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Preventing and responding to gender-based violence in humanitarian crises

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About the authors

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Cover photo: A woman in Monrovia takes part in the '16 Days of Activism' campaign launched by the United Nations Mission in Liberia (UNMIL) to strengthen the rights of women and stop gender-based violence.
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Contents

List of acronyms

CHW	community health worker
DRC	Democratic Republic of Congo
EA$E	Economic And Social Empowerment for women
GBV	gender-based violence
FGM	female genital mutilation
FORAL	Foundation RamaLevina
GAF	Global Assessment of Functioning
GBVIMS	GBV Information Management System
IPV	Intimate Partner Violence
IRC	International Rescue Committee
KnWO	Karenni Women's Organisation
LAC	Legal Assistance Center
MIP	Men Involved in Peace-Building
MISP	Minimal Initial Service Package
MSF	Médecins Sans Frontières
PFI	Peaceful Family Initiative
PTSD	Post-Traumatic Stress Disorder
TaT	Talking about Talking
VSLA	Village Savings and Loan Association
WEP	Women Empowerment for Peace

Chapter 1
Introduction

In recent years, international concern over gender-based violence (GBV) in emergencies has grown exponentially. Beginning in the mid-1990s with small programmes in a few countries, GBV interventions providing at least basic survivor care and support are now the norm rather than the exception in humanitarian programming. This period of growth has also seen the development of a number of good practice standards, guidelines, training resources and other technical tools and materials.[1] However, while international attention to GBV has increased substantially, there remains a lack of data on and understanding of good practice in relation to GBV programming in humanitarian contexts, and a lack of consensus on how to apply GBV concepts and terminology. Indeed, while good practice exists, much of the evidence for and learning from it has not been adequately documented or disseminated, and there remain differing views amongst humanitarian practitioners on concepts and terminology (i.e. gender-based violence versus sexual and gender-based violence), focus (women and girls only, or men and boys as well) and humanitarian programming priorities (protection and prevention, providing medical and other services to survivors). This has resulted in a lack of agreement on how to define, prioritise, prevent and respond to gender-based violence in humanitarian contexts. In addition, the ethical implications of carrying out studies on GBV, given the sensitivity of the issues involved, have in some cases made conducting research and sharing of results and learning problematic.

In response to these challenges, this Network Paper maps and critically analyses good practice in preventing and responding to gender-based violence in humanitarian contexts to support humanitarian practitioners and policymakers to improve the quality of GBV programming. It is based on a review of the literature relating to gender-based violence in emergencies, funded by the UK Department for International Development (the review is available at r4d.dfid.gov.uk). The review aimed to answer a number of key questions around the monitoring and evaluation of existing programmes; key features of 'successful' programming; needs assessments, programme design and funding; the effects of mainstreaming GBV programming in humanitarian action; and the state of knowledge and use of GBV guidelines. Overall, the review found that the literature in this area is inadequate. Very few programme studies used rigorous evaluation methods, and there was little mention of monitoring programme progress and outcomes, as opposed to process and outputs (a weakness not unique to this sector). Only 15 of the approximately 100 guidelines, tools, papers, evaluations, studies and other documents reviewed were deemed robust enough to be included on the basis of their quality and relevance (see Box 1, p. 2).

The programmes reviewed in the documentation focused on awareness-raising, women's empowerment, psychosocial care and community-based healthcare. Five of the programmes reviewed were multi-sectoral, and in one (Oxfam's civilian protection programme in the Democratic Republic of Congo (DRC)), GBV was mainstreamed into the agency's wider protection work. Particular research gaps identified by the study include a lack of evidence on the incidence of violence, and quality and outcomes of interventions; a lack of developed understanding of methods of addressing different forms of gender-based violence at specific stages of emergencies (and whether interventions are appropriate to the needs of survivors of particular types of GBV); a paucity of evidence on the impacts of GBV interventions in post-disaster settings; and a lack of evidence from regions other than Africa.

The paper is structured as follows. Following a brief discussion of key concepts and definitions in relation to GBV, Chapter 2 presents an overview of the extent of GBV in emergencies, and some of the challenges in responding to the problem. Chapter 3 then analyses some of the literature on the evidence of GBV programming effects in humanitarian settings, and draws out key lessons with regard to good practice. Chapter 4 discusses some of the key issues emerging from this review, and Chapter 5 concludes the paper with a discussion of the implications of the findings for research, policy and programming on GBV.

Key concepts and definitions

'Gender-based violence' is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV can constitute either an abuse or a violation of human rights. Many – but not all – forms of GBV are illegal and criminal acts in national laws and policies.[2] GBV has a greater impact on women and girls than on men and boys, linked to their subordinate status in society and their greater vulnerability to violence, though it is important to note that men and boys may also be victims of gender-based violence, especially sexual violence.

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1 See for instance Interagency Standing Committee (IASC), *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*, 2005; IASC Sub-Working Group on Gender and Humanitarian Action, *Establishing Gender-based Violence Standard Operating Procedures (SOPs) for Multisectoral and Inter-organisational Prevention and Response to Gender-based Violence in Humanitarian Settings*, May 2008; Gender-based Violence Area of Responsibility Working Group, *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*, July 2010.

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2 IASC, *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*.

Box 1

Documents and programmes reviewed

Awareness-raising at community level

Beyond Borders, *Rethinking Power's SASA! Adaptation in Haiti: Project Final Report for UUSC* (Washington DC: Beyond Borders, 2013).

Search for Common Ground, *Informing Refugees and Returnees on Gender based Violence: Program Evaluation* (Kinshasa: Search for Common Ground, 2011).

International Rescue Committee, *Part of the Solution: Engaging Men as Partners To Prevent Violence Against Women and Girls: Principles and Promising Practices* (New York: International Rescue Committee, n. d.).

Women's empowerment

International Rescue Committee, *Getting Down to Business: Women's Economic and Social Empowerment in Burundi* (New York: International Rescue Committee, n.d.).

Psychosocial care

J. K. Bass et al., 'Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence', *New England Journal of Medicine*, 368(23), 2013.

S. Manneschmidt and K. Griese, 'Evaluating Psychological Groups Counselling with Afghan Women: Is This a Useful Intervention?', *Torture*, 19(1), 2009.

S. Hustache et al., 'Evaluation of Psychological Support for Victims of Sexual Violence in a Conflict Setting: Results from Brazzaville, Congo', *International Journal of Mental Health Systems*, 3(7), 2009.

Community-based health care

A. Kohli et al., 'Community-based Health Programme for Survivors of Sexual Violence, Rural South Kivu, DRC', *Conflict and Health*, 2012, 6(6).

Multi-sectoral

S. Ayoo, *Women Empowerment for Peace (WEP) Project, Northern Uganda*, Care International in Uganda/Care, 2008.

K. Falb, *IRC Thailand: Gender-based Violence Program Evaluation* (New York: International Rescue Committee, 2011).

A. Guedes, *Addressing Gender-based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis*, LTG Associates Inc, Social and Scientific Systems Inc, United States Agency for International Development, 2004).
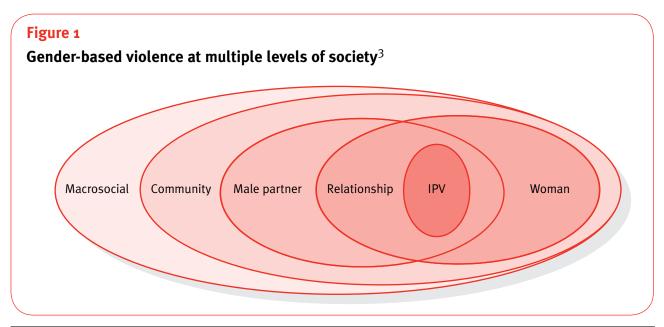
G. K. Mwangi, *CARE Refugee Assistance Project, Dadaab: Gender Based Violence Program Evaluation* (Atlanta, GA: CARE USA, 2012).

J. Spangaro et al., *What Evidence Exists for Initiatives To Reduce Risk and Incidence of Sexual Violence in Armed Conflict and Other Humanitarian Crises? A Systematic Review*, PLOS ONE, May 2013.

Multi-sectoral – mainstreamed

M. Canavera, *'We Cannot Wait for Others To Come Protect Us': Lessons Emerging from Oxfam GB's Community-based Civilian Protection Programme in the Eastern Democratic Republic of Congo* (Oxford: Oxfam GB, 2011).

S. Hughes, *Final Evaluation of Oxfam GB's Protection Programme in DRC* (Oxford: Oxfam GB, 2012).

Figure 1

Gender-based violence at multiple levels of society[3]

3 In the figure, IPV refers to Intimate Partner Violence. Although there are different definitions of IPV, here we refer to all physical, sexual or psychological harm perpetrated by a current or former partner or spouse, which can include the threat of violence (L. E. Saltzman et al., *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0* (Atlanta, GA: CDC, 2002)).

The nature and extent of specific types of GBV vary across cultures, countries and regions. Common forms of GBV include:

- Sexual violence, including sexual exploitation/abuse and forced prostitution.
- Domestic violence.
- Trafficking.
- Forced/early marriage.
- Harmful traditional practices such as female genital mutilation (FGM) and honour killings.

Women's experiences of violence are associated with a complex array of individual, household, community and social factors. Academic Lori Heise has developed an 'ecological model', based on Bronfenbrenner's social ecological model, which illustrates the multi-faceted nature of violence at different levels, involving power relationships between individuals and contextual factors (see Figure 1). This can be a useful framework to show the multiple levels at which gender-based violence can occur, including in conflict or disaster settings, and the ways in which cultural and societal values and beliefs contribute to gender inequality (at the individual, household and community level), and are reflected in gender-biased policies and laws.

Chapter 2
Gender-based violence in emergencies

The nature and extent of GBV in emergency contexts

During conflicts and natural disasters, civilians are at significant risk of harm through violence, abuse or deliberate deprivation, and national governments may lack the willingness or capacity to meet their need for protection. In the context of complex emergencies and natural disasters, women and children, and sometimes men, are vulnerable to exploitation, violence and abuse simply because of their gender, age and status in society.

GBV can occur at any stage of an emergency (see Box 2, which highlights the nature and extent of GBV in the DRC, Liberia and Haiti). In the context of armed conflict and displacement, sexual violence is the most immediate and dangerous type of gender-based violence. Communities are disrupted, populations are moving and systems for protection are not fully in place. In conflict situations, acts of sexual violence can either be random, or they can be systematically used as a weapon of war. The experience of conflict and displacement, with their resultant socioeconomic impacts, such as loss of work and income, as well as changes in social roles and status, can destabilise communities and societies, creating divisions and potentially establishing violence as a societal norm. In camp settings, the most common form of sexual and gender-based violence is Intimate Partner Violence (IPV).[4] A systematic review of GBV prevalence in complex emergencies found that overall rates of IPV tend to be much higher than rates of wartime rape outside of the home.[5]

Box 2

Gender-based violence in post-conflict and emergency settings: examples from DRC, Liberia and Haiti

In Eastern DRC, up to 40% of women have experienced sexual violence.[6] All of the armed forces involved in the conflict, including national and neighbouring government forces, have committed acts of rape and sexual violence. Rapes are often extremely brutal and it is common for victims to be gang raped, tortured and mutilated. Many rapes also occur in public settings, often with the forced attendance of victims' relatives. In a nationwide survey, 1.69–1.8 million women reported having been raped in their lifetime, including by armed forces, but significantly more (3.07–3.37m) reported experiencing IPV.[7] As in all contexts, these figures are far from comprehensive given the lack of up-to-date statistics and the fact that many cases go unreported.

During the conflict in Liberia in 1999–2003, rape was systematically used as a weapon of war. Up to 75% of the total population of women were sexually violated or raped, and large numbers of women were abducted and forced to sexually service members of armed groups. Many women and girls were raped more than once, at different times and by different perpetrators, and some were forced to marry their abusers. Although the conflict ended a decade ago, the risks to women and girls remain very high. A 2005–2006 study at a Monrovia hospital in which 658 rape survivors were interviewed established that most perpetrators were known to the women they assaulted, that 85% of the survivors were under the age of 18 and that 48% of the survivors were between five and 12 years of age.[8] Other, more 'normalised' forms of GBV unrelated to conflict are also prevalent in Liberia, including forced and early marriage.

Although Haiti has had a long history of gender discrimination, GBV and particularly rape, after the earthquake in 2010 reports of sexual violence increased significantly.[9] Women reported increased vulnerability to sexual violence due to the destruction of their livelihoods and support networks, as well as insecure conditions in camps and shelters. Rape survivors ranged in age from five years to 60. Several had been raped on more than one occasion, either after the earthquake or during previous periods of unrest. A culture of impunity and the inaccessibility of the justice system make it particularly difficult to prevent and respond to GBV.

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4 R. Horn, 'Responses to Intimate Partner Violence in Kakuma Refugee Camp: Refugee Interactions with Agency Systems', *Soc Sci Med*, 70, 2010.

5 L. Stark and A. Ager, 'A Systematic Review of Prevalence Studies of Gender Based Violence in Complex Emergencies', *Trauma, Violence and Abuse*, 12, 2011.

6 K. Johnson et al., 'Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo', *JAMA*, 304(5), 2010.

7 A. Peterman, T. Palermo and C. Bredenkamp, 'Estimates and Determinants of Sexual Violence against Women in the Democratic Republic of Congo', *American Journal of Public Health*, 101(6), 2011.

8 D. Landis, 'Examining Promising Practice for Young Survivors: An Integrated Review of Sexual and Gender-based Violence Programming in Liberia', Child Protection in Crisis Network for Learning and Action, 2012.

9 Amnesty International, 'Aftershocks: Women Speak Out Against Sexual Violence in Haiti's Camps', 2011.

Survivors of GBV may experience several physical and mental health impacts including physical injury, maiming, gynaecological disorders, unwanted pregnancies, risks to health from unsafe abortions, sexually transmitted infections, mental distress, depression, anxiety, death as a result of suicide, murder or 'honour killings', as well as negative social outcomes such as stigmatisation and ostracism by families and communities and powerful feelings of shame. Rape survivors may be abandoned or divorced by their husbands, and in some instances are forced to marry their attackers. In Haiti, almost all of the rape survivors interviewed in one study had some form of physical pain or injury, including stomach pain, headaches, difficulty walking or vaginal infection and bleeding.[10]

Challenges in tackling GBV in emergencies

Although there are guidelines and codes of conduct for GBV programming in emergency settings, there are a number of challenges to implementing them in practice. GBV programmes need to be sensitive to local socio-cultural norms and the inequalities which hinder women's access to services; up-to-date and relevant data on GBV prevalence is necessary in order to provide appropriate responses, but is often difficult to obtain; lack of capacity and resources are constraints to implementing programmes; and limited coordination between relevant agencies and services makes an integrated response difficult.

Socio-cultural norms around gender inequality and GBV

Attitudes towards women and the gender inequalities that increase women's vulnerability and contribute to GBV are very difficult to shift. Men may find it difficult to understand GBV as more than just individual acts of violence, and may resent being 'targeted' as malefactors when their experience of conflict and displacement may well have been extremely traumatising itself. More broadly, the wider issues of power and control and the normalised types of violence affecting women and girls, such as forced and early marriage and FGM, are deeply embedded within the societies in which they occur. Several programmes discussed in this paper have tried to change attitudes and behaviour, and progress has been made in certain areas, but achieving meaningful and sustainable change at the societal level is a very long and difficult process.

Lack of data to inform appropriate programme responses

The lack of up-to-date and reliable data on the prevalence rates and types of GBV in emergency contexts is a particularly challenging obstacle to designing appropriate and effective GBV programmes. Much of the violence is hidden and goes unreported, particularly domestic violence or IPV, and women may fear the repercussions of reporting incidents, such as forms of stigmatisation that could jeopardise their future. Linked to this is a lack of rigorous monitoring and evaluation to assess the impacts of response programmes and refine them accordingly. There is very little mention of monitoring in the majority of the programme documentation looked at in this study, and very few programmes included baseline data to measure changes in attitudes and behaviour.

Capacity and resource constraints

Capacity and financial constraints can also be considerable. One study, in Uganda, found that staff at government health facilities were overburdened with guidelines and training and lacked the confidence and skills necessary to treat and counsel GBV survivors.[11] At the national level, governments often lack the capacity and the financial and human resources needed to implement GBV interventions, a common problem across post-conflict countries in the process of reconstruction, where other sectors are more likely to be prioritised.

Staff capacity too can be a key challenge. Staff working on GBV issues require specific skills and knowledge to appropriately deliver prevention and response programmes and services. Referral service providers, including health workers and the police, also need expertise in dealing with survivors of GBV. Staff must be trained in a culturally appropriate, sensitive manner in order to deliver awareness strategies that engage the community, and that challenge existing socio-cultural norms and embedded gender inequalities. In the context of a humanitarian emergency, however, such skills may be in short supply, or may not be prioritised as urgently required.

Limited coordination

Problems of coordination across all the different actors and sectors involved in emergency response constitute another key obstacle to effective GBV programming, discussed in more detail below. There may be issues of trust between national and international actors, as well as competition between agencies to secure funding for their programmes. Several of the studies looked at in this paper highlighted problems with coordination, especially in ensuring that GBV survivors had access to the numerous services that they needed, including legal aid institutions and health care. The need for a more holistic approach to care, protection and support for survivors of sexual violence, the need to put the survivor at the centre of the process and the need to strengthen links for the referral of survivors and their partners to psychosocial support and mental health services (and links to other services more broadly) are all issues of concern. Poor implementation of other services is also a significant constraint, with delays and inadequate quality common.

10 L. Davis and B. Bookey, 'Fanm Ayisyen Pap Kase: Respecting the Right to Health of Haitian Women and Girls', *Health and Human Rights*, 13(1), 2011.

11 M. Hentonnen et al., 'Health Services for Survivors of Gender-based Violence in Northern Uganda: A Qualitative Study', *Reproductive Health Matters*, 16(31), 2008.

Chapter 3
Good practice in GBV programming in emergencies

This chapter gives a brief survey of key aspects of good practice in GBV programming in emergencies. Based on the available literature, it focuses on two key areas: preventing GBV, and improving the response to GBV when it occurs. *Preventing* GBV involves efforts to reduce the incidence of violence, as well as interventions that increase knowledge of GBV issues and change attitudes and behaviour. Improving the *response* to GBV entails improving access to services for survivors, including medical/healthcare and psychosocial help to deal with the trauma of the event, as well as improved access to legal services and security. This chapter looks at what works and why in facilitating positive outcomes in terms of preventing and responding to GBV in emergencies.

Preventing GBV

Reducing the incidence of GBV

Only one programme in the study, the International Rescue Committee (IRC)'s Economic And Social Empowerment (EA$E) programme in Burundi, evaluated change in the incidence of violence. The programme combined an economic element – Village Savings and Loan Associations (VSLAs) – with a discussion series called Talking about Talking (TaT).[12] The discussion series was initiated in response to concerns that, by affording them greater control over resources and financial decision-making within the household and hence upsetting the household status quo, women's participation in VSLAs could potentially put them at greater risk of violence at the hands of their partners. The TaT discussions were intended to address this risk by enabling discussion of gender roles in financial decision-making. The evaluation of the programme found a decrease in IPV and physical harm among participating households and an increased role for women in decision-making, most marked in decisions about how to spend the woman's own income, but notable also in general purchasing decisions and on how many children the household should consider having.[13]

Changing attitudes towards GBV

Awareness-raising initiatives – whether standalone interventions primarily aimed at changing attitudes and behaviour towards gender-based violence, or as part of a broader programme (such as in partnership with economic interventions or multi-sectoral programmes) – can change community attitudes and perceptions in a number of ways. Beyond Borders' Rethinking Power Programme in post-earthquake Haiti and the Search for Common Ground programme in the DRC have both taken a community-based awareness-raising approach to change attitudes and

perceptions of GBV (see Box 3). The programme is credited with increasing recognition that a man imposing his control over the family finances constitutes a form of violence, as well as successfully challenging the perception that it is the fault of the woman if a man rapes her. Listeners to a radio show produced by the programme also reported being less likely to blame a rape on the victim. In focus groups listeners condemned the perpetrators, while offering support to the victims, and two-thirds of listeners said that the main theme for them related to the myth that women are raped because they wear provocative clothing.[14] In Haiti there was a significant decline in the number of people who believed that a man was entitled to beat or abuse his wife if he found out that she was HIV-positive.[15]

A key finding from the awareness-raising programme in DRC was that multiple exposure to awareness-raising messages

> **Box 3**
>
> ## Awareness-raising interventions in Haiti and DRC
>
> The Rethinking Power Programme, implemented in post-earthquake Haiti in 2010, was a community-based programme aimed at preventing violence against women and girls and reducing the incidence of HIV. The programme is based on four key components: field activities using 'SASA!: An Activist Kit for Preventing Violence against Women and HIV', adapted for Haiti; the creation and adaptation of learning materials; technical support for other organisations; and the engagement of community networks to support survivors of violence. The programme included a film, radio and TV campaign, training of community activists and community meetings.
>
> The Search for Common Ground programme in the DRC aimed to better inform refugee and returnee populations on how to prevent sexual and gender-based violence and provide support for victims. It was implemented in 2009 for 12 months. The programme approach consisted of sensitisation and dialogue with refugees and adolescents through mobile cinema screenings and a radio programme, *Uishi na Upende*. In all there were 41 public screenings in North and South Kivu, attended by over 30,000 people. The radio programme was broadcast on 51 partner stations in the Swahili-speaking zone of the DRC.

12 International Rescue Committee, *Getting Down to Business: Women's Economic and Social Empowerment in Burundi* (New York: IRC, n.d.), pp. 1–3.

13 Changes in the incidence of reported IPV were significant: women in the high or moderate risk category at baseline reported a 22% reduction in the incidence of violence in the two weeks before the evaluation, and a 46% reduction in physical harm.

14 Search for Common Ground, *Informing Refugees and Returnees on Gender based Violence: Program Evaluation* (Kinshasa: Search for Common Ground, 2011).

15 Beyond Borders, *Rethinking Power's SASA! Adaptation in Haiti: Project Final Report for UUSC* (Washington DC: Beyond Borders, 2013).

intended to change attitudes, behaviour and knowledge (combining mobile cinema and radio programming) was particularly effective in contributing to raising awareness and changing the attitudes of participants.

Attitudinal changes were also reported from Oxfam's Protection Programme in Eastern DRC (see Box 4). The programme has achieved positive effects on women's empowerment and on gender equality by using Protection Committees to change attitudes about girls' education, early and forced marriage and (to some extent) inheritance rights for women. Most communities where the programme has functioned have also shown increased attention to women's rights and gender equality.[16]

Two refugee programmes have also reported positive changes in attitudes and perceptions. The CARE International Refugee Assistance Project in Dadaab, Kenya, initiated an integrated GBV programme, including education, behavioural change, livelihoods support, referral, counselling, clinical services and legal and litigation support. The programme's behaviour change activities included talks by the police on law enforcement, awareness campaigns, radio programmes, sports, discussions and debates, focus groups, community training and neighbourhood forums. The programme also provided livelihoods support for survivors of GBV, as well as response services including documentation of GBV cases, referrals, counselling and psychosocial support, clinical services, legal and litigation support and a safe haven for survivors. As a result of outreach campaigns by agencies such as CARE, awareness of the effects of FGM has increased substantially, as has awareness, reinforced by religious leaders, that FGM is not a religious obligation on Muslims. The incidence of GBV more generally also reportedly declined, though it is unclear how this was evaluated.[17]

The second refugee programme – IRC Thailand's GBV programme – operates in two camps along the Thai–Burma border. In 2009, the IRC developed a partnership with the Karenni Women's Organisation (KnWO) to build its capacity to lead GBV response and prevention activities in the camps. KnWO also manages and supports Women's Community Centres. These provide services such as safe, temporary housing, GBV case management, psychosocial support and other activities to care for survivors of GBV. These response services coordinate with the IRC Thailand Legal Assistance Center (LAC) to provide survivors with increased access to justice by strengthening the informal camp justice system and facilitating access to the formal Thai justice system. Two key activities of the IRC GBV programme include the Peaceful Family Initiative (PFI) and the Men Involved in

Box 4
Oxfam's Protection Programme in Eastern DRC

Oxfam's Protection Programme in Eastern DRC has targeted 50,000 people. Women's rights and gender equality are integrated within the programme's human rights/protection framework, which seeks to enable communities to establish their own broad protective environment. The programme is based around four key activities: community mobilisation for the right to protection, improving relationships with authorities, expanding access to referral services and advocacy. Sensitisation tools (posters, radio broadcasts) are used to encourage dialogue within communities.

Community Protection Committees are at the centre of the programme. Each committee comprises equal numbers of men and women (six of each), and committee focal points for receiving and referring cases of sexual violence and other abuses are also divided equally, with two men and two women. In most committees there is an understanding that female survivors of GBV should speak with female focal points. Women's Forums complement the Protection Committees, and serve as a protected space for women reluctant to discuss protection and rights issues in front of men. As of mid-2012, 56 committees had been set up. To extend the geographical reach of the programme, community outreach workers are also recruited, again divided equally between women and men.

Peace-Building (MIP) Project. The PFI involves three-day workshops teaching couples practical skills to strengthen healthy family relationships, manage stress and anger and resolve conflicts peacefully. Participating couples reported utilising a large amount of the knowledge and skills they learned in the PFI training, and the majority said that it had been useful, and that they shared their knowledge with other families.[18] MIP activities have included GBV training, awareness-raising campaigns and open dialogue with men on issues related to gender, family, violence and health. Interventions focused on training unemployed men on GBV prevention, men's action group discussions and awareness-raising efforts, including poster discussions, dramas and campaigns. Although the programme acknowledges that changing attitudes is a slow and sensitive process, particularly in a closed camp environment, over time men's awareness of key concepts around GBV has grown significantly, and men are increasingly willing to be involved in community change projects and to become more knowledgeable about issues such as GBV.[19]

16 M. Canavera, 'We Cannot Wait for Others To Come Protect Us': Lessons Emerging from Oxfam GB's Community-based Civilian Protection Programme in the Eastern Democratic Republic of Congo (Oxford: Oxfam GB, 2011); S. Hughes, Final Evaluation of Oxfam GB's Protection Programme in DRC (Oxford: Oxfam GB, 2012).

17 G. K. Mwangi, CARE Refugee Assistance Project, Dadaab: Gender Based Violence Program Evaluation (Atlanta, GA: CARE USA, 2012). This is the only study looked at here that specifically discussed FGM as a form of violence.

18 K. Falb, IRC Thailand: Gender-based Violence Program Evaluation (New York: International Rescue Committee, 2011).

19 M. Alvarado and B. Paul, 'Involving Men on the Thai–Burma Border', Forced Migration Review, no. 38, October 2011.

> ### Box 5
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> ### The Association Najdeh programme in Lebanon
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> The Association Najdeh programme in Lebanon provides services for Palestinian refugees, including vocational training, literacy, pre-school education, income-generating activities for women and awareness-raising on topics such as domestic violence and reproductive health. The domestic violence component includes action research, strengthening staff capacity to respond to GBV, community awareness-raising and conflict management workshops and counselling centres. According to one review of initiatives addressing gender-based violence, the programme is a rare example of an initiative in a conflict-affected setting with an explicit focus on domestic violence.[20]

Despite progress, perceptions and gender norms can be entrenched and very difficult to change. Changing attitudes towards women's reproductive and sexual rights (e.g. a married woman's right to refuse sex with her husband) and norms around the gendered division of labour within the household (e.g. a woman deciding to go to work while her husband stays at home and takes care of the children) is a long-term process, and wider issues of power and control and the normalised types of violence affecting women and girls, such as forced and early marriage and FGM, are deeply embedded within society. None of the programmes looked at in this study measured changes in attitudes and perceptions in the long term, and only a handful noted changes in wider community attitudes beyond the target group.

Changing behaviour and increasing knowledge of GBV issues

A number of programmes succeeded in changing behaviour among men, women, the broader community and local authorities. IRC's EA$E programme, for instance, helped to improve women's decision-making and negotiation skills within the household, increasing women's capacity to make spending decisions and decide the number of children the household should have. Disagreements were more often negotiated jointly, rather than being resolved by the unilateral decision of the man, and tolerance of IPV decreased. However, these results were not even across all areas of household life; while changes were noted in some decision-making areas, attitudes in others, such as when to have sex and how much alcohol or cigarettes to buy, seemed more entrenched. Likewise, while negotiated solutions seemed acceptable in some areas, women were not seen as having the right to overrule their husbands. Changed attitudes towards IPV were most marked when it concerned a woman's neglect of her children, but in areas

where the man was more directly affected – the food is burnt, the wife goes out without telling her husband or argues with him – the programme seemed to have much less impact, suggesting that IPV may be more or less acceptable depending on the context in which it occurs, and the extent to which the woman's action impinges on the man. Women involved in Oxfam's Community Protection Committees in Eastern DRC felt 'extremely empowered' by their participation, and many cited the protection programme as a key factor in their ability to stand up for themselves in public and private settings.[21] The CARE refugee programme in Dadaab, Kenya, reported a shift to a less severe form of FGM known to Somalis as *Sunna*, although the majority view within both camps where the programme was working was that the actual practice of FGM could not be stamped out altogether, and it has apparently continued underground.[22] In Northern Uganda, CARE International's Women Empowerment for Peace (WEP) Project (Box 6, p. 10) saw the incidence of early marriages decline as women insisted that their daughters went to school, and the community at large came to see the value of education.[23]

Another approach, similar to that adopted by the MIP project in Thailand, is to specifically engage men to tackle the root causes of violence. In Liberia, for instance, the IRC created Men's Action Groups to encourage men to speak out in their communities and to challenge other men on issues around GBV. These efforts were intended to support the activities of IRC-supported Women's Action Groups, and their work around the prevention of and response to victimisation, women's increased access to and control over resources and women's participation in community decision-making and leadership. Changes in men's behaviour in relation to GBV included greater cooperation and willingness to speak out against violence, less resistance from men in their communities and improved community responses to survivors and more consistent support in addition to the condemnation of perpetrators. There was also a perceived reduction in violence against women and girls.[24]

Several programmes have also succeeded in improving knowledge of GBV issues. The IRC awareness-raising programme in DRC, for instance, has improved knowledge of the laws around sexual and gender-based violence, including the legal penalties for rape. There was also a slight reduction in the number of people who (wrongly) believed that settling a rape case out of court was legally binding.[25] Likewise, CARE International's WEP Project

20 A. Guedes, *Addressing Gender-based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis*, LTG Associates Inc, Social and Scientific Systems Inc, United States Agency for International Development, 2004.

21 Canavera, *'We Cannot Wait for Others To Come Protect Us'*.

22 Mwangi, *CARE Refugee Assistance Project, Dadaab*.

23 S. Ayoo, *Women Empowerment for Peace (WEP) Project, Northern Uganda, Care International in Uganda/Care*, 2008.

24 International Rescue Committee, *Part of the Solution: Engaging Men as Partners To Prevent Violence Against Women and Girls: Principles and Promising Practices* (New York: International Rescue Committee, n. d.).

25 Search for Common Ground, *Informing Refugees and Returnees on Gender based Violence*.

Box 6

The Women Empowerment for Peace (WEP) Project

The multi-sectoral Women Empowerment for Peace (WEP) Project in Northern Uganda was a three-year project begun in 2007. It aimed to enhance the capacity of women in Northern Uganda to exercise their rights and address the policy and cultural barriers to the implementation of UN Resolution 1325 on 'Women, Peace and Security'. It included economic empowerment, psychosocial support, advocacy and human rights and peace-building components. The economic element aimed to increase the participation of women and girls in decision-making at household level through income-generating and other activities promoting shared access and control of resources. It provided foundation and refresher training to trainers, trained women and men on savings and loan associations (VSLAs) and small enterprise development and linked the WEP target group with income-generating activities under a sister project, Social Mobilization of Women Affected by Conflict.

The psychosocial support component included training community members and VSLA leaders on psychosocial skills; providing one-to-one psychosocial counselling; establishing a referral network with health institutions; conducting group therapy sessions; organising and procuring materials for music and dance therapy; providing technical and financial help and transport to community networks; including discussions on SGBV in community dialogues with men and women and traditional and religious leaders; and supporting advocacy campaigns against GBV. The advocacy and human rights component included training for community members and government and civil society representatives on relevant policies and laws, facilitating dialogue with communities on negative and positive cultural and religious practices and supporting advocacy on specific cultural practices.

in Northern Uganda had some impact in increasing communities' knowledge of policies, laws, human rights standards and women's rights.[26]

Responding to GBV

Improving access to services

The difficulties involved in accessing services generally in emergency settings are well documented. For women specifically, obtaining services related to gender-based violence is particularly problematic because of the barriers they face in terms of time, money and socio-cultural norms that discourage them from using these services, including stigma. There is some evidence that GBV interventions are

26 Ayoo, *Women Empowerment for Peace (WEP) Project*.

improving the provision and utilisation of GBV response services, increasing the capacity of staff to understand, coordinate and refer GBV survivors to relevant services and improving confidentiality and cultural sensitivity in the delivery of services.

Work by the Congolese NGO Foundation RamaLevina (FORAL) in rural South Kivu province, Eastern DRC, is noteworthy here.[27] In 2004, FORAL started a mobile health programme for vulnerable women and men to address barriers to access identified by GBV survivors and their families. Mobile health services were expanded in 2010, and a clinical monitoring and evaluation system was developed to record patients' histories, their experience of sexual violence, the medical care they had received after the assault, the results of the clinical exam, any symptoms indicative of physical and mental health problems and planned treatment and follow-up. FORAL also engaged community members through partnerships with community health workers (CHWs). Findings from a study of the revised programme show that access to healthcare for survivors of GBV and their male partners increased, the quality of services improved and community members participated more actively in education sessions held at the beginning of each mobile clinic. The evaluation system developed by FORAL helped care providers and CHWs set up appointments for follow-up in a confidential setting. Clinic activities begin with health education led by the FORAL physician and the health centre nurse, offered to all village members in the local language. Other studies of interventions addressing sexual violence in other contexts have also found that community involvement can encourage survivors to make use of treatment services.[28]

Oxfam's Protection Programme in Eastern DRC has also increased the accessibility of services and follow-up for victims of violence and abuse (notably sexual violence). The Protection Committees have improved the follow-up care available to survivors of sexual violence through initial listening sessions and the referral of individuals to care, protection and support services (medical, psychosocial and legal) within 72 hours of the incident. Focal points within the Protection Committees serve as links between the community and service providers, gauging trends and potential access barriers.[29] Likewise, the refugee interventions in Kenya and Thailand have both increased capacity to respond to GBV survivors. CARE International's programme in Dadaab has increased institutional and technical capacity to raise awareness of GBV and handle referrals through new approaches such as community neighbourhood forums, the active use of media (radio and newsletters) and strengthening GBV reporting structures,

27 Kohli et al., 'Community-based Health Programme for Survivors of Sexual Violence'.
28 J. Spangaro et al., *What Evidence Exists for Initiatives To Reduce Risk and Incidence of Sexual Violence in Armed Conflict and Other Humanitarian Crises? A Systematic Review*, PLOS ONE, May 2013.
29 Canavera, *'We Cannot Wait for Others To Come Protect Us'*; Hughes, *Final Evaluation of Oxfam GB's Protection Programme in DRC*.

Box 7

Key features of successful GBV response services

Ensure confidentiality and anonymity in accessing services, and reduce stigma by ensuring that services are not viewed as only for victims of violence. FORAL in the DRC has taken steps to protect the identity of survivors of GBV, build relationships with patients and provide targeted health education, as well as providing services within a dedicated space in the community, to ensure that visits to the mobile clinic were seen as part of normal health services, not services only for raped women.

Be culturally sensitive and utilise local expertise. In addition to trained medical staff, a coordinator and a logistician, FORAL has engaged respected community members through partnerships with health workers from the community, building relationships with survivors and educating them about available health services. FORAL also formed partnerships with government and Church-sponsored primary health centres and hospitals in the area and neighbouring zones. These partnerships have been critical to demonstrating respect for existing expertise, ensuring that services are appropriate and not redundant and gaining support from local leaders and healthcare providers. It has also enabled capacity-building between FORAL and existing health systems in the area, resource sharing and discussions about sustainability.

Frequent visits by the service provider to patients. The mobile health clinic in DRC makes four visits a month to

patients in order to allow for relationship-building between the provider, the GBV survivor or other vulnerable women and their male partners, and to ensure retention of patients and improve quality of care at follow-up.

Enhance staff knowledge and capacity in the area of GBV. All FORAL staff received training in the provision of ethical, compassionate and competent care for GBV survivors. Increased staff knowledge and capacity were also reported in the programmes in Dadaab, Eastern DRC and Thailand.

Effective coordination between services and links with other sectors and actors. In the Dadaab refugee programme, inter-agency coordination meetings were regular and efficient, though the role the police played in ensuring access to justice and protection for survivors of GBV was more problematic.

Efficient M&E systems. In DRC, the new medical record system allowed FORAL to better understand its target population and the effectiveness of treatment. Staff report that completing the forms is not a time-consuming task. Minimising the burden of documentation for both patient and clinic staff was a priority due to the limited duration of the clinic (six hours daily), the number of patients (30–60), travel time and the home responsibilities of patients.

such as gender reporting desks and gender recovery centres.[30] Eight out of ten reported incidents are brought to the attention of the police, with the remainder being reported to other agencies, indicating that awareness campaigns on the importance of accessing legal protection and clinical services have been effective (albeit traditional approaches and stigma can still prohibit the reporting of incidents). Virtually all reported cases are referred to hospital within 72 hours. Similarly, IRC's GBV work in Thailand has increased the capacity of staff to respond to the needs of GBV survivors in terms of better case management and counselling and legal assistance, as well as enhancing the technical capacity of implementing staff.

Psychosocial care and counselling

In the context of high rates of depression, anxiety and post-traumatic stress disorder (PTSD) among survivors of sexual violence, psychotherapy/counselling interventions can play a crucial role in improving survivors' emotional and physical wellbeing, even if counselling is received some time after the incident. In Kabul, for instance, German NGO Medica Mondiale has offered group counselling to GBV survivors using four key techniques: psycho-education to

help women understand their reactions and behaviour; the removal of or relief from distressing symptoms; teaching new social skills; and developing new support networks with group members. Even though the counselling took place years after the actual abuse or violence suffered by the women, the vast majority of participants reported an improvement in their social life or general health, and about half of participants said that their mood had improved. There were also improvements in family relations, and in dealing with feelings of stress or shyness.

One of the key factors in the apparent success of this programme was its use of a group approach. In the group environment, the women were able to express and verbalise their complaints and found ways to share their problems with others. The format was replicated in each session, teaching the women to be patient and to take time to listen to others' problems, give their opinions and share their experiences. This process was a new experience for most participants, particularly women marginalised by widowhood, poverty or lack of education or affected by domestic violence. Physical and psychological exercises also proved helpful in relieving stress and pain, and these techniques were shared more widely with children and other women in the neighbourhood. The group process

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30 Mwangi, *CARE Refugee Assistance Project, Dadaab.*

built on group interaction and the support of peers, rather than focusing on the individual interaction between counsellor and client, and emphasised group strength rather than individual learning.[31]

Similar conclusions about the benefits of group work emerge from a trial of therapeutic interventions in North and South Kivu. In the study, researchers selected a small sample of villages to provide group cognitive processing therapy (a protocol-based therapy for treating depression, anxiety and PTSD in survivors of sexual violence) and individual therapy to women affected by GBV. The therapy was adapted for illiterate participants and those potentially exposed to ongoing violence. The adaptations included an initial individual psycho-educational session, oral (rather than written) completion of assignments during group sessions and the simplification of materials to facilitate understanding and memorisation. The aim was to evaluate the benefits of adding group therapy to existing case management services and individual counselling. Therapy was delivered by psychosocial assistants experienced in providing case management and individual counselling to survivors of sexual violence. Training for the assistants was conducted by the IRC in case management and on specific topics, including counselling, family mediation, stress management, the clinical care of survivors and sexually transmitted diseases. Qualitative studies identified the main mental health problems of survivors of GBV as abandonment and rejection by family and friends, concerns about providing for themselves and their families, fear and stigma. Informants described psychological symptoms consistent with depression, anxiety and PTSD.

The cognitive processing therapy was conducted in groups of six to eight women; each of the 11 sessions was two hours long, and there was one individual session as well. Each psychosocial assistant concurrently led three groups. Participants in the therapy group had access to the psychosocial assistants as desired outside the sessions. Individual help included psychosocial support and economic, medical and legal referrals. Psychosocial assistants were available throughout the treatment period for women who sought their services. An evaluation was performed at baseline, at the end of treatment (the intervention period lasted from April to July 2011), and six months after treatment ended. Overall, the study found that, while depression and anxiety decreased in the group receiving individual support, the improvement was significantly greater with group therapy, and was sustained for longer. Although prior research suggested that short-term therapies may not be effective for populations exposed to ongoing trauma or multiple severe traumas, in this study all the participating villages reported at least one major security incident during the trial, including attacks, displacement due to fighting and robbery by armed groups. There was also concern that providing

therapy to illiterate people would be challenging. The findings therefore suggest that, despite illiteracy and ongoing conflict, if properly adapted this evidence-based treatment can be appropriately implemented and effective in contexts of chronic insecurity, like the DRC.[32]

The third example looked at in this study is an evaluation of psychological care for women affected by sexual violence in the Congolese capital Brazzaville. Women attending the Médecins Sans Frontières (MSF) programme for sexual violence in Brazzaville were selected to evaluate the psychological consequences of rape and the late effect of post-rape psychological support. A total of 178 patients met the eligibility criteria (women aged more than 15 years, raped by unknown individuals wearing military clothes and admitted to the MSF programme between 1 January 2002 and 30 April 2003, and living in Brazzaville).

Initial psychological care included the provision of a safe and empathetic environment so that women could share their experiences; active listening, allowing for the expression of emotions such as distress, fear, guilt, shame, anger, depression and anxiety; allowing the expression of personal views about events and distress, including cultural representations; assessing familial and social consequences; normalising women's reactions to reassure rape victims that most women who had undergone such violence experienced similar reactions; supporting the development of coping strategies; and working on acceptance and the development of future perspectives and plans.

Three different assessment tools were used to describe the psychological symptoms remaining one year after the trauma, and their residual impact: the Trauma Screening Questionnaire; an assessment scale to address medico-psychological care in emergencies (EUMP), designed for this study; and the Global Assessment of Functioning (GAF) scale. The findings suggest that the benefits of post-rape psychological support, integrated into sexual violence medical services, were positive. In more than two-thirds of the patients there was a clear improvement of psychological state, including reduced PTSD. However, this improvement cannot be attributed with certainty to the psychological care these women received.[33]

A number of key features emerge from the interventions reported on here. The first, demonstrated by the DRC study, is the importance of appropriate training and supervision, as well as the adaptation of the therapy to the target group (in this case illiterate participants and those potentially exposed to ongoing violence). With appropriate training and supervision, psychotherapeutic treatments such as cognitive processing therapy can

31 S. Manneschmidt and K. Griese, 'Evaluating Psychological Groups Counselling with Afghan Women: Is This a Useful Intervention?', *Torture*, 2009, 19(1).

32 J. K. Bass et al., 'Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence', *New England Journal of Medicine*, 2013, 368(23).

33 S. Hustache et al., 'Evaluation of Psychological Support for Victims of Sexual Violence in a Conflict Setting: Results from Brazzaville, Congo', *International Journal of Mental Health Systems*, 3(7), 2009.

be successfully implemented and can have an effect in settings with few mental health professionals. The authors of the research suggest that this therapy holds promise as a community-based service for sexual-violence survivors in similar contexts, and warrants confirmatory studies and scaled up evaluations. Second, the Congo study notes that psychological support can have a long-term positive impact among victims of sexual violence during conflict, and underscores the importance of multidisciplinary care. Like the DRC work, the study emphasises the need to adapt diagnostic and assessment tools for psychological and psychiatric care in difficult contexts to ensure that they are appropriate.

Improving the legal and security environment

Some GBV programmes aim to improve access to legal services for survivors through referral to legal assistance services to pursue cases in court, as well as improving security through coordination with local police and security forces. This is, however, an area of significant weakness, not least because making progress in access to justice and security relies on the cooperation of amenable local and national authorities, both of which tend to be absent in contexts of high rates of GBV.

In the IRC Thailand programme, approximately half of the survivors utilised legal assistance services to pursue justice. Surveys indicate very high levels of satisfaction with the legal process and LAC staff, if not with the actual justice outcomes achieved.[34] A central component of the Oxfam protection programme in the DRC has been improving relations with the authorities and working with the military and the police to reduce human rights violations. The programme has contributed to reducing impunity and increasing the degree to which local authorities assumed responsibility for the protection of civilians.[35] However, changes to justice and security outcomes were limited across other programmes. In Dadaab police and justice services were not very effective, and the number of GBV perpetrators arrested was very low. Focus group discussions revealed a lack of trust in the police, who let perpetrators go free, and people generally preferred to resolve cases through customary justice structures.[36] A review of the WEP project in Northern Uganda likewise found a significant gap in terms of support for survivors to seek legal redress, as well as minimal impact on the justice sector; at the time of the evaluation of the programme only four perpetrators had been arrested in the target area, and none had been jailed. Women participants said that the lack of justice for GBV was due to the culture of impunity and silence around the issue, as well as mistrust of the police.[37]

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34 Falb, *IRC Thailand*.
35 Canavera, *'We Cannot Wait for Others To Come Protect Us'*.
36 Mwangi, *CARE Refugee Assistance Project, Dadaab*.
37 Ayoo, *Women Empowerment for Peace (WEP) Project, Northern Uganda*.

Chapter 4
Key issues

In addition to highlighting the good practice emerging from programmes addressing GBV in emergencies, this Network Paper also sheds light on a number of pertinent issues in relation to policy and programming in this area arising from the programmes reviewed. This chapter reflects on the following issues: the different types of violence which interventions address; the role of needs assessment/prevalence data in informing programme design and funding; the effects of mainstreaming GBV as opposed to vertical GBV programmes; knowledge on the interpretation and use of guidelines on addressing GBV; addressing GBV against men and boys; and including girls in GBV response.

What types of violence are addressed in GBV programming?

The core standards for minimum GBV interventions explicitly state that sexual violence is the type of GBV of most concern in the early stages of emergencies (although they also go on to say that other forms of GBV may be more urgent in some situations, and that assessment is needed).[38] This is underscored by UN Security Council Resolutions in 2008 and 2010 mandating specific actions, interventions and data on sexual violence in armed conflict. Reproductive health guidance, including the Minimal Initial Service Package (MISP), also focuses on sexual violence. This is reflected in funding patterns, as donors too tend to focus on sexual violence committes during conflict.[39]

Prevalence research, however, suggests that IPV may be more pervasive, and there is anecdotal evidence that transactional sex is a significant problem in many settings.[40] Yet IPV is addressed by only a handful of the interventions discussed here. The IRC programme in Burundi is the one example of an intervention deliberately designed to tackle IPV. Interventions that aim to reduce other forms of GBV, such as domestic violence and early or forced marriage,

tend to be prevention (awareness-raising and sensitisation) programmes, as opposed to response programmes (for example the Beyond Borders Rethinking Power's SASA! Programme in Haiti and the IRC programme in Liberia). Some of the multi-sectoral programmes do widen the scope of GBV beyond sexual violence to include domestic conflict, such as the IRC programme in Thailand, the Association Najdeh programme in Lebanon and the psychosocial counselling carried out by Medica Mondiale in Afghanistan, as well as FGM in Dadaab. The Women's Empowerment Programme in Northern Uganda also includes other forms of GBV, such as abduction, maiming, physical assault and forced and early marriage. On the whole, however, these seem to be treated as lesser priorities, or are indirectly addressed via interventions focused on sexual violence. This gap in programming is of particular concern given the high prevalence of other forms of GBV beyond rape by strangers, and the particular risks faced by young girls in terms of early and forced marriages.

Are programmes informed by needs assessments and prevalence data?

There is insufficient information globally about the prevalence of different types of GBV, and even less prevalence data from humanitarian settings.[41] GBV prevalence research is sensitive and, when conducted in humanitarian contexts, requires additional methodological, safety and ethical measures.[42] It can also be costly in terms of both human and financial resources. That said, according to the IASC Guidelines on GBV, the presence or absence of prevalence data should not affect the initiation of a holistic and multi-sectoral humanitarian response to GBV in any setting. The Guidelines explain that various forms of GBV are known protection problems in these settings, and therefore minimum interventions must be put in place.

Few studies reviewed here explicitly talked about using existing prevalence data or conducting a needs assessment prior to the intervention. For the studies that are the exception, previous programming experience or specific/targeted needs assessment amongst the programme target population had been used to inform programme design. For example, in the IRC Burundi programme previous experience and research indicated that having women participate in economic activities, such as VSLAs, could potentially put them at a higher risk of violence. To mitigate these risks, IRC added the TaT discussion group series to the VSLAs, providing opportunities

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38 IASC, *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*.

39 J. Ward, *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-conflict Settings: A Global Overview* (New York: The Reproductive Health for Refugees Consortium, 2002); G. D'Odorico and N. Holvoet, 'Combating Violence against Women (VAW) in South Kivu: A Critical Analysis', *Journal of International Women's Studies*, 11(2), 2009; T. McGinn et al., 'Family Planning in Conflict: Results of Cross-sectional Baseline Surveys in Three African Countries', *Conflict and Health*, 5(11), 2011.

40 Stark and Ager, 'A Systematic Review of Prevalence Studies of Gender Based Violence in Complex Emergencies', found wide-ranging prevalence data for sexual violence, intimate partner violence and other forms of GBV. Transactional sex is often used interchangeably with prostitution, but it differs from formal prostitution or sex work in that it can include any sexual act that is exchanged for goods and services, monetary and non-monetary. There is usually no explicitly negotiated exchange, and it usually occurs within a relationship (K. Stoebenau et al., 'More Than Just Talk: The Framing of Transactional Sex and Its Implications for Vulnerability to HIV in Lesotho, Madagascar and South Africa', *Globalization and Health*, 7(34), 2011).

41 World Health Organisation, London School of Hygiene and Tropical Medicine, South African Medical Research Council, *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence* (Geneva: WHO, 2013); C. Watts and C. Zimmerman, 'Violence Against Women: Global Scope and Magnitude', *The Lancet*, 359, 2002.

42 WHO, *Ethical Safety Recommendations for Researching, Documenting, and Monitoring Sexual Violence in Emergencies* (Geneva: WHO, 2007).

for dialogue about joint financial decision-making between men and women in the household. Another example is the mobile health clinic programme in DRC, which conducted a situational assessment of the health needs of survivors in Walungu Territory. The situational assessment included interviews with local leaders, healthcare providers, community members and survivors of GBV on their priorities for local programmes and resources. The findings from the situational assessment indicated that priorities for programmes focused on two main areas: improved access to quality health services with skilled healthcare providers, who had specific training in care for GBV survivors; and increased opportunities for GBV survivors to contribute economically to their family and community.[43] Association Najdeh also conducted a survey to assess levels of domestic violence among refugee mothers and children in order to design its programme response.[44]

Interviews with practitioners in the field suggest that the time, energy and funds required to obtain prevalence data is often prohibitive, particularly in the first phase of an emergency. The conversation is usually framed as either/or: either we take the time to measure prevalence while lifesaving services are limited or delayed, or we initiate services and gather information later from programme reports to understand prevalence and do a prevalence survey if we can. The general impression is that available funding and capacity is insufficient to do both. All of the implementation studies and papers included in this review documented staff capacity as an obstacle to implementing GBV interventions. Considerable time is spent finding appropriate staff and building their capacity to implement good-quality services and interventions. Most service providers believe that taking staff away from daily programme activities for prevalence research is not a viable option in a humanitarian setting.

What are the effects of mainstreaming GBV as opposed to vertical programming?

Only one programme – Oxfam's Civilian Protection Programme – integrated a focus on gender into its broader humanitarian protection programme. In this approach, women's rights were positioned as an integral component to human rights: in this way, men do not feel threatened by the emphasis on women's rights, but rather see women's rights as contributing to the overall goal of civilian protection. It was also reported that women felt engaged by issues that are specific to women, but also noted the importance of efforts to enhance men's protection and the protection of the entire community. The key lesson emerging from this approach is that explicitly focusing on gender equality was effective because it took a two-pronged approach: the programme focused on issues of gender equality as well as paying special attention to women's empowerment and the promotion of gender equality in specific design and implementation features. For instance, the programme incorporated gender training across its programme (as well as other Oxfam services); the Community Protection Committees included an equal number of men and women; committee focal points for

receiving and referring cases of sexual violence and other abuses were divided equally between men and women (although in most committees there was an understanding that female survivors should speak with female focal points); and Women's Forums were established as complementary to the Community Protection Committees, which served as a protected space in which women could discuss protection and rights issues particular to women.[45]

Knowledge on the interpretation and use of GBV guidelines

There are a number of guidelines, toolkits and operational manuals to support the planning, design and implementation of GBV interventions. The IASC GBV Guidelines – currently being revised – lay out a set of holistic and multi-sectoral actions and interventions to both prevent and respond to GBV in humanitarian settings. Prevention and response is to be undertaken by a well-coordinated array of humanitarian actors from the earliest stages of any emergency. The Guidelines state:

> Survivors/victims of GBV need assistance to cope with the harmful consequences. They may need health care, psychological and social support, security, and legal redress. At the same time, prevention activities must be put in place to address causes and contributing factors to GBV in the setting. Providers of all these services must be knowledgeable, skilled, and compassionate in order to help the survivor/victim, and to establish effective preventive measures. Prevention and response to GBV therefore require coordinated action from actors from many sectors and agencies.[46]

The Guidelines comprise detailed 'action sheets' that describe sector-specific prevention and response interventions and cross-cutting activities and interventions involving all sectors.

The Standard Operating Procedures guide is another 'best practice' technical guide for developing and establishing procedures for reporting and referrals, data collection, and other interventions relevant to the implementation of the multi-sectoral model for prevention and response to GBV.[47] This guide was developed by GBV experts, based on field experiences and lessons learned. The GBV Coordination Handbook is a compendium of lessons and promising practice gathered from GBV experts and field experiences.[48] The Handbook is aimed at strengthening inter-sectoral and inter-organisational coordination of GBV interventions.

43 Kohli et al., 'Community-based Health Programme for Survivors of Sexual Violence'.
44 Guedes, *Addressing Gender-based Violence from the Reproductive Health/HIV Sector.*
45 Canavera, *'We Cannot Wait for Others To Come Protect Us'.*
46 IASC, *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*, p. 2.
47 IASC Sub-Working Group on Gender and Humanitarian Action, Establishing Gender-based Violence Standard Operating Procedures (SOPs) for Multisectoral and Inter-organisational Prevention and Response to Gender-based Violence in Humanitarian Settings.
48 Gender-based Violence Area of Responsibility Working Group, Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings.

43 Kohli et al., 'Community-based Health Programme for Survivors of Sexual Violence'.
44 Guedes, *Addressing Gender-based Violence from the Reproductive Health/HIV Sector.*

Do programmes target men and boys?

Only one programme sought to provide response services to men – the FORAL healthcare programme – but utilisation does not seem to have been as high as expected.[49] In Northern Uganda, men reportedly felt alienated from the Women's Empowerment Project even though they too were affected by the conflict.[50] A number of the prevention approaches included men as an explicit mechanism to address the root causes of gender-based violence by using specific awareness-raising activities, and by creating men's groups in which to discuss gender-based violence. Engaging men in this way appears to have resulted in positive effects on knowledge, perceptions and attitudes towards violence, as well as, in one case, a reduction in the incidence of violence.

A number of challenges in working with men were identified in the studies looked at here. These included losing sight of the original purpose as men tend to focus on their own issues, the replication of gender inequality in group dynamics and men taking the lead and 'advising' women on how they should act to end violence. Overcoming these problems entails investment in specialised staff training to ensure that facilitation skills can deal with the issues outlined above, as well as a high degree of gender awareness and an organisational commitment to gender-equitable practices. Another challenge is engaging male partners in health education and clinical care. Tactics to improve the treatment of partners may include inviting men to health education sessions, improving partner communication, assessing for issues of interpersonal violence and safety in the relationship and reducing stigma associated with exposure to violence and sexually transmitted diseases.

Do programmes target girls?

Girls seem to be another neglected category in GBV programming; they are mentioned little in the literature on GBV, and only one awareness-raising programme looked at here – the Search for Common Ground in the DRC – explicitly targeted young people. Although FORAL projects identified females younger than 20 years that had experienced sexual violence, the majority (60%) of women seeking and receiving services from the programme's mobile health clinics were over 40 years of age, and fewer than 1% of those receiving services were under 20. Although young women acknowledged a need for health care, they were concerned that, while seeking care, they would be seen by older women and therefore be stigmatised. A study of Ugandan adolescents also identified lack of privacy and confidentiality as an obstacle to accessing reproductive health services, alongside a lack of trusted information sources, misinformation about family planning methods and a general sense that it was inappropriate for young people to access sexual health services.[51]

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49 Kohli et al., 'Community-based Health Programme for Survivors of Sexual Violence'.

50 Ayoo, *Women Empowerment for Peace (WEP) Project, Northern Uganda*.

51 A. Flaherty, W. Kipp and I Mehangye, 'We Want Someone with a Face of Welcome': Ugandan Adolescents Articulate Their Family Planning Needs and Priorities', *Tropical Doctor*, 35, 2005, cited in Kohli et al., 'Community-based Health Programme for Survivors of Sexual Violence'.

Chapter 5
Conclusion

This Network Paper has reviewed a range of interventions addressing gender-based violence in emergency settings. This concluding chapter draws out the key lessons in terms of good practice, and the implications for future programming and research priorities. Given the deeply embedded cultural and social norms around gender-based violence, any intervention designed to address its causes, consequences and effects can only work at the margins; bringing about real, meaningful change will be a slow, long-term process, in which humanitarian response can play only a small part. That said, GBV is the subject of increasing international attention, and will be an increasing concern for humanitarian agencies working in crisis environments. As such, humanitarian actors need to understand it better, and design better interventions to address it, both in the immediate emergency phase and over the longer term.

One of the key conclusions of this paper is that, currently, knowledge of GBV in emergencies – its causes and forms, the attitudes and behaviours that enable, conceal and perpetuate it, the social and psychological context in which it exists, its prevalence in particular circumstances and what works in addressing it – is inadequate. In many circumstances concrete data simply does not exist; where there is any data, it tends to be anecdotal or circumstantial. To some extent this reflects the sensitivity of the subject: measuring the nature and prevalence of GBV in a crisis is much more complex and difficult than measuring malnutrition or reporting on the availability of drinking water, for example. But that does not exempt actors working in this area from finding ways to augment the evidence base to ensure that their programmes are based on as solid a foundation as possible. Pertinent questions for programming might include: Which aspects of GBV are more or less critical in different contexts? What measures are in place to address transactional and survival sex or trafficking in emergency contexts? What types of intervention might be needed to respond to intimate partner violence versus rape perpetrated as an act of war? What specific challenges do girls face in terms of GBV prevalence and barriers in accessing services? Where do men and boys fit, both as perpetrators and as victims? What are the social, political, legal, cultural or ethnic issues driving or constraining gender-based violence in a particular setting, and what can humanitarian agencies do about them?

The challenges involved in getting at questions such as these are substantial, ranging from cultural and social sensitivities particular to GBV to the more familiar resourcing and capacity problems that affect all sectors of humanitarian response. Yet it should be possible for concerned agencies and actors at least to develop a culture of sharing documentation and reports, increase awareness of the responsibilities associated with holding information relevant to GBV programming and invest more time in discussing and disseminating data, monitoring and evaluating programmes and compiling and disseminating good practice. The GBV Information Management System (GBVIMS) may be a useful tool in helping to share data.[52] It may also be possible to develop partnerships with research institutions that can provide the requisite expertise, and may provide access to research funds not typically available to implementing organisations. Donors could also demand improvements (and fund them) to ensure that monitoring keeps pace with investment in evaluation. Generating knowledge on adapting, piloting and evaluating proven GBV strategies from development settings and learning from other experiences (HIV, wider gender mainstreaming) will also be important.

There is also a need to think more deeply and clearly about how GBV programming in emergencies 'fits' with the wider humanitarian response in particular crises. It is notable that, of the programmes looked at in this paper, the majority appeared to regard efforts to tackle GBV as somehow a discrete part of the wider humanitarian response, or, like the EA$E programme in Burundi, incorporated a GBV element in an effort to offset the possible ill effects of other programmes. Multi-sectoral interventions seem to be the exception rather than the rule, and only one intervention looked at here, Oxfam's Protection Programme in the DRC, explicitly tried to mainstream GBV within a broader portfolio of humanitarian action.

Whether and how any benefits from short-term GBV programming can be sustained is also unclear; while Oxfam, for example, may hope that its Community Protection Committees will 'evolve into some form of civil society group, maintaining the role of interlocutor between the state and population, while also holding officials to account' and that the 'training, information exchange with civil society groups and alliances, skills, experience, and confidence that those associated with the committees develop will be sustained beyond the end of the intervention'. Whether this does indeed happen is outside the agency's power to control, and the dire history of violence and conflict in the DRC makes such an outcome less than guaranteed.[53]

What constitutes 'good' GBV programming?
Notwithstanding the current limits of the data on GBV, and the lack of substantial evaluative evidence in this area, the programmes looked at in this study allow for some preliminary observations about the characteristics of good GBV programming. Community-based programmes using awareness-raising techniques have succeeded in reducing the incidence and mitigating the impact of GBV and changing attitudes, perceptions, knowledge and (some) behaviour.

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52 The GBVIMS initiative was launched in 2006 by OCHA, UNHCR and the IRC. The GBVIMS Steering Committee now includes UNFPA,UNICEF, UNHCR, IRC and WHO. See http://www.gbvims.org.
53 E. Fanning and R. Hastie, *Protecting Communities in the DRC: Understanding Gender Dynamics and Empowering Women and Men*, Oxfam GB, October 2012.

Techniques include the use of media such as radio, or specifically engaging men either through targeted 'talks' or by organising men's groups (complementary to women's groups). Approaches such as these aim to engage the community, and men, in non-threatening and non-divisive ways, whilst ensuring that awareness-raising activities are culturally sensitive and resonate with the realities of people's lives.

Community sensitisation targeted at men and boys is vitally important in tackling gender-based violence by changing attitudes and behaviour towards women, for example through clear messages on the root causes of GBV, encouraging male leadership for GBV prevention through training with male community members and using male community leaders as advocates. It is also important to recognise that programming targeted at women may have adverse effects on men's attitudes, and finding ways to include men appropriately in GBV programmes without reducing the focus on women or replicating gender inequalities is critical. Ways to overcome this include ensuring a safe space for women to find their collective voice, establishing a clear mechanism for women to use when and if they are ready to participate in mixed groups and bringing men and women together on specific activities or campaigns, whilst retaining protected spaces. There is also a need to recognise and respond to the socio-cultural barriers which men face in accessing survivor services by providing appropriate and responsive services. This may include inviting men to health education sessions, improving partner communication and reducing the stigma associated with exposure to violence and sexually transmitted diseases.

For programming intended to increase women's access to services, aside from the actual provision of services which address GBV, three key features stand out. The first is the availability of integrated or multi-sectoral services combined with increased capacity and knowledge of staff to respond to GBV and refer GBV survivors to relevant services (and support the capacity of other service providers, such as the police, to respond to GBV cases). The second is addressing the stigma associated with certain forms of GBV, such as sexual violence and rape, and overcoming socio-cultural norms which prevent women from accessing services. Mechanisms for this include integrating victims and survivors of sexual violence into existing activities (e.g. economic groups, as in the Northern Uganda example) and ensuring that services are confidential. The third is increased local knowledge – either the engagement of local/traditional service providers, such as community health workers, on GBV issues, or increasing community knowledge

about the types of services available, and which services should be utilised after violence occurs. Finally, therapeutic programmes which utilise a group-based approach, which teach social skills and are adapted to the local cultural context are critical components in contributing to the improved emotional and physical wellbeing of GBV survivors.

Across all types of programming, there is a general need to improve coordination and to build the capacity of staff (and the local community). Investment is needed in continuous specialised and culturally appropriate training to staff to deliver GBV programmes, particularly in relation to the specialised skills involved in implementing awareness-raising programmes to change attitudes, perceptions and social norms, working with men and arranging referrals and service provision. In community-based programmes, ways must be found to strengthen the capacity of community workers (e.g. community health workers) and communities themselves to enable them to build on pre-existing systems and traditions to support the delivery of services to GBV survivors in a culturally and socially appropriate way.

Strengthening coordination mechanisms between sectors and programmes, and between institutions and agencies, will help build synergies with other organisations to support GBV programming. Multiple activities and strategies should be offered as part of an intervention because they are mutually reinforcing and enabling, and together offer some hope that the prevention of sexual violence in conflict, post-conflict and other humanitarian crises is possible.[54] Developing multi-sectoral strategies based on the IASC Guidelines, establishing communication plans between sectors and services, setting up inter-agency coordination meetings, developing forums or cluster meetings for collaboration, revitalising women's desks at regional levels, integrating GBV activities into district development plans and conducting joint training may all help overcome coordination problems.[55] Finally, as a sector the humanitarian community must improve monitoring and evaluation mechanisms, building robust systems and independent evaluations into programme plans and budgets to generate findings on the effects of interventions, including baseline and end-line data collection and analysis.

54 Spangaro et al., *What Evidence Exists for Initiatives To Reduce Risk and Incidence of Sexual Violence in Armed Conflict and Other Humanitarian Crises?*
55 Ayoo, *Women Empowerment for Peace (WEP) Project, Northern Uganda; Falb, IRC Thailand; Mwangi, CARE Refugee Assistance Project, Dadaab.*

References

Alvarado, M. and B. Paul (2011) 'Involving Men on the Thai–Burma Border', *Forced Migration Review*, no. 38, October.

Amnesty International (2011) 'Aftershocks: Women Speak Out Against Sexual Violence in Haiti's Camps'.

Ayoo, S. (2008) Women Empowerment for Peace (WEP) Project, Northern Uganda, Care International in Uganda/Care.

Bass, J. K. et al. (2013) 'Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence', *New England Journal of Medicine*, 368(23).

Beyond Borders (2013) *Rethinking Power's SASA! Adaptation in Haiti: Project Final Report for UUSC*. Washington DC: Beyond Borders.

Canavera, M. (2011) *'We Cannot Wait for Others To Come Protect Us': Lessons Emerging from Oxfam GB's Community-based Civilian Protection Programme in the Eastern Democratic Republic of Congo*. Oxford: Oxfam GB.

Davis, L. and B. Bookey (2011) 'Fanm Ayisyen Pap Kase: Respecting the Right to Health of Haitian Women and Girls', *Health and Human Rights*, 13(1).

D'Odorico, G. and N. Holvoet (2009) 'Combating Violence against Women (VAW) in South Kivu: A Critical Analysis', *Journal of International Women's Studies*, 11(2).

Falb, K. (2011) *IRC Thailand: Gender-based Violence Program Evaluation*. New York: International Rescue Committee.

Fanning, E. and R. Hastie (2012) *Protecting Communities in the DRC: Understanding Gender Dynamics and Empowering Women and Men*, Oxfam GB.

Gender-based Violence Area of Responsibility Working Group (2010) *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*.

Guedes, A. (2004) *Addressing Gender-based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis*, LTG Associates Inc, Social and Scientific Systems Inc, United States Agency for International Development.

Heise, L. L. (1998) 'Violence Against Women: An Integrated, Ecological Framework', *Violence Against Women*, 4(3).

Hentonnen, M. et al. (2008) 'Health Services for Survivors of Gender-based Violence in Northern Uganda: A Qualitative Study', *Reproductive Health Matters*, 16(31).

Horn, R. (2010) 'Responses to Intimate Partner Violence in Kakuma Refugee Camp: Refugee Interactions with Agency Systems', *Soc Sci Med*, 70.

Hughes, S. (2012) *Final Evaluation of Oxfam GB's Protection Programme in DRC*. Oxford: Oxfam GB.

Hustache, S. et al. (2009) 'Evaluation of Psychological Support for Victims of Sexual Violence in a Conflict Setting: Results from Brazzaville, Congo', *International Journal of Mental Health Systems*, 3(7).

International Rescue Committee, *Getting Down to Business: Women's Economic and Social Empowerment in Burundi*. New York: IRC, n.d.

Johnson, K. et al. (2010) 'Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo', *JAMA*, 304(5).

Interagency Standing Committee (IASC) (2005) *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*. New York: IASC.

IASC Sub-Working Group on Gender and Humanitarian Action, *Establishing Gender-based Violence Standard Operating Procedures (SOPs) for Multisectoral and Inter-organisational Prevention and Response to Gender-based Violence in Humanitarian Settings* (2008) New York: IASC.

Landis, D. (2012) 'Examining Promising Practice for Young Survivors: An Integrated Review of Sexual and Gender-based Violence Programming in Liberia', Child Protection in Crisis Network for Learning and Action.

Manneschmidt, S. and K. Griese (2009) 'Evaluating Psychological Groups Counselling with Afghan Women: Is This a Useful Intervention?', *Torture*, 2009, 19(1).

McGinn, T. et al. (2011) 'Family Planning in Conflict: Results of Cross-sectional Baseline Surveys in Three African Countries', *Conflict and Health*, 5(11).

Mwangi, G. K. (2012) *CARE Refugee Assistance Project, Dadaab: Gender Based Violence Program Evaluation*. Atlanta, GA: CARE USA.

Peterman, A., T. Palermo and C. Bredenkamp (2011) 'Estimates and Determinants of Sexual Violence against Women in the Democratic Republic of Congo', *American Journal of Public Health*, 101(6).

Saltzman et al., E. L. (2002) *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0*. Atlanta, GA: CDC.

Search for Common Ground (2011) *Informing Refugees and Returnees on Gender based Violence: Program Evaluation*. Kinshasa: Search for Common Ground.

Spangaro, J. et al. (2013) *What Evidence Exists for Initiatives To Reduce Risk and Incidence of Sexual Violence in Armed Conflict and Other Humanitarian Crises?* A Systematic Review, PLOS ONE.

Stark, L. and A. Ager (2011) 'A Systematic Review of Prevalence Studies of Gender Based Violence in Complex Emergencies', *Trauma, Violence and Abuse*, 12.

Stoebenau, K. et al., (2011) 'More Than Just Talk: The Framing of Transactional Sex and Its Implications for Vulnerability to HIV in Lesotho, Madagascar and South Africa', *Globalization and Health*, 7(34).

Ward, J. (2002) *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-conflict Settings: A Global Overview*. New York: The Reproductive Health for Refugees Consortium.

Watts, C. and C. Zimmerman (2002) 'Violence Against Women: Global Scope and Magnitude', *The Lancet*, 359.

World Health Organisation, London School of Hygiene and Tropical Medicine, South African Medical Research Council (2013) *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence*. Geneva: WHO.

WHO (2007) *Ethical Safety Recommendations for Researching, Documenting, and Monitoring Sexual Violence in Emergencies*. Geneva: WHO.

Annex 1
Key milestones in the evolution of GBV programming in humanitarian settings (1985–2011)

Timeline	Key milestones
1985	• Third World Conference on Women • Working group on refugee women convened
1989	Appointment of UNHCR Senior Coordinator for Refugee Women
1990	UNHCR published *Guidelines on Protection of Refugee Women*
1994	WCRWC published *Refugee Women and Reproductive Health: Reassessing Priorities*
	International Conference on Population and Development in Cairo • Identified GBV as a pillar of reproductive health
Late 1980s, early 1990s	Special 'victim of violence' projects (UNHCR) including sexual violence • Ad hoc and short-term projects often using year-end funds • Beginning of recognition that sexual violence survivors are in need of specialised services and support
1990s	Media coverage of high levels of sexual violence in conflicts in Bosnia and Rwanda
early–mid-1990s	Humanitarian reform is underway • Cluster system to be established • Will affect how GBV interventions are coordinated and supported within the humanitarian system
1992	Inter-Agency Standing Committee (IASC) formed
1994	World Bank publishes *Violence against Women: The Hidden Health Burden* by Lori L. Heise with Jacqueline Pitanguy and Adrienne Germain
1995	UNHCR publishes *Guidelines on Sexual Violence Against Refugees*
	Reproductive Health Response in Conflict Consortium (RHRC) formed
1996–2000	UN Foundation (Ted Turner donation) funds to UNHCR • Multi-sectoral GBV programming initiated in five countries in East and West Africa • *GBV Situation Planning Workshop Guide* published
1998	Heise paper proposing an ecological framework for understanding and addressing gender-based violence: *Violence Against Women: An Integrated, Ecological Framework*
late 1990s	Rise in use of Behaviour Change Communication to reduce sexually transmitted infections; HIV/AIDS prevention programmes increasingly use BCC techniques
	Masculinities programmes initiated in Central/South America. These programmes target men with the aim of increasing health and reducing the use of violence
2000	UN Security Council Resolution 1325 on 'Women, Peace and Security': first Resolution to link women to peace and security agenda • Participation and representation of women in all aspects of peace and security • Protection of women as a group with specific needs • Prevention of sexual and other violence
2001	UNHCR GBV Lessons Learned Conference • Discussion of multi-sectoral lessons learned from UN Foundation project • Identified sexual exploitation/abuse as serious issues in the field
	WHO/UNHCR publish *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons*
2001–2005	Reproductive Health Response in Conflict (RHRC)'s GBV Initiative • *If Not Now, When* report published describing the nature and extent of GBV in humanitarian/ emergency settings • *GBV Tools Manual* published • *Communication Skills* training manual published

Annex 1 (continued)

Timeline	Key milestones
2001–2007	RHRC's GBV Technical Support Project • On-site technical support for training and development of GBV programmes in 16 countries • *GBV Emerging Issues* report published describing common programming experiences, successes and issues around the globe • *Training Manual/Facilitation Guide* published for multi-sectoral GBV training and planning
2002	Sexual exploitation and abuse scandal in West Africa • Report from Save the Children and UNHCR alleging that this is a widespread problem affecting children and perpetrated by humanitarian staff and peacekeepers • UN agencies and NGOs respond with investigations and form working groups to address the problem
2003	UN Secretary General's *Bulletin on Sexual Exploitation and Abuse* • Outlines six core principles for humanitarian staff conduct • Requires Codes of Conduct for all UN and partner agencies
2005	WHO/UNHCR publish revised and updated *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons*
	Around this time, GBV programmes in humanitarian settings increasingly engage men and boys in prevention programming, drawing on masculinities work in Central and South America, Africa and elsewhere
2006	Brussels Symposium and Call to Action to address sexual violence in armed conflict (June 2006), which led to UN Action (2007)
2007	IASC publishes *Guidelines for GBV Interventions*
	UNFPA/GBV AoR initiate a two-week GBV Coordination training course
	WHO publishes *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*
	UN Action formed
2008	IASC/GBV AoR publish introduction and training package for the *Guidelines for GBV Interventions*
	GBV Area of Responsibility formed within the Protection Cluster • First planning meeting to develop goals, objectives and work plan (reviewed and revised annually)
	GBV AoR publishes *GBV Standard Operating Procedures (SOP) Guide*
	UNSCR 1820 on conflict-related sexual violence First Resolution to recognise sexual violence as a self-standing security issue • Acknowledges that sexual violence is linked with reconciliation and durable peace • Excludes sexual violence crimes from amnesty provisions • Specific training of troops on prohibition of sexual violence • Requests improved mechanisms for protecting women/girls in and around UN-managed camps • Requests the Secretary-General to include an 'analysis of the prevalence and trends of sexual violence in armed conflict' in annual reports
2009	UNSCR 1894 on Protection of Civilians (PoC) • Reaffirms compliance with international obligations relating to the protection of civilians • Requires humanitarian access • Peacekeeping operations to have 'Comprehensive Strategy on PoC' • Requires bridging peacekeeping mission and humanitarian community (Protection Cluster)
	UNSCR 1888 on conflict-related sexual violence • Creates Special Representative to the Secretary-General on Sexual Violence in Conflict • Establishes Women Protection Advisers (WPAs) • Requires improved data collection and reporting on trends • Requires annual reports, including on conflict-related sexual violence

Annex 1 (continued)

Timeline	Key milestones
2010	GBV AoR adds new essential resource publications to support GBV programming: • training manual as a companion to the *GBV SOP Guide* • *GBV Coordination Handbook* • *Caring for Survivors* training pack
	GBV AoR publishes *GBV Coordination Handbook*
	UNSCR 1960 on conflict-related sexual violence • Expands mandate to comprehensively address sexual violence when used as a tactic of conflict, or resulting as a consequence of conflict • Strengthens accountability architecture for holding perpetrators to account including by listing perpetrators and establishing monitoring, analysis and reporting arrangements ('MARA')
2011	GBV AoR creates online GBV Community of Practice (closed by end of year)
2012	UK Foreign Office launches its Preventing Sexual Violence Initiative (PSVI)

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