

Part 3

Varied Programs, Shared Challenges

Angola

Getting started in a war zone

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

DISPLACED POPULATIONS

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

GBV

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

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

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

GBV INITIATIVES AND PROGRAMS

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

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

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

GBV TA MISSION

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

TA ASSESSMENT AND RECOMMENDATIONS

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

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

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

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

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

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

Eritrea

Initiating a GBV program with IDPs and returnees

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

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

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

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

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

DISPLACED POPULATIONS

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

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

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

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

Harmful traditional practices include female genital mutilation and virginity checking.

GBV

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

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

GBV INITIATIVES AND PROGRAMS

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

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

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

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

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

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

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

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

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

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

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

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

GBV TA MISSION

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

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

TECHNICAL ASSISTANCE AND TRAINING

2001 Start-Up Assistance

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

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

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

2002 Follow-Up Visit

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

TA ASSESSMENT

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

TA RECOMMENDATIONS

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

Guinea

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

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

DISPLACED POPULATIONS

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

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

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

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

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

CASE STUDY

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

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

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

—Mary's sister reporting from Guinea, 1999

GBV

Prior to and During Flight

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

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

In the Country of Refuge

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

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

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

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

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

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

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

GBV INITIATIVES AND PROGRAMS

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

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

GBV TA MISSION

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

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

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

TA ASSESSMENT

Interagency Coordination

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

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

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

UNHCR

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

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

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

IRC's GBV Program

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

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

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

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

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

ARC's GBV Program

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

TECHNICAL ASSISTANCE AND TRAINING

Interagency, Multisectoral Coordination

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

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

Training and Technical Support with IRC

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

Training with UNHCR

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

TA RECOMMENDATIONS

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

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

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

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

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

Serbia

Refugees, IDPs, citizens—a country in transition

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

DISPLACED POPULATIONS

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

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

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

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

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

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

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

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

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

GBV

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

GBV INITIATIVES AND PROGRAMS

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

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

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

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

GBV TA MISSION

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

TA ASSESSMENT

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

The Network of Trust meets regularly for three general purposes:

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

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

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

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

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

Two CARE projects currently underway are relevant to GBV:

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

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

TECHNICAL ASSISTANCE AND TRAINING

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

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

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

- Organized and led a roundtable discussion with approximately 25 gender education project trainers engaged by CARE. The training served as an introduction to GBV and interdisciplinary prevention and response, with a focus on war-affected populations.
- Held two participatory gender-awareness workshops with all CARE Belgrade staff (approximately 50 people). Staff reactions to these workshops were mixed, and a number of staff were resistant to concepts of gender equality, a common occurrence in initial gender workshops world wide.
- Conducted an in-depth training session with six to seven interested CARE staff that focused on the “gender and development” approach. Provided worksheets and tools for gender analysis in developing programs.
- Conducted a workshop with government ministries in Vranje, including police and representatives from the legal justice system. Attendance was very low (three people). The workshop focused on interagency response and collaboration needed between government and nongovernment organizations, and included a brief discussion of how to engage colleagues (i.e., those not present).
- Conducted a workshop with thirteen staff members in Vranje area Centers for Social Work, with specific focus on response to domestic violence and child sexual abuse.
- Led a roundtable workshop with seven national human rights and psychosocial NGOs based in Vranje. The training covered GBV prevention and response and encouraged start-up of initiatives to address GBV in the displaced populations.

TA RECOMMENDATIONS

Leading Women's NGOs and Interested Interagency Colleagues

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

CARE and Partners

Gender Project

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

Centers for Social Work

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

CARE Staff

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

NGOs in Vranje

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

Sierra Leone

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

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

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

DISPLACED POPULATIONS

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

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

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

GBV

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

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

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

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

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

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

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

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

GBV INITIATIVES AND PROGRAMS

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

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

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

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

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

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

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

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

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

GBV TA MISSION

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

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

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

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

TA ASSESSMENT

UNHCR

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

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

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

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

IRC

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

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

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

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

FAWE

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

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

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

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

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

TA ASSISTANCE AND TRAINING

Country Wide GBV Planning

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

Training and Consultation with UNHCR

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

Training and Technical Support with IRC

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

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

Training with FAWE

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

TA RECOMMENDATIONS

UNHCR

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

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

IRC

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

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

FAWE

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

Thailand

First steps in GBV program planning

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

DISPLACED POPULATIONS

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

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

GBV

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

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

Rape

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

Domestic Violence

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

Child Sexual Abuse

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

Sexual Exploitation and Abuse

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

GBV INITIATIVES AND PROGRAMS

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

GBV TA MISSION

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

TA ASSESSMENT

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

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

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

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

Health Care

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

Psychosocial Services

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

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

Security Systems

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

Legal Justice Systems

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

TA ACTIONS

Nu-Poh and Umpiem Mai Camps

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

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

Mae Kong Kha Camp

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

Mae Hong Son, Camps 2 and 3

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

Country Wide

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

TA RECOMMENDATIONS

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

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

Zambia

Initiating a GBV program with refugees

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

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

DISPLACED POPULATIONS

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

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

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

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

GBV

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

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

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

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

GBV INITIATIVES AND PROGRAMS

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

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

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

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

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

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

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

GBV TA MISSION

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

TECHNICAL ASSISTANCE AND TRAINING

December 2001, First Visit

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

TA Recommendations

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

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

August 2002, Follow-Up Visit

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

TA RECOMMENDATIONS

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

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