Real-Time Accountability Partnership

Baseline Assessment Final Report – Executive Summary

International Solutions Group

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Executive Summary

Introduction and Background

Over the last decade there has been a great deal of research, advocacy and consensus on the need for prioritisation and accountability in gender-based violence prevention/response in emergencies. However, stakeholders in humanitarian action have had little success in defining what prioritisation and accountability look like concretely in humanitarian settings.

The Real-Time Accountability Partnership (RTAP) seeks to address this important issue by focusing on strategic actions that fall within the responsibility/mandate of key humanitarian actors during each phase of the Humanitarian Program Cycle (HPC).

The **RTAP goal** is that all humanitarian actors prioritise and integrate the prevention of and response to GBV across sectors, and that this response is coordinated across all humanitarian assistance and protection actions.

(Proposed) RTAP Action Framework – The RTAP is proposed to be operationalised via an "Action Framework" comprising of a Theory of Change (TOC) and five Action Sheets that will provide detailed strategic actions for key stakeholders at five specific stages of the HPC: Preparedness, Needs Assessment & Analysis, Strategic Response Planning, Resource Mobilisation, and Implementing & Monitoring Response. It may also include a monitoring framework and guidance on governance.

RTAP Partners include one bilateral donor: USAID's Bureau for Democracy, Conflict and Humanitarian Assistance and Office of U.S. Foreign Disaster Assistance (OFDA); all three lead UN protection agencies (UNHCR, UNICEF and UNFPA); the lead UN coordination agency (UN OCHA); and one international NGO, the International Rescue Committee (IRC). These partners are working together to pilot a model response in two current crises, and will use the results to establish clear benchmarks on accountability for timely GBV prevention and response by the humanitarian community.

International Solutions Group (ISG), an international Monitoring and Evaluation firm, has been contracted to conduct a **baseline assessment** for the Real-Time Accountability Partnership (RTAP). This assessment aims to establish a basis for examining changes triggered by the piloting of the proposed RTAP Action Framework.

The specific objectives of the assessment are to:

1. Consider current RTAP partners' (and other relevant stakeholders) performance in relation to GBV prevention and response roles and responsibilities laid out in the draft Action Framework and linked Action Sheets;
2. Highlight barriers and enabling factors - both internal and external - to effective implementation of these roles and responsibilities;
3. Present any programming and managerial recommendations to support the success of implementation of the draft Action Framework specifically, and RTAP broadly, at both the field and global levels;
4. Present recommendations on the utility and viability of the draft Action Framework itself, as well as the TOC and Action Sheets;
5. Establish specific baseline measures (i.e. indicators) linked to the draft Action Framework against which progress can be monitored.

The baseline assessment involved the collection of qualitative and quantitative data via global and country-level research in five emergency contexts: Myanmar, Iraq, Nigeria, South Sudan, and Turkey (Syrian cross-border, Gaziantep hub) from April – July 2016. A report from each country visit informs this final synthesis report with global-level recommendations for moving RTAP forward.

UNHCR The UN Refugee Agency

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OCHA

Approach and Methodology

The assessment was conducted between February/March and October/November 2016. It utilised document review, Key Informant Interviews (KIIs) and a self-administered online survey. This combination of methods enhanced the quality and credibility of findings and conclusions through the convergence and overlapping of different data sources and methods of data collection.

Field Research: The assessment included field visits to each of five case study countries: Myanmar, Iraq, Nigeria, South Sudan, and Turkey (Syrian cross-border, Gaziantep hub). Country reports were prepared after each field visit as a means of documenting and sharing emerging findings with the RTAP partners.

Key informant interviews (KII) were conducted with a **total of 193 people, 23 at global level and 170 at country level**. The interviews focussed on understanding to what extent interviewees were addressing GBV but also on what the specific barriers and enabling factors were to meeting their GBV-related responsibilities across the humanitarian programme cycle.

These groups were organised into three levels to facilitate data collection & analysis:

1) *Leadership* (i.e. donors, HC/RC, DR/HC, OCHA, gov't);

2) Mainstreamers (i.e. cluster leads and other humanitarian actors who work outside of GBV);

3) *GBV Specialists* (i.e. UN protection lead agencies and I/NGOs who work specifically on GBV).

Online Survey: To assess the extent to which the elements of the proposed RTAP Action Framework are already being applied across the baseline countries, the research team implemented an online survey to be completed by GBV stakeholders across the three key

levels. The term 'GBV stakeholder' was defined as those who are engaged directly in supporting or undertaking GBV-related response/risk mitigation/mainstreaming activities, notably senior decision-makers in organisations with a GBV mandate, protection cluster (and GBV sub-cluster) members, programme implementing partners.

The specific questions asked in the survey correspond to the elements of the proposed RTAP Action Framework, and provide a reference whereby future changes can be determined after the RTAP pilot has concluded.

Distribution of the survey was done via field visit country-based RTAP *Focal Points* that were appointed by the RTAP steering committee as key GBV stakeholders at the commencement of the baseline assessment. In total, 78 respondents completed the survey.

Key Findings

Application of the Proposed RTAP Action Framework at Baseline

General GBV Prevention/Response Activities

An **online survey** of GBV stakeholders within the five case study countries provides a self-reported baseline of how well actors perceive their organisations are undertaking specific GBV-related activities.

	Iraq Avg	Myanmar Avg	Nigeria Avg	South Sudan Avg	Syria Avg	Overall Avg
Leadership (7 activities)[1]	n/r[1]	29%	n/r[1]	52%	43%	39%
Mainstreamers (13 activities)	54%	75%	65%	89%	86%	75%
GBV Specialists (25 activities)	81%	79%	91%	79%	63%	79%

For **leadership**, the self-reported rating for the *quality* and *extent* of the activities they undertake was just 39%. Commonly undertaken activities noted by respondents were:

- *Education of media on women and girls' rights and violations of these;*
- *Monitoring & reporting violations of women and girls' rights*.

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

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

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

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

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

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

For **GBV Specialists**, high scores (79%) indicate positive perceptions among this group of their work. Notable areas of high performance were:

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

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

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

[1] No leadership stakeholder from Iraq or Nigeria completed the online survey

Humanitarian Programme Cycle Activities

Preparedness: Preparedness is weak for all stakeholders. **Donors** rarely noted GBV prevention and response preparedness actions, with 52% of GBV specialist stakeholders reporting dissatisfaction with rapid deployment of skilled GBV experts. According to the GBV specialists surveyed, many GBV actors undertake activities supporting preparedness, such as the development of contingency plans; however, preparedness efforts should be more systematically coordinated without being 'reactive' to donor guidance/priorities.

Needs Assessment/Analysis: Responses from **leadership** related to needs assessment and analysis indicated insufficient inclusion of GBV-related data in proposals and reports. **Donors** reported that their role was limited to requiring funding applicants to complete GBV assessment/analysis as part of proposals.

Among **mainstreamers**, respondents were unhappy regarding what they perceived as a lack of support to collect robust data on which to base response plans.

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

GBV is not consistently mainstreamed in the HRPs of any of the five research countries.

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

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

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

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

Implementation and Monitoring: For **leadership**, an area of positive performance was engagement of women, girls and at-risk groups in the HPC. However, this observation does not correlate well with others stakeholders, suggesting an optimistic picture portrayed by mainstreamers to leadership. A key finding related to **donor** roles was a lack of accountability for GBV mainstreaming. A 'siloed' approach and lack of follow up was noted as a barrier to ensuring that commitments to GBV risk mitigation are met once funding is approved.

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

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

Enabling Factors for addressing GBV Across the Programme Cycle

1. Enabling Factors – General

- Agency polices and strategic plans are critical to driving accountability to GBV programming;
- Surge support should not replace GBV staff positions;
- Strategies for high-level ownership of GBV at agency level and across the humanitarian community.
- A range of useful GBV tools support programming;
- Specialised global and regional technical support within agencies to support field actors in addressing GBV is foundational to success.

2. Enabling Factors – Preparedness

- Surge capacity—particularly by UNFPA and donors was emphasised as a key to facilitating preparedness;
- Technical support from GBV specialists to HC/RCs is critical to ensure attention to GBV in preparedness;
- Capacity-building of local responders is key to preparedness, as is development of preparedness/ contingency plans by the GBV sub-cluster.

3. Enabling Factors – Needs Assessment & Analysis

- Shared methodologies for field GBV assessments are critical to ensuring GBV data is comparable and can be used collectively to inform country-wide response;
- Donor support to GBV-specific assessments enables focused attention and may boost donor buy-in;
- Mainstreamers' assessment processes are enhanced when they work with GBV specialists, and supports cluster leadership commitments to GBV risk mitigation;
- Inclusion of GBV issues in broader protection assessments can be one strategy to ensure GBV is addressed in protection planning processes.

4. Enabling Factors – Response Planning

- Protection cluster objectives of the HRP should always include an indicator(s) on GBV;
- Joint cluster strategies and projects are effective for response ownership/commitment;
- Mainstreaming GBV via cluster training at the process start can facilitate integration of GBV across all HRPs;
- Short-term surge support to clusters (in addition to training) to facilitate integration of GBV is very useful, with the caveat that this surge support must have a strategy for ensuring long-term buy-in of the clusters;
- Pre-existing gender focal point networks can be mobilised for integration of GBV in cluster planning;
- Advocacy with leadership and the HCT at country level is critical to including GBV in planning processes.

5. Enabling Factors – Resource Mobilisation

- Coordinated global initiatives such as the Call to Action and Safe from the Start can enhance commitments to GBV, including among donors;
- Multi-year grants are vital to GBV- programming;
- Tracking GBV funding can allow the GBV community to identify shortfalls and advocate for resources;
- Mainstreaming tools linked to funding, such as the Gender Marker, are useful in ensuring non-specialists include attention to GBV in proposals;
- Concerted GBV community advocacy is critical to building donor support and generating resources.

6. Enabling Factors – Implementation and Monitoring

- Sufficient technical staff on the ground is vital;
- For GBV Specialists, collaboration with the Protection Cluster as well as Child Protection actors contributes to positive outcomes in maximising resources and funds;
- UN Women collaboration can link humanitarian work with the Women, Peace and Security agenda as well as with local women's activists and to promote strategies to bridge the humanitarian/development divide;
- Standardised monitoring systems ensure accountability
- RC/HC and OCHA commitment to ensuring monitoring of GBV in implementation of plans and agreements;
- For mainstreamers, strong agency and global cluster support for implementation of risk mitigation activities.

7. Enabling Factors – Coordination

- Donor funding for coordination is essential to ensuring effective GBV programming;
- Regular and dedicated space for GBV issues to be tabled at coordination fora such as the HCT and ICCG is a key enabling factor for humanitarian attention to GBV;
- Employing techniques that support local partner investment in coordination enhances commitment to GBV coordination & programmes.

Barriers to addressing GBV Across the Programme Cycle

1. Barriers – General

- GBV global & regional technical support is generally insufficient to adequately support field operations;
- Challenges in staffing GBV specialist positions because of the limited pool of GBV experts, particularly evident in the lack of dedicated IM personnel;
- Senior management in some RTAP agencies do not promote nor resource agency attention to GBV, resulting in uneven institutional commitment to GBV at the field;
- Varied security, social, political contexts poses challenges to sharing learning across GBV programmes.

2. Barriers – Preparedness

- Preparedness planning is not a core part of GBV work, including GBV sub-cluster planning, in part due to overreliance on donors to take lead on priorities;
- A a divide in some agencies between development and humanitarian work that undermines the ability to exploit development processes to engage in preparedness;
- Humanitarian leaders (i.e. RC/HC, OCHA) lack technical guidance for GBV in preparedness planning processes.

3. Barriers – Needs Assessment & Analysis

- No inter-agency package of approved assessment tools and few IM officers limits partner ability to collect, consolidate and use data for advocacy & programming;
- A focus on prevalence data to drive prioritisation of GBV programmes by donors and others, even though establishing GBV programmes is responsibility of humanitarian actors regardless of available data;
- Donors reliance on protection assessments to determine their funding priorities for protection, and these assessments do not always include attention to GBV;
- Non-specialist assessments do not include GBV as cluster partners do not understand obligations to GBV risk mitigation. Few available GBV experts to assist clusters to integrate GBV issues into their assessments.

4. Barriers – Response Planning

- UNFPA is occasionally not included in the HCT;
- Lack of donor GBV advocacy in the HCT/pooled funding;
- Poor support to RC/HCs for GBV attention in planning;
- GBV coordination partners can have too many specialist responsibilities to support mainstreaming in planning;
- GBV sub-clusters often lack strategic plans, limiting ability to identify, resource and action goals and objectives;
- GBV is not always identified with separate HRP indicators, requiring GBV actors to conduct advocacy with the Protection Cluster;
- Cluster leads are not always comfortable using the GBV Guidelines and see mainstreaming as a GBV actor role.

5. Barriers – Resource Mobilisation

- Limited funding challenges scaling up GBV programming;
- Short-term cycles limit the success of GBV interventions;
- Donors prioritise "hardware' interventions and require support by GBV specialists to ensure GBV attention;
- Donors do not earmark nor track funding to GBV-related initiatives, limiting ability to report on GBV commitment;
- Lack of mainstreaming funding beyond GBV Guidelines trainings, limiting clusters' ability to follow up;
- Poor support to CLAs from regional offices for reviewing cluster partner proposals for integration of GBV;
- GBV sub-clusters typically lack a sub-cluster resource mobilisation strategy to facilitate access to funding.

6. Barriers – Implementation and Monitoring

- Insufficient INGOs with humanitarian GBV capacity.
- Poor local partnerships, particularly women's movements;
- Surge mechanism overreliance for core programming;
- A lack of evidence-based programming;
- The GBV field does not have good data sources;
- Limited accountability mechanisms to ensure commitments by humanitarian community are met;
- Global clusters not holding field clusters accountable, or supporting their implementing GBV Guidelines;
- Weak data collection impacts the ability to track programmes, trends and to build the evidence base.

7. Barriers – Coordination

- Competition between agencies, few field leadership options, poor technical capacity of GBV coordinators, multiple programme responsibilities of coordination leadership, poor local partner input;

- Ill-defined GBV AoR process for supporting field;
- Poor leadership on GBV in coordination fora;
- No standard/regularised strategy for the GBVSC and other clusters to coordinate mainstreaming.

Key Points of Leverage

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

1. Leadership

- USG policies and legislation such as the U.S. Government GBV Strategy, the National Action Plan on Women, Peace and Security and Safe from the Start as entry points to support GBV programming and to promote accountability of funding recipients;
- OCHA's new Gender Policy as a mechanism for monitoring HC uptake of GBV concerns and for supporting inclusion of GBV in HC TORs;
- UNFPA's programme criticality assessment of GBV as level 1;
- CERF identification of GBV as life-saving;
- UNFPA's engagement with the OCHA Senior Transformative Agenda Implementation Team in the GBV Champions for HCs and planned high level country missions linked to RTAP steering committee;
- GBV integration in the Staff College for HCs;
- IASC EDG, whose chair has protection and women's issues close to the top of his list at all time;
- Engaging those who have signed up for the Call to Action and Safe from the Start—most particularly donors- in strategic dialogue about gap-filling, also to expand donor engagement with RTAP;
- Revisions to the Sphere Standards for inclusion of GBV integration and specialist responsibilities.

2. Mainstreamers

- Ensuring detailed information on GBV is integrated in surge training for non-GBV specialists;
- Linking RTAP commitments to the rollout of the GBV Guidelines;
- RTAP organisations' own internal sectors—not only in terms of stimulating internal agency mainstreaming of risk mitigation, but also to support, where relevant, specialised programming integration (e.g. CMR in SRH for UNFPA);
- Regularising the inclusion of discussion on GBV risk mitigation in the HRP planning process (as seen in Turkey) to ensure it remains on the table;
- Ensuring discussion and monitoring of GBV integration throughout the program cycle in inter-cluster and interagency forums such as the HCT and the ICCG;
- Ensuring GBV focal points at cluster level as an entry point to promote GBV mainstreaming (or, in the case of Turkey, training gender focal points on GBV issues), including uptake of the IASC GBV guidelines;
- Including GBV responsibilities in HR processes and documents for cluster coordinators/ mainstreaming actors, such as inductions, Terms of References and Performance Appraisals.

3. GBV Specialists

- Taking advantage of existing tools to create a core resource pack for the GBV community that aligns priorities and methods, particularly for assessment and monitoring;
- Initiatives on improving early warning systems for CP that could be expanded to include GBV, as well as the development of new tools for impact monitoring of CP programmes that might inform the development of similar tools for GBV;
- UNICEF's extensive networks and current work on child protection as well as across other sectors.

Stakeholder-Specific Conclusions

Leadership

1. While many donors interviewed confirmed strong institutional policy commitments to GBV, this was not always evident in terms of levels of funding on the ground. Accountability to global commitments is lacking in reviews of programme and strategic performance with insufficient internal technical support to donors on GBV issues and funding needs. Donors interviewed indicated they are not tracking their GBV allocations, another barrier to promoting accountability to GBV commitments.
2. In countries where donors provide significant GBV programming support, funding does not appear to be linked to a GBV sub-cluster strategic plan, which may undermine a cohesive and coordinated GBV response. In addition, funding is often short-term.
3. Several interventions that promote success of GBV programmes are not regularly funded by donors. For example, preparedness planning or GBV-specific assessments. Despite coordination being fundamental to GBV programming, donors seem less likely to fund GBV coordination positions, including for information management, than to fund programmes.
4. Donor accountability mechanisms for GBV integration appear weak: standard indicators from the GBV Guidelines (or any mainstreaming indicators) are not required in proposals or project reports.
5. Donors do not typically leverage their influence for advocacy to ensure attention to GBV in HNO and HRP processes, or in pooled funding mechanisms.
6. While HC/RCs in countries visited by the RTAP team expressed strong support to addressing GBV, most do not regularly undertake advocacy on GBV issues, despite their critical role in ensuring GBV integration into HNO and HRP processes, and in establishing monitoring of HRP commitments to GBV. In all countries, the HC/RC/DRHC expressed need for global guidance and in-country technical support to assist them to monitor and address GBV issues.
7. Like HC/RCs, OCHA representatives expressed strong support for addressing GBV. However, several informants noted that OCHA participation in activities linked to GBV was determined by personalities rather than a job requirement, e.g. the OCHA/UNHCR joint project in Nigeria to support GBV Guidelines mainstreaming. Other activities related to GBV OCHA colleagues said they might undertake were external advocacy, support to data collection through the HNO, monitoring and advocacy for inclusion of GBV in the HRP, ensuring regular attention to GBV in the HCT and ICCG agendas, and monitoring of pooled funds for attention to GBV. One colleague suggested that OCHA's field monitors could be sensitised on GBV issues to be better equipped to identify and share in GBV concerns evidenced in their monitoring.
8. UNFPA is not always included in the HCT—a serious concern that contributes to challenges in ensuring GBV is recognised in HCT discussion and decision-making processes.

Mainstreamers

1. Cluster coordinators and other cluster partners are very receptive to integrate GBV in humanitarian response activities. However, few clusters were undertaking actions to support this. For example, almost no clusters had GBV focal points in GBV sub-clusters, nor was it common for GBV specialists to attend other cluster meetings, (recommended by the GBV Coordination Handbook). In Turkey, however, gender focal points in clusters were identified as potential targets for training on GBV.
2. Cluster representation of GBV issues in the HNO and HRPs was irregular, with a belief across countries that GBV is a protection concern. Even so, the RTAP team were told of some model projects (e.g. IOM's support to the CCCM cluster globally on GBV integration) with potential for clusters to lead on their own integration. Another good practice was observed in Turkey where discussion on GBV risk mitigation across clusters was included in HRP planning. In addition, survey responses indicated some degree of integration of GBV across clusters—suggesting the need to better capture what clusters are doing.
3. Most cluster coordinators met by the assessment team noted that initiating and following through on integration of GBV Guidelines recommendations would require dedicated support of an international GBV specialist deployed for a short-term (i.e. six month) contract. In those countries where the Guidelines have been rolled out (South Sudan and Iraq) there was little evidence of training impact, indicating need for ongoing support after completion.

GBV Specialists

1. There is a global lack of GBV technical experts, undermining ability of agencies and organisations to recruit and deploy GBV staff to country operations. There is also a limited number of INGOs with GBV core competency, and limited technical support at agency HQ and/or regional levels to support field operations.
2. Institutionalisation of GBV commitments at country level is variable across RTAP agencies, in part because field actors may not be aware of their agency mandates and policies. Currently this is most evident with UNICEF. As a global lead UN agency on GBV in emergencies, UNICEF's agency mandate to address GBV is not consistently being realised at the country level. In South Sudan UNICEF has a large GBV programme, while in two other countries visited for the RTAP assessment UNICEF has no GBV specialist staff. Poor institutionalisation of UNICEF GBV commitments in some countries is a vacuum in GBV specialist programming, undermining UNICEF's ability to leverage leadership of other sectors to mainstream the GBV Guidelines recommendations.
3. Significant advances are being made by UNFPA in terms of ensuring UNFPA staff for coordination. However, GBV sub-clusters are not operating optimally in most countries visited for a variety of reasons:
    a. *Territorialism*. Some settings see competition for "control" of the GBV mandate that compromises partnership. Even where positive relationships among GBV partners exist, there is often a perception that the sub-cluster is a UNFPA domain rather than a shared partners domain. This can be exacerbated by the fact that national sub-cluster leadership typically wears two hats: coordination and UNFPA programme oversight.
    b. *Lack of support to participation of government and national partners*. Generally, there was limited engagement of national partners in GBV coordination mechanisms. The coordination mechanisms appeared to be very "UN-centric."
    c. *Limited strategic visioning of sub-cluster partners.* Several sub-clusters have workplans, but these tend to reflect short-term priorities. No GBV sub-clusters had a strategic plan that articulated short- and long-term sector goals; value-added of different partners; or plans for sustainability of the sub-cluster. sub-clusters do not have country-wide preparedness & contingency plans, although contingency planning is underway in Iraq (linked to Mosul), and the GBV sub-cluster in South Sudan has supported site-specific contingency planning.
    d. *Limited staffing of the sub-cluster*. As a reflection of the significant challenges in deploying GBV staff, sub-clusters often had no IM specialist, a considerable gap considering the value of data for advocacy as well as the challenges in the GBV sector regarding capturing and reporting on data.
    e. *Lack of uptake of Coordination Handbook recommendations*. A surprising number of GBV coordinators were not familiar with and/or not using the GBV Coordination Handbook. Linked to this, few had received any training or technical support on how to lead coordination.
4. While UNFPA has placed GBV at Programme Criticality Level 1 for Iraq and South Sudan, other agency commitments to this are not clear. Ensuring Programme Criticality for GBV is at level 1 for all RTAP partners reinforces the fact that GBV services are life-saving and critical to maintain even in a level 4 emergency.
5. Donor engagement by the GBV sector seems to be primarily undertaken bilaterally, rather than as part of an overall strategic planning process of GBV partners. The lack of a shared vision has resulted in large funding allocations to a single partner, which can undermine collaboration, cohesion and accountability.
6. The GBV community does not appear to link regularly with the women's movements in country, often taking a more technocratic approach to GBV response, despite global evidence of the importance of engaging women's movements to support women's rights and protection. Linking to local women's movements is also critical to preparedness and to bridging the humanitarian/development divide.
7. Some assessment processes-such as the assessment undertaken for the cross-border Syria response-have proved vital to mobilising funding to GBV programmes. To date, however, assessments are often not aligned in methodology, compromising the ability to draw data together to present a comprehensive picture of GBV issues and needs.
8. While there are many tools available for GBV programmers, many of these have not been aligned. There is not standard suite of tools for the global GBV community, and attention to monitoring and evaluation remains particularly weak.
9. Donors and programmers identified joint projects alike as a strategy for accessing funds; to date, however, there appears to be limited joint projects among GBV partners, or between GBV partners and other cluster partners

Utility of the Proposed RTAP Action Framework

1. The organisation of the draft RTAP Action Framework's Action Sheets in terms of the humanitarian programme cycle is a helpful way for stakeholders to consider their responsibilities.

2. Additional GBV-related activities reported by survey respondents (beyond those articulated in the draft Action Framework - see Section 3.2.1) illustrates programmatic areas the draft Action Sheets do not account for. Assessment findings have also generated areas for focus (e.g. the GBV community linking with local women's movements) that are not captured in the draft Action Sheets. During rollout of RTAP, the Action Sheets may need to be adjusted at the country level per contextual priorities and challenges. The action points within the draft Action Framework could be shortened and the language simplified.

3. Challenges remain in GBV Sub-cluster coordination, and in GBV specialists coordinating in regular and predictable ways with mainstreamers and leadership. Coordination may therefore be an important area to address in a stand-alone Action Sheet.

4. Several stakeholders noted the importance of linking with their agency's global team for technical assistance and/or with other global support mechanisms. IRC's large system of global and regional technical advisors is one good example. Another is the support South Sudan received from the global GBV AoR following the Juba crisis. Notably, however, the draft Action Sheets do not provide any specific global level actions for accountability to field support (e.g. developing a suite of globally endorsed tools for GBV specialists), or other key global actions required to promote field-level action (e.g. advocacy with global cluster leads to support inclusion of Guidelines recommendations in cluster policies). This suggests the need for one or more action sheets that focus on global responsibilities for RTAP implementation.

5. A particular area of limited accountability/capacity in all assessed countries is at the leadership level. However, in the RTAP TOC less attention is accorded to responsibilities of leadership, such that the current TOC may not be maximally useful in framing and mobilising leadership accountability, notable at State-level.

Uptake of RTAP and the Draft Action Framework

1. Stakeholders suggested expansion of RTAP to include additional donors and INGOs at global and field levels. Further, expanding membership to the GBV AoR leadership to serve in an advisory role could add value.

2. Multiple respondents noted that for RTAP to be successful, it needs to be "owned" at country-level, rather than something purely received from headquarters. At the same time, global agency policies and strategic plans—as well as global cluster policies and guidance—were noted by multiple interviewers as key drivers of accountability. This suggests that while country-level implementation of RTAP will need to be led by country partners, global agency/organisational policy commitments can reinforce country-level action.

3. In line with the recommendation for specific agency/organisational commitments, it was also suggested that uptake of RTAP will depend on TORs and performance review systems for all key stakeholders, e.g. the HC/RC, OCHA Representative, Cluster Coordinators, the Representatives of protection lead agencies, etc. While this is an important goal for ensuring accountability, it may not be achievable in the period of RTAP rollout, in which case other mechanisms for performance accountability should be agreed upon by RTAP partners on the ground at the outset of the RTAP pilot.

4. Many respondents flagged a concern about "guideline fatigue", suggesting the critical importance of framing the Action Sheets as a tool for field colleagues to better capture and/or improve existing work, rather than something that introduces entirely new work, and delivering them via accessible media such as through small booklets capturing key actions for specific audiences, computerised monitoring checklists for quick completion and analysis, etc.

5. Stakeholders across all levels, but particularly those in leadership and mainstreaming roles, stressed the point that additional human resources would be required to build their expertise in addressing GBV.

Recommendations

Structure and Content of the Draft Action Framework

1. For the current proposed Action Framework:
   a. Review existing actions against those included by respondents to the survey as well as additional points raised in discussions with KIIs and presented in the recommendations below.
   b. A specific coordination action sheet.
   c. Global stakeholder action sheets.
   d. Supplement existing RTAP TOC with additional specific actions for leadership.
   e. Before finalising a draft of the action sheets and the TOC, submit to select RTAP field and global partners for review.
2. In keeping with requests to limit additional guidelines, finalised drafts of the RTAP Action Sheets shared with selected rollout countries as a series of online lists from which field teams can select components to be transferred to a monitoring system linked to indicators. (See Section 7 for a preliminary sample of indicators.) For those who prefer hard copies, the computerised system will allow for printing checklists/actions targeting specific stakeholders.

Uptake of the Draft Action Framework

1. Engage more donors and INGOs in the RTAP core global group (and, by relation, in the country RTAP teams) to generate a broader base of support for RTAP.
2. Develop a strategic plan and timeline of key actions at the global level for support to the RTAP rollout at the field level. The strategic plan should include an update process for the draft Action Sheets based on assessment findings, identifying priorities for global RTAP to support field accountability, identifying how assistance is provided for rollout at field level and planning for key actions for RTAP global partners.
3. Recognising the value of agency-specific policies and commitments to drive action, use the global strategic plan to develop individualised agency commitments of specific RTAP partners that are signed off by senior management at headquarters. Ensure the finalised global plan and the agency-specific commitments reflect RTAP's goal of improving rights, well-being and safety of women and girl survivors and those at risk and commit each of the RTAP partners to activities that build on the value-added of their agency.
4. With support from global RTAP (i.e. via a facilitator), RTAP partners to form a governance group in the pilot countries (as well as at least two non-pilot countries, for comparison purposes). Establish clear terms of reference, accountabilities and responsibilities among members.
5. Develop a tripartite management system for the governance group: 1) within the governance group itself, identify a leader from any of the partners; 2) identify an oversight committee for the governance group composed of one member from each of the levels of stakeholders: leadership, mainstreamers and GBV specialists, tasked with high-level governance group decisions; 3) invite women's activists to serve an independent oversight function, to whom the governance group reports on a regular basis.
6. Conduct a workshop with the RTAP governance group, oversight committee and women's advisors to review the draft Action Framework and to develop a strategic plan that is in line with the RTAP draft Action Framework and the recommendations outlined below, but is also based on priorities identified at the field level. Support partners to input specific actions/commitments into a simple monitoring system to periodically report progress. Support the group to identify its own accountability mechanisms.
7. Assist in mobilising human/financial resources for the implementation of the strategic plans.[2] Ensure that any human resource allocations (e.g. surge support to the HC/RC's office related to GBV, and/or to clusters to facilitate integration of the GBV Guidelines' recommendations) are accompanied by a plan to capture lessons learned and good practices, including how learning from the surge support is sustained.
8. Establish governance processes between global and field levels to facilitate regular monitoring among RTAP partners of strategic plan implementation at global and field levels. Ensure that field-level monitoring reports are shared with global RTAP partners biannually and shared with an RTAP community of practice website/GBV AoR website.
9. Consider strategies for integrating long-term governance mechanisms into existing humanitarian structures, e.g. as a subgroup of the HCT.

[2] The research team notes that UNHCR has already allocated $100K for each of 2 pilot countries.

Stakeholder-Specific Recommendations

The recommendations below address actions for specific stakeholders and can be used to inform the revisions to the draft Action Sheets as well as to inform strategic planning at the global and field levels.

Leadership

Short- to medium-term

DONORS

1. A mechanism should be established to link key donors to the GBV sub-cluster in a regularised and holistic way, either through donor participation in the sub-cluster, or in regular (e.g. quarterly or biannual) interface/briefings with a group of GBV partners to facilitate donor support to a coordinated and cohesive GBV response.
2. Donor funding for GBV specialist interventions should align with known strategies for improved GBV programming, including funding for GBV coordinator positions (including IM), funding for sector-wide GBV specialist assessments in the early stage of emergencies, as well as longer-term funding for GBV, especially in protracted emergencies. Donors should also encourage INGOs to expand their programmes on GBV to ensure a broader base of experts.
3. Donors must ensure inclusion of GBV Guidelines indicators in their proposals and monitoring and evaluation requirements and frameworks and, where possible, undertake to ensure improved attention to GBV in HNO and HRP processes, as well as in the delivery of pooled funds. Donors should fund surge support to clusters to assist in developing strategies for mainstreaming GBV Guidelines recommendations into cluster work plans and programmes.

HC/RC and OCHA

1. The HC/RC should ensure that GBV is integrated into HNO and HRP processes, and that the HCT meetings periodically allot attention to GBV.
2. Dedicated technical surge support in the HC/RC's office should be considered as one method to highlight the issue to ensure high-level attention to GBV, especially in large complex humanitarian emergencies where there are many competing demands on the HC/RC.
3. OCHA field monitors should be regularly trained on basic GBV issues and referrals.
4. UNFPA should be included in all HCTs of every humanitarian response.

Longer-term

DONORS

1. Donors should undertake a review of practices that promote enforcement of their global commitments to GBV at the field level, such as ensuring that attention to GBV is included in performance reviews of relevant donor staff and there is sufficient internal technical support (through trainings on GBV to non-experts, as well as through internal GBV experts) that donors can access to guide decisions around funding for GBV projects and programmes.
2. Donors should develop mechanisms to routinely track their funding allocations for GBV specialised programming to ensure they are meeting their GBV commitments.

HC/RC and OCHA and Missions

1. GBV-related requirements signed off by the HC/RC and ERC should be included in the HC/RC TORs. HC/RCs should receive training on GBV responsibilities, e.g. through the Staff College. They should be required to report on GBV actions as part of performance reviews. The GBV Champions Initiative can be linked to RTAP to highlight positive action by HCs.
2. OCHA FTS should disaggregate financial data on the Protection Cluster to sub cluster level to facilitate tracking of support for GBV programming.
3. In settings with peacekeeping missions, the DSRSG should have attention to GBV included in their TOR and should be trained on GBV responsibilities, with related performance reviews

Mainstreamers

Short- to medium-term

1. Cluster coordinators should assign a focal point to participate in the GBV coordination mechanism, and they should seek out a participant from the GBV sub-cluster to regularly attend their cluster meetings.
2. Even if not in the brief summaries of the HNO and/or HRP, all clusters should have GBV included in their cluster action plan. If the cluster does not have an action plan, then all clusters should produce and post to their cluster website a (minimum) 1-page commitment statement about attention to GBV within their cluster to draw attention to the issue among partners.
3. Clusters should be supported to regularly capture good practices linked to GBV through periodic self-assessments of cluster partners distributed and then collected and analysed by cluster coordinators as a standard part of IM.
4. Dedicated surge support (sitting in the HC's office, OCHA, or UNICEF) should be considered as one method for supporting all clusters for a set period (e.g. six months) to facilitate cluster uptake of the GBV Guidelines recommendations in proposals and monitoring and evaluation.

Longer-term

1. Integration of GBV in global cluster commitments, polices, guidance and workplans should be reviewed by global cluster coordinators to ensure global cluster leadership on uptake of the recommendations in the GBV Guidelines.
2. All cluster coordinators should receive training on GBV as part of their induction processes and attention to GBV should be integrated in coordinators' TORs and performance management tools at the global level. Where possible, regional offices of cluster lead agencies should be mobilised to assist cluster coordinators to review cluster partner proposals for integration of GBV.
3. Tools should be developed to help GBV specialist INGOs that have other multiple sector programmes ensure integration of GBV in their other sector programmes and track good practices.

GBV Specialists

Short- to medium-term

1. All national GBV sub-clusters should be led by a UNFPA coordinator whose sole responsibility is coordination. There should also be a co-lead at the national level (government agencies where appropriate) and an IM officer for coordination. At the sub-national level, coordination should be shared as possible with other UN protection partners (especially UNICEF), I/NGOs and local government partners to promote shared accountability for coordination. Ensuring shared coordination should be identified in GBVSC strategy plans, with indicators to measure how this is being achieved. All coordinators, whether from UN, INGO or government agencies, should be trained on the Coordination Handbook, and regular reviews on quality of coordination (e.g. regular anonymised surveys) should be undertaken with coordination partners and shared globally (with the GBV AoR) as part of a monitoring process that enables coordination mechanisms to flag and address coordination concerns and to receive support from the global GBV AoR as needed.
2. The GBV sub-cluster at the national level should undertake a strategic planning process that engages UN, I/NGO and government partners in a discussion about short- and long-term goals linked to addressing GBV and how actions to meet these goals will be resourced and implemented by GBV partners. To the greatest extent possible, local actors should be identified as key partners in meeting these goals and strategies developed to support their ability to implement key GBV responsibilities so to ensure the GBV sub-cluster and the GBV response itself is not "UN-centric" and without a vision of sustainability. This strategic planning should include contingency planning laying out programme criticality for GBV partners.
3. Related to this, GBV partners should support the inclusion of the women's rights community in GBV response from the preparedness stage forward. In particular, INGOs should be mobilised to link with local women's rights advocates and groups as a standard part of programme response, so to avoid the problem of GBV programming becoming overly technocratic and not grounded in the women's movement. GBV partners should also link with broader efforts that support gender equality; however, it is critical that specialised GBV programmes are not subsumed under gender equality programmes, so that separate specialist approaches to GBV continue to be supported.

4. The GBV community should strive to standardise its assessment tools and processes to improve the nature and extent of data on the scope of the problem, protection needs, and availability of services. GBV-specific assessments should be undertaken as a matter of course in the early stages of emergency (perhaps using IRC's four-phase approach as a model or UNICEF's assessment tools), and tools should also support harmonisation of general protection and child protection assessment tools to include GBV.
5. Similarly, a core suite of tools that bring together existing global guidance for GBV field actors should be developed. These tools should include guidance on monitoring and evaluation, as well as a core set of indicators-from which GBV actors can draw for inclusion of at least one separate GBV indicator in the HRP and in other monitoring processes—that assist GBV actors to report less on activities and more on impact. This core suite of tools should also support agencies (and/or the GBV coordination mechanism) to track GBV programmes so that regular "stocktakes" can be undertaken to capture information about who and where services are being provide and with what degree of funding, and where there are significant gaps. This information can be used for advocacy and learning at the country and global levels.
6. Joint projects should be scaled up among GBV partners, as well as between GBV partners and other cluster partners.

Longer-term

1. Resources and strategies should be identified to not only continue to support UNFPA and others' efforts to build GBV short-term surge capacity, but to also develop a significantly larger cadre of GBV specialists (to serve as technical advisors at global and regional levels, and be deployed to humanitarian settings), for example through links to academic programmes, as well as through agency initiatives (e.g. UNHCR's Programming for Protection). INGOs should be supported in efforts to train junior professionals in GBV through approaches such as DFID's twinning strategy to expand the base of expertise.
2. All national-level leadership of RTAP agencies with specialist programming responsibilities (currently UNICEF, UNFPA, UNHCR and IRC) should ensure that heads of office at the country level have attention to GBV included in their TORs and they should receive training on their responsibilities. They should be required to report on GBV actions as part of their performance review.
3. All RTAP partners should ensure GBV is assessed at Programme Criticality 1. In settings where this is not the case, efforts should be made to internal conduct advocacy about the fact that GBV services are life-saving and critical to maintain in a level 4 emergency.