IRAQ

GBV Sub-Cluster Strategy for 2016

Global Protection Cluster
GBV Prevention and Response

GBV Sub-Cluster - Iraq
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Contents

Acronyms

AoR	Area of Responsibility
CRSV	Conflict-Related Sexual Violence
DTM	Displacement Tracking Matrix
DCVAW	Directorate for Combatting Violence against Women
GBV	Gender-Based Violence
GBVIMS	Gender-Based Violence Information Management System
HRP	Humanitarian Response Plan
IASC	Inter-Agency Standing Committee
ICCG	Inter-Cluster Coordination Group
IDP	Internally Displaced Person
IOM	International Organization for Migration
IPV	Intimate Partner Violence
ISIL	Islamic State of Iraq and the Levant
KRI	Kurdistan Region of Iraq
KRG	Kurdistan Regional Government
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MoI	Ministry of Interior
MoLSA	Ministry of Labor and Social Affairs
NGO	Nongovernmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
PSS	Psychosocial Support
RRM	Rapid Response Mechanism
RPA	Rapid Protection Assessment
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedures
UN	United Nations
UNDAF	United Nations Development Action Framework
WASH	Water, Sanitation and Hygiene
WG	Working Group
3RP	Syria Regional Refugee Response Plan

Introduction

Iraq is experiencing a double crisis of displacement. Syrian refugees, which currently total over 244,527[1] individuals, have fled the armed conflict in Syria and have sought refuge primarily in the Kurdistan Region of Iraq (KRI). Compounding this crisis is the larger scale internal displacement of Iraqis who continue to flee areas controlled by the so-called Islamic State of Iraq and the Levant (ISIL) and the subsequent military operations by government and allied forces to regain territory. The country has been wracked by successive waves of displacement, with current estimates of 3.2 million internally displaced persons (IDPs) and 458,358 returnees.[2] In total, 8.2 million[3] Iraqis require immediate protection assistance as a direct consequence of violence and conflict. The number in need across Iraq is expected to increase in 2016, with further internal displacement affecting more communities and the anticipated return of some Iraqis to their areas of origin.

Gender-based violence (GBV), particularly sexual violence, is a widespread and alarming element of the dual crisis. Sexual violence is used as a tactic of terror in the armed conflict, primarily targeting women and girls of specific ethnic and religious minority groups in Iraq and Syria. Those living in areas under ISIL control are at risk of rights violations, abduction, sexual slavery, rape, torture and abuse. However, the less recognized impacts of displacement affect far more refugees, IDPs and host communities. As displacement becomes protracted, families resort to negative coping mechanisms under the strain of prolonged uncertainty and diminishing resources. For example, women and girls are subject to increasing restrictions that, while meant to protect them, in effect reduce livelihood opportunities and undermine their already weak social position. For Iraqis, displacement has exacerbated already high rates of intimate partner violence, honor crimes, sexual exploitation, harassment and early and forced marriage that existed prior to the recent conflict. The vulnerability of certain groups, such as female-headed households, widows, women with disabilities and adolescent girls, compound the challenges they face.

It is essential that GBV comes to the forefront of humanitarian response in Iraq. The specific needs of people at risk of GBV, especially women and girls, have been neglected across all sectors, while the potential to minimize GBV risks and provide quality multi-sector care for survivors is great. And as the crisis in Iraq evolves, so too must the organized, lifesaving response to GBV. Prior strategies were developmental in focus, as they were developed before the current crisis and not designed to respond to the IDP crisis that occurred. After the refugee influx and first waves of IDPs into KRI, a GBV strategy for multi-sector prevention, response and coordination in KRI was developed, but it did not account for response in the rest of the country.

In 2016, refugees are entering their fourth year of displacement, Iraqis in the central part of the country are being displaced in ever larger numbers, some families are returning to their homes without resources and services, and many Iraqis remain in ISIL-controlled areas without humanitarian access. The GBV Sub-Cluster has continually learned from past efforts and has adapted this responsive and nationwide strategy for GBV prevention, response, coordination and advocacy, in line with the Protection Cluster, Syria Regional Refugee Response Plan and Iraq Humanitarian Response Plan. This strategy is intended to provide a framework for all actors involved in addressing GBV in the humanitarian context in Iraq, including implementing agencies (governmental and non-governmental), United Nations, donors, and the broader humanitarian community.

[1] UNHCR Iraq, Inter-Agency Operational Update, 28 November 2015.
[2] IOM Displacement Tracking Matrix (DTM) Round 34. September 2015.
[3] OCHA Humanitarian Needs Overview (HNO), 2016.

Strategy Development Process

The Gender-Based Violence (GBV) Sub-Cluster strategy development process included 1) a mini-workshop with Erbil-based GBV Sub-Cluster members; 2) a consultation with the Ministry of Labor and Social Affairs (MoLSA) of the Kurdistan Regional Government (KRG); 3) a mini-workshop for Baghdad-based GBV Sub-Cluster members; 4) a consultation session with NGOs operating in central Iraq; and 5) workshops with the Dahuk and Sulaymaniyah sexual and gender-based violence (SGBV) Working Groups (WG), with consideration of 6) the initial findings of IOM's assessment of GBV risks for IDPs living in critical shelter arrangements and camps; 7) the Regional Evaluation of the GBV Guidelines Implementation; and 7) the newly revised Inter-Agency Standing Committee (IASC) *Guidelines for Integrating GBV Interventions in Humanitarian Action*.[4] The process engaged local and international nongovernmental organizations (NGOs), KRG and federal government representatives, and United Nations (UN) agencies on the most important GBV issues related to the current humanitarian crisis in Iraq.

Building on the work and experience of the former KRI SGBV Sub-Working Group and the Baghdad SGBV WG (which pre-existed the current crisis), the GBV Sub-Cluster Strategy looks at GBV in humanitarian response and with a 'whole of Iraq' approach. It addresses both prevention and response measures as well as programmatic and structural challenges.

Priority Issues

A range of gender-based violence and other protection concerns for women and girls exist throughout Iraq. Given limited resources and the need for targeted, quality approaches, the GBV Sub-Cluster will focus its response, prevention, advocacy and coordination efforts on the following priority GBV issues, as identified through the aforementioned consultations:

Domestic Violence

Actors of all types across Iraq consistently and overwhelmingly identified domestic violence (intimate partner violence, IPV, and other GBV within the home) as the number one priority GBV issue. Iraq had a high level of domestic violence before the current mass displacement, with 46% of married women exposed to at least one form of spousal abuse (UNDAF 2014).[5] From July 2015 to February 2016, 47% of reported GBV cases involved IPV, showing that IPV is serious concern among communities for which women and girls are actively seeking support.[6] Participatory assessments, NGO consultations and anecdotal reports point to a rising trend in the incidence of domestic violence, which is directly attributed to the experience of forced displacement. Consultation during strategy development strongly reinforced this message.

[4] https://interagencystandingcommittee.org/files/guidelines-integrating-gender-based-violence-interventions-humanitarian-action

[5] Due to various reasons (e.g., the stigma, shame and fear associated with GBV within communities), incidents often go unreported; thus, actual figures may be higher.

[6] GBVIMS, July 2015 - February 2016. Data is only from reported cases and is in no way representative of the total incidence or prevalence of GBV in Iraq. Statistics are generated exclusively by GBV service providers who use the GBV Information Management System (GBVIMS) for data collection in the implementation of GBV response activities in a limited number of locations across Iraq and with the consent of survivors.

Overcrowded accommodation, financial strain, shifts in traditional gender roles, insecurity and other factors directly related to displacement are contributing to high levels of stress within households, which in turn is manifesting as physical, verbal and emotional abuse targeted at women, girls and boys either due to their perceived weaker role within the household, or to enforce compliance with expected gender roles. Deeply entrenched cultural norms strongly deter women from reporting incidents, considering fear of persecution that can result in death, stigma, discrimination and shame. So-called "honor killing," or the murder of a family member due to the perpetrators' belief that the victim has brought shame or dishonor upon the family or has violated the principles of a community or a religion, often by engaging in some form of extra-marital engagement, is a common fear and prevents survivors from reporting incidents. A significant majority of Syrian refugee women (85%) said that they knew or had heard of a woman or girl being killed to preserve the family's honor.[7]

Legal redress for GBV survivors is weak, and there are many structural, socio-cultural and legal obstacles that limit prosecution. Despite new legislation, the Iraqi Penal Code continues to allow reduced sentences for "honor" crimes, lenient punishments if the accused has "honorable motives," perpetuating impunity and silence among survivors. Treatment of survivors by law enforcement officers and the inconsistent application of existing laws further exacerbate this. Levels of reporting on GBV were low prior to the conflict, with only 2.8% of women willing to report violence to the police due to fear of damaging their reputation (51.4%) or because they consider the police unable to solve the problem (30.8%).[8]

Forced Marriage, including Child Marriage

Many of the identified priority protection issues follow a similar pattern, with pre-crisis major areas of concern being exacerbated and increased as a result of the crisis. Prior to the crisis, 21% of girls aged 15-19 were married, and 5.5% of girls under the age of 15 were married despite that the legal age to marry is 18.[9] Though these are alarmingly high rates, feedback from organizations indicates that it is even higher among the internally displaced and refugee populations.

The conflict has increased the level of threat, both real and perceived, to women and girls while simultaneously deepening men's social role as 'protector.' This combination has contributed to marriage being seen as a means to protect young girls and women, increasing rates of forced and child marriage. Child marriage is likewise being used to cope with diminishing resources, especially in prolonged displacement, through reducing the household size and gaining monetary compensation from the groom. In 2015, the Education Cluster assessed the major risk factors preventing girls from enrolling to school and continuing their education, and the assessment revealed child marriage as the foremost risk factor faced by 11-18 year old girls.[10] Even prior to the onset of the recent conflict, child marriage was a risk for girls, which has been documented as prevalent among Syrian refugee girls; financial motives and protecting girls from violence and harassment are commonly cited reasons.[11] Additionally, many families are afraid to send their girls to school for security concerns as adolescent girls are particularly vulnerable to multiple forms of violence and have limited support systems and access to information and services. For example, child survivors represented 18% of the reported GBV cases from July 2015 to February 2016, demonstrating the need for GBV and Child

[7] "'We Just Keep Silent': Gender-Based Violence amongst Syrian Refugees in the Kurdistan Region of Iraq". UN Women, 2014.
[8] Iraq Woman Integrated Social and Health Survey (I-WISH) Summary Report March 2012
[9] UNDAF, 2014.
[10] Education Cluster Iraq Dashboard: Bersive 1 and 2, Qadia, Karabato 1 and 2, Chamisku, June 2015.
[11] Are we listening? Women affected by the Syrian Crisis, IRC, 2014; We just keep silent, UN Women, 2015

Protection (CP) actors to work together to respond to and prevent various forms of GBV experienced by girls and boys, including harassment, sexual abuse, child marriage.[12]

Efforts to address child marriage have brought together CP and GBV actors to strengthen case management and referral systems and increase awareness of the consequences of early marriage and rights of girls and how to address this. However, roll out of developed case management guidance has not yet reached all relevant stakeholders across governorates, and coverage of campaigns is limited. Furthermore, significant religious and legal/judicial barriers to preventing child marriages exist. The amended Law on Personal Affairs No. 188/1959 sets the minimum age of marriage at 18 years. Despite this, children between the ages of 15 and 18 can legally marry with approval from their legal guardians. The KRG raised the age to 16, but it remains below the global standard of 18 years.

Sexual Violence, Harassment and Exploitation

Uprooted from the protection of familiar communities and challenged to meet basic needs, displaced women, girls and boys face increased GBV through public harassment and exploitation. Prior to the crisis, 19.5% of women 15-54 years old were exposed to violence in the street during a one-year period, 18.9% were exposed to violence in the market, and 10.5% on transport.[13] Children have also reported harassment on the way to and during school to be a cause of dropping out.[14,15]

Sexual violence is a major concern despite it being highly underreported due to a number of serious factors, including: risks, threats and potential trauma faced by those who come forward; significant gaps in available services; restrictions on movement; shame, fear, stigma and discrimination; risks of retaliations and "honor killings"; impunity for perpetrators; and the existence of mandatory reporting of sexual violence by government health staff. Feedback from communities and service providers indicate an increase of sexual violence within communities, directly related to the crisis and mass displacement. However, when reporting of GBV does happen, it is untimely, with only 9% of GBV cases reporting within three days of the incident.[16] Timely reporting is critical for addressing the mental and physical health needs, including preventing long-lasting psychological effects of trauma and providing lifesaving HIV post-exposure prophylaxis ad other immediate medical care.

Gaps in humanitarian aid have increased risks of violence and heightened the likelihood of women and girls being forced to engage in negative coping strategies (like survival sex or early and forced marriage) to meet basic needs. Displaced women, especially widows and female-headed households, are particularly vulnerable to GBV. Safety audits in IDP and refugee sites identified security risks for women and girls, including long distances to collect water, poor lighting at sanitation facilities, and overcrowded living. A recent study among IDPs living in critical shelters and camps found that 64% of latrines surveyed were both unsegregated and without locks, representing a significant risk of violence for women and girls.[17] Threats to their physical safety and security and on-going harassment are part of the daily reality for many IDP women and girls.

[12] GBVIMS, July 2015 – February 2016. Data is only from reported cases and is in no way representative of the total incidence or prevalence of GBV in Iraq. Statistics are generated exclusively by GBV service providers who use the GBVIMS for data collection in GBV response activities in a limited number of locations across Iraq and with the consent of survivors.
[13] "Iraq Woman Integrated Social and Health Survey (I-WISH) Summary Report", March 2012.
[14] "Uncertain Futures: The impact of displacement on Syrian refugee and Iraqi internally displaced youth in Iraq". Save the Children, 2016.
[15] "Initial Findings of GBV Risk Assessment in IDP Camps and Critical Shelter Arrangements across Iraq". IOM, September 2015.
[16] GBVIMS, July 2015 – February 2016. This statistic represents all GBV cases, not just sexual violence.
[17] GBV risks amongst IDPs Living in Critical Shelters and Camps, International Organization for Migration (IOM), September 2015

Conflict-Related Sexual Violence (CRSV)

ISIL has systematically used sexual violence against women and girls to instill terror in areas under its control and as a means of suppressing or destroying communities that are not in accordance with its doctrines, targeting specific ethnic and religious communities. The ethnoreligious identity politics that predate the current crisis increase the risk of the use of CRSV in potential revenge violence, possibly in areas of return with ethnically mixed populations. Displacement caused by conflict also increases risk of GBV, including sexual violence, to women and girls on their journey to safety and within their new community. These issues require both prevention and response, but long-term support and reintegration are not widely available for survivors of CRSV who have already returned to their families and communities. Lifesaving higher-level mental health interventions are not always available, and where female gynecologists, psychiatrists and psychologists do exist, they struggle to meet demands and provide adequate follow-up care. This includes linking survivors to social reintegration services. Participants in the strategy development consultations emphasized how adequate follow-up care cannot be addressed through one-time service provision.

As areas controlled by ISIL are retaken by government and allied forces and the extent and consequences of sexual violence amongst women and girls become known, there is a time-sensitive need to initiate extensive dialogue with all sectors of Iraqi society on how to address the long-term consequences of CRSV to survivors and their families, including the children born as a result of CRSV. For example, the legal framework does not allow for the registration of children born out of sexual violence, demonstrating the complex nature of the matter and highlighting the need for urgent attention from government, religious leaders and all segments of Iraqi society. Adoption is not a common practice, and abortion remains illegal.

Lack of Social and Economic Power

Survivors' need for empowerment was commonly mentioned during the strategy development consultations, particularly in relation to the vulnerability caused by economic dependency. Women's limited livelihood options and reliance on male family members raise their susceptibility to exploitation and denial of essential resources and increase vulnerability to other forms of GBV. Women may also not have any feasible means to escape a violent situation without access to livelihoods. Additionally, economic vulnerability of female-headed households correlates with higher rates of child marriage and child labor, where girls and boys may be exposed to GBV. However, livelihood opportunities are largely unavailable for women and girls. For example, 23% of reported GBV cases expressed the need for livelihood services but no such service existed for referral.[18] Furthermore, the limited social space previously enjoyed by women and girls has been systematically eroded, as families try to protect women and girls by restricting movement and exposure to public life. The result is social isolation, disempowerment and often depression and despair, all of which hamper recovery and healing for those who have experienced GBV.

[18] GBVIMS, July 2015 – February 2016.

Objectives and Approaches

The current situation in Iraq is highly complex, with many drivers and dynamics contributing to an alarming increase in protection concerns, including GBV. Addressing GBV, in particular sexual violence, in the current context is a lifesaving priority. Yet the humanitarian response is chronically underfunded, and the GBV Sub-Cluster is caught simultaneously nurturing the development of its members while preventing and responding to GBV. For these reasons, the GBV Sub-Cluster must focus efforts on a few key areas of intervention that will produce the largest impact. Coordinated response according to an agreed plan (i.e., the GBV Sub-Cluster Strategy) will enable sub-cluster members to use resources as efficiently as possible.

The GBV Sub-Cluster Strategy consists of three objectives to address the priority issues:

1. Improve capacity for timely delivery of quality, multi-sectoral **response** for GBV survivors
2. Build community resilience to **prevent** and **mitigate** acts of GBV and harmful traditional practices
3. Strengthen **coordination** and **advocacy** on GBV prevention and response among GBV Sub-Cluster members, other humanitarian actors and clusters, Iraqi civil society, UN, government authorities and communities

Geographic Coverage:

This strategy does not prioritize specific geographic areas, given the fluid conflict dynamics and the widespread nature of GBV affecting all parts of Iraq. Instead, interventions will be prioritized based on lack of resources on the ground and scale of identified needs. In line with the Iraq Protection Cluster's approach, the GBV Sub-Cluster Strategy emphasizes the need to provide services to **non-camp** and **difficult-to-access** locations. Over 90% of IDPs and over 60% of refugees do not live in camps. Rather, they live with host families, in rented accommodation, unfinished buildings, religious buildings and other arrangements in urban and rural areas. This can create a strain on local resources and exacerbate social tensions, especially where the ethnic and/or religious demographic have changed. Furthermore, approximately 72% of IDPs are located outside the Kurdistan Region, yet a lack of protection services exists in those governorates, despite the high need.[19] Many other IDPs are living in inaccessible areas under ISIL control. Engaging in GBV prevention and response activities in these areas is difficult, and possibly life threatening, but as accessibility improves and returns increase, communities will require protection support.

Overarching Approaches:

Serving these populations requires creativity, as non-camp populations are often scattered over large areas, and data about their whereabouts is imperfect or nonexistent. Even when services are available, it is challenging to inform a scattered population about its availability. Transportation is also an issue, especially for women and girls who usually experience mobility constraints. To address this, GBV actors should focus on **mobile** and/or **integrated** service delivery approaches, utilizing shared spaces (co-locating) with other service providers, such as Child Protection, Legal and Livelihoods. And improved strategies for **communication** with communities is paramount.

[19] IOM DTM, Round 34, December 2015

To increase sustainability, efforts will be made to **strengthen national actors'** ability to provide higher quality GBV services, especially in KRI, that are survivor-centered and in line with international standards and best practices, as well as initiate structured and responsible transition of service delivery from international to national actors that includes continued mentorship and support. Sustainability also involves supporting **community-based solutions** that educate and empower the community to support survivors, address GBV risks and prevent violence.

Based on contextual gender analyses, humanitarian actors in Iraq must acknowledge the different vulnerabilities that put men, women, boys and girls at heightened risk of violence to ensure non-discriminatory care and support for all survivors; however, **attention should be given to women and girls** due to their documented greater vulnerabilities to GBV, the overarching discrimination they experience, and their lack of safe and equitable access to humanitarian assistance.[20]

The design and delivery of all interventions should be **survivor-centered,** meaning that the survivor's rights, needs and wishes are prioritized. This approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person's capacity to make decisions about possible interventions. Additionally, agencies should be guided by a **human rights-based** approach that seeks to analyze the root causes of problems and redress discriminatory practices that impede humanitarian intervention. This approach seeks to attend to rights as well as needs. And legal and moral obligations, along with accountability, inform the way these needs are determined and addressed.

Guiding Principles for all GBV Interventions:

Lastly, all elements of GBV prevention, response, coordination and advocacy should adhere to, at a minimum, the following guiding principles:

- **Safety**: The safety and security of the survivor and others, such as her/his children and people who have assisted her/him, must be the number one priority for all actors.
- **Confidentiality**: People have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality ensures the survivors, witnesses and information sources are protected, and informed consent is obtained before action is taken.
- **Respect**: All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor, and be guided by the best interests of the child.
- **Non-discrimination**: Survivors of violence should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation or any other characteristic.

Objective 1: Response

The foundation of the GBV Strategy lies in service provision for GBV survivors across Iraq. The GBV Sub-Cluster aims to ensure services are accessible, prompt, confidential and appropriate to survivor needs, wishes and decisions, and available in locations where there is need. Caring for survivors of GBV means comprehensively and systematically addressing the various needs of a survivor, which may span different sectors of assistance. Thus, a multi-sectoral model should be used to ensure holistic interventions that involve inter-agency collaboration and coordination across key sectors, including (but not limited to) psychosocial, health, legal/justice and security. The GBV Sub-Cluster Strategy complements and reflects the endorsed GBV Standard Operating Procedures (SOPs) developed for Iraq, which further detail individual organizations' roles, responsibilities and procedures with regard to GBV prevention and response.

[20] *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*. IASC. 2015

Case Management & Psychosocial Support (PSS)

Case management forms the core of GBV service provision. This aims to systematically assess the needs of a survivor and arrange, coordinate, monitor, evaluate, and advocate for a package of multiple services to meet the survivor's specific needs. While progress has been made in initiating case management services in several governorates, greater attention should be placed on **improving the quality of existing case management services** to reduce the risk of re-traumatizing and doing further harm to a survivor. Case workers should be well trained and continuously and systematically supervised and mentored by qualified personnel. They should be able to provide ongoing basic counseling and PSS to beneficiaries, and to refer survivors to higher-level psychological care if and only when appropriate. Agencies and donors should also recognize the importance of staff wellbeing, and promote and institutionalize **staff care** initiatives for GBV service providers, as burn out and the risk of secondary/vicarious trauma for case/social workers is high.

Case management and PSS are now primarily offered through static or mobile **dedicated safe spaces for women and girls**. Safe spaces ensure that women and girls feel comfortable and safe to report and receive care after a GBV incident and receive information about available services and assistance. They also create an environment in which women and girls can share their common challenges and stresses and engage in PSS, social and recreational activities, which prevent isolation and promote healing. For those who have experienced violence, trust-building social and recreational activities serve as an entry point to specialized services such as case management or PSS. New and existing PSS activities should **integrate mental health, psychoeducation, healing and positive self-esteem approaches** within programming approaches, which is currently lacking across governorates. This is particularly important so that services reach survivors who will not come forward for direct counselling but may benefit from group PSS in which they do not have to disclose GBV incidents they have experienced. If spaces also host activities for men and boys, they must not negatively affect women and girl's participation and ensure that they still remain comfortable and have means of confidentially and privately accessing GBV response services.

Government PSS and case management services, where they exist, should be holistically supported to provide quality services, instead of one-off trainings. Approaches used should be comprehensive and systematic and **address governance and service delivery needs**. Similarly, national actors have expressed the need to improve quality of care and increase their technical knowledge and skills.

In line with the principle of **non-discrimination**, service providers should ensure they are inclusive and accepting of male survivors, host community members and those of all religions/ethnicities. GBV service providers must recognize differences in caring for child and male survivors and ensure staff are properly trained and supported to ensure further harm is not done to survivors by untrained personnel. Given the lack of resources and large scale of GBV involving children, the GBV Sub-Cluster, in collaboration with the CP Sub-Cluster, in 2016 will focus on building capacity on **caring for child survivors** of sexual abuse and developing **specific PSS programming for adolescent girls**.

Properly designed and disseminated referral pathways both assist in providing survivors with timely services and ensure that the risk of re-traumatization is reduced. Led by the governorate-level GBV working groups (or lead case management agency where a working group does not exist), referral networks will be strengthened, and all service providers should be aware of appropriate services for GBV survivors. **Referral pathways should be created in a participatory and inclusive process with all relevant sectors** (governmental and non-governmental). Organizations should be assessed prior to inclusion in referral pathways, and inclusiveness of government agencies and community structures (including camp management agencies) that provide survivor-related services or are entry points for survivors should be integrated and improved. Referral pathways should reflect agreements between

Child Protection and GBV actors (if/when both are present in a given area) on which agency should handle cases of child survivors (e.g., early marriage), while a child survivor shall not be denied service if she or he chooses to report to a GBV service provider. Where possible, GBV and CP referral pathways can be integrated. Moving beyond simply disseminating referrals pathways, agencies in various sectors will be supported to understand how and when to use them and how to make compassionate and appropriate referrals that do no further harm to survivors.

Mental health and psychosocial support (MHPSS) actors form a key component of the referral system for survivors to access higher-level psychological care. Links between GBV case management agencies and MHPSS providers will be improved, and the follow up of cases will be ensured for continuation of care. Most survivors do not require higher-level MH services and can receive necessary care by well trained and supervised case workers and social workers. GBV agencies should clearly understand if/when to refer survivors to higher-level mental health care. MHPSS actors will also be better engaged in GBV contingency planning and emergency response efforts as per their essential role in first-line GBV response, ensuring qualified personnel to handle severe cases of GBV.

Health

Immediate access to medical care for survivors of GBV, particularly physical and sexual violence, is a lifesaving first-line response for the GBV sector. In many settings, the health sector is the entry point into GBV service provision for survivors. As a first contact and/or providers of lifesaving services, health care providers bear a responsibility of identifying a GBV survivor's needs with sensitivity and compassion and provide appropriate services and referrals. However, in Iraq, this is not the case due to the shame, stigma and fear associated with reporting, particularly to health providers. This is in part due to mandatory reporting laws that require government health providers to notify local authorities of any sexual violence and child abuse cases.

Additionally, there is a lack of adequately **trained medical personnel on GBV concepts and clinical management of rape (CMR)**. Survivors are not able to access the few existing CMR services due to existing policy constraints. A **national protocol on CMR** for treatment, referral and documentation does not yet exist for KRG or federal Iraq. Developing and rolling it out will require investment in streamlining systems, training, post-rape care supply chain management, and ongoing support to health facilities. In addition, medical personnel are not trained on immediate psychosocial support and confidentiality, and most of medical facilities lack adapted and private spaces to receive survivors. Fear of reprisal from survivors' families and perpetrators also deter health providers from caring for survivors and providing adequate care.

While the GBV Sub-Cluster has shifted responsibility of CMR to the Health Cluster and Ministry of Health (MoH), it remains committed to supporting the health partners, especially in ensuring quality psychosocial care in line with survivors' best interests. The GBV Sub-Cluster will also promote training/mentoring of female health staff and GBV focal points within facilities, encourage self-care for health workers, distribute treatment protocols for sexual violence and GBV referral pathways in facilities, ensure availability of post-rape kits, and conduct outreach and awareness raising on the importance of **timely reporting of sexual violence**. The GBV Sub-Cluster will advocate to ensure the **Minimum Initial Service Package** for Reproductive Health in Crisis Situations is available in all health responses, including CMR, and will continue to work with the MoH and Health Cluster to develop CMR protocol that reflect international standards that allow women to choose to whom to report cases and receive immediate treatment. The GBV Sub-Cluster will also engage stakeholders to clarify laws that pertain to women's, girls' and survivors' health, including mandatory reporting by health workers, and provision of safe abortions for those at risk of suicide from honor-related violence.

Safety and Security

Survivors of GBV, especially domestic and sexual violence, have limited options to ensure their safety and security, amid immense fear for their life (e.g., honor killing). Married women suffer immense hardship in this context, making divorce a difficult option. Though a few exist in KRI, temporary safe houses/shelters are unavailable in most locations, and when they are available, they insufficiently meet the needs of survivors and their children. GBV actors should assist the government in **creating SOPs for managing existing and creating new safe shelters** and improving critical infrastructure. Additionally, training and ongoing support to agencies operating safe shelters is essential, as well as the inclusion of specialized GBV services within shelters.

Given the militarized context and involvement of security forces in IDP and refugee movement, relocation and return, **the security sector, police and military personnel should be educated** about GBV, have **private rooms** for meetings with individuals who have been exposed to GBV, ensure **same-sex interviewers**, and institute **protocols for referrals** to other sectors. Preventing re-traumatization at the hands of the security sector is of upmost importance.

Overall, protection actors need to **improve information collection regarding gender and GBV** and understand the risks women and girls face in various displacement situations in a more comprehensive manner. GBV actors, and the GBV Sub-Cluster, have an obligation to advocate for integration of GBV in protection monitoring and assessments.

Access to Justice

Essential in meeting the various needs of survivors, as well as vulnerable groups of women and girls (e.g., female-headed households), is the provision of free or low-cost **legal counselling, representation and general court support**, where GBV can be challenged. Actors should also ensure systems are in place to **monitor court cases and judicial processes**. Strengthening access to justice will require a longer-term approach, involving improved accountability, fighting against impunity, empowering women's organizations, building the capacity of local lawyers, strengthening security and protection measures for those who seek justice, and strengthening the capacity of the judiciary and the police. In particular, police will have to guarantee respect and confidentiality and must include **trained female officers** to receive and follow-up GBV complaints. Furthermore, legal services should be made available in all locations where there is a need, and support should be provided to those who are unable to access courts or legal centers. For example, mobile legal aid services can play a key part in areas where there is a lack of services.

Capacity-building efforts for the Ministry of Interior (including DVAW), Ministry of Labor and Social Affairs and other relevant government bodies should be **structured and enforce survivor-centered approach**. Many of the legal needs of GBV survivors regard **legal documentation**. Women's vulnerability increases when they cannot access basic documents, such as marriage and divorce certificates. As such, legal aid centers should assist women in finding these, recognizing that they are critical for the enforcement of women's rights and their further protection.

Mediation is commonly used as a tool to address GBV in Iraq. This is known to be a problematic for this purpose and risks further harm to survivors; therefore, use of **mediation should be discouraged**. Where it is used, careful steps should be put in place to ensure mediation is protective of survivors. Nevertheless, capacity building should be done for actors using mediation as a tool to deal with GBV.

Objective 2: Prevention & Mitigation

In Iraq, prevailing attitudes and beliefs have been identified as enabling factors for GBV. Although a slow process, changing perceptions, attitudes and behaviors is an ongoing need and priority for long-term impact. The Dahuk GBV WG, in particular, emphasized the importance of raising women and girls' awareness of their legal rights and entitlements. With this knowledge, women and girls will be empowered to make informed decisions and have the ability to claim their rights. Community-based solutions to prevent and respond to GBV and create safer and more protected environments for women and girls are paramount for sustainability, and should include men and boys. Additionally, all humanitarian personnel should assume GBV is occurring and threatening affected populations, treat it as a serious and life-threatening problem, and take actions to prevent and mitigate it within their sectors.

Awareness Raising and Outreach

Mass awareness campaigns on GBV issues have largely focused on KRI. While there is a need to **strengthen the behavior change approach** of campaigns, greater attention should be placed on areas outside KRI for outreach and awareness raising on GBV to ensure survivors are aware of services available and encourage survivors to access resources. **Involvement of government and community structures** should be improved, and the participation of the community in design, planning, implementation and evaluation of campaigns should be ensured.

GBV service providers, especially PSS and case management agencies, are responsible for conducting targeted outreach efforts in consultation with the community and government that should include, at a minimum, causes and consequences of GBV, context-specific guidance on what to do if GBV occurs, availability of resources and services, and instructions on how to access them.

Community engagement strategies (including development of IEC materials) in hard-to-reach areas have been prioritized for 2016 to enable GBV organizations to use them to raise awareness on services and encourage survivors to access care. This is particularly important in hard-to-reach areas. Engaging community leaders is essential in securing their buy-in of services and support in referring survivors.

Essential to working with communities is ensuring open channels of communication. Pursuant to the Protection Cluster's strategy, agencies must ensure they develop **accountability mechanisms** to the affected population through functional, accessible complaint and reporting mechanisms and ensuring staff are trained on a **code of conduct**. Though ultimate responsibility for Prevention of Sexual Exploitation and Abuse (PSEA) lies with Humanitarian Country Team (HCT) in Iraq and individual agencies, the GBV Sub-Cluster will work with/support the in-country PSEA focal point network on common objectives related to addressing PSEA. Recently, guidance has been issued on the implementation of the Secretary General's Plan of Action contained in the report of the Secretary General on Special Measures for Protection from Sexual Exploitation and Abuse from February 2015. The Plan of Action is aimed at strengthening the zero tolerance policy and the UN's response to SEA under the three-pronged strategy of prevention, enforcement and remedial action.

Cross-Sector GBV Risk Mitigation

In 2016, Iraq has been selected as part of the global roll out of the 2015 IASC *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* with the support of the

Global GBV Area of Responsibility (AoR). The GBV Sub-Cluster will support other clusters with GBV risk mitigation efforts through **training and ongoing mentoring** that include **developing strategies to integrate GBV risk mitigation and response** within clusters and agencies. The GBV Sub-Cluster will also continue to advocate for the involvement of women and girls in all stages of project cycle, especially planning (e.g., site planning, WASH facility locations, NFI material selection) and assessment. Given the dynamic conflict nature in Iraq, assessments occur frequently but lack adequate gender lens, particularly with regard to identifying GBV risks. Cross-sector engagement needs to include improvements on tools and implementation of assessments to safely and ethically collect relevant data (including sex- and age-segregated, same-sex interviewing, and training interviewers on GBV sensitivity and referral).

The roll out of the *GBV Guidelines* by a GBV AoR consultant will initially focus on a few clusters in Iraq that will be chosen in consultation with global clusters to promote cluster ownership of the initiative. Interventions in Iraq will build on previous efforts by the GBV Sub-Cluster, especially the 'buddy' system whereby a GBV specialist worked with Health and WASH clusters on mainstreaming and integration. For example, sub-cluster members reviewed other cluster/sector's strategies and Humanitarian Needs Overview (HNO) and created GBV checklists for reviewing submitted Humanitarian Response Plan (HRP) proposals. This system will be bolstered, especially for clusters not included in the *GBV Guidelines* roll out by the consultant.

Social and Economic Empowerment

Education and income-generation projects also comprise both psychosocial and GBV prevention programming. Though income-generating projects promote women's economic self-sufficiency, they often can shift traditional gender roles within households and alter power differentials between male and female family members that may increase tension and lead to greater risk of domestic violence. Thus, actors need to **actively monitor and responsibly address potential GBV risks**, ensure women know how to access to response services, and actively engage men in prevention efforts. Income-generating projects should go **beyond simple vocational training** by being **well researched based on market gaps/opportunities.** Projects should be based on consultations with beneficiaries, link beneficiaries with markets and supplies for sustainability, and develop business skills.

In Iraq, cash assistance has shown promising results in supporting vulnerable households and promoting economic independence. **Cash transfer mechanisms should be strengthened** to ensure more responsible delivery that reduces risk of harm to women and girls. For example, when cash-based interventions are insufficient to meet a family's needs, are not contextualized or only target male heads of households, at-risk groups (e.g., female-headed households) may be forced or coerced to provide sex in exchange for food and material supplies or engage in physically dangerous jobs for money. GBV Sub-Cluster members should work with the Cash Working Group to develop guidance on how to prioritize cash transfers for at-risk women to meet basic needs and protect from negative coping strategies (e.g., survival sex), exploitation, abuses and GBV.

Objective 3: Coordination & Advocacy

Ensuring better, more targeted, responsible and responsive action for GBV prevention and response requires strong and supportive coordination and advocacy that are closely connected with needs of beneficiaries and service providers on the ground. The GBV Sub-Cluster will focus on improving national and sub-national coordination and data management, ensure timely and contextualized contingency plans and emergency response, adequately fundraise, and influence legal and policy frameworks relevant to women and girls, especially survivors of GBV.

Coordination and Data Management

Dialogue with the different actors and across locations revealed uneven knowledge of, and participation in, the cluster system-led response. Without coordination and communication between GBV actors, across sectors and between government and humanitarian actors, there has been duplication of efforts, disjointed strategies and inefficiently used resources. In 2016, **linkages between national and governorate-level GBV coordination structures** will be improved and structured, as will connections with other local coordination mechanisms (e.g., protection WGs, CP WGs, OCHA/ICCG) where they exist. New working groups or focal points will be formed and supported by the national GBV Sub-Cluster through a formal process based upon agreed criteria.

The GBV coordination structure lacks adequate inclusion of NGOs, with UN agencies playing the leading role in decision making, planning and strategic direction. Greater effort will be made to include NGOs as leaders in coordination given their advantage as service providers with firsthand knowledge on implementation issues and survivor needs and wishes.

The national GBV Sub-Cluster will update its **GBV SOPs** and ensure adequate roll out in the governorates. The GBV Sub-Cluster will work more closely with the Child Protection Sub-Cluster to enhance synergies and common approaches on joint projects, which include case management, adolescent girls programming, caring for child survivors of sexual abuse and child marriage issues. The GBV Sub-Cluster will also improve its responsiveness to Protection Cluster needs and improve visibility and inclusivity of GBV issues.

The need to create an evidence base through better information management and data/trend analysis was widely expressed during strategy development consultations, which would help in advocacy and designing more effective prevention and response services. However, greater efforts need to be made in ensuring all partners understand the principles of **safe and ethical data collection**, as well as **confidentiality and data privacy** to safeguard survivors, communities and service providers. In 2016, GBVIMS will expand to additional partners and include greater dissemination of shareable data. Greater effort should be made to **support partners in data collection and submission** using the tools. **Safety audits** of IDP and refugee sites will be routinely collected across governorates by trained personnel to identify GBV risks, trends across sites, and inform advocacy and cross-sector GBV risk mitigation. Information management will capitalize on existing data collection and reporting (e.g., IOM DTM, protection monitoring, RPA) and use various sources to **produce useful materials** for information sharing, visibility, advocacy and fundraising. National partners and government agencies, in particular, will be supported to improve on data collection, project monitoring and reporting (e.g., into Activity Info and GBVIMS).

Contingency Planning and Emergency Response

Lessons learned from the governorates strongly encourage support for improved contingency planning and emergency response. For example, after the retaking of Sinjar, Ninewa Governorate, by government security forces, the release of hundreds of minority women who experienced multiple forms of GBV (including gang rape) during ISIL captivity significantly overwhelmed existing response capacities for both NGOs and government in Dahuk Governorate. As the conflict in Iraq progresses, planning for similar events is necessary and must be inclusive of local government bodies that are ultimately responsible for the protection of civilians (e.g., governorate-level DoLSA, DVAW). Key multi-sector agencies that have some capacity and/or presence in these response locations should be identified and **adequately equipped with the knowledge and tools necessary for a rapid GBV response**. They must also be sufficiently funded through **emergency funding mechanisms** to enable

them to deploy immediately after conflict outbreak, working alongside or integrated within key sector responses such as health, food, CP and WASH. Contingency planning should also be linked with the existing rapid response mechanism (RRM) and rapid protection assessments (RPA) to activate emergency GBV responses following RRM distributions and RPAs, and information on GBV services should be provided at distribution points.

Providing specialized GBV response services is part of first- and second-line GBV response efforts in event of an emergency (especially in regard to CRSV). Therefore, increased involvement of MHPSS actors in GBV emergency contingency planning and response is essential.

Fundraising

All actors involved in the consultation sessions noted that financial resources are limited, which constrains their ability to implement. This is a problem across sectors as the Strategic Response Plan and HRP were both gravely underfunded, and the Government is dealing with both an expensive military operation and the depressed price of oil.

Fundraising will prioritize **meeting the unmet needs of ensuring minimum standards** in basic, lifesaving GBV service provision. To improve fundraising efforts, GBV Sub-Cluster will increase its visibility efforts and material output through improved data collection as described above and identifying target audiences for advocacy. Following the Protection Cluster's direction, the majority of funding will focus on **neglected areas outside of KRI** as they become more accessible. Funding of capacity-building projects for government and local partners should ensure additional and qualified human resources are included, given the time-consuming nature of technical support, and a **structured approach** that goes beyond training.

Based on strategic objectives and programming gaps identified by governorate WGs and focal points, the GBV Sub-Cluster will play a larger role in consistently engaging with donors and advocating for funding for GBV prevention and response. Funding for emergency response capacities will also be prioritized given the outbreak-prone nature of the crisis in Iraq.

Legal and Policy Framework

Though there are myriad advocacy needs throughout Iraq, including those specific to KRG, the GBV Sub-Cluster will focus on a few priority advocacy topics based on identified needs, evidence base, consultations and realistic achievements. These topics will be decided upon with sub-cluster members when developing a separate **advocacy strategy** that identifies key issues, relevant stakeholders and an implementation plan. Various avenues will be used to advance the advocacy agenda, including working with the NCCI Advocacy Working Group, Protection Cluster, donors, individual agencies, government counterparts, etc.

The GBV Sub-Cluster will also support **existing government- and national NGO-led efforts**, including UN General Assembly Resolution on the protection of women and girls from minority communities from violent extremism and terrorism proposed by the High Council for Women's Affairs and supported by the Government of Iraq leadership.