

Part 1

Emerging Standards

A Brief History of GBV Programming

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

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

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

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

This is not a simple task.

THE STATE OF THE ART

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

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

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

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

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

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

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

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

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

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

NEW OPPORTUNITIES

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

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

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

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

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

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

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

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

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

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

The GBV Program Model Today

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

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

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

DELINEATING THE PROBLEM

Gender

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

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

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

Power

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

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

Violence and Use of Force

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

Injury and Harm

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

Consent

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

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

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

Human Rights

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

GBV

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

DEFINING AND TARGETING GBV PROGRAMS

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

For the purposes of this Declaration, the term “violence against women” means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

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

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

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

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

COORDINATING ACTIVITIES

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

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

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

PREVENTING GBV

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

Root Causes and Contributing Factors

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

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

RESOURCES

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

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

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

Thorough Assessment

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

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

Prevention Strategies

The key to GBV prevention is education.

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

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

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

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

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

RESPONDING TO GBV

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

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

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

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

■ Community/social services:

- Community education—targeting the community, UN and NGO staff, local government authorities—for protection awareness, rights awareness, and knowledge of available assistance;
- Outreach and identification of survivors; designated place(s) where survivors can go to receive assistance without stigma;
- Counseling (i.e., short-term listening and emotional support) for survivors and families;
- Advocacy and assistance for survivors with health care, security and legal justice systems, and other needed services;
- Group activities—including income generation and microcredit projects—for survivors and other vulnerable women that focus on building support networks, reintegration into communities, confidence building, skill building, and promotion of economic empowerment.

■ Health clinic or hospital:

- Outreach and identification of survivors;
- Examination and treatment by trained staff using appropriate protocols and with adequate equipment, supplies, medicines: treat injury, prevent unwanted pregnancy, treat/prevent STIs, assess mental trauma;
- Medical evidence documentation for legal proceedings, as requested and required;
- Follow-up care and treatment;
- Referral (and transport) to appropriate levels of care;
- Collaboration and coordination with traditional healing practitioners.

Reducing GBV Risk—

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

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

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

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

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

Emerging Issues in GBV Programming

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

COMMON CONDITIONS

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

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

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

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

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

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

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

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

Assistance and Services

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

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

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

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

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

The Local Environment

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

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

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

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

COMMON ISSUES

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

Understanding GBV

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

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

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

Community-Based, Interagency, Multisectoral Integrated Action

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

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

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

COMMON NEEDS

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

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

COMMON SOLUTIONS

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

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

Mainstreaming GBV Programs

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

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

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

TWO TYPICAL SCENARIOS

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

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

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

Country A

The First Year

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

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

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

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

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

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

A Year or Two Later

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

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

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

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

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

Country B

The First Year

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

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

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

A Year Later

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

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

FINDING SOME COMMON DENOMINATORS

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

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

—UNHCR Protection Officer, 2000

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

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

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

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

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

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

GBV PLACEMENT IN AN ORGANIZATIONAL SYSTEM

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

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

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

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

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

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

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

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

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

MOVING FROM VERTICAL TO MAINSTREAM PROGRAMS

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

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

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

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

Learning from Development Programs

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

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

—GBV consultant report, 1999

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

—GBV consultant report, 2000

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

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

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

INVOLVING THE COMMUNITY

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

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

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

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

THE LONG AND BUMPY ROAD TO INTEGRATION AND MAINSTREAMING

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

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

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

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

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

—A GBV program
coordinator, 2002

Table 4–1

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

	Immediate Emergency Situation <i>In First 3 Months</i>	Fairly Stable Settings, Year 1–2 <i>Add These Components...</i>	Stable Settings, Longer term <i>Add These Components...</i>
Refugee community education	<p>One-time orientation for new arrivals with continuing information through community leaders:</p> <ul style="list-style-type: none"> ■ What to do, where to go for help after a GBV incident ■ Rights, benefits, entitlements as refugees 	<p>At least one-time training for all; posters/other materials posted in key locations at the site:</p> <ul style="list-style-type: none"> ■ What to do, where to go for help if you know of a GBV incident ■ Human rights, GBV 	<p>Variety of ongoing activities targeting specific groups (e.g., women, men, youth, children) with the goal of attitude and behavior change:</p> <ul style="list-style-type: none"> ■ Examining gender norms in the culture ■ Preventing/stopping GBV <p>Community education is led by trained and qualified refugee volunteers with material support from a designated organization.</p>
Refugee community mobilization		<ul style="list-style-type: none"> ■ Identify interested community members; mobilize them to conduct awareness-raising and encourage survivors to come forward for help ■ Women’s center or other safe space for drop-in incident reports 	<p>Over time, these groups become well trained and autonomous, with periodic meetings organized by a designated organization in the setting:</p> <ul style="list-style-type: none"> ■ Crisis response teams ■ Men’s groups engaged in prevention and working with men ■ Women’s groups engaged in prevention and working with women and children survivors ■ Youth counselors, peer educators ■ School programs about GBV
Work with local community (host country)		<ul style="list-style-type: none"> ■ Local population has access to primary and reproductive health services at refugee health clinic 	<ul style="list-style-type: none"> ■ Drama and other presentations that describe refugee life ■ Include local women in survivor services, such as support groups
Humanitarian aid staff education	<ul style="list-style-type: none"> ■ Standards of behavior and/or code of conduct, sanctions, reporting system 	<ul style="list-style-type: none"> ■ Gender ■ Human rights, GBV ■ Guiding principles for response to survivors (confidentiality, respect, safety) 	<ul style="list-style-type: none"> ■ Integration: preventing GBV through your sector’s work

Table 4-1 (continued)

	Immediate Emergency Situation <i>In First 3 Months</i>	Fairly Stable Settings, Year 1-2 <i>Add These Components...</i>	Stable Settings, Longer term <i>Add These Components...</i>
Interagency, interdisciplinary, multisectoral coordination	<ul style="list-style-type: none"> ■ System for emergency reporting, referrals, documentation, survivor assistance and security 	<ul style="list-style-type: none"> ■ Incident report and case outcome data collected, compiled, disseminated; used for planning by multisectoral actors ■ Written procedures for reporting, documentation, roles and responsibilities of all key actors, referral systems ■ Procedures incorporate the guiding principles of confidentiality, respect, safety ■ Regular planning–coordination–information sharing meetings at camp, field, national levels 	<ul style="list-style-type: none"> ■ Integration: Special GBV procedures are incorporated into other procedures and policies within each organization ■ UNHCR takes the lead to organize periodic reviews and revisions to procedures
Health	<ul style="list-style-type: none"> ■ Medical exam, treatment, follow-up post rape/sexual abuse ■ Documentation ■ Simple M&E indicator 	<ul style="list-style-type: none"> ■ Established protocols for post rape examination, treatment, and follow-up care ■ Documentation ■ Expanded M&E indicator(s) 	<ul style="list-style-type: none"> ■ Med exam, treatment, follow-up for all types of GBV occurring in the setting ■ Active screening for GBV of all female patients ■ Expanded indicators for all types of GBV interventions at health clinic ■ Community health workers, TBAs, traditional healers conducting awareness-raising in community, finding and assisting survivors
Psychosocial	<ul style="list-style-type: none"> ■ Community Services and/or Health staff providing immediate emotional support, information, advocacy for survivors ■ Documentation of incident reports ■ M&E indicators for emergency response and outcomes 	<ul style="list-style-type: none"> ■ Expanded initial support to include informing survivor about all options and potential outcomes for response services ■ Differential response for different types of GBV occurring ■ Survivor empowerment through skills training and income generation activities ■ M&E indicators for response and prevention activities and outcomes 	<ul style="list-style-type: none"> ■ Separate or specialized GBV refugee and national staff/volunteers in the Community Services organization who provide emotional support, referrals, advocacy with survivors ■ Documentation system for incident reporting and follow-up ■ Microcredit/loan programs ■ Women/survivor support groups ■ Specialized counseling for extremely traumatized individuals ■ Specialized children’s counselors

Table 4–1 (continued)

	Immediate Emergency Situation <i>In First 3 Months</i>	Fairly Stable Settings, Year 1–2 <i>Add These Components...</i>	Stable Settings, Longer term <i>Add These Components...</i>
Security	<ul style="list-style-type: none"> ■ Emergency response to incidents ■ Investigation and arrest; law enforcement ■ Survivor security and protection ■ UNHCR monitoring and advocacy 	<ul style="list-style-type: none"> ■ Private interview space in police post ■ Temporary placement, relocation options for survivors ■ M&E indicators 	<ul style="list-style-type: none"> ■ Training by police for police in appropriate response; repeated regularly for in-coming replacements
Legal justice	<ul style="list-style-type: none"> ■ UNHCR monitoring and advocacy 	<p>Informal:</p> <ul style="list-style-type: none"> ■ Leaders/elders manage only “less severe” cases, as defined and agreed with host country and UNHCR ■ M&E indicators <p>Formal:</p> <ul style="list-style-type: none"> ■ Refugee cases handled like all others by national justice system ■ UNHCR <ul style="list-style-type: none"> —System for notice of refugee cases scheduled in court —Information, support, assistance, advocacy for survivor/witnesses through all stages of process —M&E indicators 	<p>Informal:</p> <ul style="list-style-type: none"> ■ Training for leaders in human rights, gender equality; they set standards for decision making that incorporate these principles <p>Formal:</p> <ul style="list-style-type: none"> ■ Training programs for judiciary in GBV guiding principles, relevant laws, and so forth ■ National lawyers on contract for survivor/witness assistance, advocacy, support through all stages of police and judicial process

Note.

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