Peer 2 Peer Support For Humanitarian Leaders in the Field

UNFPA

IASC Inter-Agency Standing Committee

ADDRESSING GENDER-BASED VIOLENCE

Practical steps for Humanitarian Coordinators and Humanitarian Country Teams

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This note sets out practical steps that can be taken by Humanitarian Coordinators (HC) and Country Teams (HCT) to ensure that Gender-Based Violence (GBV) prevention and response is prioritised, integrated, and implemented in system-wide humanitarian response. In the new HCT terms of reference endorsed by the IASC principals, GBV is one of the four mandatory responsibilities along with the centrality of protection, Accountability to affected people (AAP) and Protection from sexual exploitation and abuse (PSEA), and demands HCT members' collective approach.

This Note has benefited from inputs and extensive consultations with experts in headquarters and field operations in Nigeria, South Sudan, Iraq, Syria, Central African Republic (CAR), the Democratic Republic of Congo (DRC), Cameroon, Burundi, and Pakistan. It also benefitted from the work of the multi-agency Real-Time Accountability Partnership on GBV (RTAP) project.

What is Gender Based Violence and why is it critical for humanitarians to address?

GBV is defined as any harmful act(s) perpetrated against women, girls, boys, and men based on socially ascribed differences between males and females. It includes acts that inflict physical, sexual or mental harm and suffering, threats of such acts, and other deprivations of liberty[1]. It can include, among other forms of violence, rape, domestic violence (including rape), forced marriage, female genital mutilation, female infanticide, trafficking for sexual exploitation, denial of resources or opportunities, and/or forced domestic labour and sexual exploitation and abuse by humanitarian workers[2].

According to research by the World Health Organisation (WHO), over 70% of women are at risk of, or have been a victim of, GBV in some crisis settings[3], with lifelong physical, emotional, social, economic and other consequences for survivors. Yet, there is still often insufficient attention, a lack of prioritisation or oversight by humanitarian leaders when it comes to GBV. There are also a number of common misconceptions:

Misconception		Reality and Action
1. Data or "proof" that GBV is happening is necessary to justify response or funding.	→	1. Assume GBV is taking place and support action to mitigate risk and reduce harm.
2. GBV is not a priority compared to other sectors.	→	2. Play a role in underscoring that addressing GBV is life – saving.
3. GBV prevention and response can only be done by GBV specialists.	→	3. Underscore the responsibility of *all* actors to treat GBV as life threatening and minimize GBV risk across *all* sectoral interventions.

All organisations involved in humanitarian response have a responsibility to protect those affected by the crisis from GBV, even if there is no data or proof of GBV happening in country. This includes programme interventions to **reduce the risk** of GBV, designing initiatives to **promote community resilience** to GBV and enable survivors and those at risk to access care and support services, and **supporting local and national capacities** (government, local authorities, and civil society) to establish systems to prevent and deal with GBV in a sustainable manner.

Frequently asked questions:

- **Gendered approach vs GBV response:** GBV response is focused on preventing and responding to violence caused by gender inequalities and discrimination, while a gendered approach aims to ensure that those who are affected by systemic and structural gender inequalities benefit equally from assistance and protection. Both are necessary and reinforce each other, as gender inequalities are the cause of and often contribute to the legitimation of violence.
- **Responding to GBV vs cultural norms:** It is often stated that some form of GBV is embedded within social and cultural norms that cannot be addressed without imposing the perception of humanitarians (eg. "Westerners imposing their cultural norms"). Yet a GBV response can be implemented with respect for cultural norms and local traditions with a mix of soft and hard activities, including for example gaining community elders' respect and support. A contextualised GBV approach can promote positive social and gender norms to address GBV and challenge norms that support violence and a culture of impunity.

KEY STEPS FOR HUMANITARIAN COORDINATORS AND COUNTRY TEAMS TO PREVENT, MITIGATE AND RESPOND TO GBV

The HC and HCT have a critical role to play in providing strategic direction to ensure GBV is accorded sufficient attention in the response, and that those affected by the crisis are protected by all humanitarian actors through commonly agreed goals.

A. STRATEGIC AND ACCOUNTABLE LEADERSHIP ON GBV

1. **Include GBV on the HCT's agenda and maintain focus on the issue.** The HC should be supported by an agency, an NGO, or a small group of interested organisations with technical expertise to move the GBV agenda forward. The champion or group should liaise directly and regularly with the GBV sub-cluster. If Protection is already an HCT standing agenda item, allocate sufficient space within this timeframe for GBV issues to be discussed.

IRAQ: Prioritisation, working together, and resource mobilisation

The Humanitarian Coordinator in Iraq worked closely with HCT members and the clusters to elevate GBV as a key priority in the response as a whole. As a result, the HCT agreed that addressing GBV would be one of the five goals identified in the Humanitarian Response Plan (HRP). This 'togetherness' of the HCT and clear messaging helped mobilise human and financial resources, including the deployment of specialist GBV capacity to work with the WASH and Health sectors in a cross-cutting manner, as well as directly supporting the work of the GBV sub-cluster.

2. **Establish a strategy for GBV prevention, mitigation and response informed by the sub-cluster expertise and endorsed by the HCT.** The strategy should be linked to the Centrality of Protection strategy and the Rights up Front initiative, with identified priorities and indicators. It should include a practical GBV mainstreaming approach reflected in the HRP and the HNO and encourage activities supporting community-based systems.

NIGERIA: A strategy that focused on local ownership and long term results

To promote government leadership on GBV, the GBV sub-cluster in Nigeria is chaired by the Federal Ministry of Women Affairs and Social Development, with UNFPA co-leading. This arrangement has helped encourage the Nigerian military to provide escorts for firewood collection in several districts to mitigate risks of GBV. The strategy also emphasises the importance of community-based systems, for example close work with traditional and religious leaders where they become key allies in the fight against GBV and take proactive roles to stop harmful practices such as child marriages.

3. **Utilise a mutual accountability approach, such as the proposed HCT Compact.** The proposed HCT Compact would provide the foundation for accountable, collective leadership to spread the workload across the members of the HCT, and not leave responsibility solely with the Humanitarian Coordinator. The organisation(s) that volunteer to provide leadership should also be held accountable for taking the GBV agenda forward.

B. SENIOR ADVOCACY ON GBV

4. **Conduct advocacy with senior levels of Government and de facto authorities on GBV.** The champion or group, including the HC, supported by the sub-cluster should work on an advocacy plan based on the GBV strategy. It should target actors who have positive or negative influences on GBV in country, including the authorities. Advocacy with the Government should focus on their leadership role to address GBV.

CENTRAL AFRICAN REPUBLIC: Advocating on GBV with non-state actors

The GBV Working Group in Ouaka Region advocated with non-state armed groups on preventing HIV and addressing GBV within their ranks. Rape cases appeared to markedly reduce in the area. Similar approaches could be linked to Government forces to further reduce incidences of GBV against the civilian population in the conflict.

5. **Engage substantively with the donor community on GBV needs.** The HC should organise regular dialogue, such as a round table with donors, to present the GBV strategy and solicit support for implementation. Having HC support for dedicated funds allocated through the CERF, pooled funds and Flash appeals is also important. The HC and the GBV focal point organisation(s) should engage directly with donors on a regular basis to keep them informed of issues, approaches, and the impact of GBV interventions programmatically and as a cross-cutting approach through all clusters.

SOMALIA: Clear engagement with the donors

The Humanitarian Coordinator in Somalia worked closely with HCT members and technical GBV expertise in the operation to establish a solid evidence-base on GBV, whilst also articulating a clear approach to address incidences of GBV via short and long term interventions. The HC hosted a roundtable with donors to solicit financial contributions and broader support to ensure the plans were operationalised.

The protection cluster has received just over 15 million USD in funds so far this year (July, 2017), of which just over 5 million USD supports GBV interventions. Thirteen out of twenty projects that are currently funded in the protection cluster are dedicated to, or include a component on addressing GBV. This illustrates a significant level of attention and funding to GBV when considering Protection covers four areas of responsibility in addition to protection as a main theme.

6. **Lead by example to show dedication to eradicate all forms of GBV with the humanitarian community and affected population.** The HC and HCT members should organise regular travels to the field to meet with field workers and the population and visit GBV prevention, mitigation and response programmes including community-based protection groups such as watch patrols or safe spaces.

PAKISTAN: Meeting with affected people and field workers

Due to visits and consultations at various field locations in Pakistan, the Humanitarian Coordinator understood that the needs assessments weren't adequately representative of women's needs. Together with members of the HCT, he realised that the situation was due to a lack of females in the needs assessments teams, and that for cultural reasons women could not be interviewed by male workers. The HC and HCT then introduced a quota of a minimum of 30% female workers in need assessment teams.

[1] Global Protection Cluster, Inter-Agency Standing Committee, "Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action", at www.gbvguidelines.org

[2] Sexual exploitation and abuse by humanitarian workers, or others in positions of relative authority, is also a form of GBV. Due to the fact that it is one of the four HCT mandatory responsibilities in the HCT Terms of Reference along with GBV, it is covered in a separate guidance note.

[3] Claudia Garcia Moreno and others, "Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner violence", Geneva, Who, 2013.

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P2P Support – The Centrality of Protection

The Peer 2 Peer Support team (formerly known as the Senior Transformative Agenda Implementation Team - STAIT) was created by, and reports to, the Emergency Directors' Group (EDG). It provides direct peer support to Humanitarian Coordinators and Humanitarian Country Teams to deliver effective, principled, quality, timely, and predictable collective humanitarian response in field operations. For more information, please visit: http://www.deliveraidbetter.org/