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Violence against Women and Girls in Humanitarian Emergencies

CHASE Briefing Paper

Despite increasing attention to violence against women and girls in crisis situations, it is still rarely prioritised in humanitarian responses [...] We need to see protecting women and girls from violence as lifesaving during emergencies, not optional.

Rt. Hon. Justine Greening MP, International Development Secretary of State,
November 2012

1. INTRODUCTION

In recent years, the international community has increasingly recognised violence against women and girls (VAWG) as a significant human rights, global health and security issue.¹ Preventing and responding to VAWG is a priority issue for the UK Government and is one of the four pillars of DFID's Strategic Vision for Girls and Women. The UK has significantly increased its international efforts to prevent and respond to VAWG but has acknowledged that much more needs to be done, particularly in humanitarian emergencies.

The UK government has made a number of commitments to addressing VAWG including in humanitarian contexts:

- DFID's commitment to consider risks of VAWG in all new and existing humanitarian programmes, and to take appropriate action
- [DFID's Strategic Vision for Girls and Women, which includes a pillar to prevent VAWG](#)²
- The [UK National Action Plan on UNSCR1325](#)³
- [The 2013 G8 declaration on Preventing Sexual Violence in Conflict](#)
- [Humanitarian Emergency Response Review: UK Government response](#)⁴

This briefing paper provides an introduction to the issue of VAWG in humanitarian emergencies. It will help advisers and others to make the case for why DFID should do more to protect women and girls in emergency situations. It is aimed at a broad, internal DFID audience: for a range of advisory groups (not just humanitarian advisers, but conflict, governance and SDAs), for programme managers and for other generalist staff working in countries prone to, or affected by emergencies.

This briefing paper draws from a range of sources and will be updated as the evidence base grows. The paper:

- Explains the risks of VAWG in emergency contexts – in situations of both conflict and in natural disasters;
- Examines what we know about the extent of VAWG in emergencies and the consequences of overlooking VAWG in emergency response;
- Synthesises existing guidance on what can be done to prevent and respond to VAWG.

Whilst the state carries the primary responsibility for protecting populations, including from acts of VAWG in conflict and natural disasters, states may be unwilling and/or unable to provide protection to their citizens and populations within their borders. In such situations, the international community also has a responsibility to use appropriate humanitarian means to protect populations from crimes, including VAWG.⁵

The paper concentrates on VAWG – reflecting the focus on women and girls in DFID's *Strategic Vision* and the position set out in the Inter-Agency Standing Committee's *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings*. These note that gender-based and sexual violence is primarily perpetrated by men against women and girls, but also recognises that men and boys can be vulnerable to sexual violence. Whilst preventing and responding to VAWG in emergencies has been a particularly neglected area, the focus on women and girls

VAWG is defined as 'any act of gender-based violence that results in or is likely to result in physical, sexual, psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'. (UN declaration on the Elimination of Violence Against Women, 1993)

should be understood as one part of a much needed push within the humanitarian system to increase protection of all vulnerable groups in emergency situations, in line with recommendations from the Humanitarian Emergency Response Review (HERR).

The paper includes an annex with a short annotated bibliography of key texts, and a longer list of key guidance literature. These set out the international guidelines, standards and resources for programming on VAWG in emergencies. Further information can be obtained from Clea Kahn c-kahn@dfid.gov.uk or Lucy Earle l-earle@dfid.gov.uk in CHASE. Key resources are available on the VAWG themesite <http://epe-insight/vawg>. The themesite also provides information on the VAWG helpdesk, a resource established to provide support to DFID staff on VAWG programming.

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2. VAWG IN EMERGENCIES – WHAT WE KNOW

Emergencies – both human-made and natural disasters – exacerbate risks to women and girls:

- Existing structures, social networks and systems that can protect women are weakened or destroyed.
- Lack of security can restrict women's social roles and movement.
- A disaster may result in women taking on new roles in the private and public sphere. In some cases this can increase opportunities for women and girls, but it can also put them at additional risk.
- The fast pace of humanitarian response means that women and girls are rarely meaningfully consulted or involved in planning and implementing programming.

- Delayed VAWG response by the humanitarian community means that considerations for women and girls are absent from early programme design and implementation, further exacerbating risks.
- Inadequate facilities and limited resources reduce women's options and increase the risk of economic and sexual exploitation.

The limited evidence on the extent and nature of VAWG in conflict and humanitarian contexts has been a key barrier to investment in VAWG programming in emergencies (see discussion below) and building the evidence base is a priority for DFID and partners. However, there is existing evidence which indicates that VAWG in emergencies is more prevalent than currently acknowledged, and has a life-threatening impact on women and girls.

2.1 VAWG in conflict

Sexual violence is used against women in wartime for many reasons, including as a form of torture, to inflict injury, to extract information, to force a population to flee, to forcibly impregnate, to degrade and intimidate, and as a way of punishing both women and their male relatives, for actual or alleged actions committed by women or their family members.⁶ In addition to the use of sexual violence as a method of warfare, women are also at increased risk of opportunistic sexual violence⁷ as a consequence of displacement and societal upheaval.⁸ Estimates of VAWG during conflicts in the 1990s demonstrate large-scale and targeted abuses against women and girls.

Data on VAWG⁹

- By 1993, the Zenica Centre for the Registration of War and Genocide Crime in Bosnia-Herzegovina had documented 40,000 cases of war-related rape.
- Of a sample of Rwandan women surveyed in 1999, 39 per cent reported being raped and 74 per cent reported they knew that sexual violence had occurred during the 1994 genocide.¹⁰
- Human Rights Watch estimate that in the Sierra Leone conflict between 215,000 and 257,000 Sierra Leonean women and girls may have been subjected to sexual violence during the conflict period.¹¹
- A 1999 Government survey of more than 2,000 sex workers in Sierra Leone found that 37 per cent were under the age of 15, and that the majority had been displaced by conflict and were unaccompanied by family.
- A 2010 population-based survey in eastern Democratic Republic of Congo found that nearly 40 per cent of women reported having experienced sexual violence and nearly 42 per cent reported interpersonal violence.¹²

2.2 VAWG in natural disasters

Evidence has also highlighted the serious impact of natural disasters on women and girls including increased VAWG. Increases in intimate partner violence were reported following the eruption of Mt. Pinatubo in the Philippines (1991), after Hurricane Mitch in Nicaragua (1998), and after the Loma Prieta earthquake in the United States (1989).¹³ The South Asian tsunami in 2004 brought to light the differential impact of disaster on women and men, as evidenced in the greater number of deaths of women due to restrictive social roles and disadvantages in terms of access to resources.¹⁴ However, the threat of VAWG following natural disaster only gained broader recognition from the humanitarian community following the 2010 earthquake in Haiti and the floods in Pakistan that same year (see below).

Haiti: Key facts ¹⁵	Pakistan: Key facts ¹⁶
<ul style="list-style-type: none"> ▪ Sexual and physical violence were well documented pre-quake ▪ Co-ordination on VAWG in initial months after the earthquake was weak ▪ 18 months after the earthquake 	<ul style="list-style-type: none"> ▪ VAWG was seen as too taboo to address after the flooding in the summer of 2010 ▪ Women's needs were absent from most of the early humanitarian reports on the disaster. Initial appeals and assessments

<p>UNHCR published a report showing that sexual abuse and exploitation were widespread mainly because women and girls could not obtain the goods and services they needed to survive</p> <ul style="list-style-type: none"> ▪ Out of \$1.4 billion funding requested for the emergency, only \$5 million (0.3%) was for Gender Based Violence (GBV) programmes 	<p>made little, if any, reference to VAWG</p> <ul style="list-style-type: none"> ▪ A 2011 report of the GBV sub-thematic group in Sukkur, Pakistan noted that VAWG was an issue but women were failing to report because of stigma and threats from the family ▪ The GBV sub-cluster was the last cluster to be established; once it was established, OCHA updates finally began to mention the urgent need for GBV prevention and response programmes ▪ Of over \$2 billion funding requested for the emergency less than 1% mentioned GBV
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2.3 How Emergencies Impact on Forms of VAWG

“If you want the card, you have to accept to sleep with the guy. The young women who get the cards are the boss’s mistresses.”

UNHCR, *“Driven by Desperation: Transactional Sex as a Survival Strategy in Port au Prince IDP Camps”* (May 2011)

There is now increasing recognition that more needs to be done to address the various forms of violence that women and girls experience. Examples of such violence include (but are not limited to) – intimate partner violence, early and forced marriage, female genital mutilation/cutting (FGM/C) and sexual exploitation. Humanitarian emergencies can exacerbate the practice of early and forced marriage (see Box below). However, evidence also demonstrates that the impact of emergencies on early and forced marriage will be different within each emergency and cultural context. Plan observed an increase in child marriage in some parts of the Sahel and a decrease in others. Reasons for the decrease included an inability to provide dowries and young boys seeking work in other areas as a result of the food crisis.¹⁷

Child marriage in emergency contexts

- After the earthquake in Haiti and the 2010 floods in Pakistan, NGO staff in both locations reported an increase in early marriage.¹⁸
- According to World Vision child sponsorship data gathered in Bangladesh in 2012, 62 per cent of the total number of children under 18 who married in the last five years were married in the 12 months following Cyclone Sidr in 2007.¹⁹
- In Cameroon in September 2012, an internal Plan assessment and programme design report found that the floods had put an economic strain on families that meant that they were willing to marry their daughters off at an earlier age. One father from the community said, “If men come for our daughters, we would give.”²⁰
- During the 2011 drought in the Horn of Africa, the Office of United States Foreign Disaster Assistance reported that, over time, families married off daughters aged as young as nine years old to pay their dowries in kind before their livestock died.²¹
- More recently, International Rescue Committee rapid assessments with Syrian refugees in Lebanon and Jordan revealed that although early marriage was commonplace prior to the conflict, early and coerced marriage had increased and the average age of girls marrying had decreased since the start of the conflict. Families have reportedly been marrying girls as young as 12 years old as a means of protecting them from rape or dishonour. In other cases, girls were married to wealthy businessmen in exchange for money to pay rent, or in exchange for free accommodation or reduced rent.²²

Sexual exploitation, trafficking and forced prostitution can also increase as a result of economic hardship. All focus groups in the International Rescue Committee's research with Syrian refugees mentioned that there were women and girls within the community who have been forced to engage in sex in exchange for resources. Migration and displacement can also have an impact on harmful tradition practices, such as female genital mutilation (see Box below).

Impact of Migration on Female Genital Mutilation/Cutting

An increase in female genital mutilation/cutting (FGM/C) can occur when migrant groups displaced by disaster introduce the practice to the host community.²³ Plan discovered in their work in Mali that the reverse was also occurring. The daughters of displaced families from the North (where FGM is not traditionally practiced), but who are living amongst host communities in the South (where FGM is common), were being ostracised due to not being circumcised. This, in turn, led to families from the North feeling pressure to perform FGM on their daughters. In the context of displacement, both the host community and the displaced communities need to be targeted with programming work to support the abandonment of FGM.

2.4 Increased risks for specific groups

Evidence on VAWG in emergency situations also suggests that specific groups of women and girls may be at particular risk because they experience multiple forms of discrimination. This includes (but is not limited to) HIV positive women and girls, older women, women and girls with disabilities, and women and girls from ethnic or tribal minorities.

Caste-based Discrimination in Disaster Response

Caste-affected communities are often the last to receive relief assistance (such as access to health services, shelter, housing and clean water) and are often more vulnerable in emergency situations because of where they live and work. For example, research following the 2004 tsunami in India and the 2002 Gujarat riots, highlighted the specific vulnerabilities of Dalit women to violence before, during and post-emergencies.²⁴ The International Humanitarian Stakeholders for Addressing Caste-based Discrimination in Disaster Response provides guidance on recognising caste-based exclusion in disaster response, tools and methods to ensure Dalits' participation in disaster response and a vulnerability mapping tool checklist.²⁵

Adolescent girls are also a group subject to high levels of VAWG including rape, sexual abuse and sexual exploitation. Plan research in Ethiopia, South Sudan and Mozambique revealed that adolescent boys and girls, and adult women and men, all consider adolescent girls to be the most affected by disasters.²⁶

Adolescent girls are at increased risk of VAWG due to a number of factors including:

- They may be perceived as “pure” (i.e. virgins), and therefore may be specifically sought and targeted e.g. because virgins are seen as more desirable, or because of misconceptions about HIV/AIDS.
- They may be more easily targeted by perpetrators within displacement settings (i.e. adolescent girls living in crowded areas and often not attending school), and at the same time lack the community protective mechanisms that might exist in a stable setting.
- They lack social power due to the combination of their age and gender.
- They are unlikely to be able to access services such as family planning due to lack of income for user-fees, lack of knowledge, embarrassment and shame, and judgemental attitudes of service providers.
- They are often missed in traditional child protection interventions in emergencies (such as child-friendly spaces), but also may not be reached with the same programming used to reach adult women. For example, adolescent girls may not feel comfortable visiting a safe space designated for adult women. Families might also place tighter restrictions on

adolescent girls' movements or give girls increased responsibilities around the home, limiting their ability to access traditional entry points to services.

An adolescent girl intervention, Pakistan post-floods

Plan International works in Southern Punjab and Interior Sindh in Pakistan, both of which were devastated by flooding in 2010. After the floods, Plan set up Non-Formal Education Centres (NFEs) for girls to attend in response to the following needs:

- More girls than boys were dropping out of school after the floods
- There was an issue of safety and security of adolescent girls in displacement camps, with various reports of increasing sexual violence: and
- Boys' schools were re-opened after the floods much quicker than girls' schools were, leaving girls vulnerable to child marriage and being denied their basic right to education.

NFEs allowed adolescent girls to continue receiving a level of education that they otherwise would no longer have had access to because of the floods. The NFEs provided a safe space and constituted a protection response as well as an education response. The curriculum combined academic studies with life skills and discussions around gender-related issues, allowing girls to discuss VAWG in a protective space and to come up with solutions to reduce vulnerability to VAWG. Qualitative case studies suggest that NFEs provide girls with opportunities to gain confidence and play leadership roles within the NFEs as well as the wider community. Further benefits include parents agreeing to delay marriage until after the completion of studies.

2.5 Operational data on VAWG

Since 2006, data collection on VAWG has been aided by the introduction of the Gender-Based Violence Information Management System (GBVIMS). This important tool is designed to enable humanitarian actors responding to incidents of GBV to collect, analyse and share data from VAWG survivors in order to inform programming.²⁷ UNFPA, UNICEF, UNHCR, the International Rescue Committee and the World Health Organisation (WHO) manage the GBVIMS. The GBVIMS was created to harmonise data collection by service providers in humanitarian settings and provide a simple system for service providers to collect, store and analyse their data, and to enable the safe and ethical sharing of reported GBV incident data. GBVIMS data is collected at the point of service provision. It allows for cross-context comparisons and can offer trends across emergency contexts. However, as a large proportion of VAWG cases go unreported, it only captures part of the picture.



Where the GBVIMS is used, DFID humanitarian advisers may have access to reports on data trends from service providers. Whether this information is available and the extent of information that service providers can share will depend on local information sharing protocols (ISPs). Service providers and GBV coordinating agencies should be able to explain whether an ISP is in place and what information sharing it permits. Other data gathering tools are discussed in section 4.1.

Due to the highly sensitive nature of GBV data, service providers and coordinating agencies use ISPs to guide how information is shared among service providers themselves, as well as how it is used to produce regional or inter-agency statistics. Sharing data improperly can

jeopardise survivors' rights to confidentiality and safety, and can bring undue attention to service providers, their clients and their communities. Unsafe data sharing can also lead to misinterpretation by actors who may not be well versed in GBV or the context in which the data was gathered. For more information please see gbvims.org

Drought in Kenya

In August 2011, as a result of a drought emergency, there was a refugee influx into the Dadaab camps in north-eastern Kenya, which had been housing refugees since 1991. These new arrivals were mostly women arriving alone or with children. GBVIMS data revealed:

- A steady increase in VAWG incidents reported beginning in April 2011 and starting to decline in September 2012, coinciding with the peak emergency period.
- The number of VAWG incidents reported to the International Rescue Committee's VAWG programme nearly doubled during the height of the emergency in Dadaab. VAWG cases reported included rape; sexual assault; physical assault; forced marriage; denial of resources, opportunities or services; and psychological/emotional abuse.
- The number of reported rapes nearly tripled during the emergency phase. The overall population in Dadaab nearly doubled during this same period, straining resources and services; meanwhile, VAWG funding was cut in half.²⁸
- The percentage of unknown perpetrators went from 7% in the pre-emergency period to 17% in the emergency period.

Conflict in DRC

There have been alternating states of emergency and stability in eastern DRC since 2003. Beginning in late April 2012, North Kivu was struck by another outbreak of conflict between State and non-State factions. The height of the crisis lasted until December 2012, although instability remains and the number of displaced people continues to be high. GBVIMS data revealed:

- Reported incidents spiked during the emergency period. In September 2012, the number of VAWG cases reported to International Rescue Committee -supported partners was 190% higher than the monthly average in 2011.
- The International Rescue Committee and its partners saw an increase in women and girls reporting all forms of VAWG during the height of the emergency including: sexual violence, psychological violence, denial of resources, physical assault and forced marriage.
- Reports of sexual violence to the International Rescue Committee and its partners increased 70% in the emergency period in DRC.
- In 2012, although there was an increase in reported cases perpetrated by a stranger (from 45% in the pre-emergency period to 58% in the emergency period), in 42% of the cases the perpetrator was someone known to the survivor.

3. CONSEQUENCES OF VAWG IN EMERGENCIES

VAWG has significant impacts on the health and wellbeing of women and girls. It is recognised as an international public health issue that results in acute and often fatal physical and psychological injuries.²⁹ These impacts, alongside the social impacts of VAWG (such as stigma and family rejection), undermine efforts to improve child, family, and community health, and to reduce the spread of HIV/AIDS.

3.1 Physical Health Consequences

A lack of appropriate services to survivors of VAWG, particularly sexual and reproductive health care, can contribute to:

- Increased risk of HIV infection and other sexually transmitted infections (STIs).
- Long-term gynaecological problems, including life-threatening complications as a result of traumatic fistula, physical injuries and shock following sexual violence.

- Unplanned and unintended pregnancies due to lack of contraception, including emergency contraception.
- Life-threatening complications from unsafe abortions, compounded by lack of post-abortion care. Access to safe abortion remains near impossible for the majority of women caught up in emergencies. 25-50% of maternal deaths in refugee settings are due to unsafe abortion. One study of maternal mortality amongst refugees in 10 countries found that 78% of deaths followed delivery or abortion. The rate for unsafe abortion in Northern Uganda is 70 per 1000 women, vs. 54 per 1000 women for the country as a whole.

The window for accessing health care to prevent pregnancy and HIV is extremely narrow, and services need to be in place from the onset of an emergency. When a woman has experienced sexual violence, she has just:

- 72 hours to access care to prevent the potential transmission of HIV;
- 120 hours to prevent unwanted pregnancy; and
- Sometimes just a few hours to ensure that life-threatening injuries do not become fatal.

The physical health consequences of violence can be particularly severe for children and adolescent girls. VAWG can lead to early and/or unintended pregnancy³⁰ and can have life-threatening consequence for girls. A girl under the age of 15 is five times more likely to die in childbirth than a woman over the age of 20.³¹ Girls may suffer uterine prolapses, fistula and other injuries to the reproductive system or rectum as a consequence of VAWG.³² There are also longer term intergenerational community-wide effects of VAWG. For example, VAWG that leads to early adolescent pregnancy can have a significant impact on birth weight and lead to growth failure.³³

3.2 Psychological Health Consequences

The psychological and social impacts of VAWG shatter trust, diminish opportunities for development and have a deep impact on the emotional and social wellbeing of women and girls.³⁴ Psychological consequences of VAWG include fear, shame, anxiety and suicidal tendencies. Incidents of VAWG can also lead survivors to withdraw from day-to-day activities and social support, making recovery more challenging. One study in the Democratic Republic of Congo has found that nearly 65 per cent of women who experienced interpersonal violence also suffered from severe depression, and 77 per cent suffered from post-traumatic stress.³⁵

The negative effects of violence on survivors' emotional wellbeing will have an impact beyond the emergency period if not appropriately addressed. A study of former combatants and survivors of sexual violence in post-conflict Liberia found that the rates of symptoms of post-traumatic stress disorder, major depression and suicidal thoughts were higher among those who experienced sexual violence compared to those who did not. 74 per cent of female combatants who experienced sexual violence suffered from symptoms of post-traumatic stress disorder.³⁶ Studies have also shown that early intervention for survivors of sexual assault is critical, because the level of distress immediately following the assault is strongly correlated to post-traumatic stress disorder symptoms.³⁷

3.3 Social Impacts

Often, violent or traumatic events affect an individual's ability to function, both as an individual and within her family, community, and society. Because local systems, services and community networks often disintegrate during emergencies, survivors have more limited means of accessing support. The threat of rejection from family members and communities, social exclusion and stigma may stop a survivor from reporting abuse and accessing care.

Responding quickly and effectively to violence in a way that meets survivors' immediate medical and psychosocial needs is the first step towards healing and building safe environments for women and girls. If VAWG programmes are established in the first days of

an emergency, women and girls are more likely to access services, take the first step toward recovery and, in turn, support others.

4. PROGRAMMING OPTIONS: WHAT CAN BE DONE?

4.1 Collecting data for programming in humanitarian contexts

Any data collection in emergencies is challenging, but given the highly sensitive nature of VAWG it is vital that approaches to information collection are in line with the internationally accepted guidance and 'do no harm' principles discussed below.

Data collection methods, such as household surveys, are very difficult in humanitarian emergencies due to under-reporting, displacement, a breakdown of systems, and safety and security issues.³⁸ Information should be collected with the aim of informing programme design and ensuring that interventions are responsive to the needs of women and girls.

It is also important to look beyond a focus on quantitative data. Other useful information sources for needs assessments and programme design include:

- Basic information on potential risk factors in the community or area of displacement, using a tool such as a safety audit or an abbreviated focus group discussion.
- Qualitative and contextual knowledge of local experts on VAWG – including local women's rights organisations and networks.³⁹
- Secondary information, such as information gathered by other sectors regarding the accessibility of basic necessities such as food and water, can often provide useful insights into context and risk factors.

Due to the particular issues raised by collecting data on VAWG in emergencies, the WHO has developed specific ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies.⁴⁰ The following sections draw on the [WHO guidelines](#) and the experiences of NGOs and should guide assessments and data collection in emergency contexts.

1. Recognise that VAWG is under-reported
Under-reporting of VAWG makes it difficult, if not impossible, to obtain an accurate measurement of the magnitude of the problem. Even in a stable context with functioning systems, such as the UK, a significant number of VAWG cases are not reported. A 2009 survey carried out by the University of Surrey suggests that in the UK over 70% of rape cases go unreported. ⁴¹ In emergency situations, often characterised by instability, insecurity, fear, dependence, loss of autonomy, the breakdown of law and order, and widespread disruption of community and family support systems, women may be even less likely to disclose incidences of VAWG. Until there are services in place that women can safely access there is little reason for them to put themselves at risk by disclosing their experience of VAWG.
2. Understand and question assessment results
Where data collection does not follow good practice, assessments and surveys may report that there are no cases of VAWG when, in reality, women do not feel safe to disclose their experiences, or do not come forward because services are not available. The scale of under-reporting and difficulty in obtaining robust data means any estimates of prevalence are likely to have a large margin of error. ⁴² In North Kivu in 2012, assessments that did not specifically look at the needs of women and girls concluded that VAWG was not happening or was not a primary concern. Despite such reports, the International Rescue Committee started services in the camps around Goma. In every camp, survivors began to report VAWG from the first day of services being available.
3. Ensure safe data collection and research
Asking questions about VAWG may put women and girls at further risk of violence and repercussions. In some emergency settings, simply participating in VAWG inquiries can

have serious, even life-threatening, implications for women, for their communities and for those collecting the information. Not only must the confidentiality and informed consent of those providing information be respected, but those undertaking information collection must ensure the potential benefits outweigh the very real risks to women's safety.

4. Use survivor-centred questions

How questions are framed can cause further trauma or stigmatisation for survivors. For example, if women are asked to recount an experience of violence to multiple people, or if a survivor is asked to verify her account, this can cause additional trauma and may discourage her from seeking services later. Particular safeguards must also be put in place if children are the subject of information-gathering.

5. Ensure basic care and support services are available

Asking specific questions about violence may lead to disclosures from survivors who need lifesaving care. Basic health care and psychological first aid must be locally available and accessible before commencing any activity that may involve women and girls disclosing information about their experience of VAWG.

6. Select and train rapid needs assessment teams

Due to these specific challenges, staff involved in researching, documenting and monitoring VAWG in emergency situations must be carefully selected, receive appropriate training and have expert knowledge of the risks, ethical considerations and challenges associated with research on VAWG. An online survey Plan conducted amongst humanitarian personnel shows that one in three humanitarian actors reported no female staff on their rapid needs assessment team looking at VAWG.⁴³ This can have implications for how comfortable women and girls feel talking about sensitive issues such as VAWG.

4.2. Comprehensive VAWG programming

4.2.1 Mainstreaming and vertical programming

VAWG programmes require investments across all humanitarian sectors, including health, food security, water and sanitation, camp management, security, education, justice and economic development. Achieving effective programming that keeps women and girls safe means ensuring both vertical (or specialised) programming and a mainstreaming approach across sectors.

Vertical (or specialised) programming is supported by VAWG experts and is critical to assessing needs, establishing survivor services, creating safe entry points to those services and engaging communities in a way that reinforces the protection of women and girls.

Examples of vertical programming could include:

- Identifying or establishing a centre or safe space focused on providing information and basic emotional support to survivors.
- Creating confidential spaces for trained VAWG caseworkers to receive survivors at key points such as health clinics, reception or transit centres, child- or women-friendly spaces, etc.
- Establishing case management systems that use appropriate intake, consent and referral forms.⁴⁴
- Engaging men and boys to identify and transform the attitudes, beliefs and behaviours that lead to VAWG. Men and boys can be engaged as allies in primary prevention,⁴⁵ although this is not a priority for the acute phase of emergency response.

VAWG prevention and response must also be seen as a cross-cutting issue and should be 'mainstreamed' into all humanitarian programming. Mainstreaming means that each sector commits to integrating violence prevention and response into their efforts. VAWG practitioners play an important role in supporting other sectors to design and implement programming in a way that keeps women and girls safe, adhering to Do No Harm principles, and in particular, mitigating the risks of VAWG. Examples may include:

- Ensuring that the health sector actively screens for survivors of VAWG in a respectful and supportive way; ensuring same sex interviewers for survivors; being able to respond to the immediate health needs of the survivor and providing services free of cost.
- Working with water and sanitation projects to mitigate the risks women and girls face when accessing water points and latrines e.g. ensuring water and sanitation actors consult meaningfully with women and girls about where to put water points, ensuring there are locks on the inside of latrines.
- Working with security sector actors to design context-appropriate actions that improve the protection of women and girls as they meet basic material needs e.g. firewood patrols.
- Work with women and girls to ensure that logistics around food distribution are mindful of their needs and safety. For example, distribution locations and hours should be chosen that are safe and easily accessible for women and girls. Security should be monitored at entry and exit roads to ensure that women and girls are not subject to violence as a result of having received food assistance. Other mechanisms that ensure accessibility for women, such as child care provision that allows women to attend food distributions, are also a critical part of mainstreaming.
- Working with camp management organisations to ensure that the layout of displacement or refugee camps meets the safety and security needs of women and girls e.g. ensuring lighting in areas of the camp where women and girls feel at most risk of violence.

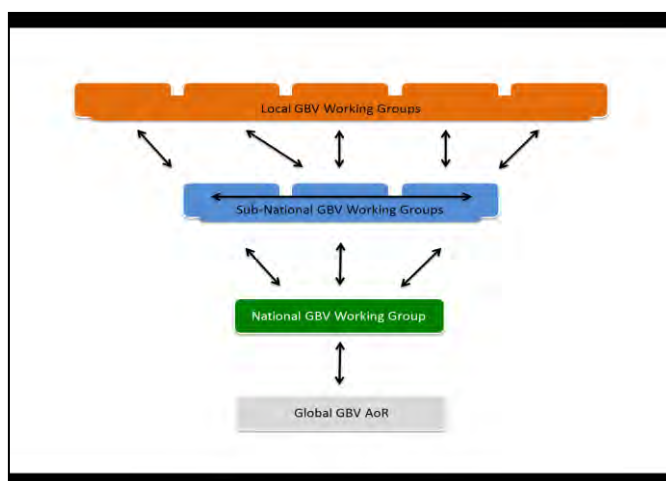
4.2.2 Coordination

GBV Coordination is key to ensuring an effective, coherent and comprehensive approach to prevention, care, support, recovery and perpetrator accountability. All actors on the ground have a responsibility to contribute to good coordination and to strengthen and enhance the protection and care of women and children in situations of humanitarian crisis. According to the principles of humanitarian aid, the humanitarian community, host governments, donors, peacekeepers, the UN and all others engaged in working with and for affected populations are collectively accountable for preventing and responding to GBV.

A 'cluster' approach is the framework for response in major new emergencies. A cluster is a coordination group focused on a key area of humanitarian response, with a lead agency(ies) that operates at the global level and at the field level. The Protection Cluster is one of 11 global clusters. It is the main forum for coordinating protection activities in humanitarian action—including GBV—and covers a wide range of activities that aim to ensure the rights of all individuals are respected, regardless of their age, gender and social, ethnic, national, religious or other background. UNHCR is the global lead agency for the Protection Cluster.

The Protection Cluster has 'Areas of Responsibility' (AoR). The GBV AoR is one of the AoRs under the umbrella of the Protection Cluster.⁴⁶ The work of the GBV AoR is conducted by the GBV AoR Working Group (GBV AoR), which is led jointly by UNFPA and UNICEF.

More information can be found in the [Handbook for Coordinating GBV Interventions in Humanitarian Settings](#).



4.2.3 All programming should be informed by women and girls

All VAWG programming actions should be informed by consultations with women and girls.⁴⁷ During the acute crisis response this may take place through initial information gathering on

what women and girls identify as priority needs and where they do or do not feel safe accessing services and humanitarian aid. Meaningful consultation approaches should be used to ensure the effectiveness and cost-efficiency of interventions. An International Organisation for Migration (IOM) assessment noted that 33 per cent of latrines built in 21 Haitian camps after the 2010 earthquake were not used, and 57 per cent were only occasionally used. Women and girls noted that they were not used because they were not segregated, not well lit, lacked locks and were culturally inappropriate. Key protection issues also emerged, as sexual violence was reported in 29 per cent of the sites.⁴⁸ This could have been prevented if women and girls had been meaningfully consulted – using, for example, focus group discussions or community mapping techniques – prior to programmatic decision-making.

4.2.4 Key actions to prevent and respond to VAWG

Considering the need for both specialised and mainstreaming approaches, key entry points for addressing VAWG are:

1. Emergency preparedness specific to VAWG
2. Ensuring survivors of VAWG have safe and timely access to services and referral mechanisms that meet their physical and psychosocial health needs
3. Provision of safe spaces for women and girls
4. Provision of material and/or cash-based assistance to meet women and girls' basic needs
5. Reducing the immediate risks to women and girls whilst laying the groundwork for a safe and supportive environment in which VAWG is not tolerated.

Across these key entry points it is vital to work closely with the community, including women and girls, community leaders, and men and boys, so that communities support women and girls and survivors of VAWG.

1) Emergency preparedness specific to VAWG

Emergency preparedness in the humanitarian sector 'involves identifying gaps and challenges to effective emergency response, and then planning and implementing a series of actions to increase response capacity and reduce potential gaps'.⁴⁹ Making commitments to emergency preparedness specific to tackling VAWG involves:

- Investing time and resources into building the capacity of staff and partners
- Working with field-based teams to identify likely emergency scenarios in their contexts
- Developing action-based plans that outline how first responders will ensure efficient, effective responses to VAWG.⁵⁰

Preparedness action plans should consider:

- How will emergency response materials be pre-positioned?
- How will decisions be made regarding deployment for assessment and response?
- How will VAWG first responders work with operational support teams to access affected sites with staff and supplies?
- How will VAWG first responders communicate and work with other actors and coordination leads?
- How will teams advocate for the prioritisation of VAWG response at the height of the emergency?

Emergency preparedness to tackle VAWG in North Kivu, DRC

The International Rescue Committee's investments in preparedness specifically related to VAWG response significantly enhanced the organisation's ability to deploy and respond in North Kivu during the crisis in 2012. Specialised response teams, with training and experience in conducting VAWG assessments and leading response to local crises, were deployed 40 times between April 2012 and February 2013. These teams, made up of case managers, health and community education staff, stayed on the ground for between two and four weeks, providing direct services where necessary and mentoring local service

providers in case management, psychosocial care, clinical management of rape and community outreach.

Results of this preparedness work include:

- VAWG response teams provide lifesaving services in the vital response window of 72 hours. Even in extremely challenging circumstances, the teams deployed to assess VAWG needs and provide critical services.
- Better response of humanitarian and community actors to VAWG due to training of over 30 International Rescue Committee staff and over 320 NGO staff, community health workers and IDP camp leaders.
- Congolese partners have a strategy to respond to VAWG even during periods of insecurity and displacement. For example, when an International Rescue Committee - supported partner fled to Uganda they continued service provision by crossing into North Kivu to provide services to conflict-affected communities.
- Better coordination and safe and ethical information sharing on VAWG during emergencies, due to the development of inter-agency emergency protocols.

2) Ensuring survivors of VAWG have safe and timely access to services and referral mechanisms that meet their physical and psychosocial health needs

VAWG programming established during acute emergency phase should focus on ensuring that survivors have:

- Safe access to health care, including appropriate drugs, supplies and equipment.
- Basic psychosocial support and information.
- Support to navigate a referral system that links them to available services.

The clinical management of rape is a priority area of emergency reproductive health response and must be a component of primary healthcare rather than an optional service. Both VAWG and health teams should integrate messages regarding the adverse health impact of VAWG in their outreach to communities. Actions include working with local health workers and community leaders to inform the community about the urgency of, and the procedure for, referring survivors of VAWG. International guidance can provide helpful information to inform programming work such as the [Minimum Initial Service Package \(MISP\) for reproductive health](#) and the WHO Guidelines for the [Clinical Management of Rape Survivors](#).⁵¹

Minimum Initial Service Package for Reproductive Health (MISP)

The Reproductive Health Response in Crisis Consortium developed a [Minimum Initial Service Package for Reproductive Health](#) (MISP) to provide an international standard which identifies a priority set of lifesaving activities to be implemented at the onset of every humanitarian crisis. MISP activities and standards provide a crucial starting point for RH services to be integrated into the health care delivery system and can be built upon to establish a more sustainable foundation during chronic crises and the recovery phase. A core component of the MISP is managing the consequences of sexual violence by putting in place measures to protect affected populations from sexual violence, making clinical care available for survivors of rape (e.g. training medical staff to provide sensitive care to clients, equipping health centres with emergency contraception and post-exposure prophylaxis to minimise HIV transmission, and referring survivors to psychosocial support) and ensuring that the community is aware of available clinical services.

Reproductive health services as a core part of emergency responses⁵²

RAISE was founded by Marie Stopes International and Columbia University in July 2006. The programme has a focus on four key areas of reproductive health: emergency obstetric care, including post-abortion care; all methods of family planning; prevention, diagnosis, and treatment of sexually transmitted infections and prevention of HIV/AIDS; and clinical management and referral for survivors of gender-based violence. By December 2010, programme partners were providing

reproductive health services in more than 80 facilities at eleven RAISE-supported project sites. These were located in six countries with substantial refugee or IDP populations: Sudan, Uganda, Chad, Thai-Burma border, Colombia and the DRC. As a result of the implementation of RAISE, more women are receiving reproductive health services, including family planning and post-abortion care. For example, the distribution of both long-term and short-term contraceptive methods increased by 428% across RAISE programme sites between 2007 and 2010. In addition, the case fatality rates for emergency obstetric complications declined across all sites. RAISE clinical training and the [publication of training manuals](#)⁵³ has contributed to an increase in skilled staff.

3) Building social support networks

Interventions that target an individual survivor's psychosocial wellbeing⁵⁴ are typically implemented in combination with social activities that help women and girls to build a support network and to decrease stigma of survivors. Activities can include life skills lessons, skills building (e.g. literacy & numeracy lessons), and health activities including health education. These interventions provide an additional entry point in the community for survivors, provide support for survivors who do not require more intensive support, and give an opportunity for survivors to gain access to skills and knowledge-building activities that may not otherwise be available to them.

Women and girls who have suffered violence need support that is geared toward building trust, connections and understanding. In emergency settings, VAWG services empower survivors of VAWG through the process of case management,⁵⁵ which helps survivors identify options, make informed decisions about what actions to take, and take steps toward accessing the services and support they choose. Psychosocial support can also be provided through the case management process, through crisis counselling or, in some settings, more regular sessions of individual counselling provided by trained caseworkers.⁵⁶

Awareness-raising on VAWG in Ivorian refugee camps

Providing support systems for survivors of VAWG also involves changing attitudes towards the acceptability of VAWG, together with safe and supportive avenues for women to report violence. ActionAid and its partners embarked on a sensitisation campaign to combat sexual violence in the camps to which Ivorian refugees fled in the aftermath of the 2010/2011 political violence in Côte d'Ivoire. Representatives from refugee camps and host communities were trained in documenting cases of violations of women's rights and in supporting survivors to report cases of VAWG. They also received training in refugee law, referral pathways to access justice, women's rights, UN Resolution 1820 and relevant national laws protecting women. Refugees learned about different forms of violence and how to report violations using referral pathways. As a result, 10 to 15 cases of VAWG were reported every day, compared to just three to four cases prior to the refugee influx. Action was also taken against aid workers who were found guilty of sexual abuse and exploitation of refugees.

Humanitarian actors that do not provide specialised frontline VAWG services themselves also have important roles to play to protect women and girls. It is important that they are part of a referral mechanism or partner with organisations who can provide the required services.

Model of referral for support services

Oxfam has adopted a gender approach across their protection programme in the DRC. Protection committees are central to the programme, and as of mid-2012 56 committees had been set up. They respond to emergency needs in their communities but also link humanitarian needs to longer-term development. An important aim of the protection programme is to help people affected by violence and abuse to access information and support services. As Oxfam does not provide specialist services, it has developed a model for 'self-referral' to ensure that the communities it works with can access services from

other providers. This is based on the proactive dissemination of information to promote 'informed self-referral.' This model is currently being developed through two pilot projects in DRC and Yemen.

In acute emergency response, assessments that use women-only focus group discussions can help ensure that women and girls are informing interventions and how and where service provision is targeted. Oxfam's protection programme in the DRC introduced women's forums as a parallel structure to protection committees. Women's forums are made up of women who are members of existing associations or groups. The aim has been to provide a space which is more accessible and open to women. It is a space where women can talk freely among themselves, and engage with humanitarian actors regarding their needs.

4) Safe spaces for women and girls

Evidence suggests that the establishment of women- and/or girl-only spaces help to reduce risks and prevent further harm during acute emergency responses.⁵⁷ These spaces, whether formal or informal, provide women and girls with a safe entry point for services and a place to access information. Safe gathering points also offer women and girls an opportunity to engage with each other, exchange information, and begin rebuilding community networks and support. In this way, safe spaces can be a key way of building women and girls' social assets.

Safe spaces in Haiti

In 2010, in post-earthquake Haiti, the Haiti Adolescent Girls Network created a programme called 'Espace Pa Mwen' ('My Space') to provide adolescent girls with a safe space where they could spend a few hours a week meeting peers, learning and playing.⁵⁸ Mentors connected girls to services, helped them to negotiate family situations, and to navigate school settings and unsafe communities.

Establishing safe spaces means managing complex and context specific risks. Approaches to safe spaces should be organised and managed in consultation with communities. In some situations, a formal "women's centre" established by an international organisation may be the most accessible and appropriate. However, this should not be a default in every context. Safe spaces may also be less formal, within the community or educational spaces and linked to women's leaders and/or networks, for example.

5) Material and/or cash-based assistance to meet women and girls' basic needs

In many cases, humanitarian agencies can improve women and girls' immediate safety and security by providing assistance to meet their basic needs. The distribution of material-based assistance is both a protection strategy and an effective way to meet women's basic needs in the early days of an emergency. Organisations can distribute "dignity" kits to women to meet women's sanitary needs, help restore dignity, promote basic hygiene and health, and help with women's protection needs, including VAWG. These kits typically contain sanitary materials, soap, a bathing bucket and clean underwear, but can also contain torches and whistles for drawing attention to protection issues. In addition, access to sanitary materials allows women and girls to resume daily activities outside the home, such as collecting water and food or attending school.

Emergency programmes may also distribute items aimed at improving women and girls' safety in camp settings, such as solar lamps and fuel-efficient stoves. These actions should always be carried out in consultation with the affected community, particularly with women and girls. Humanitarian actors should always monitor how distributions of any kind impact the safety and security of women and girls so that negative consequences can be quickly mitigated.

Case study 5: Addressing violence against girls in North Cameroon

Plan implemented a programme to protect adolescent girls from VAWG in the north of Cameroon following the floods in August and September 2012. The programme design was based on an assessment that used a participatory approach including focus groups with men, women, adolescent boys, married adolescent girls and unmarried adolescent girls, and consultations with State and non-State actors (including teachers, community leaders, midwives and nurses). This led to the design of a programme that focused on two main outputs. First, a focus on child marriage and education for girls, in order to mitigate against the expected upsurge of child marriage (as a result of the economic strain from the disaster). Plan provided material based assistance such as conditional cash transfers to households with young girls vulnerable to early marriage or forced prostitution, and a school feeding programme to encourage girls' attendance at school. Secondly, there is a focus on child protection, particularly on girls to protect them from all forms of abuse. These child protection activities focus on keeping girls in education as a protective space within emergencies, as well as community discussions on preventing harmful traditional practices.

An interim outcome evaluation shows that in Kai Kai area (northern Cameroon) the percentage of girls and boys attending primary school is currently 41% girls / 59% boys compared to overall country levels of 38% girls / 62% boys. Plan is the only organisation currently working in Kai Kai and attributes this change to the preference given to girls for distribution of school kits. There have also been changes in awareness of VAWG due to educational sessions targeting adolescent girls and their parents. In Kai Kai and Lagdo, advocacy with local authorities aimed at traditional leaders, parents and school teachers has led to more community discussion and awareness around broader harmful practices such as child trafficking, child marriage and FGM/C.

6) Reduce the immediate risks to women and girls whilst laying the groundwork for a safe and supportive environment in which VAWG is not tolerated

Programmes in emergencies should seek to reduce immediate risks to women and girls. Due to the rapidly changing nature of many emergency settings, the use of regular safety audits can help humanitarian actors monitor and highlight risks to women and girls. Immediate safety and security risks can often be addressed through multi-sectoral action such as:

- The organisation of firewood patrols to ensure safe access to cooking fuel and water. In Darfur, Sudan, UNFPA-supported sexual violence committees worked with the African Union Civil Police to arrange escorts for women and girls during firewood collection, decreasing their risk to exposure of violence.⁵⁹
- The establishment of appropriate lighting in public places;
- Work with water and sanitation actors to ensure locks on latrines and safe placement of water sources.

Many cases of VAWG can also be prevented if there is safe planning of sites where displaced populations live and if shelters are safe and meet internationally agreed-upon standards. Provision of appropriate and safe shelter is an important means of strengthening protection. For example, an assessment conducted in three settlements in Bassaso, Somalia, included women-only focus group discussions. This assessment revealed that women preferred corrugated galvanised iron shelters (despite the heat these would generate in the summer) due to the increased risk of sexual violence associated with the use of tents.⁶⁰

5. MEASURING RESULTS IN VAWG PROGRAMING

In acute emergency response, VAWG indicators should focus largely on:

- the reach, accessibility and quality of services for survivors, and
- the integration of actions that reduce risks to women and girls early in programme design and implementation.

This can be built on in protracted or transitional settings where further outcomes and impacts can be considered.

Valuable information – such as information on service coverage and utilisation – can be collected directly from service providers and programme implementers during the acute response phase. Examples of information that can be gathered from secondary sources include:

- The number of women (as a percentage of the affected population) accessing humanitarian assistance or reporting to VAWG service providers within a referral system. Increased numbers is not necessarily an indication of increases in VAWG but is an indicator of women and girls' perceptions of safety in how aid and services are delivered.
- Whether health clinics have adequate stock of post-exposure prophylaxis and whether health staff are trained in the clinical management of rape. This can point to the readiness of health actors to respond to survivors' lifesaving needs.
- The quality of case management services can be gauged early on by ensuring that there is regular case supervision and that case managers are demonstrating basic skills and knowledge.

The following table offers a selection of sample indicators linked to key VAWG emergency response outcomes.

Outcome	Sample Indicators
Survivors of VAWG have safe access to health services, in line with guidelines for the clinical management of rape	<ul style="list-style-type: none"> ▪ Stocks of appropriate equipment and medicine, including post-rape kits, in health facilities ▪ Percentage of sexual assault survivors who report within 120 hours that receive EC and HIV PEP, as appropriate ▪ Number of medical and non-medical health facility staff trained in and using the GBV guiding principles for supporting a survivor and safe referrals ▪ Weekly support and mentoring meetings held with health facility GBV focal points
Survivors of VAWG have safe access to basic, quality case management services	<ul style="list-style-type: none"> ▪ A basic case management system is established and functional, with client intake and consent forms that are accurately used and safely stored ▪ Percentage of survivors able to access case management services, including referral in line with their needs and wishes ▪ Weekly supervision meetings held to discuss challenging cases, review quality of case management services, and provide opportunities for debriefing
Survivors of VAWG have safe access to psychosocial services and community-based support networks	<ul style="list-style-type: none"> ▪ Number of women and girls actively attending safe space activities and/or seeking information and support within these spaces ▪ Number of women-led psychosocial, skill-building or life skills activities through safe spaces or other informal structures ▪ Number of women/girls participating in activities that can identify three or more other women/girls that they can turn to for support
Communities know which VAWG-related services are available and how to access them	<ul style="list-style-type: none"> ▪ Number of participants in community outreach sessions that can answer two debriefing questions about VAWG services available ▪ Number of survivors reporting to community outreach workers who are safely referred to additional services ▪ In community consultation held in each target community, at least 50% of participants are able to identify where survivors of VAWG

	can go to access services
Service provision is coordinated among service providers and VAWG focal points	<ul style="list-style-type: none"> ▪ Service mapping completed and shared with GBV working group and other relevant actors/service providers ▪ Referral network and protocol documented ▪ Number of case conference meetings held to review appropriate responses to cases in conjunction with other relevant service providers
Other sectors identify factors that increase risks to women and girls, and develop strategies to address them	<ul style="list-style-type: none"> ▪ At least one safety audit completed per target area, on minimum bi-weekly basis ▪ Other sectors take at least two actions based on recommendations from safety audits ▪ Number of women and girls of reproductive age receiving risk mitigation material support ▪ Recipients of cash or vouchers report increased safe access to food and other basic necessities for themselves and their families

6. SUMMARY OF KEY CONSIDERATIONS THAT SHOULD INFORM ALL EMERGENCY RESPONSES

Emergencies mean that women and girls are at greater risk of VAWG. Although VAWG exists across the world and in a range of contexts, the causes and consequences of VAWG are often exacerbated in emergency contexts. VAWG is rooted in gender inequality; and displacement and destruction affect women and girls differently, putting them at risk of physical, psychological and sexual violence from armed groups, from strangers, from neighbours and from family members. The threats that women and girls face during crises are compounded by the weakening or destruction of systems and structures that normally might play a protective role (such as families and communities, law enforcement, community norms or religious codes),⁶¹ as well as inadequate facilities, support services and resources.

Action to prevent and respond to VAWG must be immediate regardless of the presence or absence of concrete and reliable evidence. The very nature of emergency situations means that it can be difficult to collect high quality data, particularly on the scale of VAWG. Prevalence or incidence surveys are not feasible in emergencies where displacement, a breakdown of systems, and safety and security issues prevent the collection of rigorous population wide data on VAWG. Fear of retribution, punishment, shame, disruption to community and family support, instability, break down and lack of confidence in law and social services all contribute to women under-reporting VAWG.⁶² However, there is good evidence that in both conflict-related and natural disasters there is likely to be an increase in VAWG and it is therefore important to establish relevant services quickly. Unless there are services available (health, counselling, safe spaces), women are unlikely to disclose that they have experienced violence. International guidelines have established that all humanitarian personnel should assume that VAWG is taking place and that it is a serious and life-threatening protection issue. Even in the absence of concrete evidence, action should be taken from the earliest stage of an emergency to prevent VAWG and provide appropriate assistance to survivors.⁶³ As the response scales up and/or becomes more protracted, it is important to invest in high quality data to ensure that resources are being targeted appropriately and to monitor the impact of VAWG interventions.

All forms of VAWG in emergencies should be considered and addressed – not just conflict-related sexual violence. While sexual violence may often be the most immediate and widely recognised type of VAWG in emergencies, all forms of VAWG are exacerbated, including intimate partner violence,⁶⁴ trafficking, early and forced marriage, sexual harassment, female genital mutilation (FGM) and other harmful traditional practices, sexual exploitation and forced prostitution. For example, living in overcrowded spaces with increased stresses associated with crisis can lead to increased intimate partner violence,

and early or forced marriage may be used as a protection mechanism or a measure to address economic hardship.

All data gathering should be informed by ‘do no harm’ principles which recognise the sensitive nature of VAWG and the potentially life-threatening and traumatic nature of the issues involved:

- Programmes must be grounded in appropriate and safe information collection. In the acute phase this may include safety audits,⁶⁵ service mapping, focus group discussions or other rapid assessment tools.
- Women and girls should inform programming – meaningful consultation is essential to a ‘do no harm’ approach. To fully address the safety and security concerns of women and girls in emergencies, they must participate in planning prevention, protection and assistance activities. A ‘do no harm’ approach requires systematically assessing and mitigating the potential risks or unintended consequences that programming activities can have for women and girls. Programmes that are not planned in consultation with women and girls, nor implemented with their participation, increase the risks they face.
- Programmes must recognise the primacy of survivor safety and security by upholding the rights, dignity and choices of the survivor, protecting confidentiality and ensuring informed consent.

ANNEX 1: An overview of useful guidelines for addressing VAWG in emergencies

KEY GUIDELINES

The Inter-Agency Standing Committee *Guidelines for GBV Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, September 2005

These guidelines were developed to enable humanitarian actors and communities to plan, establish, and coordinate a set of minimum multi-sectoral interventions to prevent and respond to sexual violence during the early phase of an emergency. This includes standards for other sectors – health, protection, WASH, food security/nutrition, shelter, NFIs. When this standard was developed, the humanitarian community was focused almost entirely on rape in conflict. However, we now know that intimate partner violence, forced marriage, trafficking, sexual exploitation and other forms of VAWG are also having a devastating impact on women and girls in crisis situations. These guidelines are currently being revised (to be published at the end of 2013) and will take into account a range of forms of VAWG. Available at: <http://www.unhcr.org/refworld/docid/439474c74.html>.

World Health Organisation, *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, 2007

These guidelines outline eight essential recommendations to guide any information-gathering exercise related to sexual violence in emergencies. Available at: http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

World Health Organisation, *Clinical Management of Rape Survivors*, June 2004

This guide describes best practices for the clinical management of rape survivors in emergencies. It is intended for use by qualified health-care providers in developing response protocols, planning health-care services and training health-care providers. Available at: http://www.who.int/hac/network/interagency/news/manual_rape_survivors/en/

Gender-based Violence Area of Responsibility Working Group, *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*, July 2010

This handbook provides practical guidance on leadership roles, key responsibilities and specific actions to be taken when establishing and maintaining a GBV coordination mechanism in an emergency. It is designed to be used by individuals and agencies involved in GBV coordination activities in humanitarian emergencies, from the community level to the national and international levels. Available at: <http://gbvaor.net/wp-content/uploads/2012/10/Handbook-for-Coordinating-Gender-based-Violence-in-Humanitarian-Settings-GBV-AoR-2010-ENGLISH.pdf>

Inter-agency Working Group (IAWG) on Reproductive Health in Crises, *The Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations*, revised February 2011

This is a priority set of life-saving activities to be implemented at the onset of every humanitarian crisis. The MISP minimum standards for treatment and care must be implemented in a coordinated manner by appropriately trained staff at the beginning of a crisis. The MISP prevents excess maternal and neonatal mortality and morbidity, reduces HIV transmission, prevents and manages the consequences of sexual violence, and includes planning for the provision of comprehensive reproductive health services. Available at: <http://www.iawg.net/resources/MISP2011.pdf> (includes a distance learning module). A fact sheet is also available: http://womensrefugeecommission.org/resources/doc_download/163-fs-misp

OTHER USEFUL GUIDELINES

World Health Organisation, *Mental Health in Emergencies*, 2003

Available at: http://www.who.int/mental_health/media/en/640.pdf

IASC Handbook for Gender equality in Humanitarian Action, Women, Girls Boys & Men Different Needs – Equal Opportunities, December 2006

Available at: http://www.who.int/hac/network/interagency/news/gender_handbook_draft/en/

UN High Commissioner for Refugees, *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response*, May 2003

Available at: <http://www.unhcr.org/refworld/docid/3edcd0661.html>

UN High Commissioner for Refugees, *Action against Sexual and Gender-Based Violence: An Updated Strategy*, June 2011

Available at: <http://www.refworld.org/docid/4e01ffeb2.html>

The Inter-Agency Standing Committee, *IASC Gender Marker*, 2009

A fact sheet is available at: www.humanitarianinfo.org/iasc/downloadaddoc.aspx?docId=5135.

Various resources on the application of the gender marker are also available at:

<http://www.humanitarianresponse.info/themes/gender/the-iasc-gender-marker>

The Sphere Project, *Sphere Humanitarian Charter and Minimum Standards in Disaster Response*, 2011

This Charter acknowledges the different needs and priorities of women and girls in emergency situations and provides guidance on measures to ensure disaster response is gender-responsive. This includes recognition that women and girls can at particular risk of gender-based violence (see page 40). The MISP is also a standard in the 2011 revision of the Charter. Available at:

<http://www.sphereproject.org/resources/?search=1&keywords=&language=English&category=22&subcat-22=23&subcat-29=0&subcat-31=0&subcat-35=0&subcat-49=0>

IRC & UNICEF *Caring for Child Survivors of Sexual Abuse*, 2012

Available at:

http://www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf

International Rescue Committee, *GBV Emergency Response & Preparedness: Participant Handbook*, 2013

Available at: <http://www.gbvresponders.org/emergency-toolkit#GBV>

UNHCR Handbook for the Protection of Women and Girls, June 2006

Available at:

http://www.un.org/en/pseataforce/docs/unhcr_handbook_for_the_protection_of_women_and_girls.pdf

IASC Cluster Working Group on Early Recovery *Guide to Gender-Aware Post-Disaster Needs Assessment*, 2010.

Available at:

http://oneresponse.info/GlobalClusters/Early%20Recovery/publicdocuments/CWGER_Guide_GenderAware_PostDisaster_NeedsAssessment.pdf.

WHO *Mental Health and Psychosocial Support for Conflict-Related Sexual Violence: Principles and Interventions*, 2012

Available at:

http://apps.who.int/iris/bitstream/10665/75179/1/WHO_RHR_HRP_12.18_eng.pdf

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings 2007

Available at: www.who.int/mental_health/emergencies/IASC_guidelines.pdf.

IASC Cluster Working Group on Early Recovery. Key Things Emergency Response Actors Need to Know About Gender, 2007

Available at:

<http://onerresponse.info/GlobalClusters/Early%20Recovery/Pages/Tools%20and%20Guidance.aspx>

Interagency Network for Education in Emergencies (INEE) Gender Task Team. Preventing and Responding to Gender Based Violence In and Through Education 2006

Available at:

http://ineesite.org/toolkit/INEEcms/uploads/1113/Preventing_and_Responding_to_GBV.pdf.

The International Rescue Committee Clinical Care for Sexual Assault Survivors, 2009.

Available at: <http://clinicalcare.rhrc.org/>

Save the Children & UNFPA Adolescent sexual and reproductive health toolkit for humanitarian settings: Companion to the Interagency Field manual on reproductive health in humanitarian settings, 2009

Available at:

http://unfpa.org/webdav/site/global/shared/documents/publications/2009/UNFPA_ASRHtoolkit_english.pdf

Other useful links:

GBV Area of Responsibility: <http://gbvaor.net>

IRC-hosted GBV Responders' Network: <http://gbvresponders.org/>

GBV Prevention Network Thematic Working Group on VAW in Emergencies:

<http://www.preventgbvafrica.org/gbv-emergencies>

Gender and Disaster Network: <http://www.qdnonline.org/>

GBV Information Management System: <http://gbvims.org/>

UNFPA, Managing Gender-Based Programmes in Emergencies E-learning Course, 2012:

<https://extranet.unfpa.org/Apps/GBVinEmergencies/index.html>

Virtual Knowledge Centre to End Violence against Women and Girls (upcoming module on conflict / post-conflict):

<http://www.endvawnow.org/>

Women's Refugee Commission: <http://womensrefugeecommission.org/>

Reproductive Health Response in Crises (RHRC) Consortium: <http://www.rhrc.org/>

Women's Refugee Commission E-Learning Portal:

<http://www.womensrefugeecommission.org/elearning/preview/1-iasc-task-force-safe>.

The Coalition for Adolescent Girls: <http://coalitionforadolescentgirls.org/>

Women's Refugee Commission. 2006 (revised 2011). *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning*

Module <http://misp.rhrc.org/>

UNHCR, UNFPA, WHO *Clinical Management of Rape e-Learning Programme* 2010.
<http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/>

Inter-Agency Standing Committee, *Caring for Survivors Training Pack*, 2010
<http://onerresponse.info/GlobalClusters/Protection/GBV/Pages/default.aspx>

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¹ L. Blanchfield et. al (2010), *International Violence Against Women: U.S. Response and Policy Issues*, 26 July 2011, available at: <http://www.fas.org/sgp/crs/misc/RL34438.pdf>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67582/strategic-vision-girls-women.pdf

³ [http://www.stabilisationunit.gov.uk/attachments/article/523/uk_nap_on_unscr_1325_hmg_2010\[1\].pdf](http://www.stabilisationunit.gov.uk/attachments/article/523/uk_nap_on_unscr_1325_hmg_2010[1].pdf)

⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67489/hum-emer-resp-rev-uk-gvmt-resp.pdf

⁵ The Responsibility to Protect: <http://www.un.org/en/preventgenocide/adviser/responsibility.shtml>

⁶ See for example, UN Security Council Resolution 1820 (2008) 1888 (2009) and 1960 (2010); Secretary General (2013) *Report of the Secretary General on Sexual Violence in Conflict*, A/67/792–S/2013/149, 14 March 2013.

⁷ This refers to VAWG that is not systematic or used for a specific purpose, but rather takes advantage of the situation of conflict and societal upheaval. For example, women and girls who have fled to a refugee camp during conflict may be more likely to experience opportunistic violence because they lack shelter and protection, and are no longer surrounded by family and community.

⁸ Gender-based Violence Area of Responsibility Working Group (July 2010) *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings* available at: <http://gbvaor.net/wp-content/uploads/2012/10/Handbook-for-Coordinating-Gender-based-Violence-in-Humanitarian-Settings-GBV-AoR-2010-ENGLISH.pdf>

⁹ All facts cited from UN OCHA (2005), *Broken bodies, broken dreams: Violence against women exposed*, available at: http://www.peacewomen.org/portal_resources_resource.php?id=455

¹⁰ A survey published by AVEGA AGOHOZO in December 1999 reveals that 374 of a total 951 (39%) female respondents had directly experienced sexual violence. A total of 838 out of 1,125 (74%) said they knew that sex violence had occurred during the genocide.

¹¹ Physicians for Human Rights, *War-related Sexual Violence in Sierra Leone: A Population-based Assessment*, p. 3–4

¹² K. Johnson et al (2010). 'Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo' *JAMA*, August 4, 2010, Vol 304, No. 5. (NB: Please note that this is likely to be a conservative estimate of women who have experienced VAWG)

¹³ World Health Organisation (2005), Department of Injuries and Violence Prevention, *Violence and Disasters*, available at: http://www.who.int/violence_injury_prevention/publications/violence/violence_disasters.pdf.

¹⁴ ActionAid (2007), *Violence against Women in the Post-Tsunami Context*, available at:

<http://www.actionaid.org/publications/violence-against-women-post-tsunami-context>

¹⁵ IRC (2012) *Lifesaving, not optional: Protecting women and girls from violence in emergencies* see <http://www.rescue-uk.org/ditchley2012>.

¹⁶ Ibid.

¹⁷ Plan (2013) *Because I am a Girl. The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters*. Available at:

<http://plan-international.org/girls/reports-and-publications/the-state-of-the-worlds-girls-2013.php?lang=en>

¹⁸ Plan (2011) *Weathering The Storm: Adolescent girls and climate change*, Plan International, available at: www.planuk.org/resources/documents/35316/

¹⁹ World Vision UK (2013), *Untying the Knot: Exploring Early Marriage in Fragile States*, March 2013, available at: http://wvi.org/sites/default/files/UNTYING_THE_KNOT_-_March_2013.pdf

²⁰ Plan international (2012), *Cameroon report and programme design field visit to Far North and North*, September 2012

²¹ A. Siddiqi (2012), *Missing the Emergency: Shifting the Paradigm for Relief to Adolescent Girls*, *The Coalition for Adolescent Girls*, May 2012, available at: <http://www.coalitionforadolescentgirls.org/wp-content/uploads/2012/05/2012-05-23-Missing-the-Emergency-FINAL1.pdf>

²² IRIN (2012), 'Conflict Pushes Syrian Refugees to Marry Off Daughters' 23rd July 2012, available at: www.crin.org/resources/infodetail.asp?id=29084

²³ International Organisation for Migration (2009), *Supporting the Abandonment of Female Genital Mutilation in the Context of Migration*, available at:

http://www.iom.int/jahia/webdav/shared/shared/mainsite/projects/documents/fgm_infosheet.pdf

²⁴ http://www.europarl.europa.eu/meetdocs/2009_2014/documents/droi/dv/201/201102/20110228_510eustudy_en.pdf and http://www.idsn.org/fileadmin/user_folder/pdf/New_files/India/2012/IDSN-EU_study_on_CBD_in_humanitarian_response_by_NDW.pdf

- ²⁵ L. Macqueen Paul (2011), *Addressing caste discrimination in Humanitarian Response*, National Dalit Watch, November 2011.
- ²⁶ Plan (2013) *Because I am a Girl. The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters*. Available at: <http://plan-international.org/girls/reports-and-publications/the-state-of-the-worlds-girls-2013.php?lang=en>
- ²⁷ For more information on the GBV IMS please see <http://www.gbvims.org/what-is-gbvims/>
- ²⁸ In 2010, UNHCR estimated that the overall population in the Dadaab camps was at 276,599 persons. In October 2011, it has risen to 525,000 refugees. See <http://www.hapinternational.org/projects/field/hap-in-dadaab.aspx>
- ²⁹ Inter-Agency Gender Working Group (2010), *Gender-Based Violence: Impediment to Reproductive Health*, available at: http://www.igwg.org/igwg_media/gbv-impediment-to-RH.pdf.
- ³⁰ For example in Haiti in July 2010, Plan carried out an adolescent sexual and reproductive health assessment mission where key informant interviews with the Ministry of Health, Profamil (IPPF clinic) and L'hôpital Saint Michel in Jacmel all reported a dramatic increase in adolescent pregnancies since the earthquake
- ³¹ See <http://web.unfpa.org/mothers/facts.htm>
- ³² Save the Children (2013), *Unspeakable crimes against children: Sexual violence in conflict*, available at: <http://www.savethechildren.org.uk/resources/online-library/unspeakable-crimes-against-children>
- ³³ United Nations Standing Committee on nutrition (2010), *6th report on the State of World Nutrition*, Nov 2010 <http://www.unscn.org/files/Publications/RWNS6/report/chapter3.pdf>
- ³⁴ WHO and PATH (2005), *Researching Violence against Women: A Practical Guide for researchers and activists*, p.21
- ³⁵ K. Johnson, et al. (2010) "Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo," *Journal of the American Medical Association*, August 4, 2010, Vol. 304, No. 5.
- ³⁶ K. Johnson et al (2008). "Association of combatant status and sexual violence with health and mental health outcomes in post conflict Liberia," *Journal of the American Medical Association*, 2008; Vol. 300, No. 6, pp.676-690.
- ³⁷ K.A. Chivers-Wilson (2006), "Sexual assault and posttraumatic stress disorder: A review of the biological, psychological and sociological factors and treatments," *McGill Journal of Medicine*, July 2006, Vol. 9 (2), pp.111-118.
- ³⁸ For further information on issues with population-based methods to collect data on VAWG in conflict please see F. Roth et al. *Using Quantitative Data to Assess Conflict-Related Sexual Violence in Colombia: Challenges and opportunities* (2011), available at https://hrdag.org/content/colombia/SV-report_2011-04-26.pdf
- ³⁹ F. Roth et al. (2011) *Using Quantitative Data to Assess Conflict-Related Sexual Violence in Colombia: Challenges and opportunities*, available at https://hrdag.org/content/colombia/SV-report_2011-04-26.pdf
- ⁴⁰ World Health Organisation (2007), *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, available at: http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf
- ⁴¹ See http://www.surrey.ac.uk/mediacentre/press/2009/16532_between_7090_rapes_thought_to_go_unreported_and_94_of_reported_cases_dont_end_in_a_conviction.htm
- ⁴² DFID (2013) *Violence Against Women and Girls Research and Innovation Fund. Terms of Reference for Component 2: Violence Against Women and Girls in Conflict and Humanitarian Emergencies*, 1st May 2013 p.4
- ⁴³ Plan (2013) *Because I am a Girl. The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters*. Available at: <http://plan-international.org/girls/reports-and-publications/the-state-of-the-worlds-girls-2013.php?lang=en>
- ⁴⁴ In 2013, the IRC developed detailed guidelines for case management that outline the core elements of the treatment model and how this model is adapted to meet the needs of VAWG survivors, according to age, developmental stage, and type of violence experienced. These guidelines are based on the evidence base for effective care and treatment for survivors of rape, domestic violence and other forms of trauma in the United States. For more information on these guidelines please contact the IRC. For some information on case management see <http://www.gbvresponders.org/emergency-toolkit#GBV>
- ⁴⁵ In 2013, the IRC finalized an evidence-based, field-test primary prevention intervention and resource package for engaging men through accountable practice that provides a roadmap for facilitating individual behaviour change with men in conflict-affected settings, guided by the voices and leadership of women.
- ⁴⁶ Other AoR's include Child Protection; Mine Action; Housing, Land and Property
- ⁴⁷ Consultation approaches should always be in line with international guidelines and should be designed in collaboration with VAWG experts.
- ⁴⁸ D. Mazurana et al (2011), *Sex and Age Matter: Improving Humanitarian Response in Emergencies*, Feinstein International Center, Tufts University. Available at: <http://sites.tufts.edu/feinstein/2011/sex-and-age-matter>
- ⁴⁹ Overseas Development Institute Humanitarian Practice Network (2007), *Contingency Planning and Humanitarian Action: A review of practice*
- ⁵⁰ International Rescue Committee (March 2013) *Promising Practices in GBV Emergency Response & Preparedness: Field-based learning in Haiti and the Democratic Republic of Congo*
- ⁵¹ World Health Organisation (2004), *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons*.
- ⁵² Marie Stopes International, (March 2013) *RAISE Overview*.
- ⁵³ <http://www.raiseinitiative.org>

⁵⁴ Psychosocial refers to the dynamic relationship between psychological and social effects of a traumatic event or violence on an individual. Both the psychological and social effects of emergencies continually influence each other. Humanitarian agencies have come to prefer the term psychosocial well being over narrower concepts such as mental health, as 'psychosocial' points explicitly to social and cultural influences, as well as psychological influences, on well-being.

⁵⁵ For more information on case management please see the IRC's GBV emergency and response handbook <http://www.gbvresponders.org/emergency-toolkit#GBV>

⁵⁶ International Rescue Committee (2011), *GBV Emergency Response & Preparedness: Participant Handbook*

⁵⁷ O. Robles, M. Greene (2013) Safe Spaces for Adolescent Girls in Humanitarian Settings: Issues, review of the evidence, and programming framework, Internal paper prepared for DFID by GirlHub.

⁵⁸ A. Siddiqi (2012), *Missing the Emergency: Shifting the Paradigm for Relief to Adolescent Girls, The Coalition for Adolescent Girls*, May 2012, available at: <http://www.coalitionforadolescentgirls.org/wp-content/uploads/2012/05/2012-05-23-Missing-the-Emergency-FINAL1.pdf>

⁵⁹ See <http://www.unfpa.org/emergencies/violence.htm>

⁶⁰ Inter-Agency Standing Committee GenCap Adviser, with the Emergency Shelter and NFI Cluster, *Transitional Shelter Assessment: Phase 1 report* Bossaso (14-17 April 2011), Emergency Shelter and NFI Cluster

⁶¹ Inter-Agency Standing Committee (2007), *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*; UNHCR, *Women: Particular Challenges and Risks*,

⁶² DFID *Violence Against Women and Girls Research and Innovation Fund. Terms of Reference for Component 2: Violence Against Women and Girls in Conflict and Humanitarian Emergencies* 1st May 2013 p.4

⁶³ Inter-Agency Standing Committee (2005), *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*; The Sphere Project (2011), *Sphere Humanitarian Charter and Minimum Standards in Disaster Response*; see also guidelines set out in Annex 1.

⁶⁴ Intimate Partner Violence is behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by both current and former spouses and partners.

⁶⁵ A safety audit, as referenced here, is an observation-based tool used to identify areas in a community that may be less or more safe, or less or more accessible, for women and girls. A safety audit can be quickly and easily carried out by field teams on visits to camps, host communities, urban displaced settings, or other key areas of concern, and may be used on a weekly or monthly basis to help monitor changes and highlight concerns in a humanitarian context. Results of safety audits are shared with other sectors and actors so that problems related to safety and access can be addressed. Examples of safety audits can be found here:

<http://www.gbvresponders.org/emergency-toolkit#ER>