TACKLING GENDER-BASED VIOLENCE IN EMERGENCIES

A Partnership for Accountability

- Real-Time Accountability Partnership -

Graphic: John Kelleher

Gender-based violence (GBV) is a widespread and well-recognised threat to the health, wellbeing, opportunities and lives of women and girls worldwide. The risks and realities of GBV are greatly exacerbated when a disaster strikes. Recognising the need for broad-based, fast and mutually responsible action to address GBV prevention and response in humanitarian responses, six key global-level humanitarian agencies have convened the Real-Time Accountability Partnership (RTAP).

The current RTAP members are USAID's Office of US Foreign Disaster Assistance (OFDA), all three UN lead protection agencies (UNHCR, UNICEF and UNFPA), the lead UN coordination agency (UNOCHA), and one international NGO (International Rescue Committee).

The Real-Time Accountability Partnership promotes accountability for GBV prevention and response across the whole humanitarian response system. The RTAP members work together to ensure that comprehensive GBV programming is in place across sectors during humanitarian crises, that action is coordinated, and that resources are available to address GBV, in line with the scale of the real need. To achieve this, it focuses on strategic actions within the responsibility of key actors during each phase of the Humanitarian Programme Cycle. RTAP members believe that delivering on these actions will foster the prioritization, integration and coordination of GBV prevention and response–a cornerstone of the RTAP theory of change (see below).

The partnership is currently developing an Action Framework for rollout in two humanitarian responses in 2017. International Solutions Group (ISG), an international monitoring and evaluation firm, has recently concluded a baseline assessment of GBV programming in five country-based humanitarian responses. As part of the assessment, the research team solicited high-level input at the global and country level from UN agencies, NGOs and donors to ensure the emerging RTAP framework is based on practical and grounded realities.

This baseline assessment was designed to:

- Assess RTAP members' (and other stakeholders') performances in relation to GBV prevention and response;
- Highlight barriers and enabling factors to effective action and a coordinated response to GBV;
- Recommend key actions for success of RTAP at field and global levels;
- Establish specific measures against which progress can be monitored.

RTAP Field Visit Countries

1. Gaziantep, Turkey
2. Nigeria
3. Iraq
4. Myanmar
5. South Sudan

UNFPA UNHCR The UN Refugee Agency USAID FROM THE AMERICAN PEOPLE unicef OCHA INTERNATIONAL RESCUE COMMITTEE

KEY ASSESSMENT FINDINGS

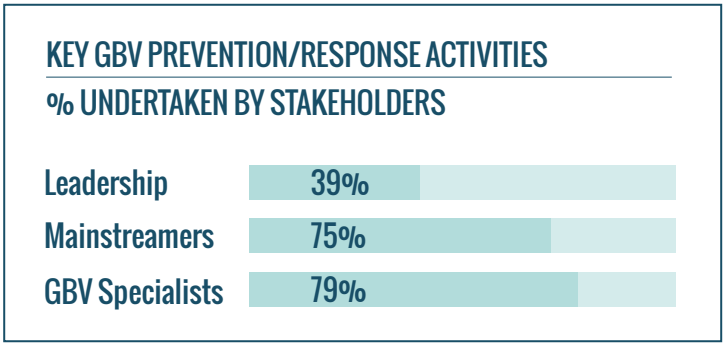
The following are some of the headline results of the baseline research among the different groups of stakeholders. These highlights provide an overview of some of the strengths, weaknesses, opportunities and challenges facing RTAP members.

General GBV Prevention/Response Activities

Research respondents were selected in accordance with the RTAP focus on key actors within the humanitarian system. These were organised in three groups:

1) Leadership (donors, HC/RC, OCHA, government);
2) Mainstreamers (cluster leads and other actors who work outside of GBV);
3) GBV Specialists (UN agencies and NGOs who work specifically on GBV).

An online survey of GBV stakeholders within the five study countries provides feedback on whether or not organisations undertake specific GBV-related activities. Each stakeholder group reports to be meeting the following proportions of key activities related to GBV risk mitigation and/or response:



Leadership stakeholders reported undertaking **an average of 39% of seven key activities.** Commonly undertaken activities respondents noted were:

- Education of media on women´s and girls' rights and violations of these; and
- Monitoring/reporting violations of women´s and girls' rights.

Gaps identified by leadership stakeholders include **some of the most critical GBV prevention and response actions which have the greatest impact,** such as:

- Rapid deployment of skilled GBV specialists;
- Mapping of GBV services;
- Implementation of Protection from Sexual Exploitation and Abuse (PSEA) protocols/community mechanisms, and;
- Training of duty bearers in their GBV obligations.

For *mainstreamers*, who rated their overall performance quite positively (averaging **75% of 13 key activities undertaken)**, the most commonly implemented or supported activities were:

- Promotion of women/girls and community participation and voice in interventions;
- Participatory risk assessments, and;
- Community member inclusion in prevention/risk reduction activities.

Poorly implemented activities for this group included arguably the most critical and straightforward action to reduce risks to women and girls, specifically:

- Safe provision of latrines, secure shelter, communal lighting, food and water, and;
- Training those with responsibility to respect, promote and realise human rights on their obligations.

For *GBV Specialists*, high scores **(79% of 25 key activities undertaken)** indicate positive perceptions of their work. Notable areas of high performance were:

- Promotion of women´s and girls' participation/voice;
- Work to ensure all humanitarian sector programming is in line with GBV Essential Actions per the "GBV Guidelines";
- Development, translation and dissemination of messages about services to women and girls, and;
- Inclusion of community members in prevention and risk reduction efforts.

Areas where GBV specialists felt that they needed to improve performance were:

- Training those with responsibility to respect, promote and realise human rights on their obligations;
- Provision of personal and/or household materials and/or cash to women and girls;
- Education of media on women´s and girls' rights and violations of these;
- Economic or livelihoods interventions for women and girls, and;
- Provision of survivor-centred legal information and support.

KEY FINDINGS ACROSS THE HUMANITARIAN PROGRAMME CYCLE

Preparedness

This phase of the humanitarian programme cycle was where stakeholders reported the greatest challenges and the fewest concrete actions to prioritize GBV prevention and response.

Donors rarely noted specific actions they undertook in the area of GBV prevention and response preparedness, and 52% of GBV specialist stakeholders reported dissatisfaction with rapid deployment of skilled experts. Many *GBV specialist* respondents noted actors undertaking activities supporting preparedness, such as the development of contingency plans; however, preparedness efforts should be more systematically coordinated without being 'reactive' to donor guidance/priorities.

Needs Assessment/Analysis

According to *leadership* stakeholders, proposals and reports have insufficient GBV-related data to understand the full picture of GBV-related risks and needs. Donors saw their de facto role as limited to requiring funding applicants to complete GBV assessment/analysis as part of proposals.

Among *mainstreamers*, respondents regretted the lack of support to collect robust data on which to base response plans.

Response Planning

Leadership roles in this area vary: some donors are active in the Humanitarian Response Plan (HRP) process, but none indicated that they advocate for inclusion of GBV prevention and response, or for GBV objectives in cluster plans.

GBV specialists felt that GBV is successfully prioritised in strategic response plans and funding requests, though were dissatisfied with respect to the financial and human resources available to meet these priorities.

GBV is not consistently mainstreamed in the Humanitarian Response Plans of any of the five research countries.

Resource Mobilisation

The research noted many challenges in resource mobilisation, particularly with respect to monitoring and tracking GBV funding. *Donors* saw their role as limited to providing funds in response to needs and requests and directly funding standalone GBV initiatives, rather than integrating resources across all programmes.

Mainstreamers noted significant challenges, most commonly around the availability of funding for preparedness activities, advocating for such resources via the GBV sub-cluster, and for briefing leaders on GBV trends and actions.

Most *GBV specialists* felt that many GBV programming standards were being largely met. Some raised specific concerns around the limited influence of national NGOs, despite their direct engagement at community level on GBV responses.

Implementation and Monitoring

For *leadership*, an area of perceived positive performance was the engagement of women, girls and at-risk groups in the planning, designing, implementation and monitoring of humanitarian action. However, this observation does not correlate well with the perceptions of other stakeholders. A key finding related to donor roles was a lack of accountability and no use of indicators for GBV mainstreaming. Furthermore, a lack of follow up was noted as a barrier to ensuring that commitments to GBV risk mitigation are met once funding is approved.

For *mainstreamers*, the best-met standard is work towards appointing a lead GBV agency in the HCT. However, stakeholders perceived that implementation of GBV risk mitigation strategies per the GBV Guidelines or other relevant policies across clusters is poor. Monitoring to ensure accountability for GBV risk mitigation is weak. Without discrete activities and indicators, it is difficult for clusters to effectively mainstream GBV, thereby undermining high-level commitments.

GBV specialists noted that the designation of GBV focal points in other clusters was not well implemented, but other measures, such as sharing of information on GBV issues with the Protection Cluster and sub-clusters, and advocacy on the needs of women and girls in different forums, were better implemented.

Enabling Factors and Barriers in Addressing GBV Across the Humanitarian Programme Cycle

ENABLING FACTORS	BARRIERS
GENERAL	
• Clear prioritisation of GBV in agency policies and strategic plans; • Strong commitment at global levels and understanding of agencies' important role to play; • Available range of useful and comprehensive GBV tools/resources;	• Insufficient GBV technical support at global/regional levels; • Varied security, cultural and political dynamics challenge cross-sharing and learning between different contexts; • Limited pool of GBV expertise, particularly IM personnel;
PREPAREDNESS	
• Good investments in training and surge capacity; • Programme criticality underscores GBV as lifesaving; • Good capacity-building of local responders;	• Preparedness not a core part of GBV work; • Lack of donor support for preparedness planning; • Poor technical guidance for humanitarian leadership;
NEEDS ASSESSMENT & ANALYSIS	
• Shared field assessment methodologies that inform overall plans; • Good donor support to GBV-specific assessments; • The inclusion of GBV issues in broader protection assessments;	• Lack of standardised toolkit for GBV specific assessment; • Non-GBV specialist assessments do not typically integrate GBV; • Demands for prevalence data undermine need for establishing GBV programmes irrespective of data;
RESPONSE PLANNING	
• HC/RC/OCHA influence on integrating GBV in HRPs and other plans; • HRP protection objectives that include GBV indicator(s); • Joint cluster strategies /projects that build ownership/commitment; • Advocacy by the GBV community with leadership/HCT at country level; • Short-term cluster/sector level surge support to facilitate GBV integration for risk mitigation; • Mobilisation of pre-existing networks of gender focal points;	• Lack of donor advocacy in the HCT or pooled funding mechanisms; • Lack of support to RC/HCs for attention to GBV in planning; • Cluster leads not always comfortable using GBV Guidelines; • Non-protection cluster partners feel overwhelmed by substantial protection guidance; • Poor strategic planning among GBV sub-clusters; • GBV not always identified with separate HRP indicators;
RESOURCE MOBILISATION	
• Coordinated global initiatives such as the Call to Action and Safe from the Start enhance commitment among all actors; • Multi-year grants for sustainability in GBV programming where appropriate; • Tracking GBV funding to identify shortfalls; • Mainstreaming tools (e.g. the Gender Marker) linked to funding; • Concerted GBV community advocacy to build donor support;	• Access to funding and short-term funding cycles; • The prioritisation by donors of "hardware" interventions; • No donor earmarking or tracking of GBV-related allocations; • Lack of mainstreaming funding beyond GBV Guidelines trainings; • Limited regional support to CLAs for GBV integration in proposals; • A lack of a resource mobilisation strategy in GBV sub-clusters;
IMPLEMENTATION AND MONITORING	
• Sufficient GBV technical staff on the ground; • Standardised monitoring systems; • RC/HC/OCHA support to monitoring of GBV in response plans; • Strong agency support, global cluster support; • Implementation of risk-mitigation activities across clusters/sectors; • GBV specialist co-operation with Protection Cluster & Child Protection actors;	• Insufficient INGO GBV capacity in humanitarian contexts; • Poor work with local partners, particularly women's movements; • Overreliance on surge mechanisms for core programming; • Poor data sources lead to lack of evidence-based programming; • Limited accountability mechanisms for GBV commitments; • Global clusters not holding field counterparts accountable;
COORDINATION	
• Donor funding for coordination staffing, mechanisms and activities; • Dedicated space for GBV issues at humanitarian coordination fora; • Techniques that support local partner engagement in coordination;	• Competition between actors; • Coordination leadership distracted by programme responsibilities when playing multiple roles; • Lack of participation of local partners; • GBV AoR's responsibilities for field operation support ill-defined; • No uniform cluster strategy for coordinating GBV mainstreaming.

THE WAY FORWARD
KEY RECOMMENDATIONS

RTAP takes advantage of the momentum created by recent unprecedented commitments to bring global attention to this long-neglected issue. For the coming pilot phase, RTAP will produce and test a framework for action to be evaluated in two settings, based on the baseline findings, to ensure that GBV prevention and response is prioritised, integrated and coordinated in line with the RTAP theory of change. The following recommendations are intended to inform global and RTAP partner field-level planning.

1- Leadership

DONORS

- ✓ Establish a mechanism to facilitate more meaningful engagement and donor support for a coordinated and cohesive GBV response;
- ✓ Align donor funding for GBV specialist interventions with established strategies for GBV programming
- ✓ Ensure inclusion of GBV Guidelines indicators in proposals and M&E requirements and frameworks;
- ✓ Review and adapt practices to promote donor enforcement of global commitments to GBV at field level;
- ✓ Develop mechanisms to routinely track donor funding allocations for GBV specialised programming.

HC/RC and OCHA and Missions

- ✓ Ensure that GBV is meaningfully integrated into HNO/HRP processes, and within HCT meetings;
- ✓ Dedicate technical surge support in the HC/RC's office to ensure high-level attention to GBV;
- ✓ Include UNFPA as lead GBV agency in all HCTs;
- ✓ Include GBV-related requirements (signed off by the HC/RC and ERC) in the HC/RC TORs and provide appropriate training;
- ✓ Disaggregate Protection Cluster financial data to sub-cluster level (OCHA Financial Tracking Service);
- ✓ Include attention to GBV in the DSRSG TOR and provide appropriate training and performance appraisal.

2- Mainstreamers

- ✓ Assign a national focal point to participate in the GBV coordination mechanism (Cluster coordinators at field level);
- ✓ Include GBV in all cluster action plans;
- ✓ Support clusters to regularly capture good practices linked to GBV through periodic self-assessments;
- ✓ Request dedicated surge support as one method for supporting all clusters to facilitate cluster uptake of the GBV Guidelines;
- ✓ Global cluster coordinators to review integration of GBV in global cluster commitments, policies, guidance and work-plans;
- ✓ Train all cluster coordinators on GBV as part of their induction processes and include with performance management tools at the global level;
- ✓ Develop tools to help GBV specialist NGOs with existing multiple-sector programmes cross-integrate GBV.

3- GBV Specialists

- ✓ Serve as national-level coordinator with sole responsibility of coordination to lead the GBV sub-cluster, and as appropriate, share coordination with other UN protection partners, NGOs and government partners;
- ✓ Undertake a strategic planning process within the GBV sub-cluster that engages UN, government, and national NGO partners in a discussion about setting and meeting short- and long-term goals linked to addressing GBV;
- ✓ Support the inclusion of women's organisations and civil society in GBV response from the preparedness stage forward;
- ✓ Standardise assessment tools and processes to improve the nature and extent of data on the scope of GBV, needs, and availability of services;
- ✓ Implement more (and larger) joint projects among GBV partners, as well as between GBV partners and other cluster partners, to maximise synergies;
- ✓ Identify resources and strategies to continue to support UNFPA and others' efforts to build GBV short-term surge capacity, and develop a larger cadre of GBV specialists;
- ✓ All national-level leadership of RTAP agencies with specialist programming responsibilities to ensure that heads of office at the country level have attention to GBV included in their TORs, with appropriate training and performance reviews.

KEY POINTS OF LEVERAGE

During the assessment process, interviewees noted potential leverage points for supporting the RTAP goal of improved accountability for addressing GBV in humanitarian settings.

1- Leadership

- ✓ US Government policies such as the U.S. GBV Strategy, the National Action Plan on Women, Peace and Security and Safe from the Start as GBV programming entry points and methods to promote accountability of grantees;
- ✓ OCHA's new Gender Policy as a mechanism to monitor HC uptake of GBV concerns;
- ✓ CERF identification of GBV as life-saving;
- ✓ Integration of GBV in the Staff College curricula for Humanitarian Coordinators;
- ✓ IASC Emergency Directors Group, whose current chair prioritises protection and women's issues;
- ✓ Engagement of Call to Action and Safe from the Start signatories in strategic dialogue;
- ✓ Revision of the Sphere Standards to include GBV integration and specialist responsibilities.

2- Mainstreamers

- ✓ Integration of GBV information in surge training for non-GBV specialists;
- ✓ Linking RTAP commitments to the rollout of the GBV Guidelines;
- ✓ RTAP partner mainstreaming of risk mitigation and specialised programming integration;
- ✓ The HRP preparation process: regularising GBV risk mitigation discussions;
- ✓ Regularising GBV integration discussions in inter-cluster/interagency forums (HCT and the ICCG);
- ✓ GBV focal points at cluster level as an entry point for GBV mainstreaming;
- ✓ HR processes and documents for cluster coordinators and mainstreaming actors.

3- GBV Specialists

- ✓ Existing tools that can make up a core resource pack that aligns priorities and methods;
- ✓ Initiatives on Child Protection early-warning systems to include GBV;
- ✓ Integration of actions to prevent and respond to GBV within UNICEF's work on Child Protection and other sectors.

THE RTAP THEORY OF CHANGE

Implementation of the recommendations and use of the key points of leverage above will lay the groundwork for the prioritization, integration and coordination of GBV prevention and response. This objective is a cornerstone of the theory of change that guides RTAP. The theory of change, presented here, sets out a common understanding of the necessary outcomes and commitments to ensure that women and girls are free from all forms and threats of GBV – the long-term, intended impact of RTAP.