Promising Practices in GBV Emergency Response & Preparedness

Field-Based Learning in Haiti and the Democratic Republic of Congo

May 2013

This document was developed with the support of USAID's Office of U.S. Foreign Disaster Assistance
Introduction

The International Rescue Committee (IRC) works toward a world in which women and girls are free from violence, and are valued, equal members of their communities. With this vision in mind, IRC’s Women’s Protection and Empowerment (WPE) Unit has invested in emergency response and preparedness over the past 15 years, seeking to ensure that women and girls have access to lifesaving services during and after emergencies. The IRC developed an evidence-based program model (see page 4) and technical resource package, and has trained and mentored field-based practitioners as they respond in acute emergencies. From 2011-2012, support from the United States Office of U.S. Foreign Disaster Assistance (OFDA) allowed the IRC to roll out this model for strengthening emergency preparedness and response at a local level in two unique contexts affected by cyclical crisis – North Kivu, Democratic Republic of Congo (DRC), and Haiti. The IRC trained 43 GBV field-based practitioners during the project period, and supported these first responders as they applied new skills and knowledge in the field.1 The IRC’s trained field teams also carried out further training for 275 staff from state and non-governmental partners and sister organizations.

The IRC’s experience through this project brought to light how that even in contexts in which GBV programs exist, teams are not often equipped to react, adapt their approaches and launch response to new emergencies. Teams working in North Kivu and Haiti required investment in GBV-specific emergency preparedness and capacity building in order to put in place effective response to emerging crises. When preparedness efforts engaged operations teams and local partners, included the prepositioning of GBV supplies and equipment, and involved internal and external advocacy – after these steps, the IRC and its partners observed a meaningful impact in how quickly they could meet the lifesaving needs of women and girls.

This paper, based on qualitative in-depth interviews and an after-action review workshop,2 is organized into the following key areas of analysis and learning:

- Preparedness
- Deployment and direct response
- Working with other actors

The fact that the IRC was able to focus time and resources in these areas, as they are specific to GBV, was unique. The promising practice this paper seeks to highlight is the importance of this investment and organizational commitment to GBV emergency preparedness, with the ultimate goal of ensuring that survivors access life-saving services and are protected from further harm during crises.

A Note on Context

By focusing learning in contexts affected by human-made and natural disasters – North Kivu and Haiti – the IRC aimed to generate lessons applicable to a range of emergency contexts. Events in each country shaped how trained GBV first responders were able to prioritize emergency preparedness and deploy for emergency response over the course of the project.

In North Kivu, ongoing conflict and security concerns presented significant challenges. Despite this, over a period when security rapidly deteriorated, the IRC carried out 15 GBV-specific emergency assessments, seven direct responses and nine training and follow-up missions.3 (Direct responses involved the deployment of GBV psychosocial and health staff to provide crisis counseling and ensure health services during the week immediately following an upsurge of violence or displacement in North Kivu. Training and

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1 Of those trained, 15 were IRC staff and 27 were the staff of local partners and one was a government actor. All training participants had an existing foundation and experience in GBV concepts and programming.

2 The after-action review workshop was designed to provide field teams with an opportunity to reflect on challenges and ways to improve future in-country GBV emergency responses. The AAR, held in North Kivu, was facilitated by the IRC WPE technical advisor in DRC, in cooperation with a representative from the WPE Technical Unit in New York. Seven IRC field staff and eight IRC partner staff participated in the workshop; five of these individuals only participated in specific sessions focused on partners.

3 The humanitarian crisis in North Kivu intensified in the second half of 2012 as fighting escalated between the Congolese government army and rebel groups, including the Movement du 23 mars (M23).
follow-up missions involved the deployment of these same teams to areas where other actors were willing to step in, but requested capacity building and reinforcement during the initial, acute response window.)

In Haiti, where systems and services destroyed or weakened by the 2010 earthquake in Port-au-Prince have not yet been fully rebuilt, the IRC focused on community-based interventions to reduce risks to women and girls that arise during the tropical storm season. This meant working with local authorities to establish safer temporary displacement sites ahead of large tropical storms, and engaging local communities in discussions and action planning to reduce risks to women and girls during potential upheaval or displacement.

The structure of the IRC program in each country also influenced GBV emergency preparedness and response efforts. The IRC has been an important actor in GBV prevention and response in eastern DRC for more than a decade. As a result of the ongoing conflict, the IRC and its partners have increasingly focused on GBV emergency preparedness and response since 2008. The IRC has also made significant investments in senior GBV technical expertise to ensure the quality of programming.4

The IRC’s WPE program in Haiti was started in response to the country’s 2010 earthquake, at which time activities focused on life-saving emergency response efforts. The WPE program later shifted toward strengthening support systems for adolescent girls, a highly vulnerable population in Haiti, and working with local organizations to spearhead innovative GBV prevention work. It is a young program with a smaller team, GBV emergency preparedness has remained part of the IRC’s work in Haiti due to the annual tropical storm season and periodic political instability.5

The IRC emergency response program model is presented on the following two pages. This model, intended to guide emergency response program design and implementation in acute crises, is based on years of experience in rapid response to GBV during crisis. The model is focused on the first 12 weeks of an emergency – a critical response window, and is when humanitarian actors most often sideline the needs and considerations of women and girls. The IRC program model can be used as a guide in most contexts, but should also be closely examined in light of the specific contextual considerations, analysis of needs, and pre-existing services and actors.

This document also refers to the following annexed resources:

Annex 1 – GBV emergency preparedness: Key actions and commitments (fact sheet)
Annex 2 – GBV emergency response model with sample indicators
Annex 3 – GBV emergency preparedness planning tools (templates)
Annex 4 – GBV emergency assessment toolkit
Annex 5 – Project indicator table from the IRC’s OFDA-supported project, Improving GBV Response, Preparedness & Prevention Capacity in Disaster Situations, October 2011-December 2012

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4 The IRC’s WPE programming in DRC is led by a Director of WPE Programs, a WPE Program Advisor based in Kinshasa, as well as provincial WPE technical coordinators. The team also includes a WPE Monitoring & Evaluation Coordinator.
5 The IRC’s WPE programming in Haiti is led by a WPE technical coordinator.
**GBV EMERGENCY RESPONSE PROGRAM MODEL**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Examples</th>
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<tbody>
<tr>
<td><strong>IMMEDIATE AND CROSS-CUTTING ACTIVITIES</strong></td>
<td></td>
</tr>
<tr>
<td>• Advocate for action based on identified gaps in health services, medicines and commodities, and technical capacity*</td>
<td>Work with health actors to identify and train GBV focal points in all health facilities</td>
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<tr>
<td>• Identify service providers already providing GBV case management services</td>
<td>Establish regular meetings between service providers**</td>
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<tr>
<td>• Train GBV caseworkers in the provision of basic case management, including GBV guiding principles and survivor-centered, age-appropriate approaches</td>
<td>Establish case management system, including appropriate intake and consent forms</td>
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<tr>
<td>• Identify or establish private/confidential spaces for consultation within health centers</td>
<td>Ensure safe, confidential storage of all client information</td>
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<tr>
<td>• Train health facility medical and non-medical staff on GBV guiding principles for supporting a survivor and providing safe referrals</td>
<td>Provide weekly supervision and mentoring to GBV caseworkers</td>
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<tr>
<td>• Identify/establish safe spaces through which survivors can access basic emotional support, accurate information about services and referral from trained staff/volunteers</td>
<td>Provide context-appropriate group activities for women and girls through safe spaces</td>
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<tr>
<td>• Identify women’s groups/networks that can provide survivors basic emotional support and accurate information about services</td>
<td>Provide individual psychosocial support for survivors through trained staff and/or partners***</td>
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<tr>
<td>• Work with communities to understand their perceptions of safe, accessible entry points for services for survivors of GBV****</td>
<td>Train and mentor psychosocial staff and service providers</td>
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<td>• Develop functional, appropriate referral pathways</td>
<td>Establish regular meetings between service providers**</td>
</tr>
<tr>
<td>• Disseminate information on referral pathways among service providers and GBV focal points</td>
<td>Provide other sectors with information related to referral pathways and GBV guiding principles</td>
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<tr>
<td>• Advocate for and participate in inter-sector/cluster coordination on women and girls</td>
<td>Advocate the establishment of GBV working group focal points to attend other key meetings and ensure information exchange</td>
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<tr>
<td>• Lead and/or advocate for the distribution of context-appropriate risk mitigation material support (i.e., dignity kits, solar lamps, etc.)</td>
<td>Advocate for the GBV working group to lead training of all sectors and service providers on IASC GBV Guidelines</td>
</tr>
<tr>
<td>• Lead and/or advocate for actions that reduce risks for women and girls (i.e., firewood patrols, community patrol groups, appropriate lighting in public places, locks on latrines, etc.)</td>
<td>Advocate for establishment of and training on in-country PSEA protocols (including clear reporting protocols) and training for staff carrying out distributions of food and non-food items****</td>
</tr>
<tr>
<td>• Develop clear, targeted recommendations based on assessment and analysis of needs and risks (see Immediate and Cross Cutting Activities, below)</td>
<td>Build inter-agency consensus around advocacy messages and strategies where possible</td>
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<tr>
<td>• Disseminate targeted recommendations to specific audiences, including other sectors/clusters, donors and governments</td>
<td>Establish a policy to reinforce the importance of staff self-care and to provide concrete options for staff support, including regular debriefing for staff involved in service provision to GBV survivors</td>
</tr>
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**IMMEDIATE AND CROSS-CUTTING ACTIVITIES**

- Carry out rapid assessment to identify factors that increase women and girls’ vulnerability to violence, gaps in services, and obstacles to service delivery and survivors’ access to services. Methods may include safety audits, service mapping, focus group discussions, and key informant interviews.
- Develop and put in place safety plans for staff, partners, and volunteers.
- Establish a policy to reinforce the importance of staff self-care and to provide concrete options for staff support, including regular debriefing for staff involved in service provision to GBV survivors.

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**Survivors of GBV have safe access to health services, in line with guidelines for the clinical management of rape**

- Advocates for action based on identified gaps in health services, medicines and commodities, and technical capacity.
- Work with health actors to identify and train GBV focal points in all health facilities.
- Identify service providers already providing GBV case management services.
- Train GBV caseworkers in the provision of basic case management, including GBV guiding principles and survivor-centered, age-appropriate approaches.
- Establish case management system, including appropriate intake and consent forms.
- Train health facility medical and non-medical staff on GBV guiding principles for supporting a survivor and providing safe referrals.
- Identify or establish private/confidential spaces for consultation within health centers.
- Train health facility medical and non-medical staff on GBV guiding principles for supporting a survivor and providing safe referrals.

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**Survivors of GBV have safe access to basic, quality case management services**

- Develop and put in place safety plans for staff, partners, and volunteers.
- Establish a policy to reinforce the importance of staff self-care and to provide concrete options for staff support, including regular debriefing for staff involved in service provision to GBV survivors.
- Identify service providers already providing GBV case management services.
- Train GBV caseworkers in the provision of basic case management, including GBV guiding principles and survivor-centered, age-appropriate approaches.
- Establish case management system, including appropriate intake and consent forms.
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**Survivors of GBV have safe access to psychosocial services and community-based support network**

- Develop and put in place safety plans for staff, partners, and volunteers.
- Establish a policy to reinforce the importance of staff self-care and to provide concrete options for staff support, including regular debriefing for staff involved in service provision to GBV survivors.
- Identify service providers already providing GBV case management services.
- Train GBV caseworkers in the provision of basic case management, including GBV guiding principles and survivor-centered, age-appropriate approaches.
- Establish case management system, including appropriate intake and consent forms.
- Train health facility medical and non-medical staff on GBV guiding principles for supporting a survivor and providing safe referrals.
- Identify or establish private/confidential spaces for consultation within health centers.
- Train health facility medical and non-medical staff on GBV guiding principles for supporting a survivor and providing safe referrals.

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**Communities know which GBV-related services are available and how to access them**

- Develop and put in place safety plans for staff, partners, and volunteers.
- Establish a policy to reinforce the importance of staff self-care and to provide concrete options for staff support, including regular debriefing for staff involved in service provision to GBV survivors.
- Identify service providers already providing GBV case management services.
- Train GBV caseworkers in the provision of basic case management, including GBV guiding principles and survivor-centered, age-appropriate approaches.
- Establish case management system, including appropriate intake and consent forms.
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**Service provision is coordinated among service providers and GBV focal points**

- Develop and put in place safety plans for staff, partners, and volunteers.
- Establish a policy to reinforce the importance of staff self-care and to provide concrete options for staff support, including regular debriefing for staff involved in service provision to GBV survivors.
- Identify service providers already providing GBV case management services.
- Train GBV caseworkers in the provision of basic case management, including GBV guiding principles and survivor-centered, age-appropriate approaches.
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**Decision-makers act to improve protection of women and girls**

- Develop and put in place safety plans for staff, partners, and volunteers.
- Establish a policy to reinforce the importance of staff self-care and to provide concrete options for staff support, including regular debriefing for staff involved in service provision to GBV survivors.
- Identify service providers already providing GBV case management services.
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**Advocacy leads to increased funding and improved policies/systems to protect women and girls**

- Develop and put in place safety plans for staff, partners, and volunteers.
- Establish a policy to reinforce the importance of staff self-care and to provide concrete options for staff support, including regular debriefing for staff involved in service provision to GBV survivors.
- Identify service providers already providing GBV case management services.
- Train GBV caseworkers in the provision of basic case management, including GBV guiding principles and survivor-centered, age-appropriate approaches.
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- Identify or establish private/confidential spaces for consultation within health centers.
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* This includes the presence of health workers trained in the clinical management of rape and provision of appropriate medicines and supplies in health facilities.
** This is often provided as part of the case management process. In an acute emergency response, individual psychosocial support may only be possible during the initial case management meeting with a survivor.
*** This may take place through the use of focus group discussions, community mapping exercises, or other approaches.
**** These meetings are among service providers, to follow up on existing referrals and address challenges specific to referrals and case management. These are separate from GBV working group coordination meetings.
***** For information and support on the Protection from Sexual Exploitation and Abuse by UN and related personnel, see: www.un.org/en/pseataskforce.
Promising Practices in GBV Emergency Response & Preparedness

Each section below explores one area of learning, and links it to practical the experience and reflections of field-based GBV first responders in North Kivu and Haiti.

PREPAREDNESS

What is it? Commitment to GBV emergency preparedness was the cornerstone of the project IRC undertook in North Kivu and Haiti. This means investing time and resources into building the capacity of IRC staff and partners. It also means working with these field-based teams to identify likely emergency scenarios in their contexts, and to develop and take action based on plans that outlined how GBV responders would ensure emergency response materials were pre-positioned, make quick decisions regarding deployment for immediate assessment and response, work with operational support teams to access affected sites with staff and supplies, communicate and work with other actors and coordination leads, and advocate for the prioritization of GBV response at the height of emergency.

It is important to note that while each country program planned and prepared for scenarios specific to their contexts – conflict and displacement in the case of North Kivu, tropical storm season and related displacement in the case of Haiti – the goal of their investment in preparedness was not limited to planning for one, discrete event. It was, rather, a commitment to ensuring that IRC teams and partners would be better equipped to react and respond to the urgent needs of women and girls in contexts that have seen a wide array of cyclical human-made and natural crises. IRC teams in North Kivu and Haiti were able to emphasize skill building and practice, tool development and adaptation, and internal and external relationship-building to facilitate stronger emergency response. In this way, the preparedness undertaken through this project represents a departure from a more traditional understanding of contingency planning for one anticipated event, such as an election.

What did preparedness look like? The IRC’s GBV Emergency Response & Preparedness (ER&P) training, facilitated by members of the IRC WPE Technical Unit, introduced field teams to the approaches and tools that they would use to carry out preparedness planning and GBV-specific emergency response. A total of 318 GBV emergency responders and medical actors were trained in North Kivu, and 47 in Haiti.

This investment in people – the first responders and their support networks – was followed and made effective by a preparedness process that went far beyond the training.

The preparedness plans put in place in North Kivu and Haiti were based on a tool that IRC has also field-tested with

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Text box 1

**Taking action before the crisis:**

**A case for proactive support**

In North Kivu, the IRC mapped and identified gaps in services in areas likely to be impacted by conflict, coordinated with on-site actors, and then took steps to address needs related to capacity and materials.

In one case, the IRC carried out a support mission in a territory targeted for upcoming military operations against local rebels. IRC met local service providers; discussed likely scenarios and needs; provided training on case management, crisis counseling and community outreach; and trained medical personnel on the clinical management of rape.

“The preparedness plans helped us to be everywhere, in new zones... We knew already whom to address when we arrived at new sites,” reflected one IRC staff.

Military operations took place in this area shortly after IRC’s mission. Service providers later reported feeling better equipped to handle the increased caseload of GBV survivors as a result of the preparatory training and support.

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6 The IRC WPE Technical Unit facilitated the initial training in North Kivu for 22 participants. The trained IRC field team then went on to lead additional training for 256 partners and staff in North Kivu, both as part of preparedness and during deployments, as explained further in the section on Deployment & Direct Response. The IRC also trained 40 medical supervisors and nurses in North Kivu on the use and disposal of medical equipment and consumables, as part of a broader training on the clinical care for sexual assault survivors.

7 Training in Haiti included an initial training targeting GBV actors, and a later training targeting medical actors with a focus on their role in supporting GBV emergency response.
country teams and GBV working groups in contexts including South Sudan, Ivory Coast and Kenya. The tool asks field teams to identify actions or tasks that need to take place in the near term in order to ensure emergency response capacity. In the case of North Kivu, this included, for example, purchasing and pre-positioning post-rape kits and client intake and consent forms, and establishing communication protocols for staying in touch with and supporting local partners during a deteriorating security situation. In Haiti, the preparedness plan focused on outreach with women’s groups and local authorities to inform how information would be delivered to women and girls during crisis and how temporary shelters were being structured in advance of tropical storms.

As part of the preparedness plan process, IRC teams in North Kivu and Haiti also examined likely scenarios that would impact where they would need to respond in emergency, and what the scale of need would be. In North Kivu this led pre-positioning of materials in likely affected areas as well as a preemptive support mission to an area where military operations were expected in the near future (see text box 1).8

In North Kivu, the IRC also created local, specialized response teams responsible for conducting GBV assessments and leading emergency response. Each team included a supervisor responsible for assessing needs in their respective technical fields – one generalist health supervisor, one GBV health supervisor, one psychosocial supervisor and one community education supervisor. These teams are trained and experienced in using IRC’s GBV emergency response program model to guide immediate response and program design. Having skilled teams in place meant that the IRC was poised to deploy and be part of first-line response in crisis.

While developing preparedness plans, IRC teams in North Kivu and Haiti sought organizational support at senior levels, including affirmation of IRC’s organizational priority around GBV emergency response and a commitment of technical support from national and New York levels.

**What was learned?** In North Kivu, investments in preparedness had clear impacts on IRC’s ability to deploy and respond, as is outlined in the next section. The preparedness measures taken also influenced how confident staff felt in their ability to put in place rapid programming that would improve protection of women and girls. Staff deploying to areas in which materials had been pre-positioned said later, for example, that knowing they had the ability to offer lifesaving solutions such as post-rape care and on-site case management reinforced their confidence and commitment when deploying to a new crisis.

Because the IRC has a longer history of emergency response in DRC, the WPE team had a platform from which to build and made significant achievements with internal preparedness efforts. The WPE team in North Kivu has years of experience and training that helps them manage the pressures of responding to emergencies. They also have a team of in-country GBV experts who provide sound leadership and support. All of this proved pivotal in ensuring rapid and effective response when crisis hit.

Making the preparedness planning process successful was more challenging in Haiti, where the IRC team faced gaps in leadership. As a result, the IRC in Haiti was not able to reach the same point in the process, and in later reflection pointed to weaknesses in the team’s response to tropical storm season. Basic measures taken in North Kivu, such as establishing communication protocols with partners and preparing communication materials on why and where survivors of violence could access services, were delayed in Haiti and impacted the team’s ability to respond to needs after tropical storms Isaac and Sandy. This highlights the importance of long-term commitments to preparedness, investments in staff skill building, and senior-level commitment, particularly in contexts that are likely to experience crisis.

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8 The military operations described in text box 1 were led by the Congolese army and the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO).
**PREPAREDNESS: Actions & Tools**

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<thead>
<tr>
<th>ACTION</th>
<th>SUPPORTING NOTES, TOOLS &amp; RESOURCES&lt;sup&gt;9&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Train field-based staff and partners on GBV emergency response and preparedness</td>
<td>IRC GBV Emergency Response &amp; Preparedness training presentations and participant handbook</td>
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<tr>
<td>Provide regular post-training practice sessions, through which GBV first responders use tools and build teamwork</td>
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<tr>
<td>Establish a context-specific preparedness plan, outlining actions needed to ensure emergency readiness, and engaging with other sectors/actors to ensure commitment and support</td>
<td>IRC preparedness plan templates and the GBV assessment checklist (See Annex 3)</td>
</tr>
<tr>
<td>Develop emergency scenarios likely to unfold, and take preemptive action to pre-position materials – post-rape kits, medical examination forms and case management forms – and equip local service providers with skills and support</td>
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<tr>
<td>Develop context-relevant assessment tools and checklists, and decision-making and communication matrices</td>
<td>IRC GBV assessment toolkit, including safety audit, service mapping, focus group discussion, community mapping and individual interview tools, as well as the GBV assessment checklist (See Annex 4)</td>
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<tr>
<td>Identify trained GBV first responders to be part of first-line deployment in crisis, or establish actual local GBV response teams</td>
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<tr>
<td>Train GBV staff on security and communication protocols, ensuring they have a direct line to supervisors for technical support during response</td>
<td>This is specific to each organization and program; suggested local response team make up includes medical, psychosocial and community education staff.</td>
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**DEPLOYMENT & DIRECT RESPONSE**

**What is it?** The IRC teams in North Kivu and Haiti aimed to build on their preparedness work by deploying to emerging crises in their contexts, leading GBV-specific rapid assessments, and where possible either putting in place direct response services or working with existing actors to ensure capacity on the ground.

**What did deployment look like?** Response took shape in very different ways in the two contexts, again largely due to the senior commitments and resulting capacity of the North Kivu team versus the lack of senior leadership for the IRC team and partners in Haiti.

- The IRC team in Haiti was able to input into multisectoral assessments, but did not lead GBV-specific assessments during acute crisis response. Through local partners and site-based volunteers in Port-au-Prince, the IRC did ensure regular psychosocial support and referral for survivors after tropical storms and distributed material assistance meant to reduce risks to women and girls. The IRC teams in Haiti expressed a need to make that work more meaningful by working with health actors during preparedness processes, ensuring service

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<sup>9</sup> All of the resources and tools noted throughout this document are available through the IRC’s GBV Responders’ Network: [www.gbvresponders.org](http://www.gbvresponders.org). For specific tools, including the program model, indicators, preparedness planning templates, assessment tools and training materials, see the GBV Emergency ToolKit section of the web site: [http://www.gbvresponders.org/emergency-toolkit](http://www.gbvresponders.org/emergency-toolkit).
providers were equipped with supplies, and putting strategies in place to respond in newly-affected sites. In short, they felt that strong and continued emphasis on the preparedness process outlined above could have made their response more effective and achievable.

In North Kivu, having trained and experienced emergency response teams, supported by clear deployment and response protocols, allowed a more comprehensive approach during crises. IRC teams in North Kivu carried out more than 40 GBV emergency assessments and response missions in 2012. The IRC teams that had been trained and selected during the preparedness phase deployed to new crises and stayed on the ground for an average of two to four weeks in each deployment. They carried out a rapid GBV assessment, provided direct services where other service providers were non-existent or unable to meet increased needs, and trained and mentored local actors in case management, psychosocial care, clinical management of rape and community outreach. This support at the peak of the crisis allowed existing service providers to refresh skills, access technical supervision and understand how their service provision might change in order to accommodate increased caseloads during the emergency period. It also reinforced best practices in ongoing service provision and referrals.

In addition to the provision of lifesaving services, IRC’s GBV emergency response program model outlines interventions in coordination and advocacy that are necessary to further reduce risks and harm for women and girls. IRC’s ability to carry out and then share results from rapid assessments in North Kivu gave the organization the information needed to advocate with other actors and sectors to address gaps in service provision and to promote action to reduce risks to women and girls. In some cases IRC led risk reduction activities, such as distribution of dignity kits. In other cases, IRC assessments highlighted actions that other sectors could address. IRC was also able to point to several areas of North Kivu where initial needs assessments reported that GBV was not a concern, but where survivors started seeking support on a daily basis once the IRC and its partners initiated specialized services.

**What was learned?** Between April 2012 and the end of the year, the IRC provided GBV response services to 2,086 survivors in North Kivu, including 224 survivors who received services during short-term, emergency deployments. Between April and September 2012, cases of GBV reported to an IRC partner increased by 129% as fighting and displacement in eastern DRC surged. GBV emergency preparedness impacted first responders’ ability to cope with increased needs and caseloads, and their ability to work in a rapidly evolving context. In North Kivu, staff working with the Union pour l’Emancipation de la Femme Autochtone (UEFA), IRC’s local partner, crossed the border into DRC to provide services each day despite being displaced themselves into neighboring Uganda. This ability to ensure continuity of services during a critical response window was echoed in Haiti, where the IRC focal points and partners provided crisis counseling and case management in their homes in the camps during Hurricane Isaac.

Investments in preparedness and training also impacted the quality of response and how local partners were able to implement and work in line with international guidelines. UEFA, for example, took measures to protect sensitive client information before fleeing as conflict drew near their area of work. Psychosocial staff buried case files that might have otherwise been confiscated by military actors, and upon returning to the site later found that all files were safe and in tact. UEFA staff linked actions such as this one, as well as their provision of services while displaced in Uganda, with IRC’s training and regular contact and communication with field staff during the height of the crisis.

In both North Kivu and Haiti, IRC teams and partners pointed to a need for stronger tools and support around case management in emergencies. Case management tools and approaches are often not harmonized across agencies, which presented challenges when IRC provided short-term support and services but then needed to handover to another agency. Clarity around a basic case management package in emergencies, including where and how to shift to a more simplified client intake form, could result in a wide array of organizations being better equipped to meet increased needs during crisis. As a result of this learning, IRC has started work on further elaborating what this core case management package involves.

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10 Dignity kits meet the immediate hygiene needs of women and girls of reproductive age. They typically include sanitary materials, soap, buckets, and may include a whistle and/or flashlight to enhance security.
And for agencies using the GBV Information Management System, feedback from this project led to the development of a more simplified client intake form specific to emergencies.

Although the IRC team in North Kivu viewed capacity building as successful and essential as part of response, the team also noted that training provided by the IRC during the acute crisis increased requests for additional support and intervention. The IRC emergency response teams, already active in other response efforts, struggled to provide adequate follow-up support. This also meant that IRC was unable to ensure the quality of interventions after pulling out of the area. This presents several challenges for organizations scaling up efforts across a wide geographic region, where one actor cannot meet all GBV response needs. Broader organizational commitments to human resource development and GBV emergency preparedness could help address this challenge, as would the existence of strong technical leadership in local, regional and national coordination mechanisms.

Finally, a key area of learning as a result of this project was around risk reduction, and specifically around the provision of material and/or cash-based support as a means of meeting women and girls’ immediate needs. This aspect of GBV emergency response is part of the IRC program model. In Haiti, the IRC reached more than 560 vulnerable women and girls with material assistance in response to tropical storms, and distributed shelter materials to 450 families, including female-headed households. First responders in both North Kivu and Haiti noted a need for expanded guidance on what types of assistance are the most useful and safe in diverse contexts, how these should be prioritized and provided, and how to link with other actors in their provision. This is another area IRC is currently exploring, and specifically revisiting its program model and resource package to more fully address.

### DEPLOYMENT & DIRECT RESPONSE: Actions & Tools

<table>
<thead>
<tr>
<th>ACTION</th>
<th>SUPPORTING NOTES, TOOLS &amp; RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify priority affected areas and advocate for GBV assessment and presence</td>
<td>This is dependent on context, but will also be driven by a preparedness plan that is fully developed and in place.</td>
</tr>
<tr>
<td>Carry out GBV-specific assessments, using information to guide response and to advocate with other actors</td>
<td>IRC GBV assessment toolkit, including safety audit, service mapping, focus group discussion, community mapping and individual interview tools (See Annex 4)</td>
</tr>
<tr>
<td>Lead short-term deployments to ensure lifesaving services</td>
<td>IRC GBV emergency response program model and program model with sample indicators for emergencies (See Annex 5)</td>
</tr>
<tr>
<td>Provide direct GBV services, in partnership with local actors where possible, while at the same time training and mentoring to strengthen local service providers’ capacity to meet continued needs</td>
<td></td>
</tr>
<tr>
<td>Establish immediate links with GBV focal points in health centers and local psychosocial service providers, and provide daily remote support and contact</td>
<td>Updated service mapping and communication matrices that have been put in place during the preparedness phase will facilitate this.</td>
</tr>
</tbody>
</table>

### WORKING WITH OTHER ACTORS

**What is it?** The IRC’s GBV-specific emergency response and preparedness extended beyond the organization, including engagement with partners, sister organizations, state actors and local communities. Establishing a wider net of actors ready to support GBV response allowed the IRC to play a more proactive role in areas likely to be affected by conflict or natural disaster, and to have wider geographic reach in response. How the IRC worked with other actors through the preparedness planning and response phases was tailored to the role they were equipped to play and their own specific mandates and priorities. This required a significant investment of time in relationship building, which sometimes started through the inclusion of state actors and local service providers in the IRC training on GBV Emergency Response & Preparedness.

**What did working with other actors look like?** As noted above, work with other actors was highly dependent on context and local capacities. Some of the strongest examples of collaborative actions taken in North Kivu were those that addressed problems linked to the supply of medicines to health facilities and
the sharing of sensitive information during emergencies. These are obstacles that can significantly slow GBV response. IRC worked with authorities and communities during emergency preparedness planning and discussions, carrying out joint assessment missions with health authorities to identify ruptures in post-rape kit stocks. IRC also worked with UNICEF, UNHCR and MONUSCO to establish an emergency-specific information sharing protocol that outlined how GBV information and data would be ethically and safely shared during emergencies. These and other collaborative preparedness measures reinforced emergency protocols and strengthened key relationships.

Joint advocacy also played a role in IRC’s response in North Kivu. When humanitarian actors failed to prioritize GBV interventions, citing a lack of survivors reporting, the IRC worked with UNICEF and others to push for GBV-specific response despite the absence of “evidence.” Advocacy for the prioritization of GBV as a part of lifesaving emergency response in eastern DRC continues. The process of engaging allies and senior decision makers at the provincial, national and international levels laid a foundation for stronger messaging and support.

In Haiti, engaging others in preparedness focused at the community level, and was integrated into the work of activists who typically focus more broadly on GBV prevention and awareness. The IRC’s partner in Jacmel, Limyè Lavi (LL), works with a network of activists who are responsible for delivering information and leading dialogue about preventing violence against women and girls. Because of their positions of leadership, these activists were well positioned to play a role in informing communities about the arrival of Hurricane Issac. Prior to the storm, for example, one such local activist reached out to the government’s Civil Protection Department and offered to support safety audits in emergency shelters that had been set up in case of need. The activist helped identify potential risks women and girls might face, and advocated for the local authorities to address concerns, such as privacy in bathing areas and safety of areas for non-accompanied minors and female-headed households. Another IRC partner, KOFAVIV, focused their preparedness messaging and action on local women’s committees, as explained in text box 3.

What was learned? Working with external actors in the preparedness phase was a key to more effective and efficient collaboration toward protecting women and girls when the crisis hit. IRC teams in both North Kivu and Haiti felt that increasing the involvement of external actors, particularly state actors, in skill building efforts could open doors for more joint planning, assessment and action.

The IRC teams in both North Kivu and Haiti used safety audits and community consultations to help inform their understanding of risks to women and girls, and to gauge changes in the environment as the situation evolved. Teams using these tools sometimes struggled, however, to successfully engage other sectors in reducing these risks. They often felt that risk mitigation continues to fall on GBV service providers, despite the fact that preventative approaches are clearly linked to the full range of humanitarian sectors, including camp management, security, shelter, food and non-food item distributions, and water and sanitation. As highlighted within the section on deployment and response, the IRC teams identified a need for more concrete, actionable guidance on reducing risks to women and girls.

Text box 3

Community-level preparedness: Learning from local organizations and networks

Like Limyè Lavi, KOFAVIV, an IRC partner in Port-au-Prince, took on community-level work as part of emergency preparedness following training with IRC. KOFAVIV integrated information on measures to follow during a hurricane and how women and girls could avoid risks during displacement into their awareness-raising program. They organized meetings with their network of local volunteers on how they would work together during an emergency, and they formed women’s committees and distributed whistles and flashlights to them to enable women to stay contact with each other during an emergency.

11 “Evidence” or “proof” that GBV survivors are coming forward is frequently demanded by humanitarian decision makers, despite the fact that this contradicts best practice, as outlined in the Inter-Agency Standing Committee’s Guidelines for Gender-based Violence Interventions in Humanitarian Settings.
This included a request for guidance on strengthening accountability for GBV risk mitigation as part of emergency preparedness and response, in line with the IASC GBV guidelines.12

<table>
<thead>
<tr>
<th>WORKING WITH OTHER ACTORS: Actions &amp; Tools</th>
<th>SUPPORTING NOTES, TOOLS &amp; RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage state actors and local civil society in specific training on GBV emergency response, follow-up discussion regarding emergency response protocols and responsibilities, and preparedness efforts</td>
<td>IRC GBV Emergency Response &amp; Preparedness training presentations and participant handbook</td>
</tr>
<tr>
<td>Foster the participation of local and state GBV actors in safety audits, community consultations, and the identification and establishment of likely population collection and transit points to identify and reduce risks to women and girls</td>
<td>IRC GBV assessment toolkit, notably safety audit, focus group discussion and community mapping tools (See Annex 4) Also see the Inter-Agency Standing Committee, <em>Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies</em> (2005)</td>
</tr>
<tr>
<td>Work with health and other actors during preparedness phase to update mapping of key services, including information on staff presence, identification of training and support needs, and availability of stock such as medicines and equipment</td>
<td>IRC GBV assessment toolkit, notably the service mapping tool (See Annex 4)</td>
</tr>
<tr>
<td>Identify and train GBV focal points within local service providers, including health facilities and organizations offering psychosocial support and case management</td>
<td></td>
</tr>
<tr>
<td>Maintain consistent bilateral and multilateral communication among allies and senior decision makers to maintain strong relationships and evolve key advocacy messages</td>
<td>This requires relationship building and the development of strong advocacy messages. How advocacy is carried out and who is targeted will be decided based on context, presence of other actors, and safety and security considerations for GBV staff, service providers and volunteers. Also see the IRC GBV Emergency Response &amp; Preparedness participant handbook.</td>
</tr>
<tr>
<td>Advocate for the need to prioritize GBV intervention as a life-saving component of emergency response</td>
<td></td>
</tr>
</tbody>
</table>

**Conclusion**

The IRC’s GBV emergency response and preparedness capacity building efforts in North Kivu and Haiti provided an opportunity to document the opportunities and challenges the field faces when responding to GBV in emergencies. Implementing the IRC program model enabled field teams and partners to be quicker, more effective and more efficient in their emergency response work in North Kivu and Haiti. This model, which provides the framework for IRC’s capacity building and response, is provided in annex 1.

IRC’s experience implementing this model, and the challenges field teams sometimes faced, also brought to light the importance of having trained teams and organizational commitments to emergency preparedness specific to GBV. Without one or the other, quality GBV emergency response cannot be effective. Training and mentoring increased staff confidence and readiness to engage as crises emerged by creating a platform of knowledge, tools and support. Each subsequent intervention offered GBV teams the opportunity to strengthen their foundation, to build in time for reflection and analysis, and to more effectively keep women and girls safe during emergencies. Commitment at all levels of the organization shored up the response by making resources accessible, and ensuring that women and girls were prioritized as part of direct GBV response. IRC has seen how this commitment, particularly at senior levels, also has potential for improving protection of women and girls through the emergency programming of other sectors.

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The learning captured through this project also underscores areas that require continued work and engagement. Toward this end, IRC has initiated a process of expanding its resources— in particular around case management in emergencies, working with others to mitigate risks that women and girls face, and using material and cash-based assistance as part of risk reduction—and reflecting additional guidance in the program model itself.

This project represented an important and unique investment in GBV-specific emergency preparedness. While individual examples of the impact of this investment have been shared throughout this paper, perhaps the most concrete evidence comes from North Kivu, where the work of IRC and its partner ensured lifesaving GBV response services to 2,086 survivors, 224 of whom received services during short-term deployments. This capacity comes as a result of long-term efforts toward preparedness and staff skill building in North Kivu. The actions taken there can be replicated and built upon in other contexts, but only when underpinned by meaningful commitments of time and resources toward protecting women and girls during crisis.

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**Resources and tools**

All of the resources and tools noted throughout this document are available through the IRC’s GBV Responders’ Network:


For field-ready, adaptable formats of tools and templates, including the program model, indicators, preparedness planning templates, assessment tools and training materials, see the GBV Emergency ToolKit section of the web site:


Tools and templates discussed in this document are also available in Annexes 1-4.
**GBV EMERGENCY PREPAREDNESS:**
Key Actions & Commitments

<table>
<thead>
<tr>
<th>ORGANIZATIONAL PREPAREDNESS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Train field-based staff and partners on GBV emergency response and preparedness.</td>
</tr>
<tr>
<td>• Provide regular post-training practice sessions, through which GBV first responders use tools and build teamwork.</td>
</tr>
<tr>
<td>• Identify trained GBV first responders to be part of first-line deployment in crisis, or establish actual local GBV response teams.</td>
</tr>
<tr>
<td>• Develop context-relevant assessment tools and checklists, and decision-making and communication matrices.</td>
</tr>
<tr>
<td>• Train GBV staff on security and communication protocols, ensuring they have a direct line to supervisors for technical support during response.</td>
</tr>
<tr>
<td>• Preposition GBV-specific response materials – post-rape kits, medical examination forms and case management forms – in sites most likely affected.</td>
</tr>
<tr>
<td>• Engage other sectors and operational teams within the organization in GBV-specific preparedness planning.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREPAREDNESS of OTHER ACTORS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Update mapping of key services, including information on staff presence, identification of training and support needs, and availability of stock such as medicines and equipment.</td>
</tr>
<tr>
<td>• Engage state actors and local civil society in specific training on GBV emergency response, follow-up discussion regarding emergency response protocols and responsibilities, and preparedness efforts.</td>
</tr>
<tr>
<td>• Identify and train GBV focal points within local service providers, including health facilities and organizations offering psychosocial support and case management.</td>
</tr>
<tr>
<td>• Foster the participation of local and state GBV actors in the identification and establishment of likely population collection and transit points to ensure that they are safe and suitable for women and girls.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASSESS, MENTOR &amp; ADVOCATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide direct GBV services, in partnership with local actors where possible, while at the same time training and mentoring to strengthen local service providers’ capacity to meet continued needs.</td>
</tr>
<tr>
<td>• Carry out service mapping that includes analysis of gaps and existing actors’ capacity to meet needs.</td>
</tr>
<tr>
<td>• Establish immediate links with GBV focal points in health centers and local psychosocial service providers, and provide daily remote support and contact.</td>
</tr>
<tr>
<td>• Maintain consistent bilateral and multilateral communication among allies and senior decision makers to maintain strong relationships and evolve key advocacy messages.</td>
</tr>
<tr>
<td>• Advocate for the need to prioritize GBV intervention as a life-saving component of emergency response.</td>
</tr>
</tbody>
</table>

*Note: Some of the actions noted here are easier in a context in which the “trigger” for an emergency is foreseeable, such as a military operation, a tropical storm or an election. Many preparedness actions can also be incorporated, however, into routine programming as part of good practice.*
Annex 2: GBV Emergency Response Model with Sample Indicators

The following version of the IRC GBV emergency response model offers suggested indicators that fall within each ‘pillar’ of the model. Not all of these are appropriate for all programs and emergency contexts, and they are not comprehensive. They are simply indicators that the IRC teams in the field have found meaningful and measureable in some contexts.
<table>
<thead>
<tr>
<th>SAMPLE INDICATORS</th>
<th>MIKE TOOL(S)</th>
<th>SAMPLE INDICATORS</th>
<th>MIKE TOOL(S)</th>
<th>SAMPLE INDICATORS</th>
<th>MIKE TOOL(S)</th>
<th>SAMPLE INDICATORS</th>
<th>MIKE TOOL(S)</th>
<th>SAMPLE INDICATORS</th>
<th>MIKE TOOL(S)</th>
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<tbody>
<tr>
<td>Number of medical staff trained in the GBV guiding principles for supporting a survivor and a safety referral</td>
<td>Training records</td>
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<td>Prevention of sexual assault in health facilities</td>
<td>Health facility checklist</td>
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<td>Health facility records</td>
<td>Prevention of sexual assault in health units</td>
<td>Health facility records</td>
</tr>
</tbody>
</table>

**Survivors access appropriate services in a safe and timely manner**

| Surveys of GBV have safe access to health services, in line with guidelines for the clinical management of rape | Surveys of GBV have safe access to health services, in line with guidelines for the clinical management of rape | Surveys of GBV have safe access to health services, in line with guidelines for the clinical management of rape |
| Surveys of GBV have safe access to psychosocial services and community-based support networks | Surveys of GBV have safe access to psychosocial services and community-based support networks | Surveys of GBV have safe access to psychosocial services and community-based support networks |

**Interventions to address GBV are coordinated**

| Service provision is coordinated among service providers and GBV focal points | Service provision is coordinated among service providers and GBV focal points | Service provision is coordinated among service providers and GBV focal points |
| Other sectors identify factors that increase risks to women and girls, and develop strategies to address them | Other sectors identify factors that increase risks to women and girls, and develop strategies to address them | Other sectors identify factors that increase risks to women and girls, and develop strategies to address them |
| Advocacy leads to increased funding and improved policies/systems to protect women and girls | Advocacy leads to increased funding and improved policies/systems to protect women and girls | Advocacy leads to increased funding and improved policies/systems to protect women and girls |

**Decision-makers act to improve protection of women and girls**

| Advocacy for end-to-end GBV risk assessment and GBV risk management system is established | Advocacy for end-to-end GBV risk assessment and GBV risk management system is established | Advocacy for end-to-end GBV risk assessment and GBV risk management system is established |
| Advocacy for end-to-end GBV risk assessment and GBV risk management system is established | Advocacy for end-to-end GBV risk assessment and GBV risk management system is established | Advocacy for end-to-end GBV risk assessment and GBV risk management system is established |
| Advocacy for end-to-end GBV risk assessment and GBV risk management system is established | Advocacy for end-to-end GBV risk assessment and GBV risk management system is established | Advocacy for end-to-end GBV risk assessment and GBV risk management system is established |

**Note:** GBV is denoted in gray beside more sophisticated indicators and may be too ambitious during acute emergency response.

The following two tools are designed to help field-based practitioners prepare and plan in anticipation of an emergency. There are many different ways to talk about preparedness. The tools shared here can help field practitioners plan for specific scenarios and identify actions needed to ensure they are better equipped and poised to respond. Investing in preparedness, however, goes far beyond one, discrete event. The preparedness process also means skill building and practice, tool development and adaptation, and internal and external relationship-building to facilitate stronger emergency response.

Two preparedness plan templates are offered here. The first is built around aimed for emergency response outcomes. The second is built around scenarios of ‘escalated’ and ‘widespread’ response needs. This latter plan is often most helpful when a team is focused on one, specific event such as an election or upcoming military operation, and has brainstormed how potential scenarios could unfold.
GOAL: Women and girls have safe access to services and are protected from further harm.

<table>
<thead>
<tr>
<th>Target Outcomes</th>
<th>Immediate Action</th>
<th>Likely Scenario</th>
<th>Timeline for Action</th>
<th>Resources Needed</th>
<th>Resources Available</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH:</strong> Minimum clinical health services are available in hospitals in likely affected areas</td>
<td></td>
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<td></td>
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<tr>
<td><strong>CASE MANAGEMENT &amp; PSYCHOSOCIAL:</strong> GBV survivors are able to access basic case management services -- emotional support, information and appropriate referral</td>
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<tr>
<td><strong>REFERRALS:</strong> Referral pathways in each likely affected area are functional and regularly updated</td>
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</tr>
<tr>
<td><strong>INFO. &amp; AWARENESS:</strong> Communities have access to information about why and how GBV survivors can access life-saving services</td>
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<tr>
<td></td>
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</tr>
<tr>
<td><strong>RISK REDUCTION:</strong> All actors and sectors act in accordance with GBV guiding principles; women and girls have access to material and/or cash-based assistance to reduce their exposure to risks</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
**OBJECTIVE:** To ensure GBV response capacity in line with the GBV emergency response program model, during changes in context including increased demand/need and decreased security/access.

<table>
<thead>
<tr>
<th>Impact on GBV Capacity (Scenario Planning)</th>
<th>Preparedness Interventions</th>
<th>Focal Point</th>
<th>Timeline</th>
<th>Resources Needed</th>
<th>Resources Available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Activity(ies)</td>
<td>How</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escalated Response Needs:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widespread Response Needs:</td>
<td></td>
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</tbody>
</table>
Annex 4: GBV Emergency Assessment Toolkit

The following tools are part of the IRC’s GBV-specific Assessment Toolkit. Each of these tools may be more or less useful in a specific emergency context, and all are intended to be adapted to local contexts.

The first tool presented is a simple assessment checklist for GBV field teams. This is followed by five assessment tools: 1) safety audit, 2) service mapping, 3) individual interview, 4) focus group discussion, and 5) community mapping guidance. A brief note on the use of each tool is included within the tool itself. Further guidance on how to decide which tool is most appropriate to a specific context and considerations for adapting the tools can be found in the GBV Emergency Response & Preparedness Handbook.
<table>
<thead>
<tr>
<th>GBV Rapid Assessment CHECKLIST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff</strong></td>
</tr>
<tr>
<td><strong>Team Coordinator:</strong> Leads in monitoring quality of the assessment as well as analysis and compilation of information</td>
</tr>
<tr>
<td><strong>Team Leader(s):</strong> Leads field teams in the implementation of the assessment, working closely with other team leaders, translators and the team coordinator</td>
</tr>
<tr>
<td><strong>Translator(s):</strong> Each team leader will have a translator identified from the local community who will be briefed on his/her role in the assessment beforehand; they will also be oriented on codes of conduct, and be clear about their ToR (including payment, working hours, etc.) before the assessment</td>
</tr>
<tr>
<td><strong>Transcriber:</strong> Transcribers from the local community will help with translating and transferring information from the assessment forms into a compiled database</td>
</tr>
<tr>
<td><strong>Driver(s):</strong> Drivers will be identified within the organization or on a contractual basis and will be briefed on the purpose of the assessment and codes of conduct; every effort will be made to keep the same drivers throughout the entire assessment period</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
</tr>
<tr>
<td><strong>Mobile Phones:</strong> Each staff will have one charged phone with substantial credit that they will use throughout the assessment</td>
</tr>
<tr>
<td><strong>Communication Tree:</strong> Clear lines of communication in case of security concerns and for general reporting; each team member will share their phone numbers with one another before the assessment commences; the team coordinator (or other security focal point) will also have phone numbers for all team members</td>
</tr>
<tr>
<td><strong>Daily Debrief:</strong> Team coordinator leads team debriefs at the beginning and during set intervals during the assessment</td>
</tr>
<tr>
<td><strong>Movement Plan:</strong> Ensure team members are aware of the time of departure and return each day</td>
</tr>
<tr>
<td><strong>Logistics &amp; Security</strong></td>
</tr>
<tr>
<td><strong>Security &amp; Coordination:</strong> A meeting area will be determined each morning by assessment team leaders and will be revised each morning, as appropriate and necessary</td>
</tr>
<tr>
<td><strong>Transport:</strong> Adequate vehicles will be requested through logistics available to travel to the assessment sites and stay on-site through the entire day</td>
</tr>
<tr>
<td><strong>Supplies</strong></td>
</tr>
<tr>
<td><strong>Water &amp; Snacks:</strong> Each car/team should have sufficient safe drinking water and snacks for the day</td>
</tr>
<tr>
<td><strong>Assessment Forms:</strong> Copy or print multiple copies of the assessment forms that have been adapted by the team in advance</td>
</tr>
<tr>
<td><strong>Excel Database:</strong> Develop a tool that can be used to organize and compile assessment information into one place</td>
</tr>
<tr>
<td><strong>Pens, Notebooks &amp; Folders:</strong> All assessment team members should carry several pens and a notebook</td>
</tr>
<tr>
<td><strong>Time-Keeping:</strong> Ensure team members have a watch or cell phones so that they can keep time</td>
</tr>
<tr>
<td><strong>Identification:</strong> Ensure all team members have badges with a way to make them visible</td>
</tr>
<tr>
<td><strong>Clipboards:</strong> When using the actual assessment forms, clipboards may be useful</td>
</tr>
<tr>
<td><strong>Clear Plastic Pouches:</strong> Plastic envelope for holding forms and paper</td>
</tr>
<tr>
<td><strong>Other Preparations</strong></td>
</tr>
<tr>
<td><strong>Discussion with Local Authorities:</strong> The team coordinator will organize a discussion with relevant authorities so they understand the purpose and process of the assessment, and give appropriate approval</td>
</tr>
<tr>
<td><strong>Service Availability &amp; Referrals:</strong> Document the referral plan and procedures for survivors who may report their cases according to services available in the area</td>
</tr>
</tbody>
</table>
# GBV Assessment Tools

## Part 1: SAFETY AUDIT

**Note:** This tool is based upon observation. It may or may not be relevant in all contexts. In areas of insecurity, you should not fill in the questionnaire while walking around the site/community; rather, take mental note of questions and observations and fill in the form later, after leaving the site/community.

**Team:**

**Geographic location:**

**Camp coordinator(s):**

### Overall Layout

<table>
<thead>
<tr>
<th>Night lighting (Exists? Sufficient? Etc.)</th>
<th>Problem?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<td>____________________________</td>
</tr>
</tbody>
</table>

### Water and Sanitation

<table>
<thead>
<tr>
<th>Water points (Distance? Secure location? Time to wait? Etc.)</th>
<th>Problem?</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
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</table>

<table>
<thead>
<tr>
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<th>Problem?</th>
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</thead>
<tbody>
<tr>
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<td>____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Showers (Distance? Separated for gender? Locks/no locks? Etc.)</th>
<th>Problem?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
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<td>____________________________</td>
</tr>
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</table>

### Household

<table>
<thead>
<tr>
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<th>Problem?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>____________________________</td>
</tr>
</tbody>
</table>
### Community

**Schools** (Distance? Safety of access route? Presence of armed actors in vicinity? Etc.)

Yes | No |
--- | --- |

---

**Markets** (Distance? Safety of access route? Presence of armed actors in vicinity? Etc.)

Yes | No |
--- | --- |

---

### Presence of Armed Actors

**State military** (Presence in/around civilian areas? Rapport with communities? Etc.)

Yes | No |
--- | --- |

---

**Other armed actors** (Presence in/around civilian areas? Rapport with communities? Etc.)

Yes | No |
--- | --- |

---

**Barriers/checkpoints** (Existence? Blocking key routes to health centers, schools, etc.? Etc.)

Yes | No |
--- | --- |

---

### Other Comments

Please include any other observations, including those related to movements of women and girls outside the camp for water, firewood, etc.
GBV Assessment Tools

Part 2: SERVICE MAPPING

Note: This tool is for use during interviews with service providers. All sections may apply to some service providers, while for others (i.e., a health clinic) it may only be relevant to focus on one section.

Team:

Geographic area:

Estimated catchment population:

1. Organization:

2. Did you provide services before the crisis? Yes No

3. What type of services do you provide to survivors of GBV?
   - Health
   - Psychosocial / case management
   - Legal
   - Protection/ security
   - Sensitization / prevention

Health

Specific geographic location(s) of service provision:

4. What type of medical personnel work for your organization here?
   - Nurses: How many? _____
   - Doctors: How many? _____
   - Midwives: How many? _____
   - Gynecologists: How many? _____
   - Surgeons: How many? _____
   - Other: How many? _____

5. Do you have GBV focal points? Yes No

   If yes, who? ___________________________________________________________

6. Have the medical personnel received any specialized training on clinical care for survivors of GBV? Yes No

   If yes, who provided the training? When was the training provided?

   ________________________________________________________________
7. Have the medical personnel received any specialized training on the provision of care for child survivors of GBV?
   Yes    No

   If yes, who provided the training? When was the training provided?

8. Do you have complete post-rape kits available?    Yes    No
   □ PEP
   □ Emergency contraception
   □ STI medicines / antibiotics
   □ Hepatitis B vaccination
   □ Tetanus vaccination

9. Do you have trained social workers on staff?    Yes    No

   If yes, how many? ____________

10. Do they have a safe, confidential space to receive survivors?    Yes    No

   If yes, request to see the space. Is it safe and confidential? Record your observations here:

   ____________________________________________________________________________

   ____________________________________________________________________________

   Psychosocial

   Specific geographic location(s) of service provision:

11. What specific services do you provide?
   □ Basic emotional support
   □ Case management
   □ Psychosocial support
   □ Group activities
   □ Other? ______________________________________________________________________

12. Do you have a safe, confidential space to receive survivors?    Yes    No

   If yes, request to see the space. Is it safe and confidential? Record your observations here:

   ____________________________________________________________________________

   ____________________________________________________________________________
IRC Assessment ToolKi

13. Do you have a woman’s center or other dedicated space to facilitate survivors’ access? Yes No

If yes, request to see the center. Was the center busy? Was it filled with mostly women? Mostly men? Record your observations here:

__________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________

14. What specific age groups do your activities serve?
☐ Children
☐ Young adolescents (10-14)
☐ Older adolescents (15-18)
☐ Adult women (18+)

15. Are your psychosocial services provided by:
☐ Trained volunteers If yes, how many? __________
☐ Partners (NGO, CBO, etc.) If yes, how many? __________
☐ Staff of your organization If yes, how many? __________

16. If you work with local NGOs/CBOs, what organizations are they and how many practitioners do they have on staff?

17. What kind of training have your volunteers and social workers received?

Safety and protection

Specific geographic location(s) of service provision:

18. What specific services do you provide?
☐ Safety and security planning for survivors
☐ Safe houses
☐ Community solutions (i.e., a safe house within the community)
☐ Patrols
☐ Others? ____________________________________________________________________________________________________________

19. What specific age groups do your activities serve?
☐ Children
☐ Young adolescents (10-14)
☐ Older adolescents (15-18)
☐ Adult women (18+)

Difficulties / Challenges

20. What are the significant challenges your organization faces in service provision?
21. Do you turn away women and girls because of a lack of available resources?  Yes  No

Other Comments

Contact Person for the Organization

Name: _____________________________________________

Telephone: _____________________________

Email: ________________________________
GBV Assessment Tools

Part 3: INDIVIDUAL INTERVIEW

Note: This tool is for use during key informant interviews. Key informants may include individuals with a particular kind of community-level access or information (i.e., doctor, teacher, village chief, camp leader, women’s committee leader, etc.); however, this tool can also be used for individual interviews with randomly identified community members. (Remember, you must always get consent prior to involving someone in information collection.) Individual interviews take time; you should take into account the available resources and time during the prioritization of key informants to be targeted. Some of these questions are sensitive; you should review ethical considerations prior to the interview, particularly considering the security of both parties. It is possible to take out some questions if necessary due to security or other concerns. Fill out the relevant sections in regards to your key informant.

Team:

Interview date: __________________________ Place of interview: __________________________

Translation necessary for the interview: Yes No

If yes, the translation was from __________________________(language) to __________________________(language)

Key informant’s role in the community: __________________________

Sex of key informant: Male Female

Age of key informant:

Important note: It is extremely unlikely that you will need to or be prepared to involve children in information collection as part of this rapid assessment. Be sure to revisit the WHO guidelines on Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies, and to think through other means of gathering relevant information regarding the situation for girls under 18.

☐ 10-14 years
☐ 15-19 years
☐ 20-24 years
☐ 25-40 years
☐ Over 40 years

General Information

1. Is the concerned population displaced as a result of the crisis? Yes No

2. If yes, what kind of community does the concerned population live in since the crisis?
   ☐ Organized camp
   ☐ In a host community
   ☐ Unorganized settlement

1
IRC Assessment Toolkit

☐ Public building (school, abandoned building, etc.)
☐ Returnees living in village/home of origin
☐ Returnees in a secondary displacement

3. If the population lives in an organized camp, the camp is managed by which of the following (please specify):
☐ Government __________________________
☐ Armed forces __________________________
☐ UN agency ____________________________
☐ NGO _________________________________
☐ Private individual/organization __________
☐ Other – If “other,” please specify: __________________________

4. Are there reports of unaccompanied children in this community?  Yes  No

Access to Basic Services

5. What services are safely available to adult women in the camp? If relevant, please note the organization offering these services.
☐ Food aid / food distributions __________________________
☐ Shelter __________________________
☐ Non-food items (specify which NFIs) __________________________
☐ Health care (including reproductive health) __________________________
☐ Hygiene/dignity kits __________________________
☐ Education __________________________
☐ Women-friendly spaces __________________________
☐ Clean water __________________________
☐ Latrines __________________________
☐ Other – If “other,” please specify: __________________________

6. What services are safely available to child and adolescent girls in the camp? If relevant, please note the organization offering these services.
☐ Food aid / food distributions __________________________
☐ Shelter __________________________
☐ Non-food items (specify which NFIs) __________________________
☐ Health care (including reproductive health) __________________________
☐ Hygiene/dignity kits __________________________
☐ Education __________________________
☐ Women-friendly spaces __________________________
☐ Clean water __________________________
☐ Latrines __________________________
☐ Other – If “other,” please specify: __________________________
7. What are some reasons that girl children, adolescent girls, or adult women are unable to access some of these services?
   - Priority is given to men
   - No female staff providing services
   - Lack of sufficient medicines at health facilities
   - Girls/women not permitted to access their services by their families
   - Not safe for girls/women to travel to the service sites
   - Locations of services are not convenient for girls/women
   - Hours are not convenient for girls/women
   - Other – If “other,” please specify: __________________________

8. Do girls and women go outside the community to earn income to meet basic needs?  
   - Yes  
   - No

9. What are women and girls doing to generate income to meet basic needs? (Select all that apply.)
   - Begging
   - Collecting firewood
   - Collecting straw
   - Having sex in exchange for money
   - Domestic work
   - Other – If “other,” please specify: __________________________

10. Do women and girls usually travel outside the community in groups or alone?
    - Alone/individually
    - In groups

Security and Safety of Women and Girls

11. What are the most significant safety and security concerns facing adult women in this community? (Select all that apply.)
    - No safe place in the community
    - Sexual violence/abuse
    - Violence in the home
    - Risk of attack when traveling outside the community
    - Risk of attack when going to latrines, local markets, etc. Please specify: __________________________
    - Being asked to marry by their families
    - Trafficking
    - Unable to access services and resources
    - Don’t Know
    - Other – If “other,” please specify: __________________________

12. What are the most significant safety and security concerns facing child and adolescent girls in this community? (Select all that apply.)
    - No safe place in the community
    - Sexual violence/abuse
    - Violence in the home
    - Risk of attack when traveling outside the community
    - Risk of attack when going to latrines, local markets, etc. Please specify: __________________________
    - Being asked to marry by their families
    - Trafficking
    - Unable to access services and resources
    - Don’t Know
    - Other – If “other,” please specify: __________________________
13. Has there been an increase in security concerns affecting girls and women since the emergency?
   Yes  No

14. Has there been a noticeable increase in rape/sexual violence being reported since the emergency occurred?
   Yes  No

15. What types of violence have women reported?

16. What types of violence have adolescent girls reported, if different from above?

17. What types of violence have girl children reported, if different from above?

18. In what context in the community does rape/sexual violence occur? (Select all that apply.)
   - At home
   - When girls/women are traveling to the market
   - At latrines/bathing facilities
   - When girls/women are collecting firewood
   - At school
   - When collecting water
   - When going to access services (food aid, etc.)
   - Don’t Know
   - Other – If “other,” please specify: ____________________________

19. To whom do women most often go for help, when they’ve been victims of some form of violence?
   - Family member
   - Community leader
   - Police
   - NGO working with women
   - Any female aid worker
   - UN Agency
   - Friend
   - Don’t Know
   - Other – If “other,” please specify: ____________________________

20. To whom do child and adolescent girls most often go for help, when they’ve been victims of some form of violence?
   - Family member
   - Community leader
   - Police
   - NGO working with women
   - Any female aid worker
   - UN Agency
   - Friend
   - Teacher
   - Don’t Know
   - Other – If “other,” please specify: ____________________________
21. Do any of the following groups have access to the camp or community?
- [ ] Military
- [ ] Informal militia groups
- [ ] Police
- [ ] Peacekeepers
- [ ] None of the above

22. Are there reports of sexual abuse or exploitation of girls and women?  
   Yes  No
   If yes, by whom?
- [ ] Government ________________________________
- [ ] Military ________________________________
- [ ] Police ________________________________
- [ ] Peacekeepers ________________________________
- [ ] UN agency ________________________________
- [ ] NGOs ________________________________
- [ ] Other ________________________________

23. What safety measures have been put in place by police and/or peacekeeping forces to minimize any potential risk to girls and women?
- [ ] Increase in number of police
- [ ] Increase in number of female police officers
- [ ] Police/peacekeeping patrols around the community
- [ ] Increase in number of female police officers
- [ ] Increase in number of female peacekeepers
- [ ] Community safety groups
- [ ] Firewood collection patrols
- [ ] Educating girls/women on how to report incidents
- [ ] Don’t know
- [ ] Other – If “other,” please specify: ________________________________

24. Are there safe shelters or places that adult women can go to if they feel unsafe?  
   Yes  No

25. Are there safe shelters or places that adolescent girls can go to if they feel unsafe?  
   Yes  No

26. Are there safe shelters or places that girl children can go to if they feel unsafe?  
   Yes  No

**Health Response to GBV**

27. Are health services available for girls and women in the community/ camp?  
   Yes  No

28. If yes, do girls and women have access to the health services at anytime?  
   Yes  No

29. Are there female doctors, nurses and/or midwives at the health facilities?  
   Yes  No

30. What are some reasons that girl or women survivors of GBV may not be able to access health services?
- [ ] Fear of being identified as survivors
- [ ] Distance to health facility
- [ ] No female staff
- [ ] No availability of confidential treatment
- [ ] Lack of trained staff
- [ ] Don’t know that they should access the facility for treatment
- [ ] Don’t know
IRC Assessment Toolkit

☐ Other – If “other,” please specify: ____________________________

Psychosocial Response to GBV

31. Are there psychological and/or social support systems for adult women survivors? Yes No

32. If yes, what kinds of support systems are available to adult women survivors? (Select all that apply.)
☐ Drop-in Centers
☐ Peer Support groups
☐ Case management with individual counseling
☐ Skills building
☐ Education
☐ Income-generating activities/vocational training
☐ Mental health referrals
☐ Other – If “other,” please specify: ____________________________

33. Are there psychological and/or social support systems for girl-child and adolescent girl survivors? Yes No

34. If yes, what kinds of support systems are available to girl-child and adolescent girl survivors? (Select all that apply.)
☐ Drop-in Centers
☐ Peer Support groups
☐ Case management with individual counseling
☐ Skills building
☐ Education
☐ Income-generating activities/vocational training
☐ Mental health referrals
☐ Other – If “other,” please specify: ____________________________

35. Is there a functional referral system between health providers and organizations providing psychological or social support? Yes No

36. Are there informal community-based networks of women? Yes No

37. What are some reasons that girl or women survivors of GBV may not be able to access psychosocial support services?
☐ Fear of being identified as survivors
☐ Distance to facility
☐ No female staff
☐ No availability of confidential support
☐ Lack of trained staff
☐ Don’t know that they should access the facility for treatment
☐ Don’t know
☐ Other – If “other,” please specify: ____________________________
GBV Assessment Tools

Part 4: FOCUS GROUP DISCUSSION

Note: This tool should be used during small group discussions. The team should ensure participants that all information shared within the discussion will remain confidential; if the secretary takes down notes, s/he will not have any information identifying or associating individuals with responses. Some of these questions are sensitive. You should take all potential ethical concerns into consideration before the discussion, considering the safety of respondents, ensuring that all participants agree that no information shared in the discussion will be divulged outside the group, and obtaining informed consent from participants. The group should be made of like members – community leaders, adult women, youth, adolescent girls, etc. – should not include more than 10 to 12 participants, and should not last more than one to one-and-a-half hours.

In order to increase acceptance and ensure that participants are not the targets of community suspicion, threats or violence, be sure to consider:

1. If you do not feel it is safe to have this discussion, or that it may cause risk for staff or participants, do not proceed.
2. Before mobilizing participants, meet with community leaders and/or local government to explain the purpose of the assessment visit – to better understand the health and safety concerns affecting women and girls after the crisis – and the presence of the assessment team in the community.
3. Where possible, link with a range of local women’s leaders – formal and informal – during participant mobilization. Women leaders may be involved in one focus group, but should not be present in all groups to ensure that women feel free to speak openly.
4. Where relevant, carry out focus group discussions in the displaced, refugee or returnee community, as well as in the host community.
5. Ensure that staffs facilitating focus group discussions do not ask probing questions in an effort to identify the perpetrators of violence (i.e., one specific armed group).

Focus group discussion facilitator:

Secretary (if applicable):

Geographic region:

Date: ____________________________ Location: ____________________________

Translation necessary for the interview: Yes No

If yes, the translation was from ____________________________ (language) to ____________________________ (language)

Sex of FGD participants: Male Female

Age of FGD participants:

- □ 10-14 years
- □ 15-19 years
- □ 20-24 years
- □ 25-40 years
- □ Over 40 years
ESSENTIAL STEPS & INFORMATION BEFORE STARTING THE FOCUS GROUP DISCUSSION

Introduce all facilitators and translators

Present the purpose of the discussion:
- General information about your organization
- Purpose of the focus group discussion is to understand concerns and needs for women and girls
- Explain what you will do with this information and make sure that you do not make false promises
- Participation is voluntary
- No one is obligated to respond to any questions if s/he does not wish
- Participants can leave the discussion at any time
- No one is obligated to share personal experiences if s/he does not wish
- If sharing examples or experiences, individual names should not be shared
- Be respectful when others speak
- The facilitator might interrupt discussion, but only to ensure that everyone has an opportunity to speak and no one person dominates the discussion

Agree on confidentiality:
- Keep all discussion confidential
- Do not share details of the discussion later, whether with people who are present or not
- If someone asks, explain that you were speaking about the health problems of women and girls

Ask permission to take notes:
- No one’s identity will be mentioned
- The purpose of the notes is to ensure that the information collected is precise

QUESTIONS

A. We would like to ask you a few questions about the security of women and girls after the crisis:

Note: You may choose to use community mapping to approach questions 1-2.¹

1. In this community is there a place where women and girls feel unsafe or try to avoid? (Day? Night?) What is it that makes this place unsafe?

2. From whom can women and girls seek assistance in case of a security problem?

3. According to you, what could be done in this community to create a safe environment for women and girls?

4. Describe what kinds of violence women and girls faced during the crisis (not only acts of violence committed by armed actors). Adapt this question to reflect the specific context.

5. What happens to the actors of these acts of violence against women and girls? Are they punished? If so, how?

¹ See the GBV Sub-Cluster Community Mapping Guidance Note.
6. Without mentioning names or indicating any one means, according to you which group(s) of women and girls feels the most insecure or the most exposed to risks of violence? Why? Which group(s) of women and girls feels the most secure? Why?

7. How does the family treat a woman or a girl who was the victim of rape or sexual assault? How do they support her?

8. What do women and girls do to protect themselves from violence? What does the community do to protect them?

B. We would like to ask you some questions about the services and assistance available since the crisis:

Note: You may choose to use community mapping to approach questions 10-11.²

9. What do women usually do after they have experienced such violence? Do they seek help?

10. When a woman or girl is the victim of violence, where does she feel safe and comfortable going to receive medical treatment?

11. Are there other services or support (counseling, women’s groups, legal aid, etc.) available for women and girls that are victims of violence?

² See the GBV Sub-Cluster Community Mapping Guidance Note.
C. We would like to ask you questions about a possible incident: Develop a short, contextually appropriate case study in which a woman is raped and is afraid to tell her family about what happened. Use this to frame the below questions. Be sure that the case study does not use a specific name for the woman, so it is clear that this exercise is hypothetical and is not linked to anyone specific in the community. A few sample case studies are provided below, but must be adapted and selected based on the context.

Sample case study 1: A young girl left her shelter during the night to use the latrine. She reached the latrine and entered, but while inside heard noises nearby. When she exited the latrine a man grabbed her, pulled her behind the latrines and raped her.

Sample case study 2: During an attack on the village a woman’s husband left the tukul to defend the cattle. While he was gone, rebels entered the tukul and raped the woman. The rebels attempted to abduct the woman, but she screamed and in the chaos of the attack was able to escape.

Sample case study 3: A young widowed woman is alone in the returnee community, the sole caretaker for her two young children and her aging father. While in line to register for food distribution an NGO worker says he will give her an extra sack of rice each month if she visits him in the evenings to “keep him company.”

12. If a woman reported that she experienced violence similar to the woman in the story, how many of you would believe her story?

13. Why do women and girls hesitate to share experiences like this with other people?

14. Where could this woman go to receive appropriate assistance? What kind of assistance and support could she receive?

CONCLUDE THE DISCUSSION

- Thank participants for their time and their contributions.
- Remind participants that the purpose of this discussion was to better understand the needs and concerns of women and girls since the crisis.
- Explain the next steps. Again, repeat what you will do with this information and what purpose it will eventually serve. Also inform participants if you will be back.
- Remind participants of their agreement to confidentiality.
- Remind participants not to share information or the names of other participants with others in the community.
- Ask participants if they have questions.
- If anyone wishes to speak in private, respond that the facilitator and secretary will be available after the meeting.
GBV Assessment Tools

COMMUNITY MAPPING: GUIDANCE NOTE

A community map is an excellent tool for collecting qualitative data, especially in cultures that have a strong visual tradition. Maps can be created on paper with colored pens or in the dirt/sand using natural materials such as sticks and pebbles.

During a GBV-specific assessment this approach can be incorporated into focus group discussions as a means of better assessing the community’s knowledge of services available to women and girls (number, location and quality of medical and psychosocial care, for example), challenges women and girls may face in accessing services (privacy, distance, safety, for example), and the community’s perception of areas that present high risks to women and girls (public or remote areas where sexual assaults or harassment are likely to take place, for example).

To incorporate community mapping into your assessment, follow the introductory guidance found in the Focus Group Discussion tool. Identify questions that may be “mapped” rather than addressed through discussion, and proceed with the following steps:

1. Request that a participant draw a map of the general area, camp or site. (Have materials ready – sticks, stones or other potential drawing materials – ready in case participants do not naturally reach for something.)

2. As the map is taking shape, other participants are likely to provide input or to get involved. Give plenty of time and space.

3. Wait until participants have completely finished before you begin asking questions. Then use the below questions to help you understand risk factors and services for women and girls. After each question, give participants time to consider and indicate their responses on the map.
   a. Where do people in the community go if they need medical treatment?
   b. Where do people in the community go if they want to express a concern about safety?
   c. Is there a place where women can go to discuss problems together?
   d. Are there places on the map that are not safe for women and girls during the day?
   e. Are there places on the map that are not safe for women and girls during the night?
   f. Where might a woman go for help if she is the victim of violence?
   g. Where might a girl go for help if she is the victim of violence?

4. Record any visual output from this process, whether it is drawn on the ground or on paper. Be accurate and include identifying information (place names and the date the map was created).

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Annex 5

The International Rescue Committee:

Improving GBV Response, Preparedness & Prevention Capacity in Disaster Situations
October 1st 2011 through December 19th 2012

Selected Indicator Table from Final Performance Report Submitted to OFDA

<table>
<thead>
<tr>
<th>Number and percent of community members who can report at least two negative effects of GBV on their community</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North Kivu</strong>: Based on an endline survey: 80% (58/72) of people who can report at least two negative effects of GBV on their community. This is a 17% increase since the beginning of the project [Baseline: 68% (30/44), endline: 80% (58/72)]. Haiti: 73.5% (30/42) training participants can report at least two negative effects of GBV on their community. In addition, LL surveyed the communities where community activists were working to see how well messages spread through the community.</td>
</tr>
<tr>
<td>• 15% increase in community knowledge that a man imposing control over family finances is a form of violence [Baseline: 51% (304/597), endline: 60% (395/659)];</td>
</tr>
<tr>
<td>• 100% decrease in community attitudes that generally, it is a woman’s fault if a man rapes her [Baseline: 26% (155/597), endline: 13% (86/659)];</td>
</tr>
<tr>
<td>• 79% of community members (77% female; 81% male) recognized that it has an impact on children when there is beating, fighting and insults between the husband and wife;</td>
</tr>
<tr>
<td>• 33% decrease in community attitudes that, when a man learns his wife or partner has HIV, he has a right to beat or abuse her [Baseline: 44% (263/597), endline: 33% (217/659)].</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Number and percent of target population reporting increased access to gender-based violence services</th>
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<tr>
<td><strong>North Kivu</strong>: 80% (58/72) of target population can identify existing services, their importance, and how to access them, representing a 60% increase. [Baseline: 50% (53/106), endline: 80% (58/72)]. 130,177 people were reached through community education. Haiti: 60% (99/165) of target population can identify existing services, their importance, and how to access them; 24,301 people were reached through community education. LL established the foundations and community buy-in to start developing a plan for community-based response by mentoring 20 members of local women’s groups in case management and community dialogues around survivor support.</td>
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<th>Number of males sensitized to gender-based violence issues</th>
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<td><strong>North Kivu</strong>: 62,801 men and boys were reached through community awareness sessions (48% of indicator B)</td>
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<tr>
<th>Number of people trained in GBV emergency preparedness, mitigation, and management</th>
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<tr>
<td><strong>North Kivu</strong>: 278 GBV emergency responders from the IRC and partners participated in the ER&amp;P training. 74% (190/256) of trained GBV emergency personnel achieve a score of 70% or above.</td>
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1 Calculation as follows: The difference of the first percentage minus second percentage (80%-68%=12%) is divided by the second percentage (12/68=0.17) multiplied by 100 = 17%. This formula was used throughout the report to measure increase in knowledge.

2 Due to security constraints, it was not possible to access and conduct the endline study in the same sites as the baseline study. However all respondents were randomly selected in both the baseline and endline surveys.

3 The initial measurements were done with 14 focus groups in seven sites. In the comparison, focus groups (which had different respondents), participants were able to identify additional existing services, their importance, and how to access them in their area. However this methodology was difficult to quantify. In Dec. 1 was conducted that informed the indicator above.

4 A core component of the SASSI approach (and thus a community-based preparedness plan) is to establish firm community buy-in around prioritizing GBV related issues and the importance of organizing collective action. This process depends on how long it takes a community to begin buy-in to these issues. In the case of the communities that LL is working with, it took the full project period to garner a sufficient level of buy-in. LL will continue to work with communities to develop the response plans in 2013.

5 Some training participants did not take both the pre test and post test. This attributes differences in the denominators throughout the report of participants who took the pre/post tests and the actual number of participants.

6 Facilitators from the IRC’s WPE Technical Unit facilitated one training in DRC for 22 participants. The DRC program trained 256 partners and staff in North Kivu from the ER&P curriculum.

7 This training occurred a week after Tropical Storm Isaac passed over Haiti which impacted the number of health workers available to attend.
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<th><strong>Number and percentage of beneficiaries retaining GBV emergency preparedness, mitigation, and management knowledge three months after training</strong></th>
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<tbody>
<tr>
<td><strong>North Kivu and Haiti</strong>: 79% (15/19) of the participants who took the post-test evaluation six months after the training scored the same or better than their post-test evaluation.</td>
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<tr>
<th><strong>Number and percentage of participants in the GBV in Emergencies Thematic Working Group (TWG) workshop that apply tools</strong></th>
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<tr>
<td>81% (19/23) of the TWG members attending the ER&amp;P training improved their scores from the pre- to post-test. 39% (9/23) of participants score of 70% or above.</td>
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<th><strong>Number of minimum interventions in response to emerging crises</strong></th>
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<td><strong>North Kivu</strong>: 16 rapid assessments and 41 emergency GBV response interventions were conducted. During these interventions 197 women received essential services including quality medical care.</td>
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<tr>
<td><strong>Haiti</strong>: Two emergency assessments and emergency interventions were conducted. IRC distributed 738 hygiene kits, 76% (562/738) to female-headed households and/or identified vulnerable women and girls; IRC distributed shelter materials to 450 vulnerable families.</td>
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<tr>
<th><strong>Number and percentage of GBV responders trained on how to safely and ethically to use the GBVIMS in emergencies</strong></th>
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<tr>
<td><strong>North Kivu</strong>: 41 GBV responders trained on how to use the GBVIMS in emergencies. 100% (29/29) completed 70% or more of the emergency GBVIMS form.</td>
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<tr>
<td><strong>Haiti</strong>: 14 GBV responders trained in case management skills, including safe and ethical management of client information. 100% (14/14) improved their scores. 71% (10/14) achieve a score of 70% or above.</td>
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<th><strong>Number of people trained in the use and disposal of medical equipment and consumables (North Kivu)</strong></th>
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<td>40 medical supervisors and nurses were trained in the use and disposal of medical equipment and consumables as a part of the CCSAS training.</td>
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<th><strong>Number and percent of target population participating in psychosocial activities</strong></th>
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<td><strong>North Kivu</strong>: 1,167 GBV survivors received psychosocial care and case management; 29 psychosocial staff received training and technical support in case management.</td>
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<tr>
<td><strong>Haiti</strong>: 1,877 GBV survivors received psychosocial care and case management; 100 young girls participate in life-skills activities; 14 psychosocial staff received training and technical support in case management.</td>
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<th><strong>Number and percent of beneficiaries reporting improved capacity to carry out productive family/community roles/responsibilities</strong></th>
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<tr>
<td><strong>North Kivu</strong>: 78% (52/67) of service providers trained in case management and/or psychosocial services met quality criteria consistently.</td>
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<tr>
<td><strong>Haiti</strong>: Due to staff turnover at the management and psychosocial assistant level, the Haiti team was unable to measure the consistency of meeting the criteria for quality case management. It was determined that IRC staff and partners would benefit from refresher training in case management. There was a 33% increase in knowledge as a result of the training among the 14 IRC and partner staff that attended.</td>
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<th><strong>Number and percent of beneficiaries reporting improvement in their feeling of well-being or ability to cope</strong></th>
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<tr>
<td><strong>North Kivu</strong>: 88% (554/626) of survivors discharged after receiving psychosocial services demonstrated an improvement in their psychosocial well-being.</td>
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<td><strong>Haiti</strong>: The original management team did not set up interviews with survivors because most survivors were not seen directly by IRC staff but by partner agencies like KOFAVIV. The new program management began to establish M&amp;E tools to assess this indicator in November:</td>
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<td>- 1:1 ratio between GBV survivors’ registered /GBV survivors referred</td>
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<td>- Number of follow-up visits (at least one per GBV survivor)</td>
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<td>- Monitoring of GBV survivors’ well-being by IRC staff (60% of survivors of rape stated that they were satisfied with the services they received)</td>
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8 IRC was only able to reach 19 of the 45 trainees from Haiti and DRC to measure retention six months later. In Haiti, many of the participants no longer worked in their organization. In DRC, there was staff turnover in UEFA and many fled the M23 incursions.

9 Note that there was a wide difference between the IRC and partner staff. IRC staff improved by 44%; partner staff, who had a lower baseline knowledge, increased their knowledge by 88%.