Sophie Read-Hamilton in training materials for GBV counselors in refugee camps.

- Providing helpful information and support, such as information on what exactly might happen if the survivor chooses to report an incident to the police or details of what to expect in a post rape medical examination; and accompanying the client to the police post or health center if the survivor chooses to pursue these actions.
- Determining whether the client is clinically depressed, the degree of depression, and the risk of self-harm.
- Assessing the client's resourcefulness.
- Exploring possible actions to be taken with the client.

Preventive Counseling

Prevention counseling is directed toward preventing a crisis before it develops, or trying to stop a problem from getting worse—for example, harming others or oneself. Thus, it focuses on stopping or minimizing a problem, for others or for oneself. Providing information to the client about possible referrals for other assistance and the possible consequences of an action is a critical component of this type of counseling.

RESOURCES

The RHRC GBV Tools Manual *(in press) includes sample job descriptions, recruitment tools, and interview guides for GBV counselors.*

Problem-Solving Counseling

Problem-solving counseling involves active listening and response that can help clients identify problems, better understand the problems, analyze problems, and weigh alternative solutions. The aim is to help the client accept or change his or her circumstances and reduce the adverse impact of problems on psychosocial well-being and functioning.

Decision-Making Counseling

Decision-making counseling is a continuation of problem-solving counseling . Often, difficult decisions include risks. It is not the counselor's task to make decisions for the client or to play an advisory role. The counselor's role involves the following support:

- Exploring with the client the possible responses and consequences of decisions.
- Providing information that may help the client to make informed decisions.
- Aiding the client to formulate a possible plan of action based on the decisions made.
- Assisting the client to accept responsibility for actions and responses that may come from the decisions.
- Supporting the client and promoting positive coping skills.

Supportive Counseling

In support work, the counselor offers emotional and practical help. For example, the counselor might help a client to express and manage overwhelming emotions or to cope with difficult emotions. She might also take an active role in supporting a client by serving as an advocate and accompanying the client to the doctor, police, or court.

Spiritual Counseling

Religious leaders in the community are well placed to cater to the spiritual needs of people. Spiritual counseling can provide a continued sense of hope and can help establish a sense of peace, comfort, and solace.

Table 9–1. Examples of GBV After-Effects and Psychosocial Assistance Needed*

After-Effects and Consequences	Potential Manifestations of After-Effects	Assistance Potentially Offered by GBV Counselors
Emotional: ■ Fear ■ Anxiety ■ Anger ■ Depression ■ Guilt ■ Shame	■ Eating problems ■ Sleeping problems ■ Feeling of fear ■ Anxiety attacks ■ Explosive anger ■ Extreme passivity ■ Self-hate ■ Self-doubt and low self-esteem ■ Social isolation ■ Inability to concentrate ■ Uncontrollable crying	Counseling to— ■ Reassure, help the client understand these responses are normal to a traumatic experience ■ Help the client understand what she has experienced and to develop a sense of control over her life ■ Help the client overcome feelings of guilt, self-blame, anger, and fear ■ Help the client understand she is not responsible for the assault, she is not alone, and others have had similar experiences; she can live a normal life ■ Help the client to fully understand the choices and consequences for help with health, security, legal issues, and other psychosocial programs Referrals, advocacy, and follow-up to— ■ Support and assist the client to carry out her decisions, if any, to seek additional help
Social: ■ Blaming the victim ■ Social stigma, rejection	■ Social isolation ■ Stronger self-hate and low self-esteem ■ Failure to seek help ■ Increased risk to abuse, exploitation	Interventions with the community to help create community awareness about GBV so that survivors will receive support, both within the family and within the larger community Skills training and economic empowerment programs
Severe psychological: ■ Posttraumatic stress disorder ■ Mental illness ■ Suicide ideation	■ Inability to function as a member of the family or the community ■ Suicide attempts	■ Health examination, possibly medication ■ Counseling from a trained mental health professional ■ Close monitoring to prevent suicide
Additional considerations for specific types of GBV:		
Rape, sexual abuse— ■ Feeling that she somehow caused it ■ Emotional effects of health outcomes (e.g., unwanted pregnancy, HIV/AIDS, disability)	■ More severe emotional and social dysfunction ■ Suicide ■ Infanticide or rejection of baby	■ Counseling as described above ■ Support groups ■ Referrals and advocacy for help with health care, child care, and so forth
Sexual exploitation and harassment— ■ Fear of retaliation	■ Silence ■ Repeat incidents due to fear, silence, isolation	■ Developing trust ■ Providing support and advocacy if she chooses to report the incident to appropriate authorities
Domestic violence— ■ Feeling that she deserved it ■ Physical disability ■ Child abuse ■ Death by murder or suicide	■ Helplessness ■ Hopelessness ■ Repeatedly placing herself and her children at risk with the abuser	Counseling to— ■ Help her think carefully about her situation ■ Develop a safety plan ■ Reassure her it is not her fault ■ Assure her she is not alone or strange ■ Work through making her own choices ■ Help the client deal with feelings of fear, helplessness, and hopelessness that make it hard for her to make decisions or take action Skills training, economic empowerment, support groups to— ■ Help her increase self confidence and gain control over her life ■ Develop a support network, learn that she is not alone, that other women face similar problems

Notes.
*This table is only a sample and a guide. Assistance provided must be based on the unique and specific *needs* of the individual survivor. The assistance options listed here are generally appropriate for adult clients; there may be special or alternative considerations for child survivors, which are not included here.

CHAPTER 10

Working with Abused Children

The extent of child sexual abuse is unknown in many countries. GBV targeting children in populations affected by armed conflict is receiving more attention in recent years. This chapter discusses ideas for strengthening GBV program action in addressing child sexual abuse.

Child sexual abuse is one of the most appalling acts a human being can commit, and mere mention of an occurrence generates a strong emotional reaction in almost everyone. This is probably one reason why so many people cling to the belief that sexual abuse of children (and its frequent corollary, child exploitation) is rare. They also believe that the cases that do occur are committed by extreme social deviants outside of one's circle of relatives, friends, neighbors, and coworkers—and certainly not by a child's caregivers. Helping to perpetuate the myth is the tendency of child survivors, families, and communities to deny the problem or keep it out of the public eye.

A case of child sexual abuse comes to light if it is officially reported to a GBV or other program, or sometimes to the police. Children are loathe to speak about the attack, but sometimes an adult will report the crime not because the child has revealed the incident but because the child shows signs of abuse (e.g., a six-year-old girl complains of pain in the genitals and walks with difficulty).

GBV RISKS AND PROBLEMS FOR CHILDREN

The UN Convention on the Rights of the Child (1989) defines a child as a person under age 18. Although the specific risks and consequences of GBV vary between young children, older children, and adolescents, there are general risks and issues that are shared by all children.

> The risk to a child of being sexually abused, and the consequent health and emotional problems, are similar to those of adults. But here, again, there are differences. Children are essentially powerless to resist the attack or do anything about it afterward. They lack the proper context to understand what has happened. Their short life experience also makes them more vulnerable to trickery and coercion. The child's innate, human reluctance to talk about a sexual incident grows even stronger if the abuser is a family member or a trusted outsider, especially if the child views the perpetrator as a protector. In such cases, a child's instinct may be to protect the other party even if that person is the abuser. Or, if they have been separated from their families, they may not know a trusted adult who can protect and help them.*

Sexual abuse is only one type of GBV that children can come up against. In the 1994 groundbreaking World Bank paper, Lori Heise described a range of GBV that occurs across the life cycle of girls and women (see Table 10–1).

*Excerpts from UNHCR and Save the Children–Sweden, *Action for the Rights of the Child,* UNHCR, Geneva, 1989.

Table 10–1. Gender Violence Throughout the Life Cycle

Life Cycle	Types of GBV
Prenatal	Sex-selective abortion; battering during pregnancy; coerced pregnancy; pregnancy due to rape
Infancy	Female infanticide; emotional, physical, sexual abuse; differential access to food and medical care for female infants
Childhood	Forced marriage; genital mutilation; sexual abuse by family members and strangers; differential access for girls to food, medical care, education; child prostitution; and other forms of sexual exploitation
Adolescence	Dating and courtship violence; economically coerced sex; sexual abuse in the workplace and school; rape; sexual harassment; forced prostitution; trafficking in women
Reproductive age	Abuse of women by intimate male partners; marital rape; dowry abuse and murders; partner homicide; psychological abuse; sexual abuse in the workplace; sexual harassment; rape; abuse of women with disabilities

Note.
Adapted from Lori Heise, J. Pitanguy, A., Germain. *Violence Against Women: The Hidden Health Burden*. World Bank Discussion Paper Number 255, 1994.

Children also suffer when GBV occurs in their families. For example, when children witness the battering of their mother, they are traumatized by this experience, and many children raised in abusive households will either become batterers or choose abusive partners when they are adults.

All types of child abuse are of growing concern to GBV programs, because it often occurs in families where other domestic violence takes place. An occurrence of child abuse may be an indicator that the child and family members are also at risk for GBV.

RESPONDING TO GBV AGAINST CHILDREN

Once a case of sexual abuse surfaces, it is important that the child's caregivers and the responding organization take appropriate and specialized actions. Working with a child is different from working with an adult, and techniques appropriate for working with the youngest victims are different from those for older children.

Intervention requires the utmost skill and sensitivity: on the one hand, failure to intervene when child abuse or neglect is alleged or suspected can leave the child (and possibly other members of the family) in a highly vulnerable situation; on the other hand, insensitive intervention can leave the child even more vulnerable than before.†

I think we need to look at where child protection and gender-based violence intersect rather than treat them as separate social problems.

—A GBV coordinator, Tanzania, 2002

On the rare occasions when child sexual abuse is reported to a GBV program, the incident quickly becomes common knowledge through word-of-mouth from the parents and neighbors. The community is usually horrified. At such times, the widespread knowledge of abuse can be a springboard to educate the community on gender and GBV and expand the awareness about the nature and extent of GBV in children, thus mobilizing the community in prevention campaigns.

Conversely, this public knowledge can have serious repercussions for the child. In many cultures, loss of virginity is cause for social rejection. For boys victimized by sexual abuse, particularly adolescents, the shame and social stigma can be unbearable.

†UNHCR and Save the Children–Sweden. *Action for the Rights of the Child,* 1989.

PREVENTING GBV AGAINST CHILDREN

The techniques used to prevent GBV among children are generally the same as those used with adults, for example,

- Empower potential victims with information about their rights, using language they can understand (e.g., picture posters, school programs, drama shows, and puppet shows about "good touches" and "bad touches").
- Ensure that safety and security systems are accessible and effective (e.g., train security staff how to listen to children).
- Educate those who work with children, especially teachers, to watch for specific behaviors and signals.
- Inform potential victims where to go for help if an incident occurs (e.g., established focal points in schools and children's programs).
- Monitor children who are the most at risk (e.g., carefully supervise and oversee foster families who care for unaccompanied children; reach out to children whose mothers are GBV survivors).
- Engage the refugee, IDP, and humanitarian aid communities in information and education activities on GBV (e.g., teach the community how to help child victims).
- Monitor incidents and share (nonidentifying) information with all involved.
- Work with everyone to strengthen prevention.

SPECIAL EXPERTISE, INTERAGENCY COLLABORATION

GBV programs must take into account the special needs of the abused child, and the type and extent of GBV suffered by him or her. These needs must be incorporated into program design, monitoring, and evaluation. Unfortunately, the programs designed to protect and provide psychosocial services to children in displaced settings are almost always separate from GBV programs. Often, they conduct parallel, even overlapping, staff training and program activities. Moreover, it is rare to find a counselor in either program with special training and expertise both in working with child survivors and negotiating the GBV response system that might be available in the setting.

GBV programs must collaborate, coordinate, and communicate closely and carefully with other children's programs, such as programs that protect

CASE STUDY

A foster family discovers that an orphaned five-year-old girl in their care has been raped. They take the girl to the UAC office, run by an NGO, and talk with the worker, someone whom they all know well and trust. The worker does not know what to do and takes them to the GBV office, run by a different NGO. The girl is frightened. The GBV counselor is a stranger to her and does not know how to interview a child.

The foster parents are afraid to report the case to the police because the community perceives the police to be abusive and distrustful of refugees. The GBV counselor wants to take the child to the health clinic, although the counselor knows that no one at the clinic is trained in rape examination of children. The foster parents agree to the health exam.

No one is comfortable explaining to the girl what is going to happen to her at the health clinic, and she becomes even more frightened. The foster parents and staff in both NGOs agree that the need for a health examination outweighs the concerns about frightening the child further. Thus, because these programs have not yet figured out how to work together, a child is potentially severely traumatized by their "help."

unaccompanied children, children's play therapy programs, and of course, schools. This collaboration may not always be easy and is often confounded by turf issues and competition for funds. But developing a shared understanding of the problems children face in, during, and after a conflict is a good first step. It is important to clarify needs and then design services.

The GBV interagency planning team could consider the following questions:

- What problems do refugee and IDP children face in this setting and what are their needs?
- Is it necessary, or even appropriate, to have separate and distinct programs for children and adults, each with a specialty GBV area?
- How can children's services be coordinated to better address their overall needs, including GBV?

Many GBV programs receive reports of child abuse and are unsure of how to respond. Displaced communities often view the GBV program as their help center for conflict resolution, family violence, and sexual abuse. This trust in the GBV program could be leveraged to increase the coordination between the GBV program and other child protection programs.

GBV has devastating effects on the physical and mental health of children, including their ability to learn and communicate. This, in turn, may have a profoundly negative impact on the family and community.

—UNHCR and Save the Children–Sweden, Action for the Rights of the Child*, 1989.*

CHAPTER 11

Partnering with Traditional Leaders

This chapter discusses engaging traditional systems of legal justice in prevention and response to GBV. Traditional governing bodies are key actors in the informal legal justice sector.

In most displaced settings, there is at least one body that oversees community governance and problem resolution. Composed of community leaders, these entities, or courts, are extremely powerful and influential. Naturally, they play a central role in prevention of and response to GBV.

COMMUNITY-BASED GOVERNING BODIES

The level of authority and degree of influence of these courts, as well as the limits placed on them, depends on the country's laws and whether the group is part of a long-standing traditional system. Sometimes, there is more than one such group in the community. Following are brief descriptions of community-based governing bodies.

- **Camp Governing Committee**: Usually made up of a chairperson and a number of deputies who oversee the day-to-day functioning of the community. The committee is the primary liaison with the UNHCR, NGOs, and host government representatives. Its functions are similar to those of a city council in a major urban area.
- **Chief or Administrator of Customary Law**: Recognized and permitted by a government. The party responsible for administering customary law may be a group of people elected by the community or a chief who is considered royalty and whose position is inherited.
- **Elder Tribunal**: Composed of respected elders who hear disputes and determine responsibility and consequences. It may be a formal and organized group or a loosely formed committee of advisors. Often, it is part of one of the bodies described above.

TYPICAL FEATURES

Limited Participation of Women

These bodies are usually made up of men, although there are exceptions. UNHCR is increasingly promoting the equal participation of women in decision making, and refugee-governing bodies are including more women. However, in most cases, the women's influence and power is very limited.

Role in GBV Prevention and Response

The court decisions not only determine guilt or innocence, but also influence individual behavior, community attitudes, and beliefs about the problems and issues that come before them. Thus, they have the potential to deter GBV in their community.

Technically, some countries can prohibit these courts from serving in a legal justice role. The standard rationale is that severe problems and crimes, such as rape, attempted rape, and assaults with injuries, must be handled by government law enforcement agencies. In reality, however, host governments and UNHCR lack the resources to manage the myriad conflicts and problems that occur day-to-day in a displaced setting, and usually encourage community-based problem solving. Consequently, in many places, traditional courts handle very serious crimes and adjudicate cases of rape, incest, attempted rape, forced marriage, and domestic violence. Although GBV survivors rarely report an incident officially, they would be less loathe to tell their story to someone they trust, in this case, a trusted and influential body for problem solving: a traditional court.

Hard data are not yet available on the kinds of decisions these community leaders make. Yet the general impression among women refugee leaders, NGOs, and UNHCR is that the courts tend to find in favor of men and ignore or minimize the human rights of women. Unfortunately, many of their decisions reflect their society's gender norms and expectations, resulting in further victimization and perpetuation of GBV.

BUILDING CAPACITY

Understanding the Community

International and national GBV staff are usually acquainted with community leaders and try to engage their participation, support, and leadership in program activities. Unlike refugee GBV staff, however, international and national staff are often unfamiliar with the processes and details of the traditional court system. Given the potentially large role and enormous influence of the tribunals, it is essential that the GBV program design include a thorough understanding of traditional systems in place in the community and a plan for influencing any needed change in these systems.

Building Capacity in Traditional Courts

There have been some efforts to influence change in tribunal decisions by providing these leaders with training in human rights and gender issues. Largely, however, these courts still receive little attention. The GBV program staff can step in here. Women community leaders could greatly influence the actions and decisions of traditional courts, but they may need support and skill building to learn how to speak up and become an equal part of the decision-making process. Links established with these courts would open the way to training, or at least encourage discussion of human

CASE STUDIES

A wife batterer receives a small fine or is told to apologize when, in fact, the assault was quite serious and is part of a long-standing pattern of abuse. The survivor herself is ordered to apologize and pay a fine for her disobedience.

A refugee man admits to sexually abusing his seven-year-old daughter. He is made to pay a large fine to the tribunal and, because there is no jail in the camp, is confined for only five days in a small hut near the camp committee office.

rights and gender equality in decision making. GBV program staff can also assist the traditional courts to formalize systems for record keeping and monitoring decisions and outcomes.*

Unpublished training and capacity-building materials have been developed in many countries by UNHCR protection staff, GBV coordinators, and other knowledgeable persons. UNHCR is a particularly important player in efforts to build the capacity of these bodies. The *Step by Step Guide for Protection Officers*† provides important guidance, for example—

- Should the survivor/victim wish to pursue justice through traditional and customary laws, the protection officer should ensure that the procedures and processes are fair and just.
- In the event that [customary law] fails to provide justice in accordance with internationally accepted standards, the protection officer should advise the survivor/victim of these limitations.
- The final decision on which process and procedures will be adopted rests with the survivor/victim.
- The protection officer should monitor and keep track of cases in which traditional and customary laws are used.
- The protection officer should ensure that traditional dispute-resolution mechanisms are consistent with national laws and international human rights standards. When these alternative structures violate national law, protection officers should conduct training and awareness raising with the community and encourage the refugee community to modify its conflict-resolution practices in accordance with international human rights standards.

In keeping with the community-based focus of GBV programs, building the capacity of the traditional courts and other central community structures is a logical and necessary undertaking. This kind of capacity building can bring about radical changes in community attitudes, knowledge, and behavior, and do much to prevent GBV and sustain community-based action to address the problem.

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*Chapter 7, Monitoring and Evaluating Programs, discusses data collection and some of its uses.
†UNHCR. *Prevention & Response to SGBV in Refugee Situations: Inter-Agency Lessons Learned Conference Proceedings* (Appendix 2), 2001.

Part 3

Varied Programs, Shared Challenges

CHAPTER 12

Angola

Getting started in a war zone

The southwest African nation of Angola recently emerged from a civil war waged since independence from Portugal in 1975, ending with the signing of a cease-fire agreement in 2002. Disputes over diamonds and oil were central to this bloody conflict, which displaced approximately 4 million Angolans. The government of Angola earns billions of dollars annually through the export of petroleum and diamonds.

DISPLACED POPULATIONS

In addition to its own millions of internally displaced persons, Angola is a country of refuge for people fleeing conflict from nearby Democratic Republic of Congo. At the time of the GBV TA field visit, the government deemed many areas of the country to be inaccessible to humanitarian aid organizations. UNOCHA estimated very high levels of unmet needs for even the most basic services such as water, food, and shelter.

GBV

Current data about physical, emotional, and sexual abuse among the Angolan population was not available at the time of the field mission. UNHCR and UNFPA compiled data from records in the Angolan Ministry of Family and Promotion of Women, spanning from 1997 to 1999. During this period, there were 3,550 cases of violence against women: 60 percent were domestic violence and 30 percent were sexual assault

A 1999 UNFPA reproductive health survey in the IDP communities in Huila and Benguela Provinces showed that, among 710 women and men interviewed,

- 20.5 percent reported knowing of a woman who was forced to have sex;
- 38 percent of the women interviewed had suffered aggression from her husband or intimate partner;
- 35.8 percent of those interviewed knew of women who engage in prostitution to buy food;
- 14.7 percent knew of men who engage in prostitution.

GBV INITIATIVES AND PROGRAMS

The Ministry of Family and Promotion of Women conducts a range of programs concerning issues of gender equality and GBV. The Ministry operates family counseling centers in Bengo and Luanda, and the majority of cases concern domestic violence. The Ministry also advocates for legislative changes to improve the legal status of women and conducts gender awareness training for parliamentarians and other government officials.

Women's NGOs in Angola are fairly well organized, but generally lack sufficient financial resources to implement programs. Depending on security issues in the provinces and funds available, GBV-related activities have included training for journalists and police, legal and emotional counseling for survivors, and public advocacy. *Rede da Mulheres*, secretariat for the network of women's organizations in the country, has 80 member organizations in seven provinces and identifies organizational development and capacity building as the greatest needs among members.

In 2000, UNHCR and UNFPA proposed an ambitious project to develop prevention and response to GBV in Luanda, Uige, and Zaire Provinces. The proposal included reproductive health care, legal counseling, legislative advocacy, and psychosocial services. The project was funded late 2001, but only at 20 percent of the requested amount. Information was not available about project revisions to accommodate the reduced funds or implementation plans.

GBV TA MISSION

In 2001, the RHRC identified Angola as one of the countries with probable high needs for GBV programming in the displaced populations. The GBV TA contacted UNFPA, UNHCR, and IMC in Angola to offer assistance. UNFPA and IMC invited the GBV TA for a short mission for orientation to the situation in Angola and discussions about possible future TA visits. The GBV TA undertook a one-week mission to Luanda, Angola's capital city, in November 2001.*

TA ASSESSMENT AND RECOMMENDATIONS

Orientation and assessment included interviews with staff in UNFPA, UNOCHA, IMC, national NGOs and women's organizations, Angola's Ministry of Family and Promotion of Women, and review of UNFPA, IMC, and Ministry program documents.

At the time of this visit, relevant programs serving refugees and IDPs were in a state of flux due to the ever-changing security issues and new funding limitations for international organizations serving refugees in the country. Organizations were reluctant to plan a specific future GBV TA mission.

The framework exists in Angola for interagency multisectoral prevention and response to GBV. NGO and government efforts have, in the past, included training and advocacy with psychosocial, health, security, and legal justice providers. All of these efforts could be organized and

*Confined to the capital city, Luanda, because of highly unstable conditions elsewhere, the GBV Technical Advisor was unable to visit any campsites. The TA visit was also short in duration (one week) and focused almost exclusively on building interest among humanitarian organizations to address GBV. Assessment and analysis in this report are therefore limited.

expanded, with collaboration and interagency planning. The GBV TA outlined possible actions for a future visit, mainly focused on facilitating interagency planning.

Within six months of the GBV TA mission to Angola, the country director at IMC and contact person at UNFPA left to pursue other employment. These were the two individuals most involved during the GBV TA's visit. At the time of this writing, there are no GBV TA missions planned for Angola.

CHAPTER 13

Eritrea

Initiating a GBV program with IDPs and returnees

Eritrea, a Red Sea coastal nation on the horn of Africa, achieved independence in 1991, after enduring a 30-year war for independence from Ethiopia. A 2½-year border conflict in 1997–2000 displaced more than 1 million Eritreans.

Several years of drought in Gash-Barka, Eritrea's most fertile agricultural region, coupled with the destruction of villages and infrastructure and the presence of landmines and other unexploded ordnance, have severely hampered the country's efforts to resettle its people and rebuild.

Looking to address the myriad needs of its war-affected population, Eritrea is open to internationally assisted capacity-building efforts; many large and small-scale projects are underway to build the capacity of the government in all ministries, at all levels. The government does monitor local and international nongovernmental organizations closely.

In traditional rural Eritrean society, men are the wage earners, and women are the domestic workers. Women have few rights and privileges in practice, although Eritrean laws and policies are changing, and the legal status of women is gradually improving. However, educational levels, skills, and income-generating opportunities for women are very low, especially in the lowland areas. Many live in poverty.

During the war for independence, Eritrean freedom fighters included women and men fighting side by side. Many of the women are now in government leadership positions.

DISPLACED POPULATIONS

Since the signing of the peace agreement with Ethiopia in 2000, internally displaced persons have been returning to their communities. But about 50,000 are unable to return, delayed by the presence of land mines, destroyed homes, and lack of security. Most of the remaining IDPs are from villages in the temporary security zone (TSZ) between Eritrea and Ethiopia set up by UN peacekeepers now monitoring the area.

In addition, Eritrean refugees living in Sudan, some for more than two decades, have begun UNHCR-assisted repatriation to Eritrea. Most returnees go to newly established villages in the Gash-Barka zone near the Sudan border to the west.

More than 10,000 documented people with no legal status (i.e., Eritreans who had been long-time residents of Ethiopia but were deported to Eritrea) live primarily in temporary camps in remote areas. They are neither IDPs nor refugees and may receive some limited humanitarian assistance. Many

other refugees, expellees, and IDPs live with host families or blend in with the local population in urban centers; not all are officially accounted for.

GBV

Harmful traditional practices include female genital mutilation and virginity checking.

For generations, nearly every form of GBV has occurred in Eritrea. Women report the most common form of GBV to be spouse abuse. Rape is believed to be less common. During focus groups and individual interviews, however, all the women respondents reported they knew of a rape incident in their village, extended family, or circle of friends. During the recent border conflict with Ethiopia, there were reports of rape committed by soldiers in the occupied zones. Sexual abuse and exploitation is rumored (but not confirmed), reportedly committed by teachers and military commanders. Eritrean society is quite traditional; most victims of rape, sexual abuse, and exploitation are blamed for the incident and are often punished and rejected by their families and communities.

Recently, with the presence of UNHCR and international NGOs in returnee areas, a few young, unmarried returnee women have been seen at health facilities for pregnancy. Many state that their pregnancy resulted from a rape that they had never reported. Some fear for their lives if their families learn of the pregnancy, and they request protection and assistance. In Eritrean society, protection and assistance are normally provided by the extended family; however, in these cases, such protection would not be forthcoming. This problem presents a challenge to UNHCR and its partners in returnee areas: to facilitate community-based solutions.

GBV INITIATIVES AND PROGRAMS

In 2001, CARE Eritrea and its local partner Haben, an Eritrean NGO, obtained funds to develop GBV prevention and response programs in two areas of the country. In the Senaafe area near the TSZ, the program serves the war-affected population who either fled conflict or remained in enemy-occupied territories during the recent war with Ethiopia. In the Gash-Barka zone, the program targets returnees from Sudan, most of whom are moving into newly established villages in remote areas. Before the CARE-Haben program, there were no specific counseling or social services projects for GBV survivors. The National Union of Eritrean Women (NUEW) has long been interested in the problems of GBV and has offices in all urban centers in Eritrea. Services for GBV survivors include legal advice, assistance, and supportive counseling. Many women ask NUEW for help with domestic violence.

Since 1995, the National Union of Eritrean Youth and Students and NUEW have been operating FGM awareness-raising projects. These involve poster and pamphlet campaigns, dramas, discussions, and some media coverage. The campaigns do not identify clear targets or indicators of progress, so it is not known if they have been successful in reducing the incidence of FGM.

Over the past 20 years, NUEW has established an impressive network of women's groups organized at national and subnational levels, with a paid NUEW representative heading each level. Information flows between the village and national levels via monthly reports.

The National Union of Eritrean Women estimates that more than 90 percent of the women in Eritrea are dues-paying members in its national network.

The Ministry of Health and several international NGOs provide health care, including reproductive health services. The National Union of Eritrean Youth and Students (NUEYS) operates reproductive health and counseling clinics in four towns and conducts special outreach for youth. NUEYS also conducts community education to prevent HIV/AIDS. There are no post rape or other GBV protocols; staff have not received specific training in sexual violence. Abortion is legal in Eritrea only with approval from a team of physicians who verify that pregnancy is due to a rape or is life threatening for mother or baby; such approval is rare. Drugs to treat

sexually transmitted diseases are available, but few STIs are reported at health centers. Rural drug vendors, operating in most towns and villages, provide medications and treatment for a fee.

CARE and Haben are implementing the new GBV program in partnership. CARE's role is to lead program development and management, provide pass-through funds, and simultaneously build Haben's capacity to manage the program independently. The expectation is that, in the long term, Haben will be a strong NGO able to design, manage, monitor, and evaluate effective programs. CARE is using a participatory approach with Haben, conducting planning and decision making with a group of Haben supervisors. This approach has proven effective, although it takes more time than if CARE were implementing the program directly.

The CARE-Haben team compiled a comprehensive national situation analysis about GBV in Eritrea that includes information on services both available and lacking, the legal environment, and community attitudes, knowledge, and practices concerning GBV. Interagency GBV planning and coordination teams meet regularly at both program sites and in Asmara. One component of the program is to build the capacity of assistance providers such as doctors and police.

In early 2002, the International Medical Corps jump started provider training by conducting GBV response training for its medical staff in Gash-Barka. A few doctors and a number of nurses are trained in post rape medical management.

Communities welcome the GBV program. The challenge now is to gain active community participation amid the extreme poverty and unmet basic needs of the displaced populations.

Start-up of the community-based education, provider training, and capacity building is slower than originally planned. Finding the necessary staff with the right mix of language skills in the target communities has been a challenge. The great distance between the two program sites and vacancies in supervisory positions have caused delays in staff training, thereby delaying activities at the program sites.

The program is funded for another 12 months. With community goodwill and staff in place, plus lessons learned about the time it takes to move forward, CARE and Haben have developed a realistic plan for the next steps in program implementation.

GBV TA MISSION

At CARE's request, the GBV Technical Advisor visited Eritrea for four weeks in October/November 2001, to assist with detailed program planning and start-up activities. A three-week follow-up visit was made in July/August 2002.

Government ministries have pledged strong support for GBV programming and are offering concrete assistance.

TECHNICAL ASSISTANCE AND TRAINING

2001 Start-Up Assistance

- Assisted CARE and Haben to identify and engage the key stakeholders for the program. Facilitated discussions with government ministries, UNHCR, and NGOs to establish links with existing programs for partnering and collaboration. Discussed areas for collaboration with each of these groups in order to develop ongoing coordination, communication, and cooperation.
- Facilitated stakeholder training and planning workshops in Asmara and in Gash-Barka. Training included GBV definitions and recommended practices for interagency prevention and response. The meetings included government ministries, UNFPA, NUEW, and NUEYS. Specific areas for coordination and information sharing were established, as well as commitments for ongoing monthly planning and coordination meetings. The government ministries that were represented offered strong support.

- Provided training and technical assistance with the CARE program manager and project officer and the Haben program coordinator to develop a detailed implementation plan for the two new GBV projects. A log frame was developed, including a framework for monitoring and evaluation. CARE and Haben were to finalize it and establish details of M&E data collection, analysis, and reporting.
- Provided written resource materials, training, and guidance about recommended strategies for interagency multisectoral GBV program development and management. Included needs assessments and situation analyses, staff training, community education, and training and capacity building with provider organizations.
- Assisted CARE to develop a training program for Haben's GBV managers, supervisor, and staff; provided technical assistance for the topical areas and overall plan. CARE will write the training manual, using materials provided. Conducted a training workshop with four new Haben project staff and oriented them to the project plan and underlying foundation for the work (e.g., concepts of gender, power, abuse, GBV, and prevention and response action).

2002 Follow-Up Visit

The mix of languages and long distances between sites have made training, supervising, and developing GBV staff a challenge.

- Conducted follow-up training with CARE-Haben staff, building on the prior training but employing a more advanced focus on details of prevention and response.
- Provided technical advice and assistance to CARE and Haben to strengthen their ability to facilitate the next steps with the interagency teams (e.g., developing procedures for reporting, documentation, referrals, advocacy, and coordination).
- Assisted CARE to lead the first-year program evaluation and planning for the coming year with Haben managers and supervisors. Provided technical assistance to develop the log frame, especially monitoring and evaluation plans.

TA ASSESSMENT

The CARE-Haben program is in its infancy. It has faced numerous start-up challenges to find and keep staff. Most staff positions are now filled, and program managers are developing training plans. It is anticipated that these efforts will continue and that fully trained and qualified program staff will be in place before the end of the year.

TA RECOMMENDATIONS

1. Develop procedures for GBV incident reporting, referrals, documentation, information sharing, and coordination with teams at each site.
2. Give the GBV program a name; make sure it is understandable in the local languages and does not provoke immediate resistance in these traditional societies. Moreover, the name should communicate the GBV program goal of empowering women.
3. Given the extreme poverty and high levels of basic needs at the program sites, CARE-Haben should add skills-training and income-generation activities to the program. The challenge will be to implement these new components while training program staff in the skills and knowledge needed to prevent and respond to GBV.

CHAPTER 14

Guinea

Three years of GBV programming amid constant refugee movements and low levels of assistance

The Republic of Guinea, a West African country rich in natural resources with a relatively stable government, has been host to at least one-half million refugees from neighboring Sierra Leone and Liberia since the late 1980s. The refugees have been fleeing from long-standing multifactional internal conflicts, marked by ethnic violence and shifting international alliances. Over the past decade, large numbers of refugees have repatriated to their respective countries, only to come back to Guinea as a result of continual political instability and violence.

DISPLACED POPULATIONS

Liberians began arriving in Guinea in 1989, after 10 years of civil strife and escalating ethnic tensions had plunged the nation into one of Africa's bloodiest civil wars. In the early 1990s, Sierra Leoneans started arriving. The influx grew much heavier in 1998, when combatants began targeting civilians; the atrocities included extreme torture and sexual abuse.

Refugees arrived in Guinea severely traumatized—many had been sexually abused or were sick or pregnant.

It was at this time that the UNHCR and the International Rescue Committee began special programs to assist survivors of sexual violence. However, the presence of the large number of refugees over a protracted time stretched the resources of poverty-stricken Guinea. In addition, inadequate funds and lack of appropriate staffing levels limited UNHCR's ability to help the refugees.

Continuing rebel activity and insecurity in Liberia and Sierra Leone spilled over into Guinea in 1999 and 2000. The border areas exploded into chaos and violence. Refugee camps were attacked by both Guineans and combatants rumored to be from Liberia and Sierra Leone. International staff were evacuated, suspending programs to help refugees until the situation calmed down. Peace was restored quickly, refugee camps were moved far from the border, and programs resumed. During the violent crisis, many incidents of rape and other sexual abuses occurred; many of these survivors live in refugee camps.

Sierra Leoneans are repatriating to their country now that peace has been restored, but Liberians continue to run from fighting in their country to seek refuge in Guinea.

CASE STUDY

My sister Mary was abducted by the RUF [Sierra Leone rebel forces] to entertain the "Generals." The Generals, sometimes more than 10 of them, would have sex or, let me say, rape Mary for many days and nights. To keep her under their control, they forced her to smoke opium or drink concoctions they prepared, to the extent that her bladder was damaged.

Today, Mary is a shadow of herself, an eyesore, urinating on herself even when walking because it comes without control. Her beautiful steps have given way to open-legged walking because of the prolonged forced and often hard marathon sexing she had to undergo.

Worse still for Mary is that she is presently somehow mentally deranged, surely because of the hard drugs that she was forced to take.

—Mary's sister reporting from Guinea, 1999

GBV

Prior to and During Flight

During the war in Liberia, half the women experienced some kind of violence from a soldier or rebel; 17 percent reported rape, attempted rape, or sexual coercion. Belonging to certain ethnic groups increased the danger.*

The war in Sierra Leone was particularly harsh, capturing the attention of the media. Alarming numbers of women and children were severely brutalized, before and during flight, by rebels and other combatants. There are a large number of confirmed reports of torture, sexual slavery, sexual violence, mutilations, and amputations committed by combatants against civilian women, children, and men.† Gang rape was common. Rebels often held Sierra Leonean females for days while numerous men repeatedly raped them.

In the Country of Refuge

Many forms of GBV are occurring in the camps, as indicated by incident reports to the GBV program and through anecdotal information, although data are sketchy. Rape and other forms of sexual abuse occur; reports indicate that sexual exploitation is pervasive.

Forced early marriage is reportedly higher in the camps than in the home country, due to extreme poverty. The majority of GBV incidents reported are domestic violence.

Refugee women's groups in many camps have resumed traditional practices of female genital mutilation.

Sierra Leonean and Liberian refugees live under Guinean law. A survivor can report sexual violence and other crimes to the Guinean police. However, skepticism about the authorities' response and shame about the experience (the woman is frequently blamed) often keep survivors from telling anyone, let alone a Guinean official.

Customary law is practiced in the camps, with traditional courts made up of refugee leaders. Many reported cases are brought to these courts for adjudication. As in most settings world wide, customary law is a reflection of cultural values and norms. Thus, in Guinea, decisions by these courts often result in further discrimination and victimization of women.

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*S. Swiss, P. Jennings, G. Aryee, C. Brown, R. Jappah-Samukai, M. Kamara, R. Schaack, R. Turay-Kanneh. Violence Against Women During the Liberian Civil Conflict. *JAMA*, 1998 279(8): 625–629.

†Physicians for Human Rights-UNAMSIL. 2002. War-Related Sexual Violence in Sierra Leone. Boston: Physicians for Human Rights.

GBV INITIATIVES AND PROGRAMS

The International Rescue Committee's GBV program has been in place since 1999. It is raising awareness about gender issues, including women's rights, among refugees. There is a staff presence in the camps and IRC provides compassionate and confidential psychosocial services to survivors who report incidents.

The American Refugee Committee has a GBV program, the Community Safety Initiative. ARC has made progress in building multisectoral capacity through its health care training module, GBV health protocols, and continuing education for health workers. ARC has also begun conducting awareness raising among Guinea police posted in the camps.

GBV TA MISSION

In March 2002, the GBV TA conducted a three-week visit to Guinea in response to IRC's request for assistance.

Just before the GBV TA's arrival in Guinea, BBC announced the findings of the Save the Children-UNHCR-UK report. It described sexual abuse and exploitation of refugee women and children in West Africa, often committed by humanitarian aid staff.

All organizations in the region thereupon began active problem-solving discussions, some with support and assistance from the GBV technical advisor. In Guinea, the support focused on training and facilitated planning meetings to increase humanitarian actors' awareness of the GBV problem and to design strategies for prevention. The GBV TA mission in the region was extended an additional two weeks to provide further assistance to UNHCR in Liberia and Sierra Leone, as well as Guinea.

TA ASSESSMENT

Interagency Coordination

Coordination, collaboration, and information sharing are significant challenges for the interagency GBV team in Guinea. Between 1999 and 2001, three annual GBV planning meetings, organized by UNHCR and IRC in either Gueckedou or Kissidougou, were held with representatives from UNHCR, international and national nongovernmental organizations, and government ministries. The meetings included training in the roles and responsibilities for multisectoral prevention and response to GBV, and planning for coordination and action by the various organizations involved. By the end of each meeting, participants had agreed on GBV action plans. Unfortunately, concrete follow-up action by the multisectoral and interagency representatives has been quite limited. At the time of the GBV TA visit, there were no systems in place for multisectoral coordination of GBV prevention actions; there were no written procedures or guidelines for GBV reporting, referrals, roles, responsibilities, or information sharing.

The GBV Technical Advisor held a fourth interagency meeting during the mission. Staff turnover hindered continuity of planning and implementing action after the previous three meetings. At the fourth meeting, the emphasis was on developing written procedures and guidelines so that systems for interagency action and coordination will be clear to all.

Interagency action, collaboration, and coordination has been limited. Recent efforts to develop coordination systems may prove successful if all actors participate fully.

UNHCR

UNHCR's participation and leadership in GBV prevention and response has been limited largely due to the lack of permanent posts and high turnover of short-term staff.

Its Community Services staff addresses psychosocial issues related to GBV and tries to develop a coordinated multisectoral and interagency strategy. Increased involvement is needed from staff in Protection, Field, and Health, and from heads of office. Collaboration and information sharing across sectors is limited within UNHCR and between UNHCR and its two NGO partners, IRC and ARC.

With support and assistance from these GBV programs serving refugees, UNHCR can lead efforts to build the capacity of all staff to prevent and respond to GBV, establish feasible written procedures, and hold all staff accountable for following through with responsibilities and procedures.

IRC's GBV Program

The greatest number of GBV cases would seem to derive from domestic violence (wife battering) and child sexual assault. It is not known whether these two types of GBV are indeed the most common occurrences, or if they are only the most commonly reported. An increased emphasis on program monitoring and evaluation may answer this question and guide program objectives, strategies, and activities to address the evolving needs of the refugee population vis-à-vis GBV.

IRC's GBV program can be an effective change agent with regard to multisectoral and interagency action. The organization is in a good position to take the lead in promoting and facilitating consistent interagency action, as well as active and cooperative working relations with all UNHCR sectors.

The IRC GBV program, like that of all organizations in Guinea, is facing significant changes in the makeup of refugee populations. As a result, the GBV program is having difficulty developing strategies for both the continuing repatriation of Sierra Leoneans and the increasing influx of refugees from Liberia.

Strengthened monitoring and evaluation systems, identification of relevant indicators, and increased staff supervision would help IRC to monitor and evaluate program outcomes, right-size staffing levels in camps with fluctuating populations, increase community participation, and develop a realistic phase-out and sustainability plan.

Stronger program design, monitoring, and evaluation would increase IRC's ability to provide data and information to the multisectoral actors, which would encourage increased action.

ARC's GBV Program

The IRC and ARC GBV program managers work collaboratively and cooperatively to reduce overlap or duplication. The two programs, with their slightly different emphases, complement one another well, although on paper the two programs appear to provide overlapping services.

TECHNICAL ASSISTANCE AND TRAINING

Interagency, Multisectoral Coordination

- Facilitated half-day meeting with multisectoral and interagency actors in Kissidougou. This meeting was an overview of intersectoral and interagency coordination mechanisms—those currently in place and those needed. Distributed key resource materials. The interagency group agreed to meet monthly, first to develop procedures and commitments for referrals, reporting, information sharing, and coordination, and then to continue the coordination and information sharing in monthly GBV meetings.

- Developed a draft set of procedures for this group to review, revise, and develop. Developed a set of possible outcome indicators for each sector that the IRC GBV program will introduce to the group later in the process.

Training and Technical Support with IRC

- Facilitated two-day meeting with IRC's GBV staff to describe, discuss, and promote a program shift toward increased community participation and expansion to address additional types of GBV.
- Provided advice and assistance to IRC's GBV program coordinator to increase collaboration with UNHCR and Guinean authorities; to strengthen staff supervision, training, and staffing patterns; and to effectively design, monitor and evaluate the program.
- Completed a draft of a detailed implementation plan in collaboration with IRC's GBV program coordinator to strengthen the program. This is a realistic plan that includes specific objectives, activities, timelines, and clear and measurable outcome indicators. The plan focuses on staff training and capacity building to enable staff to use a stronger community development approach in their work.
- Developed a staff awareness-training workshop guide on issues of power, abuse, gender, and exploitation. The program coordinator can repeat the workshop, conducted with IRC staff in Kissidougou, with IRC staff in each of the offices in Guinea. This workshop can also be used with staff of other NGOs and UNHCR.

Training with UNHCR

- Due to competing priorities in UNHCR's busy Kissidougou field office, reduced the planned one-day workshop to a brief (90-minute) awareness-raising session for UNHCR staff in Programme, Field, Protection, Community Services, and Health. The workshop included distribution of key UNHCR materials on GBV prevention and response and discussion of the importance of intersectoral information sharing within UNHCR.
- Conducted a separate 90-minute awareness-raising session for UNHCR secretaries, clerks, drivers, and other staff. This participatory awareness-raising workshop focused on issues of gender, abuse of power, and GBV.

TA RECOMMENDATIONS

IRC, ARC, and other organizations have been conducting community education among refugees about GBV, gender equality, conflict resolution, and related topics. Prevention of GBV has largely consisted of these education activities, with ARC providing increased attention to security issues and distribution of materials (e.g., lamps) to increase security in the camps.

Sexual abuse and exploitation are forms of GBV that can be addressed by strengthening and clarifying existing systems.

Given the new information about problems of sexual abuse and exploitation, there is an opportunity now to expand prevention activities to include all sectors and all organizations. With increased knowledge of GBV, power, abuse of power, and related issues, all stakeholders (international humanitarian relief organizations, Guinean government agencies, NGOs, and refugees) could be active participants in preventing GBV.

The IRC and ARC GBV programs are well suited to assist humanitarian organizations to provide a series of training and awareness-raising workshops and other activities for all staff (international, national, refugee). The timing is right to focus on topics of gender, GBV, human rights, power, abuse of power, culture, and behavior standards for humanitarian workers.

Another significant prevention strategy for UNHCR and all international NGOs would be to conduct information dissemination and awareness raising among all refugees. This strategy could ensure that they are aware of their rights and responsibilities, entitlements, distribution systems and rules, mechanisms for violations, and other related issues.

CHAPTER 15

Serbia

Refugees, IDPs, citizens—a country in transition

Serbia is a country in transition. The wars in the former Yugoslavia are over, there is a new government, and many people in the country and around the world are optimistic about the future. There is interest in Serbia in joining the European Union; many Serb citizens are engaged in creating the kinds of changes that will qualify Serbia for membership.

DISPLACED POPULATIONS

At the same time, the province of Kosovo remains unstable and under control of the UN Mission, delaying the return of Serb Kosovars to their homes.* There remain in the country an estimated 700,000† refugees, internally displaced, and war-affected persons.‡ *War-affected* includes former army and government employees who fled Yugoslav territories.

The majority of the 377,000 refugees in Serbia are from Bosnia-Herzegovina. There are 230,000 IDPs, most from Kosovo; another 75,000 are the war affected.

In May 2002, the Commission for Refugees of the Republic of Serbia published a national strategy for integration or return of refugees, IDPs, and war-affected persons. It was developed by a working group comprising Serbian ministries and a number of UN organizations, and included consultations with NGOs, refugee associations, and local communities.

The international community supports the nongovernmental sector with capacity building and funds for many services to the Serb population.

The displaced situation remains grim. Many of the most vulnerable people remain in *collective centers*, that is, a school, hospital, or other facility where people live dormitory-style, sometimes with a blanket or sheet hanging from the ceiling to separate families. The government's Commission for Refugees is struggling, along with its international partners, to develop durable solutions as quickly as possible, but funds are limited and being reduced every year.

The humanitarian situation in Serbia is shifting from emergency relief to development and long-term planning. The international community is pushing for return or integration of all IDPs and refugees; emergency relief funding is being reduced; UNHCR is reducing its presence; and development projects are becoming more popular.

*Serbia is also referred to as the Federal Republic of Yugoslavia.

†This report does not include information from the province of Kosovo.

‡Numbers from registration exercises conducted by UNHCR and the Serb government in 2001.

GBV

This environment of change presents an opportunity to highlight GBV in Serbia as an issue that needs government, citizen, and NGO attention country wide. Many types of GBV are occurring in Serbia. Many deem rape and other sexual abuses (including child sexual abuse), domestic violence, and sex trafficking to be the most common types of GBV.

GBV INITIATIVES AND PROGRAMS

For many years, Serbia has been both a destination point and a part of a heavy transit route in the trafficking of women and girls. It is now considering an antitrafficking law.

The feminist movement has been ongoing in Serbia for many years. A strong network of NGOs promotes and serves the rights and needs of women and children. Most of these groups are based in Belgrade, although NGOs are working in many areas of the country.

Government ministry services, such as the social welfare system, police, and the judiciary, increasingly address GBV in Serbia. Government infrastructure is in the process of changing, and many government ministries lack sufficient resources to adequately serve the Serb population, including efforts to stop GBV.

The time is right for multisectoral organizations to gather together and strengthen interagency action for prevention and response to GBV. The new Network of Trust in Belgrade, established by the Incest Trauma Center with support from UNICEF, is a promising first step. This organization is composed of representatives from government and nongovernment organizations concerned about GBV. Its activities should expand with additional support, funds, technical assistance, and training.

GBV TA MISSION

The GBV Technical Advisor conducted a two-week field mission to Serbia in late June and early July 2002. At the request of CARE Yugoslavia, the aims of this visit were to (1) assess the situation vis-à-vis interagency and interdisciplinary GBV programming for displaced populations and (2) develop ideas and recommendations with organizations on the ground for strengthening GBV prevention and response in Serbia. Clearly, a short mission like this is limited in scope, and it is not possible to develop a comprehensive and detailed understanding of the situation. It is also important to note that the mission did not include the province of Kosovo, where GBV initiatives are underway. Outcomes and recommendations from the TA visit are contingent on the continuing work and follow-through by organizations in Serbia.

TA ASSESSMENT

Fortunately, a strong network of local NGOs is already working to eliminate GBV in Serbia. Most are in Belgrade and offer women and children a range of services for various forms of GBV. Leaders of these NGOs are knowledgeable, experienced, motivated, and influential; they are developing plans to strengthen and expand efforts to address GBV in the country.

The Network of Trust meets regularly for three general purposes:

1. To exchange information, share experiences, prevent duplication, and promote collaboration.
2. To increase organizational capacities for good quality services to women and children.
3. To influence changes in public policy by raising awareness about GBV through public advocacy campaigns.

The key organizations needed for GBV prevention and response are those that address psychosocial, health, security, and legal justice needs. Psychosocial organizations are the majority in the Network of Trust. Police representation is growing and there are participants from the legal justice system. Notably missing are adequate numbers of health care providers. There was insufficient time during this mission to explore issues of health care for survivors, but there is a general impression among those interviewed by the GBV TA that the economic conditions and demands from doctors in the country make engaging health providers one of their greatest challenges.

There are no comprehensive GBV programs targeting refugees or IDPs in Serbia, outside of Kosovo.

Group 484, a national NGO serving the displaced population, has a number of psychosocial programs to support integration, adaptation, and recovery. This NGO plans to begin a domestic violence program in the coming year. There are similar projects either underway or in the planning stages among a few NGOs serving refugees and IDPs.

Discussions with key informants indicate that UNHCR does not have established GBV programs underway, and is reducing its presence in the country due to the changing refugee situation and reductions in funds.

CARE has primarily been providing emergency humanitarian aid. With the shift in Serbia from emergency needs to development needs, CARE's portfolio is also changing. CARE managers said that staff could benefit from increased awareness of the importance of gender in development as they begin to conceptualize new projects and activities.

Two CARE projects currently underway are relevant to GBV:

- A six-month gender-training project with teachers. This project is using a train-the-trainers approach and has requested GBV awareness training for the project trainers.
- A capacity-building project with the Ministry of Social Welfare Centers for Social Work focuses on deinstitutionalizing orphan children. The centers frequently see cases of domestic violence and child sexual abuse, but they have received little training and guidance on how to respond to these cases.

CARE's field office in Vranje is part of the Centers for Social Work project. In the Vranje region, there are many IDPs from Kosovo. There are no specific GBV programs serving this population, but government and nongovernmental organizations in the area are aware that GBV is a problem and are interested in developing programs and services.

TECHNICAL ASSISTANCE AND TRAINING

- Met with major women's NGOs in Belgrade; meetings provided the opportunity to share information. During the discussions, the GBV TA gained understanding of the excellent and long-standing programs and initiatives in Belgrade to address violence against women and children. The discussions also provided an informal forum for sharing information about efforts world wide to address violence against women and children in displaced settings. The TA provided them with resource materials, such as training manuals for police and health care workers, guidelines for interagency GBV initiatives, and sample materials for public information campaigns.
- Gave the Commission for Refugees the most recent written materials about GBV programming in displaced populations, as well as informal teaching about interagency action to address this complicated protection issue.

- Organized and led a roundtable discussion with approximately 25 gender education project trainers engaged by CARE. The training served as an introduction to GBV and interdisciplinary prevention and response, with a focus on war-affected populations.

Women's organizations, mostly in Belgrade, are taking the lead in addressing GBV.

- Held two participatory gender-awareness workshops with all CARE Belgrade staff (approximately 50 people). Staff reactions to these workshops were mixed, and a number of staff were resistant to concepts of gender equality, a common occurrence in initial gender workshops world wide.
- Conducted an in-depth training session with six to seven interested CARE staff that focused on the "gender and development" approach. Provided worksheets and tools for gender analysis in developing programs.
- Conducted a workshop with government ministries in Vranje, including police and representatives from the legal justice system. Attendance was very low (three people). The workshop focused on interagency response and collaboration needed between government and nongovernment organizations, and included a brief discussion of how to engage colleagues (i.e., those not present).
- Conducted a workshop with thirteen staff members in Vranje area Centers for Social Work, with specific focus on response to domestic violence and child sexual abuse.
- Led a roundtable workshop with seven national human rights and psychosocial NGOs based in Vranje. The training covered GBV prevention and response and encouraged start-up of initiatives to address GBV in the displaced populations.

TA RECOMMENDATIONS

Leading Women's NGOs and Interested Interagency Colleagues

Form a proposal or concept paper for a multiyear project to develop interagency capacity, coordination, and collaboration, as well as community-based action to address GBV. This would build on the successes and strengths of the Network of Trust. Such an initiative requires more time and resources than are currently available from NGO leaders who are engaged in these activities in addition to their other full-time work.

CARE and Partners

Gender Project

Provide follow-up training to develop specific plans with trainers for working with teachers on GBV issues.

Centers for Social Work

Continue follow-up training, which could be provided by Belgrade women's NGOs. Domestic violence and sexual abuse are complex problems, and any reports received by the centers are a small percentage of actual incidents. Although severely lacking resources, the Centers are the designated reporting center for these cases. Strongly recommend that training include developing strategies for closer liaison and referral systems with NGOs and others who can assist survivors and their families.

CARE Staff

Conduct a series of workshops and discussions to continue raising awareness of gender issues, making sure to include staff who are most resistant to these concepts. The workshops will build understanding and enable staff to perform work with greater gender sensitivity.

NGOs in Vranje

Continue the dialogue about GBV prevention and response. Liaise with the knowledgeable and experienced NGOs in Belgrade for continuing training and development of interagency plans to address GBV.

CHAPTER 16

Sierra Leone

Refugees, returnees, IDPs, citizens—a complex postwar setting

Present-day Sierra Leone is engaged in the long process of rebuilding after a civil war that was preceded by many years of economic exploitation and political instability. The decade-long civil war, ending a little more than a year ago, was characterized by brutal human rights abuses against civilians. More than half the Sierra Leonean population was displaced; many sought refuge in the capital city, Freetown, and in neighboring Guinea and Liberia.

At present, refugees and IDPs are gradually returning to their homes. Many villages were destroyed and there is much rebuilding to be done, especially in the former rebel strongholds of the Kono and Kailahun Districts. The government infrastructure is also being rebuilt, with help from the international community.

DISPLACED POPULATIONS

The displaced Sierra Leonean population today is a mix of IDPs and returnees from Liberia and Guinea, all trying to rebuild communities. In addition, Liberians flow over the border and seek refuge in Sierra Leone as the continuing conflict in Liberia escalates and de-escalates.

Sexual abuse and torture, mutilation, executions, and abduction of civilians, even very young boys, into the fighting forces were standard rebel tactics.

A massive program of IDP resettlement took place during 2001 and 2002. An estimated 12,000 officially registered Sierra Leonean IDPs remain to be resettled. However, this number does not include unregistered IDPs or IDPs absorbed into mostly urban areas.

There are also more than 100,000 returnees from Liberia and Guinea; some are moving into temporary camps. In 2002 and 2003, the UNHCR plans to escalate the facilitated return of Sierra Leonean refugees still in Guinea and Liberia.

GBV

Sierra Leonean women have been suffering GBV for many generations. A 2002 study by Physicians for Human Rights in conjunction with the UN Assistance Mission in Sierra Leone* estimates that 50,000 to 64,000 women IDPs suffered war-related sexual violence. If non–war-related sexual violence is added, as many as 215,000 to 257,000 women and girls in Sierra Leone may have been affected by sexual violence.

*Physicians for Human Rights-UNAMSIL. 2002. *War-Related Sexual Violence in Sierra Leone*.

Wife beating and other forms of abuse are generally accepted as part of marriage, even by the women themselves.

During the war, women and girls, and particularly virgins, were raped and their families were forced to watch. Women were sexually mutilated with weapons including gun barrels, knives, and burning wood. Pregnant women were disemboweled. Families were forced to commit incest.

The latest estimates indicate that between 80 and 90 percent of women undergo female genital mutilation as part of a traditional coming-of-age ritual. Members of women's secret societies, acting in accordance with traditional beliefs, perform it on young girls, generally at the age of puberty. There are signs that this "initiation" is becoming less popular, especially in urban areas, although it is still widely practiced.

Sexual exploitation, including child prostitution, is reportedly a serious problem. Perpetrators include any person with power, including some humanitarian aid workers.

In general, women and girls in Sierra Leone are in a subordinate position relative to their male counterparts. This is demonstrated through the GBV described and through consistent discriminatory practices in female access to food, education, play, and a host of freedoms. Women, displaced and undereducated, must find means to survive in a destroyed economy.

GBV INITIATIVES AND PROGRAMS

Several key organizations are committed to developing a country wide plan for prevention and response to GBV in Sierra Leone.

In 1999, after a particularly brutal rebel attack on Freetown, UNICEF and many international and national nongovernmental organizations initiated programs in the Freetown area to provide emergency and follow-up services to the large number of women and girls who had been abducted and sexually abused. The programs continued for some time, but many have since lost funding. UNICEF now oversees a network of child protection programs in several areas of the country. The child protection network includes a focus on war-related sexual violence and forms of GBV affecting children. The network also provides services for former child soldiers and children who have been separated from their families.

Also in 1999, the International Rescue Committee added assistance for survivors of GBV to its reproductive health program serving refugees and IDPs in the Kenema and Bo areas of the country. The IRC GBV program has grown significantly since that time.

Until recently, however, the continuing conflict and insecurity throughout the country prevented UN agencies, NGOs, and government authorities from developing coordinated and comprehensive services to address GBV.

At present, several key organizations are committed to developing a country wide plan: UNHCR and its implementing partners, the International Rescue Committee and the Forum of African Women Educationalists; UNICEF and its child protection partners; the Commonwealth Police Advisors (a UK-sponsored capacity-building program) and the newly established Family Support Units operated by the Sierra Leone police; and the Ministry of Social Welfare. There is, however, no established, coherent strategy yet. Many services are in place in Freetown; some services are available in refugee and returnee areas, but in most areas of the country, there are no services. Where they do exist, there are large gaps and some duplication; nearly all have been response driven with only recent attention to prevention. Regular coordination of interagency GBV programming has occurred only in Freetown and Bo with little, if any, communication between the two locations.

Additionally, due to the long-standing instability and insecurity, and continuous crises and population movements, GBV programs were unable to fully engage communities in leadership for prevention and response to GBV. Until now, GBV has been more agency driven than community driven.

Prevention and response in Sierra Leone is more complex and challenging than in some other countries due to the following factors:

- The population is a mix of refugees, returnees, and IDPs trying to rebuild communities. Massive movements continue as the conflicts in West Africa ebb and flow.
- A large number of females were sexually abused by combatants. Few have received appropriate medical treatment. Many have children as a result of rape. Many have been rejected or fear rejection by families and communities.
- Government ministries have been unable to take the lead in GBV programming due to their struggle to regain functioning in the aftermath of the protracted civil conflict.
- Humanitarian assistance in West Africa, including staffing levels in UNHCR, has for many years been too low to properly address the large needs of this troubled region.

UN agencies and international NGOs have recently accelerated and expanded programming to deal with sexual exploitation and abuse perpetrated by humanitarian workers. Pressure to take such action came after the Save the Children UK-UNHCR report on abuse and exploitation in West Africa was made public in early 2002.

GBV TA MISSION

At UNHCR'S request, the GBV technical advisor conducted a six-week field visit to Sierra Leone during March and April 2002. The request was to assist UNHCR and its partners, FAWE and IRC, to strengthen GBV prevention and response action.

Coincidentally, the international media aired the Save the Children UK-UNHCR report a few days after the GBV TA arrived in Sierra Leone. Responding to pressure, UNHCR Sierra Leone's Freetown staff got busy working on action plans in collaboration with other UN agencies and NGOs. But much of the initial planning was for parallel action and was not integrated into existing GBV efforts. At the request of UNHCR and IRC, the GBV TA mission was extended two weeks to assist in the planning, particularly for integrated action.

Sexual abuse and exploitation are among the many forms of GBV occurring in Sierra Leone.

Also, just prior to the GBV TA's arrival, the armed conflict in Liberia escalated. UNHCR Sierra Leone therefore urgently increased its repatriation of Sierra Leonean refugees in Liberia to get them out of harm's way. This meant that UNHCR staff were extremely busy and less able than originally planned to participate in GBV technical assistance and training activities.

TA ASSESSMENT

UNHCR

Many UNHCR staff in Freetown and in field offices are interested in and capable of addressing GBV, but they need comprehensive training. Additionally, they lack human resources who have the time to devote to this area. UNHCR's problems are directly related to long-standing challenges of low staffing levels and high numbers of short-term staff rotating in and out.

GBV training would broaden awareness of the larger definition of GBV, including exploitation and abuse. It would also clearly delineate the staff's specific sectoral roles and responsibilities. Written materials and guidelines could assist them to achieve these goals.

UNHCR's efforts in these areas would be greatly facilitated if they were more involved in the work of the two implementing partners for GBV.

UNHCR is hampered in monitoring progress because they are not receiving GBV data reports. UNHCR's partners, therefore, need assistance in developing effective reporting and referral mechanisms. Further training in these areas plus awareness raising among their own staff, their partners, and the refugees and returnees would also be beneficial.

IRC

Despite considerable challenges, IRC is making progress in leading efforts to develop interagency, integrated actions to address GBV.

IRC is working hard to build staff capacity, make needed program improvements, and expand into new returnee areas. In the past, the IRC program has suffered from both the armed conflict and resulting insecurity and expatriate program manager turnover. These two problems together resulted in some lack of continuity, limitations in staff training and supervision, weaknesses in monitoring and evaluation, and limited attention to prevention and community-based action. However, the recent peace has allowed IRC's current GBV program managers to address all of these issues. New program expansion into Kono is off to a strong start that includes extensive staff training and building community involvement from the beginning.

Program representation, coordination, and planning at the Freetown level have been provided by IRC representatives who do not fully understand program needs or technical issues. IRC, viewed by many as a leader in GBV in Sierra Leone, could improve overall coordination and technical guidance for its work country wide. Each field site faces similar challenges; there is a real need for Freetown-level coordination and planning.

Several of the GBV program components have been vertical and separate from existing sectors and organizations. This is most notably true for health care and legal justice follow-up. Both these areas, however, are extremely difficult in Sierra Leone, given the lack of government infrastructure. IRC's GBV program managers are working to integrate services as much as possible. The project development and its eventual integration and sustainability will be greatly facilitated by the growing collaboration with other key organizations and sectors.

FAWE

The Forum of African Women Educationalists is one of the primary national organizations engaged in the care of survivors. The organization came forward after the 1999 rebel invasion of Freetown to provide emergency assistance for the high numbers of girls and women abducted and raped during that crisis.

However, FAWE has not received either training or capacity building for designing and managing multisectoral and interagency GBV prevention and response programs. Prior to this GBV TA visit, FAWE's training focused on counseling skills and general staff awareness of sexual violence. And, predictably, their program focuses only on response, primarily skills training, and does not include all components considered to be best practice for effective GBV prevention and response, including coordinating with other actors and measuring outcomes.

A health component is included in FAWE's work (i.e., contracting with a doctor and providing medicines) for general reproductive or primary health care, which is certainly needed. But, in the majority of cases, it does not include a post-GBV exam or treatment. The health component is a vertical system, and does not help to build the capacity of the Ministry of Health or health NGOs.

FAWE may provide the most benefit to GBV survivors and women and girls at risk of GBV through their counseling and skills training. If this is

so, UNHCR could review and revise its expectations and agreements with FAWE. Nevertheless, if FAWE's objective is economic independence of survivors and vulnerable women and girls (i.e., reduced vulnerability to abuse and exploitation), providing skills training alone will not do the job. The FAWE program does not include basic numeracy training or business planning, and there are no links with potential employers or income-generation schemes (e.g., loan programs). Both are needed for participants to achieve economic independence.

TA ASSISTANCE AND TRAINING

Country Wide GBV Planning

- Facilitated a two-day planning workshop in Kenema with representatives from multisectoral organizations. Participants represented the Ministries of Health and Social Welfare-Gender-Children's Affairs, Family Support Units, Commonwealth Police Advisors, International Rescue Committee (GBV program), Forum of African Women Educatonalists (GBV program), International Medical Corps, legal aid NGOs, and several psychosocial NGOs. The workshop yielded excellent results in that the group was able to identify gaps, needs, and duplications in GBV prevention and response in Sierra Leone. The group also developed a specific plan for action to begin addressing these issues.
- Distributed a written plan to all participants and key organizations that did not participate, including UNHCR, UNICEF, and many of the international health NGOs.

Training and Consultation with UNHCR

- Participated in planning sessions with UNHCR staff from Guinea, Liberia, and Sierra Leone, to address sexual abuse and exploitation, and staff training needs.
- Conducted a one-day workshop for UNHCR field staff and implementing partners in Bo. The workshop included basic training about gender, GBV, power, abuse of power, and concrete action that can and should be taken by a variety of individuals and organizations in the field.
- Conducted a brief discussion and training session in Kono with UNHCR staff, including drivers.
- Assisted Programme staff to develop specific indicators and follow-up plans to monitor the work of GBV implementing partners.
- Provided technical assistance to the gender officer in preparation for a basic GBV workshop for all staff.

Training and Technical Support with IRC

- Provided technical assistance and consultations with IRC program managers and supervisors in Kenema, Bo, and Kono. Focused on strengthening community participation and ownership of GBV prevention and response.
- Reviewed monitoring, evaluation, documentation, and record-keeping systems; made recommendations and provided samples.
- Developed a draft program plan for the coming year, in consultation with IRC program managers. The plan included objectives, indicators, staff training, monitoring, and evaluation.
- Conducted a five-day training workshop with all GBV staff to support a shift in program emphasis toward increased community participation.

- Provided advice and guidance for training topics to be provided by IRC to FAWE. This training is included in IRC's subagreement with UNHCR.
- Provided technical advice to strengthen IRC's plan for establishing hospital-based rape referral and response centers.

Training with FAWE

- Conducted a five-day training workshop with leaders and managers from all FAWE branch offices in Sierra Leone. Participants now have the basic knowledge and tools they need to revise and strengthen their work to prevent and respond to GBV.
- Conducted a follow-up meeting with FAWE leaders to encourage follow-through with program changes discussed in the workshop.

TA RECOMMENDATIONS

UNHCR

Addressing GBV in Sierra Leone is more complex than in other countries. The GBV TA recommendations, therefore, are more detailed.

- Provide staff at all levels with training in GBV prevention and response and provide written resource materials and guides so that staff can perform their roles and responsibilities appropriately.
- Ensure that staff in all offices establish regular contacts with the GBV programs in their assigned region, attend coordination meetings, and engage in prevention and response planning and action.
- Review the report from the interagency planning workshop and assign high-level UNHCR staff to engage in the follow-up process and continued planning and action.
- Collaborate with IRC to develop and implement training programs for refugees to raise awareness of GBV, human rights, and entitlements and assistance available.
- Require health implementing partners to conduct staff training, develop GBV protocols, and participate in GBV coordination meetings and other efforts.
- Strengthen monitoring of GBV implementing partners and use the monitoring tools developed by the gender officer. Monitor FAWE's work more closely, especially outcomes, and encourage stronger liaison and coordination with IRC in Bo and Kenema. Remove the health component from FAWE's subagreement. Allow a transition period so that FAWE can make arrangements with the Ministry of Health. UNHCR's health coordinator may be able to assist with the supply of drugs for the ministry.

IRC

- Increase support to the field programs in the following two ways: (1) Establish a GBV program coordinator based in Freetown, to travel to program sites. This will improve overall program management and oversight, as well as much-needed coordination, collaboration, and communication with other organizations at the Freetown level. (2) Maintain program mangers in field sites and hire an additional program manager if the sexual assault referral center project goes forward.
- Strengthen the program by continuing to implement the plan developed with program mangers. Key areas for improvement are in staff training, community participation, involvement of men, and integration of program components into community-based services.
- Engage and train Ministry of Health and international health NGOs for health response and prevention activities.

- Continue and strengthen collaboration with the Ministry of Social Welfare-Gender-Children's Affairs to build its capacity as the country's leader in GBV prevention and response.
- Provide drugs (for STIs and emergency contraception) through the Ministry of Health or health NGOs, not vertically through IRC's GBV program. This change will need follow-up discussions with UNHCR to ensure a smooth transition. Consider linking with the Reproductive Health Group in Kono to provide health care for survivors.
- Continue the legal advice component with a view toward subcontracting this work to a partner NGO. There are legal assistance NGOs emerging that target their activities to assist women and children who have survived gender-based crimes.

FAWE

- Implement significant changes to the program as discussed and planned in the workshop. Obtain from UNHCR adequate copies of the various UNHCR books and resource materials about GBV programming and distribute to all branches.
- Coordinate work with UNHCR and IRC in Bo and Kenema.
- Transfer health component in subagreement with UNHCR to Ministry of Health.
- Upgrade skills training for GBV survivors and at-risk women and girls to include basic numeracy training and business planning.
- Establish working relationships with employers, rural credit or microfinance programs for women, and other organizations that provide avenues for income generation.

CHAPTER 17

Thailand

First steps in GBV program planning

The Kingdom of Thailand, a constitutional monarchy, is well off, relative to other countries in Southeast Asia. Its neighbor Burma, however, is one of the poorest countries in the world, with a military regime reportedly committing widespread state-sponsored human rights abuses, repressing ethnic minorities, and forcing population relocations based on economic strategy. Of the estimated 1.5 million refugees who have fled Burma, approximately half live primarily in refugee camps on the Thai-Burma border, and several hundred thousand are scattered throughout Thailand.

DISPLACED POPULATIONS

The Royal Thai Government (RTG), whose country's resources and land have been stretched by the seemingly intractable refugee crisis, has imposed increasingly severe restrictions on the rights and mobility of people from Burma living in Thailand. Those from Burma seeking refuge and deemed by the Thai government to be direct victims of the Burma conflict (i.e., persons of concern) are officially permitted to receive humanitarian aid, primarily within camp settings. Those fleeing from other regions, deemed illegal immigrants, are denied refugee services and live under the threat of forced repatriation.

Food and relief assistance to refugees who live in camps is coordinated by the Burmese Border Consortium (BBC) in cooperation with the RTG according to regulations set by the Thai Ministry of Interior. BBC cooperates with humanitarian aid partners that provide health and education services. The Committee for Coordination of Services to Displaced Persons in Thailand, formed by NGOs in 1975, serves as a communications network. The CCSDPT meets monthly to exchange information, discuss ongoing work, coordinate efforts, and assist in representing NGO interests to the RTG, international organizations, and embassies. The RTG Ministry of Interior oversees policing of the camps and refugee compliance, in general. Within the last few years, the Thai government enlisted the support of the UNHCR to register, monitor, and protect refugees within camps. UNHCR is also responsible for identifying and assisting persons of concern in urban areas.

GBV

Many forms of GBV occur in and around the camps, or occurred prior to arrival in the camps. There was no documentation available of any reported

incidents, so it is impossible to know the extent and severity of the problem. The following is anecdotal information about GBV in the refugee community.

Rape

A few women reported being raped by combatants in Burma, prior to or during flight. Women's organizations and human rights groups have reported this as a widespread problem in Burma. Rumors of rape perpetrated by Thai soldiers, once common, have decreased over the last two years. Only one such incident was remembered in the last year; these cases are usually kept quiet, with the soldier being reassigned and some money given to the survivor's family. There are occasional reports of rape perpetrated by someone the survivor knows (family, friend, neighbor, acquaintance).

Domestic Violence

Reports of domestic violence are increasing. The community's definition of domestic violence seems to include emotional mistreatment (including adultery) of intimate partners, as well as physical and sexual abuse in the home.

Child Sexual Abuse

The one identified case of child sexual abuse was perpetrated by the father; the refugee camp committee sentenced him to five months in the camp "jail."

Sexual Exploitation and Abuse

Not uncommon, this type of GBV largely affects young women and adolescent girls; it sometimes results in forced marriage. A woman who has been raped, sexually assaulted, or abused (including abuses perpetrated by husband) is viewed by the community as a failure and somewhat of an outcast. The social consequences of self-reporting are devastating.

GBV INITIATIVES AND PROGRAMS

There is no established system in place for prevention and response to GBV in any of the camps. In many locations, Burma women's organizations have established networks to receive incident reports and assist survivors. Reporting and referral mechanisms are largely informal and depend on individual personalities. On occasion, UNHCR may be informed about a case and investigate it, but this is rare. For the few cases that are reported to the women's organizations, some counseling is available, health care is usually not sought, and any quest for legal justice is deferred to the camp committee. Decisions by camp committees can often result in retraumatization of the survivor, as the decisions tend not to recognize full human rights for everyone. Thai authorities (police, courts) are not involved in GBV response in the camps; neither refugees nor NGOs are seeking their involvement or engagement.

GBV TA MISSION

In January and February of 2002, the GBV Technical Advisor conducted a four-week visit to Thailand in response to a request for assistance from the CCSDPT health subcommittee. Visits to five refugee camps and five towns included meetings with key stakeholders, group and individual interviews, participatory training workshops, and record reviews.

TA ASSESSMENT

Gender considerations are relatively new to many of the organizations working along the Thai-Burma border, and most staff of humanitarian

organizations are not trained on issues of gender in programming. In recent years, there have been some awareness-raising and training workshops on GBV and on the related subjects of human rights and protection. In 2001, there were several training workshops for NGOs and UNHCR on protection issues, including one focused on GBV issues. There are camp coordination meetings for specific sectors, such as health; coordination meetings at the field office level occur infrequently, and generally do not include specific programming issues.

Fortunately, there is a good base for implementing integrated action for prevention and response to GBV with refugees in Thailand. Schools, health centers, security systems, police presence, NGO presence, women's organizations, youth groups, and camp leadership systems, are all potential *doers* in the struggle against GBV.

The following issues and opportunities were identified at the time of the GBV TA mission.

Health Care

- Reproductive health services are available, although family planning (including condoms) is only available for a married person with consent of both spouses.
- There is no private interview space in the health facilities, even for reproductive health.
- There is inconsistent knowledge about, use of, and supply of emergency contraception. None of the health actors interviewed had ever used emergency contraception post rape.
- Recent medic training now includes gender awareness and management of cases of GBV.
- Medics in the camps are men; they function as the doctors in the settings. Female health staff are nurses and midwives.
- No information, education, and communication (IEC) has been launched to inform the community about help available at the health center in cases of sexual assault.
- Some informal systems exist; RH staff provide health care for GBV cases referred from women's organizations. These mechanisms, dependent on the personality of the humanitarian workers involved, do not capture all of the cases reported to the women's organizations.

Psychosocial Services

- The Women's League of Burma is the umbrella organization for women's groups. Based in Chiang Mai, one of its responsibilities is to build capacity of member organizations, but it lacks the resources to do so.
- Women's organizations in and outside the camps are generally not empowered and are subject to the predominant male leadership in the camps. They lack organizational capacity and need training and support. The Karen Women's Organization (KWO) in Mae La Camp appears to be the most organized and active when it comes to GBV response, benefiting from capacity building from experts in nearby Mae Sot. There are no formal capacity-building or support relationships between the women's groups and any NGO or UN agency working in the camps.
- The refugee communities have been conservative societies, but this is changing. Elders and community leaders are struggling to deal with what they view as destruction of their community morals, most often citing adultery as an example.

- The Catholic Office for Emergency Relief and Refugees (COERR) recently began offering community services, in partnership with UNHCR, to the most vulnerable refugee groups. It does not yet have the available UNHCR resources (books, guidelines, training guides) for community services programs. Staff are new; training and supervisory systems are still being developed. It will likely be some time before COERR can fully implement its community development program and incorporate GBV-related activities.
- Most camps have projects for skill training and income generation, currently targeted to women and to people who were injured by landmines.
- There is no overarching organization for social services, social welfare, or community services in the camps. This role has fallen, by default, to camp section leaders, governing committees, women's organizations, and youth organizations.

Security Systems

- Refugees generally do not perceive the Thai police or the soldiers based in the camp as helpful resources for internal camp problems, including rape and domestic violence.
- Women are not consulted on issues of security.
- UNHCR does not have a strong presence in the camps because of limitations imposed by the Thai government and lack of staff. UNHCR relies on NGOs to inform them about protection issues.
- UNHCR does not have female staff in all field offices.

Legal Justice Systems

- The camp committees, composed almost entirely of men, are the de facto community governments. All problems in the camps are referred to the section leaders, camp committee, or both. Action, or inaction, by a camp committee is reported to be highly politicized; many members are closely linked to the political or military factions in the Burma conflict. Women generally perceive adjudication of GBV cases by the committee as causing more emotional and social harm than benefit to the survivor.
- UNHCR recently conducted some human rights training with camp committees; it is a first step in developing policies that appropriately address many human rights issues, including GBV. No organization is taking a formal role to continue capacity building with the camp committees.
- The Thai government is perceived by women's groups as not involved, interested, or needed in GBV efforts. Government response to GBV among Thai citizens has not been supportive of female survivor rights. Thai women's advocacy groups are working to improve the way police and court systems deal with such cases.

TA ACTIONS

Nu-Poh and Umpiem Mai Camps

- Reviewed and made recommendations on the draft GBV protocol with the managers of the ARC International Reproductive and Child Health and the Community Health Education programs.
- Provided and reviewed several key guidelines and resources, including the Incident Report Form and various training and other materials.

- Conducted two half-day training sessions with Nu-Poh health and community services staff and the Karen Women's Organization. Topics included an overview of GBV, with a focus on the attitudes needed to encourage reporting incidents of GBV.
- Conducted a meeting with NGOs in Umpiem Mai, which included an overview and introduction to GBV.

Mae Kong Kha Camp

- Conducted a half-day informal awareness-raising and problem-solving meeting with representatives from women and youth organizations and RCH staff (Malteser Germany).
- Conducted a half-day training with teachers. Topics included an overview of gender and GBV prevention and response.

Mae Hong Son, Camps 2 and 3

- Provided technical assistance to IRC's RCH manager concerning the new WHO/UNHCR guidelines for medical management of rape cases, key information in resource materials on GBV prevention and response, and the advantages of active screening of RH clients for GBV.
- Held a discussion with a Karenni Health Department representative concerning coordination of prevention and response actions with the camp committee, social services, and other refugee groups.
- Met with representatives from women's organizations to encourage their leadership on GBV issues.

Country Wide

- Met with representatives of UNHCR, NGOs, and Burma women's organizations in Bangkok, Chiang Mai, Mae Sot, Mae Hong Son, and Mae Sariang. Provided technical advice, recommendations, and written resource materials to these groups to promote increased leadership and action in prevention and response to GBV.

TA RECOMMENDATIONS

Throughout this mission to Thailand, many specific and detailed ideas, suggestions, and recommendations were discussed. There are two overarching recommendations to strengthen GBV prevention and response in the refugee communities in Thailand:

- Multisectoral system for coordinating the action, and a strategy and action plan for prevention of GBV.
  - — Integrate issues of gender, including GBV prevention and response, into the activities of all organizations that work with refugees.
  - — Foster the understanding that GBV action is a normal part of the humanitarian responsibility of all four key sectors: health, psychosocial, security, and legal justice.
  - — Formalize support to refugee women's organizations and build their capacity to take the lead in GBV interventions.
- Humanitarian actors must increase their own knowledge and awareness of GBV and leverage their positions to influence change in gender inequalities, gender discrimination, and GBV in the refugee communities and among their own staff.

CHAPTER 18

Zambia

Initiating a GBV program with refugees

Zambia is a developing country in the southern region of Africa. Recent drought conditions, combined with politically motivated economic policies and practices, have resulted in severe food shortages. Residents in the southern areas of this massive country are starving; the country and its neighbors in southern Africa are facing famine.

The Mayukwayukwa refugee camp in Zambia was established in 1966, making it among the oldest, if not the oldest, refugee camp in the world.

DISPLACED POPULATIONS

Zambia is presently host to 270,000 refugees, according to recent figures from the UNHCR, primarily from the neighboring countries of Angola and the Democratic Republic of Congo (DRC). Some of these refugees have been in exile for more than 20 years.

The refugee camps are located in the western and northern provinces. Travel from the capital to the western area requires one full day of driving, including crossing the Zambezi River on a pontoon boat. Travel from the capital to the northern area is a day-and-a-half drive. UNHCR suboffices in the west and north cover large geographic areas and multiple camps. Refugees also live in the capital city of Lusaka and other urban centers around the country.

As is the case in most African refugee settings, funds and resources for humanitarian aid are too low to adequately meet the needs of the population. Funds for vehicles, communication, and other logistical support for field operations are also insufficient.

Given Zambia's modest resources, refugee oversight and assistance from the Zambian government has been exemplary. As part of a larger Zambian initiative to address poverty in the western provinces, host to most of the refugees, the government is developing programs to help refugees become productive members of Zambia's society. Many refugees have been integrated into the local communities and have been given plots of land for subsistence farming. However, famine conditions, coupled with the growing refugee population, continue to strain Zambia's limited resources.

GBV

In the refugee camps, there are reports and rumors of rape, domestic violence, abduction and forced marriage, as well as sexual abuse and exploitation. As with all displaced populations, the perpetrators are mostly fellow refugees, host country nationals, and sometimes even humanitarian aid staff, generally males in positions of power and control over their victims.

Reports from the conflict in DRC describe horrific sexual abuses targeting civilian women and girls, although it is not known whether such survivors are included among the refugee populations in Zambia. Actual numbers are unknown at this time; no data are regularly compiled by UNHCR or NGOs on the GBV incidents reported. Qualitative data are available through refugee staff in Community Services and GBV programs in the camps.

Many forms of GBV are crimes under Zambian law, which has a specific system for documenting medical evidence for rape and other crimes. A Zambian doctor must complete the required form. This means that refugee survivors of rape must first report to the health clinic in the camp; they are then referred to the closest government hospital for official examination and documentation. This can cause delays in response in an environment where there are insufficient vehicles and radios.

The high incidence of HIV/AIDS in Zambia has added more severe and lethal consequences to GBV.

GBV INITIATIVES AND PROGRAMS

Prevention and response to GBV in the Zambian camps are in their infancy.

Although ad hoc crisis intervention from community services workers has long been available, comprehensive GBV action has only recently been initiated in some camps.

In 2001, CARE Zambia launched a GBV program to develop multisectoral and interagency prevention and response to GBV. CARE's program includes a national GBV coordinator and refugee staff in each of two camps: Mwange in the north serving Congolese, and Nangweshi to the west serving Angolans. CARE recently hired a national coordinator to be based in Lusaka and support the work of both GBV program sites. The national coordinator is a welcome and needed addition to the program, although it took time to find the right person with the right mix of skills and knowledge. One of her responsibilities is to facilitate communication and build interagency action at field sites and at the national level. Interagency and multisectoral coordination and decision making at headquarters (national) levels in UNHCR, NGOs, and key government agencies has been notably lacking from GBV efforts.

CARE's program has already made great gains at the field sites in engaging cooperation and action with psychosocial programs, health providers (NGO and government ministry), police, the Zambian government's refugee officer, and among refugees. Interest, cooperation, and goodwill are high at the field sites. Without attention and support from the country office, however, the field-based GBV coordinators have been limited in their ability to design, implement, monitor, and evaluate the GBV program. The next steps are to build the skills of the GBV refugee staff and establish interagency procedures for GBV prevention and response.

Hodi, a Zambian NGO, is UNHCR's Community Services implementing partner in the Kala and Mayukwayukwa camps. Kala, which has mainly Congolese refugees, is located to the north near Mwange Camp. Mayukwayukwa, the oldest and largest camp, is located to the west and has a mixed population of refugees, primarily from DRC. In early 2002, Hodi expanded its community services to include psychosocial assistance to GBV survivors in Kala Camp. Similar expansion in Mayukwayukwa started in August 2002. Program development and staff training are in early stages in Kala and Mayukwayukwa. It is anticipated that Hodi will collaborate with CARE to build the interagency and multisectoral involvement needed at field and national levels.

There have been two GBV planning meetings in Lusaka, involving UNHCR, key national and international NGOs and government authorities. The most recent meeting, in August 2002, resulted in commitments from all agencies present to continue to meet regularly and establish an interagency coordination system to support GBV efforts in the field.

Collaboration between CARE and Hodi and active involvement of UNHCR is crucial during the early stages of GBV program development.

GBV TA MISSION

At the request of CARE Zambia, the GBV Technical Advisor conducted a four-week field visit in December 2001. CARE asked for technical assistance to develop a detailed implementation plan for its new GBV program and to provide initial training and technical support to the newly hired GBV national staff who would lead the program. The TA made a three-week follow-up visit in August 2002, to assess progress and provide additional support.

TECHNICAL ASSISTANCE AND TRAINING

December 2001, First Visit

- Facilitated interagency planning and coordination meetings with UNHCR, NGO, government, and refugee stakeholders in each field site and in Lusaka. Promoted and encouraged continued development of interagency teams and interagency community systems in each of these three locations.
- Conducted training with all CARE staff in both field sites to begin awareness raising about GBV and to introduce the new GBV program plans.
- Facilitated the development of a detailed program implementation plan. Included teaching with—and active participation from—CARE management and program staff in field sites and the capital. The plan included specific methods for monitoring and evaluation.
- Conducted training and technical advising with the GBV coordinators on implementation details, including situation analysis, staff training and supervision, interagency coordination systems, and monitoring and evaluation.

TA Recommendations

At the time of the first visit, the following overarching observations and recommendations were made to the interagency teams in each site:

- The new GBV programs will need careful and continuous attention and monitoring. GBV coordinators need support and supervision.
- GBV programs are highly visible. Sensitive issues will come up; there is a potential for security and protection problems for refugees and staff. Security is another reason for careful planning and close supervision and monitoring.
- Gender awareness training, GBV training, and behavior standards and accountability systems are needed for all staff, all organizations, and all levels.
- It is crucial to gain high-level UNHCR support and the active and continuous engagement of UNHCR staff from Protection, Community Services, Health, Field, and Programme.

August 2002, Follow-Up Visit

- Facilitated planning meetings at each field site and in Lusaka with the interagency team. Provided training to support taking next steps to formalize systems, including agreeing on guiding principles, establishing written procedures for reporting, documentation, referrals, follow-up, and information sharing.
- Established links between Hodi and CARE GBV programs; encouraged continuing coordination and information sharing.
- Provided training and technical assistance to CARE GBV coordinators and staff to strengthen monitoring and evaluation.
- Provided written GBV resource materials to CARE, HODI, and UNHCR.

TA RECOMMENDATIONS

Recommendations to the interagency team during the August 2002 follow-up visit include the following:

- Develop specific reporting and referral procedures, including interagency coordination mechanisms at each field site. Put these procedures in writing; translate them into French and Portuguese. Refugees are reporting GBV incidents to refugee staff, but there is no coordinated response system in place.
- UNHCR staff, especially Protection Officers, should join the interagency GBV teams at each field site and provide follow-up assistance to survivors, as needed, with the Zambian legal system.
- CARE, Hodi, and all the members of the interagency team must agree on an Incident Report Form, train all staff, and compile data regularly. This is an important first step to monitoring and evaluation.
- CARE and Hodi national and refugee staff need extensive training, and careful support and supervision.

Appendices

A. Resources

B. Sample Manual of Interagency Procedures and Practices

APPENDIX A

Resources

The publications listed are in English; many are also available in French and other languages.

KEY MATERIALS—GBV PROGRAMS IN POPULATIONS AFFECTED BY ARMED CONFLICT

Clinical Management of Survivors of Rape, WHO and UNHCR, 2002.

A step-by-step guide to the development of health care protocols for use in refugee and IDP situations.

Publication number: WHO/RHR/02.08
To order:
UNHCR DOS
94 rue Montbrillant
Geneva1202 Switzerland
E-mail: <HQTS00@unhcr.ch>

Also available through UNHCR offices world wide
Internet download: <www.rhrc.org>

GBV Tools Manual, Reproductive Health for Refugees Consortium (in press).

Forms, tools, and instructions for assessment and monitoring/evaluation of GBV programs. Includes situation analysis, prevalence survey, focus groups, sample staff recruitment guides and job descriptions, Incident Report Form, terms and definitions, M&E tracking sheets, and report formats. CD-ROM or hard copy. Publication anticipated December 2002.

To order:
RHRC c/o Women's Commission
122 East 42nd Street
New York, NY 10168 USA

Prevention and Response to SGBV in Refugee Situations: Interagency Lessons Learned Conference Proceedings, 27–29 March 2001, UNHCR, 2001.

Describes multisectoral response, prevention strategies, coordination mechanisms. Includes samples of protocols, guidelines, roles and responsibilities, program ideas, forms.

To order:
UNHCR DOS
94 rue Montbrillant
Geneva1202 Switzerland
E-mail: <HQTS00@unhcr.ch>

Also available through UNHCR offices world wide
Internet download: <www.rhrc.org>

Interagency Guidelines for the Prevention and Response of Sexual and Gender-Based Violence Against Refugees, Returnees, and Internally Displaced Persons, UNHCR (in press).

This updated version of the 1995 Guidelines includes detailed guidance for developing community-based, multi-sectoral, and interagency prevention and response plans. It describes the minimum recommended standards for survivor assistance services and prevention activities. It includes tools to conduct situation analyses, monitoring and evaluation indicators, and a new Incident Report Form recommended for use world wide. CD-ROM or hard copy. Publication anticipated 2003.

To order:
UNHCR DOS
94 rue Montbrillant
Geneva1202 Switzerland
E-mail: <HQTS00@unhcr.ch>

Also available through UNHCR offices world wide
Internet download: <www.rhrc.org>

Sexual Violence Against Refugees: Guidelines on Prevention and Response, UNHCR, 1995.

First version of UNHCR Guidelines, to be revised and replaced in 2003 (above). Describes forms of sexual violence, risk factors for refugees, guidelines for prevention and response in refugee settings.

To order:
UNHCR DOS
94 rue Montbrillant
Geneva1202 Switzerland
E-mail: <HQTS00@unhcr.ch>

French version available from UNHCR offices world wide.
English version is out of print, but remaining copies may be available.
Internet download: <www.rhrc.org>

Reproductive Health for Refugees Consortium Web Site

Annotated bibliography with links to related sites.

<www.rhrc.org/resources>

UNITED NATIONS PUBLICATIONS—GBV PROGRAMS AND RELATED TOPICS

Action for the Rights of Children (ARC) Resource Packs, UNHCR and Save the Children–Sweden, 2001.

The ARC Resource Packs cover a range of topics concerning protection of children in refugee settings and include reading, workshop materials, and references. The Exploitation and Abuse Pack looks at risk situations, preventive measures, and how to respond when children are abused or exploited. CD-ROM or hard copy.

To order:
UNHCR DOS
94 rue Montbrillant
Geneva1202 Switzerland
E-mail: <HQTS00@unhcr.ch>

Also available through UNHCR offices world wide
Internet download: <www.rhrc.org>

How-To Guides (UNHCR)

This series of booklets describes field experiences and lessons learned in RH and GBV programming.

- *How-To Guide: Building a Team Approach to Prevent and Respond to Sexual Violence in Kigoma-Tanzania*, UNHCR, December 1998.
- *How-To Guide: Crisis Intervention Teams—Responding to Sexual Violence in Ngara, Tanzania*. UNHCR, January 1997.
- *How-To Guide: From Awareness to Action—Eradicating Female Genital Mutilation With Somali Refugees, East Ethiopia*, UNHCR, May 1998.
- *How-To Guide: Monitoring and Evaluation of Sexual Gender Violence Programs, Kigoma and Ngara, Tanzania*, UNHCR,

April 2000.

To order:
UNHCR DOS
94 rue Montbrillant
Geneva1202 Switzerland
E-mail: <HQTS00@unhcr.ch>

Also available through UNHCR offices world wide
Internet download: <www.rhrc.org>

Mental Health of Refugees, WHO/UNHCR, 1996.

Broad guidelines about helping skills and some of the most common mental health needs in refugee populations. Written in simple language, this manual is intended for relief workers, community workers, health workers, teachers, and others; the reader does not need special training in psychology or mental health.

To order:
UNHCR DOS
94 rue Montbrillant
Geneva1202 Switzerland
E-mail: <HQTS00@unhcr.ch>

Also available through UNHCR offices world wide
Internet download: <www.rhrc.org>

A Practical Approach to Gender-Based Violence: A Program Guide for Health Care Providers and Managers (pilot edition), UNFPA (New York) 2001.

Step-by-step guidance on how RH facilities can begin GBV projects and integrate assessment and treatment of GBV into their services.

To order:
UNFPA
220 East 42nd Street
New York, NY 10017 USA

Refugee Children: Guidelines on Protection and Care, UNHCR, 1994.

This book is for staff in UNHCR and its operational partners. Each chapter discusses a subject from the point of view of children's needs and rights.

To order:
UNHCR DOS
94 rue Montbrillant
Geneva1202 Switzerland
E-mail: <HQTS00@unhcr.ch>

Also available through UNHCR offices world wide

Reproductive Health During Conflict and Displacement: A Guide for Program Managers, WHO, 2000.

Guidance and tools for assessment, planning, implementation, and monitoring and evaluation of RH services during the different phases of conflict and displacement. Includes a chapter on GBV.

Publication number WHO/RHR/00.13

To order:
WHO Geneva
Internet download: <www.who.int>

Reproductive Health in Refugee Situations: Interagency Field Manual, UNHCR, 1999.

Developed by an interagency team of RH experts, this manual covers basic and essential reproductive health issues, needs, and program recommendations. Includes a chapter on GBV for health providers.

To order:
UNHCR DOS
94 rue Montbrillant
Geneva1202 Switzerland
E-mail: <HQTS00@unhcr.ch>

Also available through UNHCR offices world wide

or

RHRC c/o Women's Commission
122 East 42nd Street
New York, NY 10168 USA
Internet download: <www.rhrc.org> or <www.ippf.org/resource/refugeehealth/manual/indext.htm>

WHO Fact Sheets:

- *Female Genital Mutilation*, Number 241
- *Gender Health and Poverty*, Number 251
- *Violence Against Women*, Number 239
- *Women and STIs*, Number 249

Internet download: <www.who.int/mediacentre/factsheets/en/>

RECOMMENDED BOOKS, WEBSITES, MATERIALS

Abandoning Female Genital Cutting, Population Reference Bureau, 2001.

Describes different types of FGC, prevalence and attitudes, and overview of approaches and recommended actions to end FGC.

Internet download: <www.measurecommunication.org>

Pickup, Francine. *Ending Violence Against Women: A Challenge for Development and Humanitarian Work*, Oxfam GB, 2001.

Comprehensive discussion of GBV including prevalence, impact, context, various approaches and strategies for supporting survivors, working with men, challenging attitudes and beliefs, and policy issues.

To order: Depends on country. Contact—
Oxfam Publishing
274 Banbury Road
Oxford OX2 7DZ UK
Fax: 44-1865-313925
E-mail: <publish@oxfam.org.uk>

Picturing a Life Free of Violence: Media and Communications Strategies to End Violence Against Women, UNIFEM, 2001.

Booklet to accompany electronic database of successful strategies and media materials created and used around the world. Samples of posters, radio/TV public service announcements, pamphlets, and other materials targeting various types of GBV.

Database:
<www.jhuccp.org/mmc>
To order:
<www.endvaw.org>

Population Reports: Ending Violence Against Women, Johns Hopkins University School of Public Health, Series L, Number 11, 1999.

This publication describes intimate partner abuse and sexual coercion world wide and offers specific guidance for health care practitioners and others to assist survivors and develop strategies for prevention.

To order:
Population Information Program
Johns Hopkins School of Public Health
111 Market Place, Suite 310
Baltimore, MD 21202 USA
Fax: 1-410-659-2645
E-mail: <PopRepts@jhuccp.org>
Internet download: <www.jhuccp.org>

Spindel, C., Levy, E., Connor, M. *With an End in Sight: Strategies from the UNIFEM Trust Fund to Eliminate Violence Against Women*, UNIFEM, 2000.

Lessons and good practices from Trust Fund initiatives world wide; the book includes program examples and case studies from five different regions of the world.

To order:
United Nations Development Fund for Women (UNIFEM)
304 East 45th Street, 15th Floor
New York, NY 10017 USA
Fax: 1-202-906-6705
E-mail: <unifem@undp.org>
Website: <www.unifem.undp.org>

Ward, Jeanne. *If Not Now, When? Addressing Gender-Based Violence in Refugee, Internally Displaced, Post-Conflict Settings*, RHRC, 2002.

Describes GBV issues and programs in populations affected by armed conflict in 12 countries. Includes recommendations for policy, research, and programming.

To order:
RHRC c/o Women's Commission
122 East 42nd Street
New York, NY 10168 USA

Internet download: <www.rhrc.org>

TRAINING MANUALS AND RESOURCES

de Negri, B., Thomas, E., Ilinigumugabo, A., Muvandi, I., and Lewis, G. *Empowering Communities: Participatory Techniques for Community-Based Program Development. Volume 1 (2): Trainer's Manual (Participant's Handbook)*. Nairobi: The Centre for African Family Studies (CAFS), in collaboration with the Johns Hopkins University Center for Communication Programs and the Academy for Educational Development (AED), 1998.

Trainer and participant manuals for participatory methods in developing community-based programs. Includes detailed workshop formats, handouts, exercises, guidance for the trainer.

To order:
AED
1825 Connecticut Avenue, NW
Washington, DC 20009 USA
or
Centre for African Family Studies
Pamstech House, Woodvale Grove, Westlands
P.O. Box 60054
Nairobi, Kenya
<www.cafs.org>

Internet download: <www.aed.org>

Williams, Suzanne. *The Oxfam Gender Training Manual*, Oxfam UK and Ireland, 1994.

Comprehensive training manual, with workshops, exercises, and handouts on a variety of gender topics ranging from basic information to gender analysis for program developing. Workshops for groups of men, women, and mixed groups.

To order:
Depends on country. Contact—
Oxfam Publishing
274 Banbury Road
Oxford OX2 7DZ UK
Fax: 44-1865-313925
E-mail: <publish@oxfam.org.uk>

Reproductive Health for Refugees Consortium Web Site

The Reproductive Health for Refugees Consortium Web site includes a GBV bibliography with links to various sites and training resources by sector and topic.

<www.rhrc.org>

Pretty, J., Guijt, I., Thompson, J., Scoones, I. *Participatory Learning and Action: A Trainers Guide,* International Institute for Environment and Development (IIED), 1995.

One of a series of training guides and materials on the various aspects and applications of participatory learning and action methodologies for development. This book is a comprehensive trainer's guide with workshop details, handouts, and guidance for the trainer.

To order:
Earthprint
P.O. Box 119
Stevenage, Hertfordwhire SG14TP UK
Fax: 44-1438-748844
E-mail: <orders@earthprint.com>
Website: <www.earthprint.com>
IIED, other publications and information: <www.iied.org>

APPENDIX B

Sample Draft Manual of Interagency Procedures and Practices

SAMPLE — DRAFT

for adaptation by GBV interagency teams in specific settings

MANUAL OF INTERAGENCY PROCEDURES & PRACTICES:

Support to Refugee Communities for Prevention & Response to GBV in [*name of field office or suboffice area*]

[*country*]

Developed in collaboration:

[*list all NGOs, IOs, government ministries, and so forth involved in the development of this manual in the setting*]

First Draft for review and discussion: [*date*]
Final First Version: [*date*]
Review/Revisions: [*dates in future when revisions are made*]

INTRODUCTION

Prevention and response to gender-based violence (GBV) requires a cooperative team effort from many groups and organizations. The procedures that follow were developed by representatives from the organizations [*listed on the cover*], in a collaborative effort to establish clear systems, roles, and responsibilities for each individual, group, agency, and organization involved in the prevention of and response to GBV affecting the refugee camps and refugee affected areas in the region of [*country*].

These procedures can also serve as teaching tools for anyone involved in prevention and response efforts. International and national staff rotate in and out of a country. This manual has been developed to ensure that the procedures and systems remain in place within the organizations even after individuals have left the region.

DEFINITION OF GENDER-BASED VIOLENCE*

GBV is physical, mental, or social abuse (including sexual violence) that is attempted or threatened, with some type of force (such as violence, threats, coercion, manipulation, deception, cultural expectations, weapons, or economic circumstances) and is directed against a person because of his or her gender or gender roles and expectations in a society or culture. In circumstances of GBV, a person has no choice to refuse or pursue other options without severe social, physical, or psychological consequences. Forms of GBV include sexual violence, sexual abuse, sexual harassment, sexual exploitation, early or forced marriage, discrimination, denial (such as education, food, freedom), and female genital mutilation. Not all forms of GBV are considered criminal acts in all countries.

GUIDING PRINCIPLES

All actors agree to the following principles as guides for their behavior, intervention, and assistance. All actors agree to arrange appropriate training and refresher training for all staff, as well as accountability measures for staff to use these guiding principles in their work.

Confidentiality

At all times, the confidentiality of the survivor(s) and their families will be respected. This means that information will be shared only with others who need to know in order to provide assistance and intervention, as requested and agreed to by the survivor. All written information with identifying details will be maintained in secure, locked files. If any reports or statistics are to be made public, only one responsible officer in the organization will have the authority to release such information and any identifying information (e.g., name, address) will be removed.

Respect

The actions and responses of all actors will be guided by respect for the wishes, the rights, and the dignity of the survivor. For example, actors will—

- Conduct interviews in private settings;
- Conduct interviews and examinations by staff of the same sex as the survivor (e.g., woman survivor to woman interviewer) unless no other staff is available;
- Be a good listener;
- Maintain a nonjudgmental manner concerning the survivor and her or his behavior;
- Be patient; when possible, do not press for more information if the survivor is not ready to speak about the incident;
- Ask only relevant questions;
- Do not discuss the survivor's prior sexual history;
- Avoid asking the survivor to repeat the story in multiple interviews;
- Do not laugh or show any disrespect for the survivor and her or his culture, family, or situation.

*Summarized from definitions in UNHCR guidelines and the United Nations Declaration on the Elimination of Violence Against Women.

Security and Safety

All actors will ensure the safety of the survivor, at all times. Remember that the survivor may be frightened and need assurance that she or he is safe. In all cases, ensure that the survivor is not placed at risk of further harm by the assailant. If necessary, ask for assistance from camp security, police, field officers, protection officers, or others.

Maintain awareness of the safety and security of people who are helping the survivor, such as family, friends, community service or GBV workers, and health care workers.

INITIAL REPORTS

The survivor has the freedom and the right to report an incident to anyone, for example, to—

- Leaders in the community (e.g., camp committee, block or zone leaders, religious leaders, women's group leaders);
- UNHCR, health, community services, GBV, or other NGO staff;
- Police or security in and around the camp;
- Anyone whom the survivor believes can be of assistance.

The person who receives the initial report will attend to the survivor's needs and problems as identified by the survivor. The person will consider appropriate referrals including health care, counseling, security, and legal needs and will escort the survivor to the health center, women's center, UNHCR, and/or police.

ROLES AND RESPONSIBILITIES

The following general descriptions are of roles and responsibilities in GBV prevention and response. Each organization should have detailed protocols, procedures, and policies that provide more specific guidance to staff and volunteers. All actors agree to abide by the guidelines and recommended standards for prevention and response to GBV. They are described in books and other materials, published and provided by UNHCR.

Each organization or group is responsible for ensuring appropriate training for staff and volunteers so that they are able to perform their roles and responsibilities properly.

Refugee Community

The refugee community leads the efforts to respond to and prevent GBV. Many refugee groups and organizations are involved in prevention and awareness raising among refugees in order to encourage changes in attitudes and behavior (e.g., religious, youth, women's, and men's groups, and school programs). The refugee community responds to GBV incidents by providing emotional support and referrals for survivors and by holding perpetrators accountable for their actions.

Within the refugee community, the following two groups have specific responsibilities in GBV response.

Camp Committee

- Sets the example for the community for attitude and behavior by supporting and protecting survivors and ensuring appropriate and fair consequences for the perpetrator;
- Hears and adjudicates GBV cases only as authorized; refers certain types [*to be established and agreed in* individual *country setting*] of GBV cases to the police and protection officer in compliance with national law;
- Respects the human rights of all parties when applying traditional law and judgment.

Women's Groups

Through a network of trained volunteers, the women's organization receives reports from survivors (at the women's center or through community members) and provides emotional support, referrals, and advocacy. The group is also responsible for ensuring around-the-clock availability of these services.

Lead Organization [*specify*]

The [*lead organization*] supports the refugee community by leading the coordination of all GBV activities in each camp; it—

- Facilitates the establishment of safe and confidential space in women's centers for survivors of GBV to report and seek help;
- May provide counseling, assistance, and advocacy for survivors [*if the country has a special GBV program*];
- Facilitates community-based prevention activities, including awareness raising and the establishment of men's groups to prevent GBV;
- Acts as the clearinghouse for all multisectoral data concerning GBV cases;
- Collects, compiles, and distributes reports of incident data, case outcomes, and anecdotal information about GBV occurring in the camps.

Psychosocial Programs

Such programs include community services, psychological counseling services, socialization, skill training, and income-generation programs. They provide direct psychosocial support and social reintegration for survivors and also serve a preventive function by targeting and assisting the most vulnerable refugees.

Health Post or Health Center

This health facility is responsible for medical examination, treatment, follow-up care, emotional support, and referrals. Health staff also provide medical documentation of injuries, which is required for legal proceedings.

UNHCR Protection

The protection officer oversees coordination of all GBV activity related to security and protection. He or she monitors the progress of all legal cases in the police and court system; provides support, advice, and assistance to refugee victims, witnesses, and the accused if he or she is a refugee; provides training with refugee camp committees to build their capacity to respond to GBV cases appropriately and in compliance with human rights standards; and provides training and information for refugees about relevant national and international laws.

UNHCR Health or Reproductive Health

The health coordinator provides training, resource materials, support, and assistance to health implementing partners; oversees and supports effective and efficient referral systems between different levels of health care; monitors health data (including data on GBV cases seen at the health facilities), treatments provided, and health outcomes; and participates in awareness-raising and prevention activities.

UNHCR Field Officers/Assistants

Field officers and assistants monitor issues and problems in the community; assist with security issues; provide administrative solutions to GBV issues; and participate in awareness-raising activities in the camps.

UNHCR Community Services

The community services officer and assistants provide training, resource materials, support, and assistance to psychosocial implementing partners; oversee coordination and development of all psychosocial response and prevention activities; and participate in awareness-raising and prevention activities.

Police/Security Officers

The police respond to reports of GBV crimes in accordance with national laws and policies and uphold the guiding principles established by the interagency GBV team.

Judicial System

The national court system prosecutes GBV crimes in accordance with national laws and policies, with minimal delays, and upholds the guiding principles established by the interagency team.

RESPONSE: REPORTING AND REFERRAL SYSTEM

Survivor makes initial report of incident to anyone.

(Community leaders and/or security may or may not be involved.)

[_____] refers and escorts survivor to women's center or health post or survivor refers herself/himself.

(The first organization to receive the survivor should refer her/him to the other organization.)

WOMEN'S CENTER

- Provide counseling, assure safety.
- Refer to health center.
- Complete Incident Report Form, with a copy to UNHCR Protection in a sealed envelope.
- Inform survivor of available assistance options; refer survivor for services and advocate as needed.

HEALTH POST/CENTER

- Provide medical exam and treatment.
- Document.
- Refer to women's center.

If survivor wants to pursue police action
OR
If survivor is a minor child
OR
If there are immediate safety and security risks

Then either the women's center or the health post refers and escorts survivor to police (or family or friend can escort survivor).

POLICE

- Police take statement and give survivor the medical evidence form.
- Survivor and escort take form to health post for completion.
- Survivor returns completed form to police. (Women's center or GBV staff assist with form to/from police and health post.)
- Police conduct investigation, arrest alleged assailant, and file charges with court.

Follow-up and assistance can include any of the following, *depending on survivor's choices:*

COMMUNITY

- Promote community support and acceptance of survivor.
- Assist survivor (and often assailant) to re-integrate into community.

PSYCHOSOCIAL PROGRAMS

- May provide material support, such as clothing, food, NFI in extreme cases.
- Monitor survivor's social functioning; provide counseling and assistance.
- Encourage participation in socialization and self-support/income-generation activities.

HEALTH POST

- Provide follow-up medical care and treatment, as needed.

UNHCR (PROTECTION, FIELD, COMMUNITY SERVICES, HEALTH)

- Follow up and assist with administrative solutions, as needed (e.g., relocation to another camp, resettlement, separation/issue of new ration cards, new housing plot).
- Protection will monitor status of legal proceedings; advocate as needed; provide legal advice to survivor and witnesses; and provide transportation and assistance to refugees at court.

POLICE/SECURITY

- Monitor security issues; maintain awareness of safety of survivor, witnesses, and those who are assisting the survivor. Intervene and assist as needed.

JUDICIARY

- Conduct legal proceedings, hearings, trial, and sentencing with minimum delays.

MONITORING AND EVALUATION OF RESPONSE ACTION AND OUTCOMES

WEEKLY CAMP-LEVEL GBV ADVISORY BOARD MEETINGS

- Review compiled incident data and case outcomes (nonidentifying information).
- Review, discuss, clarify, and strengthen roles and responsibilities as well as coordination.
- Identify training needs and arrange training as needed.

GBV PROGRAM (OR LEAD AGENCY)

- Compile incident data and case outcomes from all camps into one monthly report (nonidentifying information).

MONTHLY REGIONAL-LEVEL GBV INTERAGENCY COORDINATION MEETING

- Review compiled report of incident data and case outcomes from all camps.
- Review, discuss, clarify, and strengthen roles and responsibilities.
- Identify, discuss, and resolve problems; review and analyze successes.
- Identify training needs and arrange training as needed.
- Review and revise referral and coordination systems as needed.

NATIONAL-LEVEL GBV INTERAGENCY COORDINATION MEETING

- Review GBV incidents reported and case outcomes from field/sub-offices.
- Review and discuss problems identified in field programs.
- Support field level GBV action by solving problems, providing policy-level guidance, advocating for funds, recommending action, and so forth.

PREVENTION

Prevention activities include monitoring incidents and outcomes, raising awareness, and encouraging changes in attitudes and behavior.

All Actors

Maintain understanding of the types and extent of GBV occurring; the causes and contributing factors of GBV; and the attitudes, knowledge, and behavior of the community and staff of organizations that assist the community, by monitoring and analyzing data from all reported incidents and by sharing anecdotal information and observations from refugees and staff.

Identify problems and risks and continuously develop, implement, and review strategies for prevention and methods to improve response.

Participate in awareness-raising activities, training, and community education aimed at encouraging the reporting of GBV and at changing knowledge, attitudes, and behavior about gender and GBV.

Refugee Community, Psychosocial, and Health NGOs

Coordinate schedules and conduct awareness-raising activities, training, and community education aimed at encouraging the reporting of GBV and at changing knowledge, attitudes, and behavior about gender and GBV.

UNHCR Protection, Health, Security

Conduct and/or participate in training for the health, security, and legal justice sectors (including refugee camp committees) with the goal of strengthening response action and promoting changes in knowledge, attitude, and behavior about gender and GBV.

COORDINATION, MONITORING, AND EVALUATION

Regular meetings and written reports are necessary to have information sharing, coordination, and feedback among all GBV actors.

Coordination Meetings

Camp-Level GBV Advisory Board Meeting

Hold regularly scheduled meetings [*biweekly, weekly, or monthly, as agreed*] in each refugee camp. Participants include all representative GBV actors: health, community services/psychosocial programs, GBV [*if there is a separate program*], UNHCR, police/security, refugee leaders and groups. This meeting is a forum to share nonidentifying incident information, discuss and resolve specific issues in GBV response, coordinate activities, and strengthen prevention. In each camp, there will be one GBV focal point who schedules this meeting and ensures distribution of minutes.

Regional-Level GBV Coordination Meeting

Hold monthly meetings for GBV focal points in health organizations, community services/psychosocial programs, UNHCR (all four key sectors), and the host government's security and court authorities. This meeting includes the distribution and review of reported GBV case data (including outcomes), discussion and resolution of issues, coordination of activities, and general program development in both prevention and response. All actors share nonidentifying information about GBV incidents, follow-up, case outcomes, trends, and causes and contributing factors. Strategies are developed to strengthen and improve prevention and response.

To maximize regular attendance and participation, keep the meeting agenda brief and focused. The lead agency convenes and facilitates the meeting and ensures distribution of minutes.

[*Regional divisions must be established; most countries consider these regional-level meetings to be at the Sub-Office level.*]

National-Level GBV Coordination Meetings

UNHCR protection and the lead GBV agency organize regular (usually every other month) coordination meetings with leaders from all organizations involved in GBV prevention and response from all regions of the country. This meeting includes coordination of activities, identification and resolution of problems, and ongoing program devel-

opment. Participants discuss compiled incident data and case outcomes, analyze trends, and establish policy-level support for field-level recommendations and actions.

Outcome Indicators and Reports

Each sector (health, psychosocial, security, and justice) develops and monitors its own specific indicators for prevention and response to GBV, collecting and analyzing data as needed for proper monitoring and program management.

The lead agency compiles monthly GBV statistics from Incident Report Forms. UNHCR protection, field, and police/security provide additional information about case outcomes so that this information can be included in the monthly data summary. Copies of this report are provided to all focal points (camp level and regional level) monthly at coordination meetings and are sent to the national-level coordination group members.

GLOSSARY

This glossary defines the terms used to categorize GBV cases in a social services context. They are the terms used by community services, health, and GBV staff for program reports within NGOs and UNHCR. Legal definitions and criminal charges used by the police, judiciary, and other government authorities are not included here.

Perpetrator or assailant. The alleged attacker.

Survivor. The victim of the GBV incident or crime.

Incident. The GBV event.

Case. Court case; sometimes used by UNHCR to refer to a survivor.

Actor. A staff member of any organization or a community member involved in prevention of and response to GBV.

Minor or child. A person under age 18.

Categories of GBV

[*Insert your terms and definitions here.* The RHRC GBV Tools Manual *(publication pending) includes specific terms and definitions for use world wide in all settings serving displaced populations. It is recommended that each country program review those terms and include them here.*]

Non-GBV Cases

Some cases of violence that are not gender based come to GBV workers. It is tempting to call these cases GBV because these people may be at-risk for GBV. These cases should not be categorised as GBV cases, but might be counted separately when describing the program's actions and activities in reports, particularly for the area of prevention. Examples—

- Child abuse (physical or psychological abuse that is not gender based);
- Family disputes, such as arguments over ration cards or nonfood items;
- Domestic arguments and problems (e.g., polygamy-related problems, children with behavior problems);
- Reproductive health problems, such as impotency, infertility, STIs, unwanted pregnancy.

AGREEMENT AND SIGNATURES

We, the undersigned, as representatives of our respective organizations, agree to abide by the procedures and guidelines contained in this document. We also agree that copies of this document will be provided to all incoming staff in our organizations who will have roles and responsibilities in GBV prevention and response in this setting. This will help ensure that the procedures will continue beyond the contract term of any individual staff member.

_____	_____	_____
[Organization Name]	Date	Signature
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[Organization Name]	Date	Signature
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[Organization Name]	Date	Signature

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