Feasibility and Acceptability Study of the IRC’s Mobile and Remote GBV Service Delivery in Myanmar, Burundi and Iraq

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Executive Summary

Beginning in 2016, International Rescue Committee (IRC), with the support of the U.S. State Department, Bureau of Population, Refugees and Migration (PRM), and European Civil Protection and Humanitarian Aid Operations (ECHO), developed and piloted mobile and remote-based models of service delivery to address challenges typically faced by service providers attempting to reach GBV-affected populations in humanitarian settings that are hard to access because of insecurity or that have populations displaced outside of a structure refugee or internally displaced persons (IDP) camp. Within IRC, Women's Protection and Empowerment (WPE) teams provide a range of programming to women and girls, including group activities designed both to increase psychosocial support and life skills, as well as provide confidential entry points for case management services for survivors of gender-based violence (GBV). More recently, IRC has also utilized GBV hotlines as an alternative confidential entry point for case management services. IRC’s mobile and remote programming aims to increase access to GBV-related services in insecure and out-of-camp humanitarian settings while adhering to best-practice principles for survivor-centered service delivery.

In 2017-2018, research advisors, Leah James and Courtney Welton-Mitchell, collaborated with IRC to assess the feasibility and acceptability of mobile and remote GBV response models by evaluating current IRC services being piloted in Myanmar, Burundi, and Iraq. This cross-sectional mixed-methods evaluation, together with ongoing monitoring data collected by the WPE teams in each country, aimed to answer the following research questions, specific to the three humanitarian settings:

→ How feasible and acceptable are mobile and remote technology-based models of GBV service delivery for women and girls?

→ What are the infrastructure, staffing, and supervision requirements for effective delivery of mobile and remote models of GBV services?

→ What potential program modifications would likely improve/enhance the feasibility and acceptability of mobile and remote technology-based models of GBV service delivery?

→ Based on the findings with regard to the above research questions, what is the potential for scale up/implementation of such programs in other environments where IRC works?

These questions were considered with the goal of developing guidance for the broader humanitarian community regarding how to respond to GBV in humanitarian settings that are particularly insecure or have populations displaced out of a structured refugee camp.

Methods consisted of structured and open-ended individual interviews and focus group discussions with stakeholders in each country, as detailed below.

• In each country, trained local interviewers conducted structured individual interviews with adult women (age 18+) and adolescent girl (age 15-17) beneficiaries who had participated in IRC’s mobile and remote programming in recent months. Interviewees were randomly selected from existing WPE group psychosocial support (PSS) activity participants. A total of 151 adults and 30 adolescents were interviewed across the three countries. In addition, some monitoring data from program beneficiaries was utilized for this report (case management, hotline, and client satisfaction feedback).

• All IRC staff members and community focal points who met study criteria (current or former IRC WPE team members or focal points working on the project) were invited to participate in either a focus group discussion or an individual in-depth interview, depending on their role in the project (in Myanmar, a few participated in both). Following FGDs or individual interviews, all staff and focal points were invited to complete a written survey to provide supplemental information. A total of 45 staff members and 33 focal points were included across the three countries.
Local non-IRC service providers in the established referral pathway, community leaders (women and men) recruited from local leadership groups, and male community members (in Myanmar and Burundi) recruited from other IRC activities, were invited to participate in FGDs. Additionally, beneficiary community groups participated in FGDs in Iraq. A total of 150 persons participated across the three countries.

Findings are presented regarding: A) Beneficiary demographics; B) Awareness of services; C) Beneficiary access to services; D) Outreach/community engagement; E) Temporary safe spaces; F) Transportation; G) Group activities (PSS activities / Information sessions); H) Case management; I) Help-seeking for case management related needs; J) Referral pathways; K) Hotline; L) Staffing in mobile teams (including training/supports); M) Technology; N) Safety/security; O) Participatory opportunities; P) Services for male survivors of sexual violence; Q) Transitioning to local partners and program sustainability; and R) Beneficiary feedback about the interview process. Overall, the findings highlight that mobile and remote programming is challenging but both feasible and acceptable to local communities when appropriate and well supervised.

The findings section is followed by Discussion: A Response from IRC. In this section, key findings identified by IRC as particularly important for informing outward-facing recommendations are interpreted and contextualized. Attention is given to addressing constraints, including elaborating on considerations unique to remote and mobile programming. A summary of specific key findings are outlined below.

- **Overall, beneficiaries are satisfied with mobile and remote services, given restraints, and desire more services.** Beneficiaries of group activities across all settings reported general satisfaction with staff warmth and relatability, staff trustworthiness, safety and privacy of the space for group activities and privacy of the space for case management.

- **Group activities and individual interactions with staff that are not about GBV are key for discreet case management.** Staff and beneficiaries emphasized the role of psychosocial activities in decreasing stigma about help-seeking from IRC and increasing confidentiality and safety for those seeking and providing GBV-focused services.

- **Community focal points are essential for facilitating access to services.** Most beneficiaries who participated in the study identified community focal points as their entry point to activities and services.

- **More supervision and support for all staff and focal points is required.** Staff in all contexts requested additional supervision and both staff and focal points requested additional training and staff support services. Moreover, safety issues reported in the study demonstrated the urgent need for a higher level of remote technical supervision and training regarding boundaries and safety.

- **Misconceptions about service delivery are a barrier to access.** Findings highlighted confusion from staff and beneficiaries about the accessibility of services (e.g., beneficiaries believing there are age caps, that services cost money, etc.) which need to be addressed.

- **Facilitating access to referral services for mobile and remote service delivery requires increased resources.** Many respondents reported need for additional referral options, especially for shelter, legal, and economic empowerment services. While service mapping is always important for GBV response, it requires additional staff time and effort for mobile and remote programming due to implementation of services in multiple sites, frequently lacking clear borders.

- **There is interest in technology-based services, though there are some barriers to access.** Staff, focal points, and other stakeholders were generally enthusiastic about the value of hotline services and requests for more active hotline hours suggest that beneficiaries are interested and able to access services remotely. Participant responses also highlight generally positive reactions to use of tablets. However, challenges remain with limited access to phones, poor internet/phone service, and negative or mixed cultural reactions to women and girls’ phone/internet use.
Finally, in the Recommendations and Conclusions section, research advisors and IRC staff outline evidence-based recommendations for practitioners, researchers, policy-makers and donors. Information in this section is complimented by IRC’s Guidelines for Mobile and Remote Gender-Based Violence Service Delivery which were developed as part of the pilot project. Recommendations are summarized below.

**Recommendations for practitioners:**

**Staffing:**
- More staff overall were needed for mobile programming, specifically, dedicated staff are needed for hotline/support call services.
- Staff and community focal point composition should be reflective of the community (e.g., representing ethnic groups and languages of beneficiaries).
- More technical supervision and on-going coaching is required for staff and community focal point, including in-person and through scale-up of remote supervision (e.g., hotlines and case management applications).
- Staff-support and self-care approaches are critical for staff and focal points.

**Community focal point component:**
- Clear Memorandum of Understandings (MOUs) and job descriptions for the role of the focal point are needed, especially to clarify boundaries of focal point roles in regard to providing direct services.
- Focal points should be thoroughly trained on outreach strategies and involved in ensuring access for all populations in the context.
- Focal point MOUs, training, and supervision should prioritize confidentiality and safety protocols related to outreach and community engagement.

**Financial resources and infrastructure:**
- Aim to strike a balance among various priorities (cost, location, service provider and community control) when selecting spaces for mobile service provision.
- Consider budget lines for adequate transportation support for staff, focal points, and beneficiaries (including for those with disabilities), meeting the basic needs of survivors (e.g., emergency food, NFIs), securing safe places for service delivery, set up and maintenance of the hotline, and information communication and technology (ICT) equipment.

**Additional recommendations:**
- Mapping of services in each mobile site requires extensive staff time in order to develop thorough referral pathways that are responsive to the changing nature of these contexts. Strengthened coordination and advocacy for support of referral partners are needed. Referral policies and procedures should be clear, documented, phone-based, and updated regularly.
- Ensure that there are mechanisms to collect routine feedback from beneficiaries, focal points, and community leaders so that the mobile team can adjust to the changing needs of the community.
- Ongoing dialogue between staff, focal points, and beneficiaries should be conducted to identify safety risks and trainings and safety measures should be put in place to address these issues.
- Communicate clearly and consistently with beneficiaries and focal points about how beneficiaries can access services in order to mitigate potential misconceptions (e.g., that services cost money), and clarify scope of mobile services in order to address potentially unrealistic expectations given their limitations.
• Improve targeted outreach to vulnerable groups including development of appropriate outreach messages given the cultural context to ensure that male survivors of sexual violence and male and female-identified LGBTI survivors know that services exist.

• Consider mechanisms for systematically shifting ownership of activities and spaces to focal points and community groups, including by empowering community members to develop their own activities and use spaces as they desire.

• Facilitate thoughtful expansion of hotline and other technology, with an awareness of challenges regarding both technological limitations, and social norms that may discourage or create risks associated with phone and internet use by women and girls. Consider use of hotline programming for vulnerable groups facing particular stigma regarding help-seeking, such as men, boys, or LGBTI populations.

• While not unique to mobile programming, in areas where shelters do not exist, it may be useful to explore what other options may be available for short and longer-term safety should a survivor need such support.

• Plan for sustainability by including local partners from the outset of programming. If the plan entails eventual handover to local organizations, engage in ongoing capacity building, including technical trainings and organizational development.

**Recommendations for researchers and monitoring and evaluation practitioners:**

• Include perspectives from non-service using members of the community to better understand the need for and barriers to engagement in mobile and remote services.

• Include perspectives from those experiencing short term displacement.

• Collect information about alternatives to shelters.

• Collect information about what kinds of cash programming can support survivors with economic needs and what links to livelihood programming might be feasible and beneficial within mobile programming.

• Conduct further piloting of innovative programming, including remote service provision through technology (such as SMS, chat, etc.), voucher or mobile cash programming associated with case management, and joint sectoral mobile deployments.

**Recommendations for policy makers and donors:**

• For donors, consideration of staffing and budget needs outlined above is critical.

• Related to the above, consider that host community populations will also access programming especially if GBV services do not exist in host areas (remote or otherwise).

• UN agencies, donors and other stakeholders should prioritize advocacy for stronger referral options.

• Donors should facilitate and require sustainability planning and responsible handover to local partners as appropriate, including sufficient funds for capacity-building.

We are hopeful that these recommendations, resulting from lessons learned, will be used to strengthen programming for GBV survivors and women and girls in emergency and other humanitarian settings.
I. Overview of the IRC’s Mobile And Remote Programming and Associated Feasibility and Acceptability Study

A. Rationale

Gender-based violence (GBV) often escalates during humanitarian emergencies, especially when crises result in displacement.¹ Increasingly, displaced persons are living in host communities or informal settlements, with more than half of the world’s displaced people living in urban areas.² Furthermore, conflict and disasters exacerbate many forms of GBV, such as sexual violence, intimate partner violence (IPV), and early marriage. Women and girls from marginalized populations face increased risk based on intersecting inequality such as race, class, disability, sexual orientation and gender identity. Men and boys, particularly from marginalized populations, may also face risk of sexual violence in humanitarian settings. Often those populations at greatest risk of GBV reside in areas that are difficult to access, both in terms of distance and security concerns. Given this, the humanitarian community is currently grappling with the need for innovative approaches that allow humanitarian actors to efficiently access and provide support to populations at risk for GBV.

Beginning in 2016 International Rescue Committee (IRC), with the support of the U.S. State Department, Bureau of Population, Refugees and Migration (PRM), and European Civil Protection and Humanitarian Aid Operations (ECHO), developed and piloted mobile and remote-based models of service delivery to address challenges typically faced by service providers attempting to reach GBV-affected populations in humanitarian settings that are hard to access because of insecurity or that have populations displaced outside of a structure refugee or internally displaced persons (IDP) camp. Within IRC, Women’s Protection and Empowerment (WPE) teams provide a range of programming to women and girls, including group activities designed both to increase psychosocial support and life skills, as well as provide confidential entry points for case management services for survivors of gender-based violence (GBV). More recently, IRC has also utilized GBV hotlines as an alternative confidential entry point for case management services. IRC’s mobile and remote programming aims to increase access to GBV-related services in insecure and out-of-camp humanitarian settings while adhering to best-practice principles for survivor-centered service delivery.

The purpose of this associated study is to assess the feasibility and acceptability of mobile and remote GBV response model by evaluating current IRC services being piloted in Myanmar, Burundi, and Iraq.

Background: History of conflict, common forms of GBV, and limited access to services in Myanmar, Burundi and Iraq

Over the past several years, Northern Shan State in Myanmar has experienced active conflict between the Myanmar army, ethnic armed groups and militias resulting in flight and internal displacement.³ Clashes between Myanmar’s military and ethnic armed groups, including the Kachin Independence Army, the Ta’ang National Liberation Army and the Restoration Council of Shan State (RCSS/ Shan State Army) flared in late 2017 and have continued into 2018.⁴ As of April 2018, more than 100,000 are internally displaced in Kachin and Northern Shan States.⁵

GBV is common in Myanmar. According to the 2015-16 Demographic and Health Survey, at least 15% of women have experienced physical violence and 3% have experienced sexual violence. Actual rates are thought to be much higher, especially in conflict areas, where survivors may be particularly fearful about sharing their experience. Additionally, women are often trafficked to China for forced or coerced marriage, among other reasons. Although rape is criminalized under the Myanmar penal code, it is difficult to prosecute. In addition, marital rape is not considered a crime, and there are no domestic violence laws.

Violence against women appears to be particularly high in Northern Shan State. Intimate partner abuse, sexual violence perpetrated by members of the military and other armed groups, and a lack of decision-making power in the home and community are well documented by local women's groups. Recent assessments in Northern Shan and Southern Kachin States indicate that many women are at risk for GBV and generally feel unsafe in the camps for the internally displaced. The many challenges associated with the ongoing civil conflict and related displacement, exacerbated by a lack of women's rights across sectors, make it especially difficult for women to access GBV-related services in Northern Shan State.

**Burundi** continues to struggle with a political crisis beginning in 2015, myriad natural disasters (typically floods and landslides), and declining socio-economic conditions. As of March 2018, there were 174,011 IDPs in Burundi, primarily displaced by natural disasters and the sociopolitical situation. Moreover, Burundian refugees in Tanzania and elsewhere have begun returning home in high numbers. An agreement among the governments of Burundi and Tanzania and UNHCR aims for 72,000 Burundians to return home from Tanzania throughout 2018. Burundi also hosts refugees from the Democratic Republic of the Congo (DRC). Continued conflict in eastern DRC, with several armed groups located close to the borders, results in influxes of refugees flowing into Burundi. Those fleeing violence are highly vulnerable to sexual and other forms of GBV.

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13. UNFPA and DRC (2014); INTERSOS (2014); IOM (2015)
14. IOM, 2018
15. UNHCR, 2018
17. USAID and Burundi Gender Analysis (2017).
IDPs and residents are also at risk. The political crisis in 2015 has been associated with sexual violence committed by security forces, sometimes in the form of reprisals against communities perceived to support the opposition, or persecution based on political or ethnic affiliation.\(^\text{18}\) Single women are particularly vulnerable; an estimated 17% of displaced households are headed by single-women.\(^\text{19}\) Some women who live alone and have limited economic means are exposed to sexual exploitation and abuse in the attempt to feed themselves and their children.\(^\text{20}\) In addition, it is not uncommon for women to be subjected to economic, psychological, physical, and sexual violence by partners, often with limited legal recourse. Other groups that are particularly vulnerable to GBV in Burundi include widows and divorced women, undereducated women, women with disabilities, and sex workers.\(^\text{21}\) The mobility of women is limited due in part to the lack of freedom of movement imposed on the entire population by authorities, but also because women and girls fear and avoid control checkpoints, where rape and other forms of violence have occurred.\(^\text{22}\) This high level of insecurity and violence across the country restricts safe access to basic services, including limiting access to GBV response services.

In Iraq, successive cycles of sectarian violence have resulted in massive displacement. As of March 2018, there are 2.2 million IDPs, and 3.6 million returnees in Iraq.\(^\text{23}\) As detailed in a 2016 UNFPA assessment in eight conflict-affected governorates, GBV is pervasive in IDP communities.\(^\text{24}\) Women are already in subordinated positions in a patriarchal society, a situation that increases their vulnerability to various forms of GBV during conflict and displacement.\(^\text{25}\) Women and girls, especially members of minority ethnic and religious groups, have been subjected to large scale sexual violence by the Islamic State.\(^\text{26}\) Forced marriage is common. Local militias, law enforcement, and other power-holders are also sometimes perpetrators of GBV. Depletion of resources leads to increased sexual and physical exploitation of women as a means of survival. Moreover, reports suggest that, among IDPs, violence is most commonly perpetrated by family members, typically husbands.\(^\text{27}\) Cultural and religious norms, including traditional ideas about honor, are used to legitimize violence against women and girls and discourage help-seeking. Survivors of violence rarely seek support from the police or legal system due to stigma and fear of reprisal, as well as concerns about mandatory reporting laws which hold medical personnel responsible for reporting such cases to the authorities.\(^\text{28}\) Disclosure of violence, especially sexual violence, can have serious repercussions for survivors (including honor killings). For cultural reasons, women are often limited in their ability to make independent decisions about interacting with family, friends, and neighbors, thus further impeding help-seeking and increasing their isolation.\(^\text{29}\)

In the three settings described, Myanmar, Burundi and Iraq, women and girls often fail to receive services focused on GBV prevention and response.\(^\text{30}\) In order to accommodate the challenges associated with these emergency settings, IRC is engaging in innovative methods of service provision, targeting groups that are often neglected.

\(^{19}\) IOM 2018
\(^{20}\) USAID and Burundi Gender Analysis. (2017).
\(^{21}\) USAID and Burundi Gender Analysis. (2017).
\(^{25}\) UNFPA (2016).
\(^{26}\) United Nations Secretary General (2017).
\(^{27}\) UNFPA (2016).
\(^{28}\) https://reliefweb.int/sites/reliefweb.int/files/resources/gbv_sub-cluster_strategy_iraq_2016_full_endorsed.pdf
\(^{29}\) UNFPA (2016).
\(^{30}\) United Nations Secretary General (2017).
B. Description of Specific Types of IRC Mobile and Remote Programming

The IRC conceptually frames mobile GBV service delivery as distinct from traditional service delivery (commonly referred to as ‘static services’). With static services, beneficiaries are expected to access services through established centralized locations, under consistent management of GBV service providers, with regular access to confidential GBV case management services. Static services are the typical model in large IDP and refugee camps, where there are clear boundaries and defined populations. Alternatively, mobile programming may be used when people are dispersed and displaced amongst host communities in rural or urban settings where the population does not have access to static services. With mobile programming, services are provided to people where they are, and typically are available on an intermittent or rotational basis. As such, it encompasses any programming that involves physical movement to sites where populations are residing, in transit, or are commonly located and are not easily reached with traditional (static) services. Because of the transient nature of this model, mobile teams are able to see more beneficiaries across a wider physical space but spend far less time in each individual location. Because mobile staff are visiting each site less frequently, some services within mobile sites are limited compared to traditional static programming.

Two models of mobile response were piloted during this project. Short term rapid response involves the deployment of GBV mobile teams in an emergency to serve survivors who are part of/recently affected by a humanitarian crisis, in transit, or newly displaced. With short term rapid responses, the population will not remain in the site long and the GBV mobile team may visit the site once or a few times within a few days to provide crisis response, risk reduction supplies and information about the services available. Mobile response during protracted displacement involves GBV mobile teams deploying to a site (or several sites) on a rotational basis (e.g., once a week over months in each site) usually after the acute phase of an emergency has passed.

With remote GBV service delivery, services are provided over a technology platform (i.e. hotline, mobile application, chat or SMS) rather than in person. This technology greatly expands the reach of programs to provide access to crisis support and case management. Remote GBV services can be provided as a separate stand-alone intervention in places where the population cannot access services in-person or an organization cannot set up in-person services due to insecurity, or remote services can support existing mobile and static programming.

Within mobile and remote programming approaches, primary services that can be provided are:

- **GBV case management**: A structured method for providing help to a GBV survivor, based on social work case management. It involves one organization, usually a psychosocial support or social services actor, ensuring that survivors are informed of all options available to them, identifying issues and problems facing a survivor and her/his family, setting goals and care planning, following up in a coordinated way (making referrals as appropriate), and providing the survivor with emotional support and coping skills throughout the process. Case management includes ensuring access to available services through referrals. For example, health services for sexual assault survivors may be provided through referrals to other service providers or by the mobile teams directly.

- **Non-case management individual sessions**: One-on-one support for non-GBV issues, often used as a strategy to reduce potential stigma by making it appear common for case workers to talk to individual beneficiaries.

- **Psychosocial support (PSS) group activities**: Group recreation or life skills activities for women and girls, including activities for positive coping skills, community safety, and risk reduction.

- **Outreach and information/awareness raising sessions**: Activities to raise awareness about GBV and service availability and to empower and build community capacity to address GBV, including:

  » Stand-alone sessions or sessions associated with existing community mobilization initiatives designed to educate community members about women’s rights and GBV basic concepts, to reduce stigma against GBV survivors, and to inform about service availability and encourage help-seeking.

  » Sessions designed to engage community leaders and service providers, focused on topics above as well as
a means of supporting survivors with quality services, risk mitigation for GBV, ongoing service mapping, and strengthening referral pathways.

- **Support call/hotline services:** Hotlines can support mobile service delivery interventions when a mobile team is not on-site. The functions of a hotline as part of a mobile intervention are: 1) for caseworkers to speak directly with survivors and offer crisis intervention, safety planning, and information about resources and referrals, and 2) for caseworkers to provide remote technical support and supervision by speaking with community focal points and other service providers in mobile sites.

With mobile programming, IRC WPE teams strive to establish confidential “entry points” for GBV case management in private spaces linked with other non-stigmatized services or activities, such as PSS activities and information sessions. These linked activities provide the dual functions of encouraging group psychosocial support while allowing survivors a confidential means to seek services. After contextual assessments in Myanmar, Burundi, and Iraq (and given the lack of other appropriate services in which to link GBV programming in mobile sites\(^ {31} \)), entry points for case management were established in temporary safe spaces for women and girls, in which PSS activities are also conducted. Confidential hotline services provided an additional entry point for survivors.

In addition to IRC staff, community focal points are key to mobile service delivery models. Focal points are women who are often leaders from the intended beneficiary communities and are based in these communities. Focal points provide outreach regarding group activities and service availability and support psychosocial programming in safe spaces. Over the course of their engagement with IRC, WPE staff work to build their capacity to respond to disclosures of GBV in their own communities and make referrals to IRC’s case management services. In the models piloted for this project, they also provide a link for survivors to trained caseworkers via hotlines when mobile caseworkers are not on site. They also assist WPE staff to better understand the cultural context and nuanced needs of survivors and women and girls in general. Whereas focal point roles are limited to outreach and in some contexts, PSS activities, handover of case management to focal points can be considered if certain criteria are met with respect to their technical capacity, resources and infrastructure. For example, in Myanmar, all of the focal points are members of an umbrella women’s organization and IRC provides training and capacity building so that they can eventually provide case management independently. At the time of this evaluation, no handover of case management to focal points had occurred, yet these focal points are an important component of a long-term sustainability strategy.

In addition to services for beneficiaries, in all locations, IRC staff coordinates with the GBV Sub-Cluster and works to map services and strengthen referral pathways with service providers in the region and for each specific mobile site. Staff also work with community leaders and service providers on risk reduction activities and provide training on GBV Core Concepts. IRC coordinates and advocates with other organizations working in other sectors to carry out sector specific risk mitigation and prevention measures as outlined in the IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Settings.

From 2016 to 2018, Myanmar, Burundi, and Iraq were seen as pilot locations, with the understanding that IRC will evaluate this programming to determine feasibility and acceptability of the mobile and remote GBV service delivery approaches generally.

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\(^ {31} \) The program first attempted to base GBV case management services out of health clinics in Myanmar. However, private space within the health clinics that allowed for GBV case management services to be provided at the same time as health services was not possible due to land restrictions.
Myanmar

Sites and target populations: IRC is active in 21 of the 37 long-term IDP camps, located in Kutkai, Namkhan, Muse and Mansi provinces of Kachin and Northern Shan States. In addition, due to ongoing conflict, community members often flee fighting, going to a church, monastery or other public area for refuge, and returning to their community within a few weeks. Displacements usually involve fewer than 500 people at a time. IRC specifically targets newly displaced women and girls by distributing dignity kits and informing them about additional services. IRC also provides programs for 9 surrounding communities, ‘host communities’ (located in Hseni, Hsipaw, Kutkai, Lashio, Manton, Mansi, Namtu, Nawngkhio, and Tangyan) where these short-term displacements often occur.

IRC operates through collaboration with existing organizations and networks in Myanmar, working through KMSS for the IDP sites on the Roman Catholic Church grounds and working directly in the IDP camps on the Kachin Baptist Church grounds and in the Ta’ang camps. Throughout Northern Shan State, IRC works with focal points from women’s groups affiliated with the Northern Shan State Women’s Organization Network (NSSWON). Two focal points reside in local community areas (Hseni, Hsipaw, Kutkai, Lashio, Manton, Namtu and Nawngkhio) in order to expand services beyond protracted IDP sites. This allows mobile teams to more quickly reach populations displaced during cyclical emergencies. Although the hotline is available for all of Northern Shan State, dissemination of information about the hotline has been concentrated in areas with focal points.

Staffing and services. In Myanmar there are a total of eight WPE staff, including a WPE senior manager, four IRC response officers, one KMSS response officer, one NSSWON response officer, and one reproductive health (RH) doctor. Focal Points (13) and IDP Case Workers (19) live in and work at mobile sites and travel to the central office in Lashio for supervision, coaching, and support from IRC staff. From the mobile sites, they travel to villages to conduct outreach, provide information sessions and group activities (based on local interests), and link survivors to IRC response officers for case management. The IDP caseworkers provide direct case management support in the IDP camps with remote supervision via IRC response officers. The RH doctor and IRC mobile health colleagues provide information to women and girls and services in the IDP camps. The hotline for Northern Shan State is staffed by IRC Lashio-based response officers and supervised by the WPE Senior Manager at the Lashio office. Various IRC staff, particularly the responses officers and RH doctor, also participate in mobile outreach on an ad hoc/as needed basis, in response to new, often temporary displacements of less than 500 persons at a time.

Current Beneficiaries: In Northern Shan State, IRC provided in-person case management services to 35 survivors (all women; 89% above 18 years old; 74% currently married or with partners) between January 2017 and March 2018. Those receiving case management were 80% residents of local communities and 20% IDPs. Of these, 63% were Buddhist and 17% were Christian (20% did not provide such information). Data on ethnicity, language and location of the services is not available from monitoring reports, but 51% of survivors reported that GBV incident(s) occurred in Lashio province, 11% in Namtu, 9% in Kutkai, 9% in Hsipaw, 6% in Mansi, 6% in Namkhan, 6% in another state, and 3% in Tangyan.

Between July 2017, when it opened, and April 2018, the support call center (hotline) in Myanmar received 124 calls. Of these calls, 60 were from first time callers. Most (82%) of these callers were women, 17% were men, and in one case, the call was silent. Female callers were survivors of GBV (31%), focal points or case workers (24%), external service providers (20%), family, friends or secondhand reports (18%) and other (6%). Of the male callers, 20% were survivors, 60% were external service providers, 10% were family/friend/secondhand report and 10% were other. Nearly all (98%) of the female
callers were 18 or older, with 2% between the ages of 12 and 17. All male callers were over the age of 18. Most callers were from Lashio province (38%), though calls also came from Namtu (21%), Hsipaw (6%), Tangyan (6%), Kutkai (5%), Namkhan (4%), Muse (3%) and Hseni (1%). Interestingly, 16% of calls originated from outside of areas targeted by IRC for information dissemination. The majority of calls took place in Myanmar/Burmese language (73%) (though this does not necessarily reflect that the caller’s ethnic group was Bamar, as Myanmar/Burmese is the national language). Callers also spoke Shan (16%), Jinghpaw (Kachin) (6%), Ta’ang (3%), Lahu (2%), and Wa (1%). 96% of callers were residents of local communities and 4% were living in IDP camps.

In regard to PSS and information sessions, from April 2017 and March 2018, focal points provided 118 GBV education sessions (e.g., training on GBV basic concepts, availability of specific services, advocacy and prevention messages) and 186 psychosocial support activities (e.g. handicraft making, singing, game playing, etc.) to women and girls. They also provided 57 GBV education sessions to men and boys. Participants in GBV education sessions included 859 women, 109 girls, 261 men, and 31 boys under the age of 18. PSS activities were attended by 887 women and 259 girls. Additionally, 4,858 women and adolescent girls attended 406 community mobilization information sessions (e.g. international events or sessions focused on women’s rights, service availability, etc.) and 1,133 men and boys attended 189 similar sessions.

**Burundi**

**Sites and target populations:** In Burundi, IRC WPE programming targets host community members, returnees, IDPs, and refugee women and girls from the DRC living in urban areas in Bujumbura and Makamba provinces. In both provinces, the population is primarily Kirundi and French speaking.

As of May 2018, Bujumbura Mairie hosts 24,557 IDPs, approximately 75% of which were displaced by the sociopolitical situation, with the remaining 25% displaced due to natural disasters (such as floods and landslides). Moreover, Bujumbura hosts more than 20,885 refugees, representing 39% of the country’s total refugee population. In Bujumbura province, IRC WPE mobile programming is active in Kinama, Kamenge, Buterere and Gatumba.

In Makamba province, there are 12,815 IDPs. More than half (57%) of these were displaced by the socio-political situation. Programming includes the area of Kayogoro where approximately 2,500 IDPs are dispersed amongst the host community and Nyanza-Lac communes where 6,000 IDPs wait amongst the host community to cross the border to Tanzania. These locations also host a large returnee population from Tanzania. In Makamba, IRC is active in Gatabo, Kabonga, Mukungu and Bigina.

**Staffing and services:** In Burundi, mobile teams are utilized to provide services to communities who are hard to reach, primarily due to distance. Programming includes group activities tailored to local interests, GBV case management and

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33 IOM (2018).

34 IOM (2018).


one-on-one support sessions for issues not related to GBV with women and girls. There are 20 community focal points ("community activists"), 10 in Bujumbura and 10 in Makamba, who coordinate activities for women and girls in safe spaces at mobile sites. Four IRC staff members ("social assistants") move from the central office on rotation to these sites to provide information about gender based violence and case management services for survivors. Additionally, in accordance with the results of an Information Communication and Technology (ICT) and safety assessment, an informal hotline ("Service Support Line") allows social assistants and Community focal points to access remote supervision as they are serving beneficiaries in the field. Beneficiaries can also use this line to call staff directly for additional support.

Current beneficiaries: In Burundi, the WPE mobile teams provided in-person case management services to 179 survivors of GBV between January 2017 and March 2018. More than half (54%) of these cases were from mobile sites in Bujumbura and 46% were from mobile sites in Makamba. All of the survivors were female and 84% were 18 years or older. Almost half (47%) of survivors were married or cohabitating, 34% were divorced or separated, 18% were single and 1% were widowed. Data on religion, ethnicity and languages were not collected.

Between October 2017 and April 2018, the support call line (hotline) in Burundi received 484 calls. Although some monitoring reports are incomplete, existing data indicates that almost all (128 out of 132 calls were from women (98% adults and 2% girls age 17 and under) and 4 calls were from adult men. Focal points were the most common callers (all female; 57% of all calls). Fewer (17%; all female) calls came from IRC social assistants, 14% from survivors (94% female; 6% male), 8% from external service providers (all female) and other (5%; 50% female and 50% male). IRC staff collected language data on 88 calls (100% Kirundi). Location data was collected from 68 calls; 57% were from Makamaba - 28% from Gatabo, with the remainder from Bigina (19%) and Kabonga (10%). The remainder were from Bujumbura - Buterere (15%), Kinama (12%), Gatumba (7%), and Kamenge (9%).

Regarding psychosocial support and information session services, social assistants and focal points held 30 group discussions and 39 community sensitizations between July and December 2017. These activities were attended by 1,976 women and 161 men. Additionally, each of the 8 mobile sites held weekly psychosocial support activities (e.g., dancing, soap making) with 20 female participants for a total of 320 women and girls.

Iraq

Sites and target populations: As of February 2018, there are nearly 31,896 IDPs in Karbala governate. These are primarily families that have been displaced from the Ninawa-Tal Afar district, north of Mosul, since 2014. Even though Tal Afar has since been liberated, few IDP families have returned due to fear of violence, loss of family members, and destruction of their home properties. Most families are sheltered in camps or in Islamic centers, called hussainiyas. IRC mobile programming is active in three hussainiyas in Karbala (Al-Safyea, Badir Bany Hashim, and Ahali Lebanon), where services are provided to IDPs and the host community. The hotline is available to any individual in Iraq who calls but is primarily aimed at providing support to survivors, their loved ones, and service providers working with survivors in Karbala and Anbar.

Staffing and services: In Iraq, the mobile team is made up of three IRC staff: one social worker and two designated ‘community mobilization officers’. Additionally, four focal points live in the targeted communities where they facilitate group activities and link women seeking services with IRC staff by phone. When linking beneficiaries to staff, focal points often do not know which services the women request, which protects beneficiary confidentiality. The IRC staff move from the central
office to a rotation of sites to provide case management, group activities, and individual non-case management sessions. These staff also support women and girls in accessing services in the referral network, such as health services. Access to in-person support is frequently impeded by social, cultural or infrastructure-related barriers limiting women and girls’ ability to leave home and/or travel to service sites. Therefore, a hotline offers crucial access to survivors seeking crisis intervention, safety planning, referrals, and other information. The hotline also allows service providers to seek support and resources in their work with survivors. The hotline is staffed by a WPE social worker in Baghdad.

**Current beneficiaries:** In 2017, IRC provided in-person case management to 321 GBV survivors in Karbala. All were female IDPs. Most (63%) were married or cohabitating, 18% were widowed, 10% were single and 8% were divorced or separated. Almost all (96%) were above the age of 18, while 3% were between the ages of 12 and 17 and 1% were under the age of 12. Data was not collected on religion, language or ethnicity.

Between October 2017 and April 2018, the hotline received 15 calls, 47% of which were from survivors (all female). The other calls came from individuals requesting monetary or non-food item support and organizations seeking information or offering their own services (50% female, 38 % male, and 12% unreported). The majority of callers (71%) were IDPs and the remainder were residents. Calls came from Ninewa (40%), Al Anbar (27%), Baghdad (13%), Erbil (13%), and Maysan (7%). Staff have also reported that case workers and focal points received a high volume of calls that were not documented because they came directly to the staff instead of through the hotline. This direct beneficiary to case worker/focal point remote support was a significant part of the programming in Iraq.

In regard to psychosocial support and information sessions, IRC staff conducted 12 sessions covering topics such as GBV, legal, and health awareness, reaching 519 women and girls and 6 men in 2017. Psychosocial support activities, such as cooking, drawing, painting, and picnics were conducted with 64 women and 47 girls. Community dialogues and focus group discussions were conducted with 185 beneficiaries, the majority of which were held with women and girls (one dialogue also included men). Ten men participated in a Men’s Action Group, 20 women created a women’s committee and 20 girls participated in a girls committee, all designed as venues for community advocacy, often focused on shifting gender norms. Additionally, 40 service providers from organizations in IRC’s referral network were included in trainings and meetings relating to GBV work.

### C. Study goals and objectives

This cross-sectional mixed-methods evaluation, together with ongoing monitoring data collected by the WPE teams in each country, aimed to answer the following research questions:

- How feasible and acceptable are mobile and remote technology-based models of GBV service delivery for women and girls in the three humanitarian settings evaluated (select communities in Myanmar, Burundi, and Iraq)? This includes exploration of impediments to service uptake and adherence to program elements associated with international standards for the protection of GBV survivors, including confidentiality, safety, nondiscrimination, and self-determination.

- What are the infrastructure, staffing, and supervision requirements for effective delivery of mobile and remote models of GBV services in the three humanitarian settings evaluated?

- What potential program modifications in the three implementation locations would likely improve/enhance the feasibility and acceptability of mobile and remote technology-based models of GBV service delivery?

- Based on the findings with regard to the above research questions, what is the potential for scale up/implementation of such programs in other environments where IRC works?

These questions were considered with the goal of developing guidance for the broader humanitarian community regarding how to respond to GBV in humanitarian settings that are particularly insecure or have populations displaced out of a structured refuge.
D. Design/methodology

Ethics approval

Approval was granted by the IRC’s internal Institutional Review Board on November 14, 2017 (Protocol number: WPE 1.00.010). The IRC IRB was established by the Research Evaluation and Learning Unit and complies with all federal regulations as well as state and local/country laws applicable to human subjects research. The ethical review for this research was conducted independently, with no WPE staff associated with mobile and remote programs involved in this review.

Study design, sites, and sample

Research team, training, and materials

This study uses mixed methods approaches to assess the feasibility and acceptability of mobile GBV programming in Myanmar, Burundi, and Iraq. Methods include structured and open-ended individual interviews and focus group discussions (FGDs) with stakeholders in each country, including adult women and adolescent girl beneficiaries, IRC staff, IRC focal points, non-IRC service providers, community leaders, and adult men (community members). Procedures are described in detail below.

Research activities were overseen by research advisor consultants, James and Welton-Mitchell, working in collaboration with two IRC WPE staff, Laird and Neiman (Monitoring and Evaluation Officer and Service Delivery Specialist, respectively). The four coordinated with country-specific research teams. Local research team members were consultants or IRC staff not directly associated with the target populations examined in the research. Teams consisted of local research managers (in Myanmar and Iraq), female interviewers/focus group facilitators responsible for beneficiary interviews and focus groups with women (four in Myanmar, two in Burundi, and two in Iraq), and male focus group facilitators, responsible for focus groups with men (four in Myanmar, two in Burundi, one in Iraq). The Burundi team also included an interpreter/translator, while in Myanmar and Iraq, interpretation and translation were provided by the research managers. Research team members completed an intensive one-week training conducted by the research advisor consultants and the two IRC WPE staff, followed by regular (in-person and remote) supervision and debriefings throughout data collection.

Interview and FGD scripts for all participants were developed through collaboration among research advisor consultants and IRC WPE staff, with input from country program teams and local research team members. All interview and FGD instruments focused on identifying successes, challenges, and suggestions for improvement across similar thematic areas: awareness of services by beneficiaries and other stakeholders, beneficiary access to services/barriers to receiving services, outreach/community engagement, spaces where services are delivered and related transport, psychosocial support activities and information sessions, case management, referral pathways, hotline services, staffing in mobile teams (including training, supervision, and supports for staff), use of technology by beneficiaries and staff, and security.

Trainings, interviews and focus groups were conducted in staff and participants’ preferred languages (Myanmar/Burmese, Jinghpaw, Ta’ang and English in Myanmar; Kirundi and French in Burundi; Arabic and English in Iraq). All research materials were translated into preferred languages. Subsequently materials were back translated into English, and further refined before being pilot tested during the training period.

Study sites

This evaluation occurred in the following communities, across three countries, all targeted by the mobile and remote GBV case management program. See Description of IRC remote and mobile programming section above for detailed content about programming sites and target populations.

Study sites in the three countries were selected based on the following criteria:

- Representativeness
- Accessibility (including availability of a confidential interview space)
Myanmar: Lashio (staff and partners only), Manton and Kutkai in Northern Shan State.

Kutkai was chosen to represent longer term IDP camps where IRC has caseworkers, established safe spaces, and routine mobile programming. Within the Kutkai area there are camps that represent the Ta’ang and Kachin. Program beneficiaries and staff in Kutkai also speak at least one of the languages that were included for the evaluation (Myanmar/Burmese, Jinghpaw, Ta’ang). Kutkai was also chosen as it is the only province where IRC has both routine IDP programming and host community focal point programming.

Manton was chosen to represent an area where IRC has a remote focal point with the local women’s organization, including coverage of IDP camps in the area. In Manton they also spoke at least one of the languages included as an option for the evaluation.

Burundi: Bujumbura and Makamba

Data collection with staff and focal points was conducted in the central office in Bujumbura and in the Makamba office. Data from non-IRC service providers, community leaders, and male community members were collected in easily accessible conference spaces in Bujumbura and Makamba.

Locations for beneficiary data collection were chosen in line with locations in which services are implemented. Beneficiary data was collected in all spaces where services are implemented across all sites in which the mobile teams operate in Bujumbura (Kinama, Kamenge, Buterere and Gatumba) and Makamba (Kinama, Kamenge, Buterere and Gatumba).

Iraq: Baghdad (staff only) and Karbala.

Interviews and focus groups with staff who remotely supervise programming in Karbala were conducted in the IRC’s central Baghdad office. Focal point, non-IRC service provider, and community member data collection was conducted in the IRC’s Karbala office.

Beneficiary data collection was intended to be conducted in the same Karbala sites in which services are implemented. However, because one site did not have space available for interviews at the time this study was conducted, beneficiary interviews were conducted in two of the three spaces in Karbala where programming is implemented: Al-Safyea and Najaf Karbala road (serving Badir Bany Hashim and Ahalai Lebanon hussainiyas).

Adult and adolescent beneficiaries: Structured interviews

In each country, trained local interviewers conducted structured individual interviews with adult women (age 18+) and adolescent girls (age 15-17) who had participated in IRC programming in recent months. In all settings, interviewees were randomly selected from existing WPE group PSS activity participants. In addition, in Burundi, targeted case management participant sampling was conducted, such that 30 case management participants (who had also participated in PSS activities) were randomly selected from pre-existing lists of case management participants. In Myanmar and Iraq, pre-existing lists of case management participants were not available; therefore the sample was randomly selected from group activity participants only (a few of whom turned out to have also utilized case management services). Those who were selected were invited to participate in interviews using a recruitment script.

Beneficiaries who met inclusion criteria (women and girls, appropriate age, have used WPE services at least once) and expressed interest in participation were invited to scheduled interview slots at designated spaces where services are delivered. Upon arrival, beneficiaries were read an informed consent script and asked for oral consent; no names or identifying information were collected or recorded. All women invited consented to participate. Interview data was collected using offline Qualtrics survey software on tablets, supplemented with some paper surveys for specific languages in Myanmar. Interviews were approximately one hour in length. See Table 1 for sample size by location (more detailed location data is available in the beneficiary sample demographics section below).
Table 1. Beneficiary interview sample, by location

<table>
<thead>
<tr>
<th>Location</th>
<th>Adults, n</th>
<th>Adolescents, n</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td>61</td>
<td>12</td>
<td>73</td>
</tr>
<tr>
<td>Kutkai</td>
<td>30</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td>Manton</td>
<td>31</td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td>Burundi</td>
<td>60</td>
<td>12</td>
<td>72</td>
</tr>
<tr>
<td>Bujumbura</td>
<td>30</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td>Makamba</td>
<td>30</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td>Iraq</td>
<td>30</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td>Karbala</td>
<td>30</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td>TOTAL</td>
<td>151</td>
<td>30</td>
<td>181</td>
</tr>
</tbody>
</table>

Adult and adolescent beneficiaries: Monitoring data

Throughout the pilot, monitoring data was collected on an on-going basis to generate learning on program quality, staff competency and beneficiary satisfaction. Some of this monitoring data has been included in this report in order to further contextualize findings. All data were collected only after receiving informed consent. See Table 2 for methods used to collect monitoring data.

Table 2. Sources of monitoring data, by location.

<table>
<thead>
<tr>
<th>Tool</th>
<th>Myanmar</th>
<th>Burundi</th>
<th>Iraq</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GBVIMS or PRIMERO - in-person case management</strong></td>
<td>Case workers and response officers conduct intakes on paper and store case files in locked filing cabinets. These paper forms are entered into GBVIMS on a computer.</td>
<td>Social Assistants conduct intakes at mobile sites and then fill in paper intake forms by memory upon returning to the office. These paper forms are entered into GBVIMS on a computer.</td>
<td>Social workers conduct the intake in mobile sites and immediately collect data using PRIMERO on a tablet.</td>
</tr>
<tr>
<td><strong>Hotline Intake form or PRIMERO - hotline support and remote case management</strong></td>
<td>Response officers record data directly into CommCare via a tablet during or after a support call.</td>
<td>Social assistants or GBV officers record data directly into CommCare via a tablet during or after a support call.</td>
<td>Social workers record data directly into PRIMERO during or after a support call.</td>
</tr>
<tr>
<td><strong>Client Satisfaction - in-person case management</strong></td>
<td>After 3 months of case management or at the time of case closure, all beneficiaries are invited to provide feedback on the services they received. If the beneficiary agrees, supervisory or M&amp;E staff interview them and record information directly into CommCare.</td>
<td>Due to the informal nature of the support line in Burundi, monitoring data related to satisfaction with this service was not collected.</td>
<td>After a support line call, if the caller consents to providing feedback, the phone is given to a secondary individual who interviews the beneficiary and records the information directly into CommCare.</td>
</tr>
<tr>
<td><strong>Client Satisfaction - hotline support and remote case management</strong></td>
<td>After a support line call, if the caller consents to providing feedback, the phone is given to a secondary individual who interviews the beneficiary and records the information directly into CommCare.</td>
<td>Due to the informal nature of the support line in Burundi, monitoring data related to satisfaction with this service was not collected.</td>
<td>After a support line call, if the caller consents to providing feedback, the phone is given to a secondary individual who interviews the beneficiary and records the information directly into CommCare.</td>
</tr>
<tr>
<td><strong>Group Activity Tracking</strong></td>
<td>Focal points and mobile team members fill out forms weekly during group activities. These are aggregated in an excel document on a laptop.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IRC staff members and focal points: Focus group discussions (FGDs), individual interviews, and self-report surveys

All staff members who met study criteria (were current or former IRC WPE team members working on the project) were invited to participate in either a focus group discussion or an individual in-depth interview, depending on their role in the project (in Myanmar, a few participated in both). FGDs were conducted with staff in similar positions and levels. When there were no other staff in similar roles, or when it would not be appropriate to include them in focus groups (e.g., senior staff with supervisees), individual interviews were conducted instead, using the same questions as those used for FGDs, at times supplemented with additional questions relevant to the evaluation. In some cases (e.g., Myanmar) additional individual interviews were conducted with a few staff from partner organizations that were directly involved in implementation of WPE activities. All focal points operating through this project who met study criteria (currently working as focal point on projects) were also invited to participate in FGDs.

All staff and focal point FGDs and interviews were conducted by research advisors James and Welton-Mitchell in collaboration with translators as necessary. For both staff and focal points, FGDs were divided by location, language or other factors as appropriate for a given country context (e.g. in Myanmar separate groups were conducted based on work area and were facilitated in Myanmar and Jinghpaw languages). In all cases, staff and focal points were read an informed consent script and gave verbal consent, either individually or in groups. Typically, individual interviews and FGDs lasted from 45 minutes to 2 hours.

Following FGDs or individual interviews, all staff and focal points were invited to complete a written, primarily closed-ended survey to provide supplemental information. Staff and focal points were free to choose their preferred format: 1) an electronic form to be completed on computers using Qualtrics survey software; 2) a paper form to be completed individually; 3) an interview. In Myanmar most staff and focal points completed the survey on paper, with a few choosing to complete the survey electronically. In Burundi and Iraq, staff chose to complete the survey electronically while most focal points completed it on paper. In Iraq, two focal points elected to complete the survey as an interview. These surveys typically took about 30 minutes to one hour.

See Table 3 for sample sizes by location.
## Table 3. Staff and focal point FGD, interview, and survey sample by location

<table>
<thead>
<tr>
<th>Location</th>
<th>Staff FGDs</th>
<th>Staff individual interviews</th>
<th>Staff Surveys</th>
<th>Focal point FGDs</th>
<th>Focal point surveys</th>
<th>TOTAL (unique participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td>23</td>
<td>10 (5 not in FGDs)</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>38</td>
</tr>
<tr>
<td>Lashio</td>
<td>3 FGDs total: 1 FGD, Lashio-based staff (5); 2 FGDs, case workers from IDP camps (18)</td>
<td>10 (including former staff and partner staff)</td>
<td>27</td>
<td>1 FGD, 10 NSSWON affiliated focal points from local communities</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Kutkai</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manton</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burundi</td>
<td>4</td>
<td>3</td>
<td>20</td>
<td>1</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>Bujumbura</td>
<td>1 FGD, 4 <em>social assistants</em> (2 from Bujumbura, 2 from Makamba)</td>
<td>2</td>
<td>3</td>
<td>1 FGD, 10 focal points</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Makamba</td>
<td>1</td>
<td>3</td>
<td>1 FGD, 10 focal points</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iraq</td>
<td>2</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Baghdad</td>
<td>8 (current and former staff)</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karbala</td>
<td>1 FGD, 2 <em>social workers</em></td>
<td>2</td>
<td>1 FGD, 3 focal points</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>29</td>
<td>16 (not in FGDs)</td>
<td>33</td>
<td></td>
<td></td>
<td>78</td>
</tr>
</tbody>
</table>

### Additional stakeholders - service providers, community leaders, and male community members: Focus group discussions

Local non-IRC service providers in the referral pathway were invited to participate in FGDs. FGDs were divided by location and, when appropriate, by gender. In Myanmar one service provider group was conducted by research advisor Welton-Mitchell (in collaboration with the in-country research manager); the remainder of the service provider groups were conducted by local research staff following training by the research advisor. In Burundi and Iraq, service provider FGDs were conducted by research advisor James, in collaboration with translators.

Community leaders (women and men) were recruited from local leadership groups, such as camp committees, religious organizations and women's groups, and using staff contacts. In Iraq, male community leaders were recruited from Men's Action Groups led by IRC. FGDs were divided by location and in certain contexts, by gender. In Myanmar, Burundi, and Iraq, community leader FGDs were conducted by local research teams with training by research advisors.

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37 Staff and focal point surveys were conducted with staff and focal points who had already participated in interviews and FGDs, hence are not included in calculations of unique participants (with the exception of one focal point in Iraq who only completed a survey). In Myanmar, five staff who had participated in FGDs were also interviewed individually.

38 Although these men are officially beneficiaries of the WPE program, their role in this research was not to report on their experience as beneficiaries, but rather to represent perspectives of male community leaders and members on use of services, IRC’s reputation in the community, etc. As beneficiaries, their perspectives may be different than that of other male community leaders and members; however, to ensure feasible and safe recruitment, they were included in FGDs.
Male community members were recruited from other activities. In Myanmar, men were recruited from IRC GBV awareness raising sessions. In Burundi, men were recruited from Village Savings and Loans Associations (VSLAs). FGDs, divided by location, were conducted by male members of the local research teams following training from research advisors.

Finally, in Iraq, additional FGDs were conducted with members of community groups that had been implemented by beneficiaries as part of associated programming. FGDs with female adult and adolescent members of community groups were conducted by members of the local research team with training by research advisors.

See Table 4 for sample sizes by location.

Table 4. Additional stakeholder FGD sample, by location

<table>
<thead>
<tr>
<th>Location</th>
<th>Service providers</th>
<th>Community leaders</th>
<th>Male community members</th>
<th>Beneficiary community groups</th>
<th>TOTAL (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>64</td>
</tr>
<tr>
<td>Lashio</td>
<td>6 FGDs total: IDP camps &amp; communities (25 women, 19 men)</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Kutkai</td>
<td></td>
<td></td>
<td></td>
<td>2 FGDs (12 men)</td>
<td></td>
</tr>
<tr>
<td>Manton</td>
<td></td>
<td></td>
<td>1 FGD (8 men)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burundi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>Bujumbura</td>
<td>1 FGD (4 women, 5 men)</td>
<td>1 FGD (3 women, 6 men)</td>
<td>1 FGD (7 men)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makamba</td>
<td>1 FGD (4 women, 2 men)</td>
<td>1 FGD (4 women, 5 men)</td>
<td>1 FGD (10 men)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iraq</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Karbala</td>
<td>2 FGDs (one with 3 women; one with 3 men)</td>
<td>1 FGD (11 men)</td>
<td></td>
<td>2 FGDs (one with 9 women;</td>
<td></td>
</tr>
<tr>
<td>TOTAL (n)</td>
<td>65</td>
<td>26</td>
<td>40</td>
<td>19</td>
<td>150</td>
</tr>
</tbody>
</table>

Data analysis

For quantitative interview data (from adult and adolescent beneficiary interviews and staff and focal point surveys), descriptive analyses were conducted using SPSS data analysis software. For continuous or ordinal (Likert scale data), means and standard deviations were examined, while for binary data, frequencies and percentages were examined. Qualitative data from surveys were translated to English by local researchers, then coded by a research assistant, using a bottom-up approach, and organized according to emergent categories.

Qualitative data from interviews and focus groups were translated to English (as needed) and transcribed (except in the case of Myanmar where some of data was coded directly from audio recordings). Most transcripts were coded by research assistants using NVIVO software, based on thematic categories determined by topics of interest and the framework used in surveys and focus group questions.

See Table 5 for the data collection and analysis timeline.
Table 5. Data collection and analysis timeline

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data collection – Myanmar</td>
<td>February 5th- March 8th, 2018</td>
</tr>
<tr>
<td>Data collection – Burundi</td>
<td>March 5th – March 30th, 2018</td>
</tr>
<tr>
<td>Data collection – Iraq</td>
<td>March 19th – April 10th, 2018</td>
</tr>
<tr>
<td>Translation and transcription of qualitative data</td>
<td>Completed mid-March to mid-May 2018, depending on country</td>
</tr>
<tr>
<td>Cleaning, running descriptives, formatting quantitative data output tables</td>
<td>Completed mid-May, 2018</td>
</tr>
<tr>
<td>Coding qualitative survey output</td>
<td>Completed early June, 2018</td>
</tr>
<tr>
<td>Coding qualitative data from FGD transcripts</td>
<td>End May – June 15th, 2018</td>
</tr>
<tr>
<td>Writing of final report</td>
<td>End May – end June, 2018</td>
</tr>
</tbody>
</table>

E. Methodological limitations and strengths

Limitations

There are several significant limitations to this feasibility and acceptability study, many associated with the challenges of conducting research in humanitarian contexts, particularly when IDP populations are dispersed amongst host community populations rather than located in a refugee or formal IDP camp.

First, the study was limited to focus on mobile services during protracted displacement, rather than short-term rapid response services. Although short-term displacement services are provided in Myanmar, for logistical and safety reasons we could not include community members/beneficiaries experiencing short-term displacement (many of whom were no longer in the area, although some of these persons may be reflected in host community beneficiaries that were sampled). Burundi and Iraq are protracted displacement contexts.

A second limitation concerns potentially non-representative sampling. The beneficiary research sample (181 adult women and adolescent girl beneficiaries) may not be representative of the beneficiary service-user population as a whole, or of the population originally targeted by programming (which may differ from the actual service-user population). Although sampling was designed to entail random selection of beneficiaries from group activity participant lists, in reality, logistical challenges in some settings led to supplemental convenience sampling. As a result, samples may be biased in some regards (e.g., the research sample is comprised of those speaking languages used in the research and those who may be living closer to service sites than other program participants, be more frequent service users, or have closer relationships to IRC staff and focal points). These problems are likely more pronounced in some settings (Myanmar and Iraq) than others (Burundi), and are discussed in more detail in the country-specific sections below. Ultimately it is not possible to determine the representativeness of the sample due to lack of demographic information in the monitoring data routinely collected by IRC for group activity participants. Reliable broader demographic data associated with the target populations is not available either. However, this can be considered a reality of programming that, rather than targeting a defined population in a refugee camp, aims to serve large displaced IDP and refugee populations that are often integrated throughout (and hidden within) host communities.
Further, due to both confidentiality concerns from IRC, and logistics considerations, case management sampling was only possible in one setting. In Burundi, pre-existing lists of case management participants were available, allowing for random sampling of participants from these lists. In contrast, in Myanmar and Iraq a sample of group activity participants were invited to partake in the research, a few of whom had, by chance, also utilized case management services. Consequently, case management participant samples are quite small in Myanmar and Iraq, impeding meaningful analysis of case management users’ experience. Hotline participants are also very few across countries for similar reasons, including ethical and safety concerns about contacting hotline callers, especially potential GBV survivors.

A related limitation is the lack of a non-service user sample in this study. Non-service users were not sampled due to concerns from IRC regarding logistics (sampling methodology proposed by research advisors was not deemed to be feasible) and ethics (potential compromise to service-users’ confidentiality by revealing purpose of services; desire not to raise expectations by contacting community members in areas not served by IRC). Because service-utilizing and non-utilizing populations are likely to differ in important ways, implications for interpretation of results should be considered. Primary research questions concern barriers to seeking services; non-service utilizing populations are likely to offer important insights as to barriers preventing them from seeking services, while service utilizing populations are limited to recalling their own concerns (which were obviously not so significant that they were not able to access services). Whereas service users are also asked to speculate about why others may not be able or willing to access services, such secondhand reflections have clear limitations.

Community leader and service provider samples may have similar biases. Samples were drawn by research team members in collaboration with staff based on existing staff contact lists, which likely reflect pre-existing relationships with IRC. ‘Male community members’ were selected from men participating in associated IRC programming (various types of program groups) who therefore may differ in important ways from other community men (and may have very different perspectives on IRC).

In addition, some participants may have been inclined towards a positivity bias, for example, tendency to overuse the positive end of a response scale (indicating more positive attitudes). This bias has been associated with culture, especially more collectivist cultural groups (often linked to Asian, and sometimes African cultures). The humanitarian context likely also plays a role such that beneficiaries may be concerned that any negative comments about IRC may result in service cuts and/or reflect negatively on IRC staff. Staff and focal point feedback may be further influenced by concerns about how feedback will reflect on one’s own work. Efforts were made to minimize positivity bias during data collection, as interviewers and focal group facilitators emphasized the purpose of the study in improving services here and elsewhere (not on evaluating the performance of particular staff) and stressed the value of constructive critical feedback. Additionally, beneficiaries were informed during the consent process that their responses would not negatively impact their access to services, and staff and focal points were informed that confidentiality would be strictly maintained and their employability would not be affected.

In interviews and surveys, some items were skipped for some respondents. Skipped items appear to be random in Burundi, Iraq, and Myanmar, likely explained by interviewer error. In Myanmar, for language reasons, some surveys were also administered on paper, making skip logic impossible to program (unlike the surveys administered using data collection tablets). Consequently, there was some confusion on the part of a few interviewers initially about which question modules should be administered to all participants, and which should be skipped for certain subgroups, resulting in some erroneously skipped items.

In Myanmar, there are additional specific limitations of the study sites/sample due to the following – (1) we could not include more than three languages for interviews (e.g., Shan was not offered, resulting in exclusion of an important group in the host community area); (2) there are several remote areas without adequate phone reception, however, beneficiaries were not sampled from these areas (although such a sample would be useful in understanding the feasibility of the hotline and other technology-based approaches); (3) security concerns prevented access to/sampling from some areas (e.g.}

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access was blocked further into Kutkai towards the Chinese border, including to some of the more remote IDP camps). Research locations had to be modified in the weeks leading up to data collection, based on active fighting near Kutkai. Despite the fact that it was not considered safe enough for the research team to enter some areas, it is noteworthy that IRC was able to prioritize Rapid Mobile Response to some of these areas during the research period.

In Burundi, beneficiary residence status information collected during both research and routine M&E is misleading due to varying participant interpretations of the term “resident.” Per staff report, beneficiaries regularly interpreted “resident” to include returnees and even IDPs. Consequently, it is not possible to assess the extent to which the research sample and service-users overall are consistent with the target population.

In Iraq, the sampling strategy was complicated due to recent loss of complementary funding, resulting in restriction of certain activities (including group PSS and information session activities) which made recruitment during those activities (or based on those activity lists) impossible. Further, in-person case management and group activities in Baghdad had ended, leaving only one location (Karbala) in operation. Consequently, whereas two locations are sampled in Myanmar and Burundi, only one location was sampled in Iraq, resulting in half the beneficiary sample size of the other countries (30 beneficiaries).

Interviews were conducted in only two of the three hussainiyas used for service implementation (the third did not have confidential space available at the time of this research), thus privileging those living close to those sites. Moreover, some women recruited for research were not able to reach the interview sites due to restrictions by camp officials, preventing them from leaving the site during the time of this study. It was not possible to obtain permission to conduct interviews in the camp during the window allocated for this research.

Non-targeted sampling resulted in very few case management participants, especially in light of high numbers of survivors in Karbala according to monitoring data (321). It is also possible that participants underreported case management use, potentially due to perceived safety consequences of disclosing GBV in the Iraq context, but this cannot be confirmed.

Finally, a significant limitation is that beneficiary interviews were conducted primarily in Arabic despite Turkman or Shabak being the first language of almost all participants. One of the two interviewers was also a Turkman speaker and was able to translate key words and phrases as needed during interviews. Per interviewer feedback, beneficiaries were able to understand and communicate in Arabic; however, language challenges may have limited the richness of the data.

**Strengths**

Despite these limitations, these are many strengths of this study. First, the study was conducted in three very different settings, allowing for comparison of programming across cultures and humanitarian contexts. In two of the three countries, two separate regions were targeted, and in Myanmar, three language options were available to research participants. A wide range of relevant stakeholders were sampled, including adult and adolescent beneficiaries, IRC staff and focal points, non-IRC service providers, community leaders, and community men, allowing for triangulation of findings across various perspectives. Beneficiary sample sizes were decent (30 per region; 60 total in two of the three countries), facilitating meaningful analyses. The study utilized diverse quantitative and qualitative methodologies, including structured and semi-structured interviews, self-report surveys completed on paper and online, and focus group discussions. Trained local research teams were used, allowing for interviews and focus groups conducted in local languages, with culturally-attuned facilitators.

Importantly, research was conducted despite the challenges associated with collecting data in the midst of active humanitarian crises. IRC research team members were flexible and creative in developing ethical and feasible approaches to data collection, and all participants, including IRC staff, made significant efforts to prioritize participation in this study, despite many competing priorities.
Finally, many participants reported positive experiences associated with participation in interviews and FGDs. Data collected from beneficiary interviews using items from the Research Participation Questionnaire Revised (RRPO)\(^4\) indicated that participants generally felt that they had gained something positive from research participation, were satisfied that results would be used to help others and felt they had been treated with respect.

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II. Findings

IRC management note: The findings section reflects respondent input and does not imply that IRC condones or encourages specific practices reported.

A. Beneficiary sample demographics

A total of 151 adult women and 30 adolescent girls were interviewed across three countries. All were beneficiaries of IRC’s WPE mobile and/or remote services. In interviews, beneficiaries were asked to provide demographic information to contextualize the sample. Detailed information on ethnicity and location is described below. See Table 6 for other demographic information.

**Myanmar:** A total of 61 adult women and 12 adolescent girls were interviewed in Myanmar. Of adult women interviewed, 35% were from host communities: 20% were from the host community in Kutkai, with 9 (15%) from the host community in Manton. The remainder (65%) were from various IDP sites in the area: Manton KBC (20%), Manton RC (16%), Kutkai KBC (5, 8%), Kutkai RC (4, 7%), Kar Laing 1 (7, 11%) and Kar Laing (2, 3%). When adult women were asked about ethnic identity, 54% identified as Kachin, 34% identified as Ta’ang, 5 (8%) as Jinghpaw, and 1 (2%) each as Lisu and Myanmar/Burmese. Of adolescent girls interviewed, 3 (25%) were from host communities (1 (8%) was from the host community in Kutkai, and 2 (17%) were from the host community in Manton). The remainder were from the IDP camps: Manton KBC (2, 17%), Manton RC (2, 17%), Kutkai KBC (2, 17%), Gar Laing 1 (2, 17%) and Gar Laing 2 (1, 8%). Of adolescents, 6 (50%) identified as Kachin, 3 (25%) Ta’ang, and 1 (8%) Jinghpaw.

**Burundi:** Sixty adult women and 12 adolescent girls were interviewed in Burundi. Half of the adults (50%) were interviewed in Bujumbura, in four sites: Butere (11, 18%), Gatumba (8, 13%), Kamenge (6, 10%), Kinama (5, 8%). The other half were interviewed in four sites in Makamba: Gatabo (8, 13%), Kabona (8, 13%), Bigina (7, 12%), Mukungu (7, 12%). Of adolescents, half were interviewed in Bujumbura: Kinama (4, 33%) and Kamenge (2, 17%), and half were interviewed in Makamba: Kabonga (2, 17%), Mukungu (2, 17%), Bigina (1, 8%), and Gatabo (1, 8%).

**Iraq:** Thirty adult women and six adolescents were interviewed in Iraq, all in Karbala. Of adults, 63% were interviewed in caravans at Najaf Karabala Road and 37% at Al Safya. All adolescent girls were interviewed at Al Safya.

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41 Demographic information was collected from adult women and adolescent beneficiaries during structured individual interviews. However, for confidentiality reasons, detailed demographic information was not collected from smaller groups of additional research participants (e.g. staff, service providers, community leaders and men from the community).

42 Percentages are rounded to the nearest whole number and therefore sums may not always equal 100.

43 When percentages refer to small number of participants (less than 10), numbers of participants are presented alongside percentages.

44 Per local team members, in light of the historical Tutsi Hutu conflict and ongoing tensions it was not considered acceptable to collect information about ethnicity in Burundi.

45 In Iraq, information about ethnicity, religion, and related factors was considered too sensitive to include in light of current community tensions.
Table 6. Beneficiary sample demographics, across countries

<table>
<thead>
<tr>
<th></th>
<th>Myanmar</th>
<th>Burundi</th>
<th>Iraq</th>
<th>Adolescents, n = 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sample size</strong></td>
<td><strong>Adults, n = 61</strong></td>
<td><strong>Adolescents, n = 12</strong></td>
<td><strong>Adults, n = 60</strong></td>
<td><strong>Adolescents, n = 12</strong></td>
</tr>
<tr>
<td><strong>IDP/resident status, n (%)</strong></td>
<td>40 (65%) IDP; 21 (35%) resident</td>
<td>9 (75%) IDP; 3 (25%) host community</td>
<td>55 (92%) resident; 3 (5%) refugee; 2 (3%) IDP</td>
<td>100% resident</td>
</tr>
<tr>
<td><strong>Age: mean (range)</strong></td>
<td>40 (20-63)</td>
<td>16 (15-18)</td>
<td>38 (18-66)</td>
<td>16 (15-17)</td>
</tr>
<tr>
<td><strong>Marital status, n (%)</strong></td>
<td>40 (67%) married/living with partner; 14 (23%) married but not living with partner; 5 (8%) separated/divorced/widowed; 2 (3%) never married</td>
<td>100% never married</td>
<td>32 (53%) currently married/living with partner; 7 (12%) currently married/not living with partner; 17 (28%) separated/divorced/widowed; 4 (7%) never married</td>
<td>21 (70%) married/living with partner; 6 (20%) separated/divorced/widowed; 3 (10%) never married</td>
</tr>
<tr>
<td><strong>Children, n (%); number of children, mean (range)</strong></td>
<td>57 (93%) with children; mean 3.7 (1-10)</td>
<td>0% with children</td>
<td>59 (98%) with children; mean 4.6 (1-10)</td>
<td>4 (33%) with children, mean 1 (1-1)</td>
</tr>
<tr>
<td><strong>Employment, n (%)</strong></td>
<td>56 (92%) working (41% farming; 18% various day labor activities)</td>
<td>--</td>
<td>17 (28%) working (65% small business/shop, 35% selling crops)</td>
<td>--</td>
</tr>
<tr>
<td><strong>Household income compared to others in community, mean</strong></td>
<td>M = 2.6 (A bit less or about the same as others in their community)</td>
<td>--</td>
<td>M = 1.8 (A bit less than others in community)</td>
<td>--</td>
</tr>
</tbody>
</table>

46 Varying participant interpretations of the term “resident” may have led to returnees and IDPs endorsing resident status. See Limitations section for further discussion.
<table>
<thead>
<tr>
<th>Education, n (%)</th>
<th>Myanmar</th>
<th>Burundi</th>
<th>Iraq</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education, n (%)</td>
<td>6 (10%) less than primary; 23 (38%) primary; 18 (30%) secondary; 2 (20%) tertiary; 2 (3%) higher education</td>
<td>24 (40%) less than primary; 20 (33%) primary; 15 (25%) secondary/tertiary</td>
<td>8 (27%) less than primary; 18 (60%) primary; 4 (13%) secondary/tertiary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language (first/most comfortable), n (%)</th>
<th>Myanmar</th>
<th>Burundi</th>
<th>Iraq</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language (first/most comfortable), n (%)</td>
<td>37 (61%) Jinghpaw; 18 Ta'ang (30%); 6 in Myanmar/Burmese (9%)</td>
<td>8 (67%) Jinghpaw; 4 (33%) Ta'ang</td>
<td>20 (67%): Turkman; 8 (27%): Shabak; 1 (3%): Arabic</td>
</tr>
</tbody>
</table>

Notes: Participants in Myanmar were interviewed in their preferred language. Participants in Iraq were interviewed in Arabic with Turkman words used to clarify meaning as needed. All participants in Burundi were interviewed in Kirundi and were not asked to report preferred language (as reported by the research team, Kirundi is spoken by all). Participants in Iraq were not asked to report IDP status due to potential sensitivities. One 18-year-old was interviewed as an adolescent in Myanmar due to interviewer error.

**Beneficiary sample participation in WPE services**

At the beginning of interviews, beneficiaries were asked to identify which services they had participated in from a list of potential services. All services were clearly defined using standardized blurbs and/or images (see Section B. Description of specific types of IRC mobile and remote programming). See Table 7 for reported service participation.

<table>
<thead>
<tr>
<th>Beneficiary sample participation in WPE services by country</th>
<th>Myanmar</th>
<th>Burundi</th>
<th>Iraq</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, n = 61</td>
<td>Adolescents, n = 12</td>
<td>Adults, n = 60</td>
<td>Adolescents, n = 12</td>
</tr>
<tr>
<td>Group PSS activities, n (%)</td>
<td>51 (84%)</td>
<td>8 (67%)</td>
<td>57 (95%)</td>
</tr>
<tr>
<td>Information sessions, n (%)</td>
<td>45 (74%)</td>
<td>9 (75%)</td>
<td>57 (95%)</td>
</tr>
<tr>
<td>Individual sessions (non-case mgmt), n (%)</td>
<td>4 (7%)</td>
<td>0</td>
<td>22 (37%)</td>
</tr>
<tr>
<td>Case management, n (%)</td>
<td>1 (2%)</td>
<td>1 (8%)</td>
<td>26 (43%)</td>
</tr>
<tr>
<td>Support call center/hotline, n (%)</td>
<td>2 (3%)</td>
<td>0</td>
<td>9 (15%)</td>
</tr>
</tbody>
</table>
### B. Awareness of services

#### Awareness of services – services overall

In interviews, beneficiaries were asked to list all IRC services that they were aware of using an open-response format. Service providers and community leaders were also asked about awareness of services during FGDs. Please see sections H) Case Management and K) Hotline sections below for results specific to awareness of these services.

In Myanmar, when asked about awareness of activities and services available through IRC, many women beneficiaries mentioned information sharing sessions about GBV and group activities, often characterized as income generating activities (e.g., soap and balm making). Several women also mentioned that they were aware of various health care services, especially for women survivors of sexual assault. A few indicated that they were aware that IRC provides support for those experiencing intimate partner violence (IPV). The hotline/emergency phone line was also mentioned a few times.

In service provider and community leader focus groups in Myanmar (comprised of both women and men), participants mentioned awareness of the hotline, case management services (e.g., IRC “helps women who face violence”, “we can refer women to services”, IRC will “cover transportation costs” for survivors of GBV, IRC will “assist rape survivors in going to health clinics.” They described “lectures and discussions about GBV”, “empowerment raising” and activities that provide “awareness for mental health of women and girls”, and specifically mentioned soap, balm, flower making, and cooking.

In Burundi, many women mentioned services for GBV survivors and those with “domestic problems.” A few specified that IRC provides “counseling for rape survivors” and makes referrals, including for medical and legal services. Many women described information sessions and trainings, focused on violence as well as other topics. Most also mentioned group activities, including dancing, embroidery, mat making, and making soaps, and many identified VSLA (Village Savings and Loans Associations). Many women reported that IRC “listens” and “provides support” and some emphasized opportunities to talk and support each other (e.g., “we now have where to go and talk about our problems without bribing authorities, violence survivors get counseling and we have opportunity to advise each other”). A few mentioned receiving items such as clothes and soaps. Adolescent girls were less prone to mention GBV and violence specifically, but otherwise provided similar responses.

When asked what IRC does, service providers and community leaders in Burundi explained that IRC works with women and girls who have survived violence: “whenever there is an activity about GBV, IRC is very involved”. Specifically, leaders mentioned that IRC organizes “information sessions for violence survivors”, “provides transportation fees for women and girls who want to be reintegrated in their families”, “pays medical fees”, runs “group activities like embroidery, soap making, basket weaving”, helps women to start “small income generating activities”, “through the referral system, IRC helps survivors to access justice”, “helps a lot in birth registrations”, “gives an emergency kit…they can organize to give food or clothes.” Leaders also shared that “IRC organizes different training for different people (community leaders, focal points) on how to behave in rape cases and how to report them.” Respondents did not mention hotline services spontaneously, but when asked directly, some said that they were aware of these services.

In Iraq, some women beneficiaries mentioned GBV “awareness sessions”, and a few mentioned violence, harassment, and women’s rights (though were not clear about the kinds of services associated with these topics). Some mentioned group activities such as sewing, knitting, cooking, painting, and picnics. Many women mentioned “distribution of assistance”, and a few specified food aid and “health care kits”. Almost all adolescent girls mentioned “sessions on GBV” and some also mentioned safety plans, legal rights, and early marriage. One girl shared that she initially thought IRC provided education only, but later learned about awareness sessions and PSS.

Service providers shared that IRC is known for working with IDPs and for case management for women. One shared that they believe that IRC provides health and legal services. No service providers mentioned PSS activities or hotline services.
How learned about services – overall

In interviews, beneficiaries were asked to identify how/where they initially learned about IRC services from a list of potential sources (see Table 8), and then were asked to elaborate on responses using an open-response format. Community leaders and service providers were asked to share how they learned about services during FGDs.

Table 8. Top three beneficiary-reported sources of information about IRC services, by country (adults)

<table>
<thead>
<tr>
<th>Myanmar, n = 61, n (%)</th>
<th>Burundi, n = 60, n (%)</th>
<th>Iraq, n = 30, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focal point: 44 (72%)</td>
<td>Focal point: 44 (73%)</td>
<td>Focal point: 19 (63%)</td>
</tr>
<tr>
<td>IRC outreach (case worker): 18 (30%)</td>
<td>Family member: 9 (15%)</td>
<td>Neighbor: 7 (23%)</td>
</tr>
<tr>
<td>Other: Flyers/posters/cards (1 mention); neighbor/community leader (2 mentions)</td>
<td>Friend: 7 (12%)</td>
<td>Family member: 6 (20%)</td>
</tr>
</tbody>
</table>

In Myanmar, the majority of women indicated that they learned about IRC services from a focal point. Several others explained that they learned about services based on IRC outreach from case workers. A few learned about IRC services in other ways such as flyers/posters/cards (1, 8%) or from a neighbor/community leader (2). Most adolescent girls (9, 75%) learned about IRC activities from a focal point or other IRC outreach (case manager) (2, 17%), with a few being told about IRC services by a family member (1, 8%) or friend (1, 8%).

Service providers and community leaders indicated that they became aware of IRC after being approached by staff, often case workers and focal points. Some mentioned that they were provided with business cards and visual materials. Several community leaders had participated in information sessions and group activities. Others mentioned participating in committees and related coordination meetings with IRC staff.

In Burundi, most women reported that they first heard about the IRC activities from a focal point, during a training, at home, or elsewhere in the community. In open-ended items, a few described being approached by focal points who observed that they needed help: “she found me at a bar where I spent day and night because of my problems and she brought me here for help”, “she found me on the way at night when my eye was broken.” Some reported hearing from a family member or a friend, a few reported passing by the center (2, 17%) or receiving a referral from another organization (1, 8%). Most adolescent girls (9, 75%) also learned about IRC activities from a focal point. Several specifically mentioned being contacted “because she knew what happened to me” (e.g., knew specifically about an early pregnancy or abuse). A few reported being told about IRC services by a family member (1, 8%) or friend (1, 8%).

Service providers described learning about IRC from coordination meetings, from receiving/making referrals, and from trainings that IRC has conducted. A community leader shared, “IRC works differently from other NGOs because they provide many services and explain the impact of those services to the community. IRC staff first met with the local leaders and explained us its services and their impact in the community; this is how we came to know IRC.” Others shared that they learned about IRC when approached by staff who asked them to “advertise” IRC services to potential beneficiaries.

In Iraq, most adult beneficiaries described hearing about IRC services from focal points. Many also reported learning from friends, neighbors or family members (e.g., “my brother’s wife, since she participated before me”) including, in one case, a woman whose husband worked as an IRC volunteer. Just one participant reported learning about IRC from a referral from another organization. Likewise, adolescents primarily reported learning about services from focal points (4, 67%), with a few reporting neighbors (2, 33%) and family members (1, 17%) as sources.

In reviewing this report, IRC management noted that this feedback highlights practices that hold safety concerns for focal points and survivors and are not recommended as best practice in terms of the role of focal points and outreach strategies. See Section III. Discussion: A Response from IRC for further discussion.
Service providers reported learning about IRC through meetings and workshops in the area. Some shared that IRC makes referrals to their organizations.

C. Beneficiary access to services

**Barriers: Beneficiary input**

In interviews, adult and adolescent beneficiaries were asked: 1) if they had worries about barriers when initially seeking services (yes/no response options); 2) to identify the barriers they faced from a list of potential barriers (yes/no response options) (see Table 9); 3) to list any additional barriers using an open-response format; and 4) to report if they still have worries about these barriers currently, using a 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely).

Table 9. Top five beneficiary-reported worries about accessing services, by country (adults)

<table>
<thead>
<tr>
<th>Myanmar, n = 54, n (%)</th>
<th>Burundi, n = 60, n (%)</th>
<th>Iraq, n = 30, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time: 39 (72%)</td>
<td>Not enough or accurate information about services available: 57 (95%)</td>
<td>Lack of childcare: 13 (43%)</td>
</tr>
<tr>
<td>Lack of childcare: 38 (70%)</td>
<td>Opinions of family and friends about seeking help from an organization: 29 (48%)</td>
<td>Not enough or accurate information about services available: 9 (30%)</td>
</tr>
<tr>
<td>Stigma regarding help-seeking from outsiders: 31 (57%)</td>
<td>Concern about my safety: 26 (43%)</td>
<td>Difficulty with travel due to distance: 8 (27%)</td>
</tr>
<tr>
<td>Not enough or accurate information about services available: 30 (55%)</td>
<td>Concern about potential costs: 25 (42%)</td>
<td>Lack of time: 8 (27%)</td>
</tr>
<tr>
<td>Lost wages: 28 (54%)</td>
<td>Concerns about confidentiality: 20 (33%)</td>
<td>Safety during travel: 6 (20%)</td>
</tr>
</tbody>
</table>

In **Myanmar**, when asked to think back to the first time they accessed services, only 27% of adults reported worries about accessing services. When asked if they still have such worries now, most indicated “not at all” or only “slightly” and cited positive experiences with IRC (M = 1.8). Several adolescents (3, 25%) reported initial concerns about accessing services, and some indicated that they do still have some concerns, including lack of time (e.g., have to care for younger siblings) (8, 67%), stigma regarding help-seeking from outsiders (7, 58%), concerns about opinions of family/friends (6, 50%), lack of accurate information about services (6, 50%), and concerns about confidentiality (worry that what is shared will not be kept private) (6, 50%).

In **Burundi**, 43% of adults reported that they had initial worries about accessing services. Almost all reported that lack of information was a primary worry. However, when asked if they still have these worries now, mean responses were “not at all” or “slightly” (M = 1.6), with participants explaining that once they visited IRC they understood more about the services and felt better. Most (9, 75%) of adolescents reported having worries when first accessing services. Like adults, not enough or accurate information about services available was the top worry for adolescents in Burundi (endorsed by 100%). Several (3, 25%) reported concerns about potential costs. Few adolescents endorsed any other worries.

In **Iraq**, only 4 respondents (13%) reported initial worries about seeking services. Rates of current worries were low (M = 1.4). No adolescents reported having worries before or after attending and endorsed very few specific worries (most commonly time availability, endorsed by two girls, 17%).
**Vulnerable groups: Beneficiary input**

In interviews, adult beneficiaries were asked to 1) list groups likely to have difficulties accessing services using an open-ended format, and 2) rate specific groups regarding level of difficulty faced accessing services using 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely) (see Table 10).

In **Myanmar**, when asked to identify groups likely to have difficulties accessing services using the open-ended format, women identified women with children and no associated childcare options; adolescent girls; women who are sick, disabled or elderly; working women; women with husbands who might not approve; women with limited transportation options; and women who are concerned about confidentiality or are otherwise ‘shy’. Responses were similar, with a few notable differences, when examining women’s ratings for set response options (see Table 10).

In **Burundi**, beneficiary women identified the following groups likely to face barriers in accessing services: women whose husbands do not allow them to leave the house or are worried about judgment from others in the community, elderly people, people with physical disabilities, those living in remote places or who do not have means to get to the location in the community where activities take place, and people who are poor and therefore need to focus on working. A few women mentioned that some women cannot attend due to caps on numbers of group members allowed. In rating groups with the most difficulties accessing services (see Table 10), women also identified women with mental health problems and religious/ethnic minorities.

In **Iraq**, in response to the open-ended item, participants primarily identified elderly people (e.g., “elders after 40, especially if they are not widows and divorcees”) and women with restricted movement (e.g., “those who are under tribal rules can't leave home”), and women with health problems (e.g., “women with heart diseases”). When rating groups likely to face difficulties accessing services, respondents also pointed to women with mental health problems and women abused by family members (see Table 10).

**Table 10. Vulnerable groups rated as most likely to have difficulties accessing services by adult beneficiaries**

<table>
<thead>
<tr>
<th>Myanmar, n = 61 (mean)</th>
<th>Burundi, n = 60 (mean)</th>
<th>Iraq, n = 29 (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women with mental health problems (4.6)</td>
<td>Women with mental health problems (3.1)</td>
<td>Women not permitted to leave the home by family members and/or social customs (4.5)</td>
</tr>
<tr>
<td>Women with physical disabilities (4.4)</td>
<td>Women with physical disabilities (3.0)</td>
<td>Women with mental health problems (4.0)</td>
</tr>
<tr>
<td>Male survivors of sexual assault (3.8)</td>
<td>Elderly women (2.7)</td>
<td>Women who are abused by family members (4.0)</td>
</tr>
<tr>
<td>Women who are abused by family members (3.6)</td>
<td>Members of religious/ethnic minority groups (2.0)</td>
<td>Women with physical disabilities (3.9)</td>
</tr>
<tr>
<td>Women not permitted to leave the home by family members and/or social customs (3.5)</td>
<td>Adolescent girls (1.5)</td>
<td>Elderly women (3.3)</td>
</tr>
</tbody>
</table>

Note: Means use 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely).

Note: “Male survivors of sexual assault” were not included as options for Burundi and Iraq due to potential sensitivity about this item.\(^{48}\)

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\(^{48}\) When research teams were consulted on the cultural appropriateness of research tools, Burundi and Iraq teams determined that it was not appropriate to ask beneficiaries about male survivors of sexual assault, highlighting the sensitivity of programs to address sexual violence against men and the significant cultural stigma against survivors.
Beneficiary access to services: Staff and focal point input

In surveys, staff and focal points were asked “In your estimation, what percentage of all community members in our target areas who could benefit from/need IRC’s services are actually utilizing them?” using the following response scale: 1 = 0-25% (about ¼ at most); 2 = 26-50% (no more than half); 3 = 51-75% (no more than ¾); 76-100% (nearly all).

Figure 1. Percentage of community members in target areas who could benefit from IRC services that are actually using services (staff and focal point input), by country

Note: Means use a 4-point scale: 1 = 0-25% (about ¼ at most); 2 = 26-50% (no more than half); 3 = 51-75% (no more than ¾); 76-100% (nearly all).

As depicted in Figure 1, staff and focal points in Myanmar believe that most services are reaching only about half of those in need/who could benefit, while less than half in need are accessing case management services. In Burundi, staff likewise reported that services are meeting only about half of those in need, though focal points reported that between half and 75% (slightly more for group PSS and hotline participants) are being reached. In Iraq, staff reported that approximately half of potential participants are accessing most services, though fewer (approximately 25%) are reached by the hotline. Focal points generally believe that between half and 75% of participants are being reached, though slightly less for information sessions.

Barriers: Staff and focal point input

In written surveys, staff and focal points were asked to rate potential barriers to participant involvement in programming using 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely) (see Table 11). They were also asked to provide open responses about barriers in surveys, FGDs, and interviews.
Table 11. Top five barriers to use of services by beneficiaries, as identified by staff and focal points, by country (mean)

<table>
<thead>
<tr>
<th>Myanmar</th>
<th>Burundi</th>
<th>Iraq</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff, n = 27 (mean)</strong></td>
<td><strong>Focal points, n = 10 (mean)</strong></td>
<td><strong>Staff, n = 6 (mean)</strong></td>
</tr>
<tr>
<td>Household duties (3.7)</td>
<td>Lack of perceived need (4.0)</td>
<td>Length/distance of travel (3.8)</td>
</tr>
<tr>
<td>Concerns about repercussions against participant (3.7)</td>
<td>Confidentiality concerns (3.7)</td>
<td>Lack of knowledge about/understanding of services (3.7)</td>
</tr>
<tr>
<td>Confidentiality concerns (3.5)</td>
<td>Time availability/competing priorities (3.6)</td>
<td>Concerns about repercussions against the participants (3.5)</td>
</tr>
<tr>
<td>Time availability/competing priorities (3.5)</td>
<td>Concerns about potential costs (3.4)</td>
<td>Lack of perceived need (e.g., due to belief that violence is normal) (3.3)</td>
</tr>
<tr>
<td>Concerns about potential costs (3.2)</td>
<td>Household duties (3.40); Concerns about repercussions against participant (3.4)</td>
<td>Concerns about repercussions against someone else in their lives, e.g., perpetrator (2.9)</td>
</tr>
</tbody>
</table>

Note: Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely

In Myanmar, in addition to top concerns detailed in Table 11, staff and focal points also rated safety risks associated with travel (staff: M = 2.8; focal points: M = 3.1) and length/distance of travel (staff: M = 2.7; focal points: M = 3.0) as moderate concerns.49 Some staff explained that a lack of confidence or trust in services, considered a slight to moderate barrier by both staff and focal points, may occur because the services survivors receive are confidential, and therefore other community members don’t necessarily hear about case outcomes. Adolescent girls feeling uncomfortable sharing in front of adult women was a significant concern for both staff (M = 3.5) and focal points (M = 3.7).

In Burundi, as evident in Table 11, both staff and focal points identified length/distance of travel, concerns about repercussions against the participants (i.e. safety concerns due to threat of violence from the perpetrator, being socially ostracized by community), concerns about repercussions against someone else in their lives (e.g., perpetrators), and lack of perceived need (e.g., due to belief that violence is normal/should be accepted) as top barriers to use of services. Regarding barriers specific to adolescent girls, almost all staff reported that girls being uncomfortable sharing in front of adult women was an extremely important factor (M = 4.3), although focal points rated this as somewhat less significant (M = 2.1).

49 Slightly higher ratings from focal points on safety and travel related items may be explained in part by differences in the distance and type of travel for those in IDP camps (primarily served by IRC staff/case managers and other staff) compared to local communities (primarily served by focal points).
In Iraq, both staff and focal points rated childcare and opinions/opposition of others in the community as very/extremely significant barriers (see Table 11 for additional barriers). Specific to adolescent girls, staff reported that need to have another family member accompany them to service was a significant barrier (M = 3.8), and focal points reported that discomfort sharing in front of adult women is a moderate concern for adolescents (M = 3.3).

**Barriers and vulnerable groups: Additional input from stakeholders**

In FGDs and interviews, staff, focal points, service providers, community leaders, and male community members were asked open-ended questions about potential barriers to participant use of services and about vulnerable groups who could benefit from services but may be especially unlikely to access needed services. Specifically, participants were asked, “Are certain vulnerable groups (e.g. elderly, those with disabilities) not using services?” Data, coded by theme, is presented below.

In Myanmar, the following concerns were raised:

**Fear, stigma, culture and other barriers:**

- Some potential participants feel ashamed or embarrassed about seeking services. Others have fears about sharing their experience of GBV. For example, some women think they won't be believed if they share information about GBV. As one stakeholder indicated, “Because of impunity, women have been traumatized, they don’t want to speak up about what happen to them or to seek help.” Another noted, “Every time they report, it turns out like women are the problem, no one else is a problem.”

- Family members may discourage some women from attending. Specifically, some women aren’t able to participate because their husbands (or others) will not allow them to attend.

- Some potential beneficiaries (GBV survivors) may think news will spread about their situation, that confidentiality is not maintained (they are afraid they will "lose dignity/honor, "they will lose face in the community", afraid that their whole family may be ostracized, “if they inform about their cases, their family will need to get out from the camp and their family will be separated from others in the outside world”). Some also explained that this concern may be based on impressions of specific case workers, “Even though they have rules not to share other people, people who are familiar with the caseworker’s character might not believe.”

- Some don’t participate because they think that GBV is ‘normal’ or typical, especially intimate partner abuse.

**Vulnerable/underserved groups:**

- Adolescent girls have difficulties participating in services. Girls can’t and/or don’t want to come alone (‘parents will control her because they worry’), they feel shy, they don’t have free time due to school or work commitments.

- Women in remote areas have difficulties accessing services. Specifically, women in rural areas often have to work and can’t participate. In addition, women in remote areas often don’t have a phone signal and because there is no focal point in the area to share information, they don’t know about services.

- Those not residing in camps and outside of the mobile sites aren’t being reached. IRC doesn’t know about some newly displaced groups in areas lacking a strong civil society presence, so there is no outreach and these groups have no awareness of services.

- Language and education can be a barrier to engaging in services. Often those who speak different languages/dialects other than those typically/widely spoken feel uncomfortable participating. In addition, those who are not able to read and write feel uncomfortable participating.

- There is no safe space for LGBT+ individuals to engage as others will judge them.

**Perspectives on organizational support:**

- Women may not want to seek services because frustrations arise when IRC does not meet their expectations. Because many services do not exist in remote areas served by mobile teams, referral options are limited in the context (e.g., jobs, financial support, legal support/prosecution of GBV, support with finding a new residence) and is the extent of IRC’s direct services. This means women may have expectations that IRC is not able to meet.
Outreach strategies:

• Outreach should target those who have not participated in activities previously: “When people recruit participants for trainings, they tend to recruit the same people who have participated in other trainings before.” More time should be dedicated to engaging new participants.

In Burundi, the following themes arose:

Fear, stigma, culture and other factors:

• Staff and focal points emphasized specific barriers for reporting intimate partner violence. Focal points emphasized the role of normalization of intimate partner violence, “In our country, there is a tradition saying: ‘That’s how marriage is. If your husband beats you and that you talk about it to other people, this will bring shame on your family.’ These beliefs prevent women from seeking IRC services”. Likewise, community leaders pointed to “ignorance of their rights” (e.g., their right to be free of violence) as a factor preventing women from seeking services.

• Staff and focal points emphasized that women are “afraid of” and “economically depend on” their husbands, and thus worry that seeking GBV services may make their husbands “chase them” from the home. Male community members likewise shared that women may feel unsafe, one explaining, “a woman may think: If I disclose what my husband is doing to me, he may become even more violent.” A focal point explained, “Some say, if I do to talk about my case to people, where else will I go? Because I will not able to come back to my home”. Staff explained that women typically cannot support themselves or their children if separated from their husbands - hence their request for economic empowerment interventions.

• Some mentioned that these barriers may be particularly pronounced for “military members, policemen, or members of the ruling party’s wives”, explaining “Their husbands threaten to kill them if they disclose the violence they are living in.”

• Many respondents emphasized the role of stigma in regard to both GBV victimization and help-seeking. Male community members described “cultural beliefs” and “fear of discrimination,” and one explained that “it’s shameful [for women] to disclose their private life.” Service providers shared similar feedback: “in our culture there are certain things that women should not reveal.” One male community member’s input exemplified a “victim-blaming” attitude toward survivors (likely to discourage reporting of GBV): “Some girls and women can sexually provoke men and boys by their dressing or attitude. There should be information sessions for girls so as to teach them not to incite men and boys to rape them. Girls are somehow at the origin of the sexual violence they undergo.”

• Respondents stressed that women often do not have legal recourse, sometimes because men will pay bribes to avoid facing charges. Staff shared that husbands may also bribe local leaders to resolve conflicts in their favor: “I think that some local leaders also prevent women and girls from requesting for our services. Indeed because of corruption, they decide to practice the amicable settlement.”

Vulnerable/underserved groups:

• Multiple groups of respondents identified students, who are at school during service hours, and may not be informed about services, as especially underserved

• Multiple groups identified lack of childcare and lack of time availability due to other (often household) responsibilities as barriers.

• Staff and focal points identified women who are illiterate, or face language barriers.

• Staff also identified “sex workers who got involved in that activity due to their economic situation” as extremely vulnerable groups.

• Some stakeholders also mentioned the importance of targeting men with prevention activities to reduce perpetration of GBV.\textsuperscript{50}

\textsuperscript{50} Such activities would not be considered services within IRC’s WPE program model but rather primary prevention activities to stop violence from happening before it starts. IRC does not provide services to perpetrators.
Perspectives on organizational support:

- Community leaders also emphasized that community members may have lost confidence in organizational support—“many associations come, promise things to the people in the community but never accomplish their promises. So, many people become disappointed with them and feel they don’t trust them.”

Outreach strategies:

- Community leaders and male community members suggested that lack of knowledge about services was a primary barrier and that increased sensitization is needed.

In Iraq, respondents shared the following:

Fear, stigma, culture and other factors:

- Many cited cultural barriers to leaving the house and to help-seeking, e.g., “sometimes the family, like fathers and brothers are preventing women.” Staff described significant barriers related to movement restrictions imposed by male family members and due to childcare responsibilities. One woman mentioned that group activities are easier to attend than individual sessions, as women can leave the house together rather than alone, which is sometimes more permissible.

- Staff emphasized high levels of community stigma and enormous risks associated with reporting GBV: “it’s definitely happening, but they just don’t report it whatsoever because there still is a lot of honor killings. And your family will disown you, or beat you to death…so it’s just something that you just don’t tell anyone.”

- Many also described stigma associated with seeking help for mental health and other needs: “the idea in Iraq is that if you need to see a psychologist…that means that you have a massive mental illness and you need to be in a hospital or you are crazy or something.”

Vulnerable/underserved groups:

- Staff and male community leaders shared concerns about language barriers: “Many of them are just speaking Turkmani, that's why it's a problem for them to participate into those activities.”

- Service providers suggested that IDPs who live in urban settings (rather than camps) are generally underserved.

- Service providers also shared that men tend not to seek services due to enormous “taboo” about help-seeking, especially for sexual violence.

Perspectives on organizational support:

- Staff also suggested that mistrust of organizational support may impede use of services. One explained that religious and community leaders perceive IRC to be “taking their women and girls and turning them into Western women” or “think we work for the government or like spies.”

- Service providers suggested that lack of faith in organizations that “come and ask and do not give anything in return” discourages help-seeking.

Outreach strategies:

- Service providers identified barriers related to concerns about costs/fees and suggested that outreach is needed to clarify that services are free.
D. Outreach/community engagement

In interviews, beneficiaries were asked 1) to rate to what extent IRC makes efforts to reach groups who may have a hard time accessing services (using a 5-point scale, where 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely) (see Figure 2). They were then asked 2) to explain how IRC does or does not do so; and 3) how IRC might improve services to make them more accessible to these groups, both using an open-ended format.

Figure 2. Adult beneficiary input about IRC efforts to reach underserved groups.

To what extent does IRC make efforts to reach groups who might have a harder time accessing services? (Adult beneficiaries)

<table>
<thead>
<tr>
<th></th>
<th>Myanmar</th>
<th>Burundi</th>
<th>Iraq</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = not at all (1)</td>
<td>3.5</td>
<td>4.8</td>
<td>3.7</td>
</tr>
<tr>
<td>2 = slightly (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 = moderately (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 = very much (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 = extremely (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely

In **Myanmar**, adult women participants indicated that IRC makes moderate efforts (see Figure 2) to reach people who may experience barriers to accessing services. In open-ended descriptions of these efforts, women shared the following: having a call center/hotline improves access (especially when multiple language options are offered by those staffing the hotline); IRC staff make everyone feel welcome/able to participate; IRC staff have made accommodations for those who have difficulties with transportation (picking people up, visiting people, holding events closer to the specific areas where people live).

In order to improve access women suggested that IRC should:

- Hire additional staff (more than one case worker or focal point per area);
- Provide more outreach to vulnerable groups, including to those in remote areas (villages) – home visits in particular were suggested by several participants;
- Conduct more outreach to men (so men can participate in services and so husbands of women who want to participant will be more understanding);
- Put greater emphasis on ensuring referral pathways are further developed and updated;
- Increase use of visual aids in information sessions;
- Increase financial support (transportation funds, rice, etc.) to enable some that are not currently participating to engage.

In reviewing this report, IRC management noted that this feedback indicates potential safety violation of best practice guidelines, including the Interagency GBV Case Management Guidelines, as home visits are not recommended for the safety of GBV survivors. The role of focal points is not to proactively identify survivors in the community or directly provide case management services, but rather share information about services available and refer cases to the hotline or IRC case management staff when a survivor discloses to them. Extreme risks can be created for both the client and the focal point, including reprisal, stigmatization, and further violence. See Section III. Discussion: A Response from IRC for further discussion.
In Burundi, beneficiaries reported that IRC made extensive efforts (see Figure 2) to reach groups who might have a harder time accessing services. When asked to describe IRC’s efforts, women pointed to the benefit of having a mobile site in their community, and focal points based in the community who can direct women to services and make visits to their homes as needed (“We appreciate that the center is here, and they take time to go and see a person in emergency situation”). Women observed that outreach also occurs through information sessions conducted in the community, and by training participants to help in reaching other women. Some respondents emphasized that the services do not discriminate (e.g., “IRC started a center where people can freely talk, have recreational activities without any discrimination”; “They receive everyone without any discrimination, even me who was like mad, I was welcome”).

To make services more accessible, women suggested that IRC should:

- Have focal points and staff visit more areas, and/or additional focal points and staff should be recruited who are based in new areas. New mobile sites should be opened.
- Have focal points and staff conduct more group activities, sensitization sessions, and trainings.
- Use radio to raise awareness effectively.
- Facilitate transportation for women, especially elderly people and those with disabilities.
- Provide additional adjustments for people with disabilities, e.g., “provide wheelchairs for people with disability and try to find them where they live.”
- Target those who have power to impede/facilitate women’s attendance; one woman suggested to have training with local community leaders and another suggested to “train men, especially those who prevent their wives to come to the center.”
- Develop income-generating activities to increase independence, e.g., “provide capital to stop depending on husbands even for very private and fundamental women’s needs.”

In Iraq, most women reported that IRC made reasonable efforts to reach these groups (see Figure 2). Some women described receiving much-needed help from IRC (e.g., “the staff was asking about our needs and helping us by providing food, clothing, and psychological support”) and shared that “the staff was trying to reach everyone.” However, a few shared that not all women in need were reached, “the aid did not include everyone”, and that IRC assessed needs but did not follow through with services, “they just ask about needs and do not care.” Some reported that due to camp management, IRC had “bad times in reaching to us and getting approvals” and were sometimes unable to get “authorization letters to reach those who cannot attend activities.”

When asked how IRC could improve the accessibility of services, women suggested that IRC should:

- Increase visits and follow-up to allow more windows for seeking services: “increase visits to caravans because some women don't have the ability to move freely due to their husband's refusal.”
- Strive to be more inclusive, e.g., “distribution of aid and inclusion of all families.”
- Target vulnerable groups and those with specific needs: “the inclusion of older women in activities and assistance”; “increase visits and follow-up because they don't care about cases that need psychological support.”
- Change the locations of services to make them more accessible, e.g., “creating gathering points inside camps so women can participate. Not in one place.”

**Outreach: Staff, focal point, and other stakeholder input**

Staff, focal points, service providers, community leaders, and male community members were asked to describe how best to outreach to new participants, including underserved groups, in FGDs and interviews. Data were coded by theme.
In Myanmar, respondents made the following suggestions:

More/new services:

• Skill-based initiatives included in PSS activities should be focused on encouraging economic independence (should be based on vocational training that will result in actual income); should provide materials for various income generating initiatives (soap making, etc.).

• To attract more participants, focus on “fun activities” – sports activities, dances or other events.

• Integrate info sessions/GBV awareness raising, with more health seminars (e.g. various general ‘men’s health’ topics will attract men), legal issues, and other engaging topics to encourage community members to attend info sessions.

Partnerships:

• In order to encourage greater participation in services by those in need, IRC should strengthen referral pathways, especially legal support, and expand options beyond Lashio-based services.

• IRC should conduct targeted outreach to specific vulnerable groups working through existing service providers (e.g., “RC knows who are disable and how many people are disable in their area and also KBC. It will be more effective if you work with them”).

• IRC needs to find ways to address the discrepancy between areas of greatest need and the limited regions where current NSSWON focal points reside. Where other civil society partners exist, IRC should work to further engage other CSOs representing these underserved areas (empower/work with more contacts in local communities representing underserved areas).

Needs assessment:

• IRC should conduct a comprehensive needs assessment in underserved areas to better understand how to engage certain groups but be wary of raising expectations if there is nothing that can be provided in immediate short-term. It may be beneficial to link the assessment to distribution of materials such as dignity kits.

Outreach to specific groups:

• IRC should provide information sessions for men who are perpetrators/likely perpetrators, with an emphasis on mental health issues, including addressing substance abuse issues (“drugs are a big problem”).

• More outreach to specific influential groups that can encourage or block access for women, such as the military, police, local administrators, camp committee members, village leaders, religious leaders. Similarly, IRC should provide information sessions to husbands, including those who are not letting their wives attend IRC activities.

Change timing of services:

• Activities should take place at a convenient time considering school and work schedules and with an awareness of safety concerns for those traveling back to their homes in the evening after activities conclude.

• IRC should increase the hours the hotline is available (should be available night and weekends; may need an additional line; more staff). Many incidents happen at night and on the weekends.

Ensure safety:

• Potential case management beneficiaries may not engage with IRC unless immediate transfer to a safe house is an option. IRC should ensure that moving a survivor to a safe house is always an option if they are being asked to come forward/report an incident of GBV that may compromise their safety.

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53 In reviewing this report, IRC management noted that this feedback indicates potential safety violation of best practice guidelines. General outreach may reach men who are perpetrators but it is not safe to engage perpetrators directly.

54 In reviewing this report IRC Myanmar noted that such engagement with military and closely-associated authoritative bodies is beyond the capacity of WPE teams and would be associated with significant risk.
Address social norms:

- IRC should focus more on addressing rigid gender roles/social norms among adolescent girls and boys to encourage them to realize that GBV is not acceptable and participate in services.

In Burundi, stakeholders provided the following input:

More/new services:

- All advocated for increased information and sensitization sessions, workshops and trainings, designed to introduce IRC services to new communities. Focal points suggested including prizes in information sessions to increase attendance.
- Staff and focal points suggested that VSLAs and income generating projects would attract more participants. In particular, focal points shared that men may be more likely to encourage their wives’ participation in group activities if she is doing something with potential to bring money into the home.

Increased/new/creative advertisement of services:

- Leaders suggested use of a radio spot to reach potential participants.
- Multiple groups suggested increased advertisement of the hotline, through flyers with hotline numbers (suggested by staff) or more sensitization about the hotline being free (male community members).

Partnerships:

- Many respondents suggested partnerships – with community and government organizations (suggested by community leaders), with centers and shelters (suggested by service providers) and with schools (suggested by staff) as outreach strategies.

Empowering community members:

- Some respondents also suggested empowering community members to spread the word and conduct activities themselves. A staff member suggested, “In cooperation with [focal points], we can select at least five women in the community and invite them to come to the listener center, organize a kind of training for them and give them a message, to help them have the ownership of the activity in the community.” Male community members likewise suggested forming an association of community members to help with outreach.

Needs assessment:

- Community leaders suggested forming a “follow-up committee” to “contact institutions like administration, the police about women’s concerns. And then see what are the most frequent problems that women and girls report about” to reach potential beneficiaries and tailor services to their needs.

Outreach to specific groups:

- Community leaders emphasized increased outreach to people in remote areas, and provision of transportation means to allow them to come to centers.
- IRC staff, other service providers, and male community members suggested increased outreach to men and boys. Staff suggested that a hotline can be especially useful for men, because “on the phone, even if it's not a man who receives the calls, men can be encouraged to talk about their problems because they know no one will know who they are.” Service providers suggested that IRC should recruit male community focal points.
- Staff also suggested targeting students: “the time we are at the listening center, they are at school. Maybe, they even don't know about our services. I think there should be a program for them because they surely undergo violence at home or at school.”
- Staff also explained that separate services and spaces are needed for adolescent girls to increase their attendance.
A staff member explained, “One day, I organized an information session. There were some women there. When I asked about the problems they face as girls, they were not spontaneous to talk. Then I told them, maybe you are afraid of these women. Let me invite them to leave the place so that we can talk, they then talked really freely.”

**Incentivize focal points:**

- Finally, male community members suggested that incentives (boots, umbrella, bag) for focal points and community leaders who are working voluntarily would help to improve their motivation.

In **Iraq**, staff, focal points, and non-IRC service providers made the following suggestions:

**More/new services and advertisement of services:**

- All groups advocated for increased awareness sessions. Focal points suggested combining awareness sessions with “something fun,” such as dance or other competitions.
- Staff suggested use of posters, flyers, and info cards.

**Partnerships:**

- Focal points suggested better coordination with IRC’s Protection and Rule of Law team about potential referrals. Staff also shared that in some cases, it has been helpful to link with the Protection and Rule of Law team staff (who are typically male) to coordinate with religious and community leaders.

**Needs assessment:**

- Staff and service providers emphasized need for a needs assessment survey in order to understand beneficiary needs and identify underserved groups.

**Outreach to specific groups:**

- Service providers and staff also suggested targeting students through awareness sessions in school and for parents.
- Service providers suggested targeting men, including through a hotline specifically for men, and sessions for men conducted outside of working hours.
- Service providers emphasized need to reach IDPs living in urban areas outside of sites.

**Male staff:**

- Some respondents suggested that bringing on male WPE staff may help with securing community buy-in, especially with conservative male religious and community leaders.
E. Safe spaces

Beneficiary input

In interviews, beneficiaries were asked to report 1) where they received PSS services (from a list of potential locations) and 2) how private and safe these spaces felt using a 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely). Those who participated in case management services were likewise asked 1) where they received these services (from a list of potential locations) and 2) how private spaces felt, using the same scale as above. Finally, participants were asked what could be done to improve safety and privacy of spaces (open-response format).

Figure 3. Adult beneficiary input regarding privacy and safety of PSS and case management safe spaces, by country

Note: Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely

In Myanmar, women participated in information sessions and group PSS activities in the following locations: private home (46%), church or other building typically used for religious purposes (35%), community hall (26%), clinic (18%), and/or school (4, 7%). Women indicated that spaces used for group activities felt moderately/very private and safe (see Figure 3). When asked about suggestions to improve/change the spaces used for these activities to better meet their needs, a few women suggested that PSS sessions should not be held in private houses, that public spaces are preferred. Others indicated that women-only spaces should be created and maintained in public, easily accessible locations (e.g. churches). Some suggested that activities should take place without children present. Adolescents in Myanmar rated the space used for information sessions/PSS activities as moderately to very private and safe (3.5). Some adolescent girls however, raised concerns about the school space used for such activities because voices could be overheard by others outside the room and because boys were included in sessions with girls.

With regard to space used for case management in Myanmar, the one adult woman utilizing services indicated that the case management space was very private. The one adolescent utilizing case management also indicated that the space was very private and comfortable. She explained that she would be worried if others saw her interacting with the case manager, however this did not occur because, “the privacy was kept very strictly and people don’t know about it.”

In Burundi, activities took place in designated two-room safe spaces (called “listening centers”), with one room designated for PSS group activities and the other for case management. Women reported that the spaces used for group activities felt very/extremely private and safe (see Figure 3). When asked about suggestions to better maintain privacy, almost all reported that they were satisfied with the level of privacy and had no additional suggestions. However, a few participants mentioned need for larger spaces, spaces that are less hot, spaces that are further from the road to avoid disturbance from passing cars, and spaces with clean and safe latrines.
Likewise, those receiving case management services reported that the spaces used for these services also felt very much/ extremely private (see Table 3). While receiving case management activities, some (9, 35%) women reported that there were PSS activities going on in the building at the same time, but all reported that they were in a private space that was not close to the activities and could not be overheard. Only a few (3, 12%) participants reported that they would be concerned about what the community might think if they were seen interacting with staff for case management services, with one explaining that she would be worried that someone would tell her husband.

In Iraq, most women reported receiving PSS services in a hussainya (an Islamic center) (35%), in a caravan (38%) or in an outside space (7, 19%). Some participants reported that the caravans belonged to family members or other IDP community members (e.g., “one of the caravans that belongs to the IDPs, where they empty one room for us”, “one of the rooms in my brother’s caravan”). Outside spaces primarily referred to spaces used for outdoor PSS activities such as picnics and visits to religious sites. Women reported that spaces felt moderately private and very safe (see Table 3). Participants frequently suggested to change the location of services to places that are either closer to their homes (“I suggest they do the activities in one of the caravans near our homes”), more interesting (“we need to go to different places to change the routine”), or more sustainable (“best to identify a special place for activities because they are stopped during religious occasions”).

The four case management participants in Iraq reported receiving services in the home of a focal point; they reported that the case management space was moderately private. When asked how the program could have better maintained their privacy, they suggested “perfectly isolating the place” and “providing other places or schedules.”

**Staff/focal point input**

In surveys, staff and focal points were asked to rate how safe PSS spaces felt, and staff were asked to rate safety of case management spaces, both using a 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely) (see Figure 4), then were asked to explain why in an open-ended item. Staff and focal points were also asked to share about strengths and challenges with safe spaces in FGDs and interviews.

![Staff and focal point satisfaction with the safety of PSS and case management spaces](image)

**Note:** Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely

In Myanmar, staff reported being moderately to very much satisfied with the safety of spaces in which PSS activities were delivered, while focal points were slightly to moderately satisfied (see Figure 4). The following concerns were raised: “the space for PSS activities being in the camp is a downside as men would observe, and sometimes interrupt the activities”, “the space for activities being located right by the main road, people passing by observe us”, “many aspects of security issues are not within our control”.

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Staff were moderately satisfied with spaces in which case management services were provided. Again, some concerns were raised: “as people who have been to IRC’s activities would have already known about the case management and its space, the safety of beneficiaries would only be medium”, “because of the location being the camp, people are passing by often”, “counseling rooms not confidential”, “case management room and health clinic is located right next to each other”.

In Burundi, staff and focal points were extremely satisfied with the safety of spaces where PSS activities are delivered, and staff were very satisfied with the safety of spaces where case management services were provided (see Figure 4). Staff explained criteria by which spaces were selected: “It had to be a private place near the road, a house with at least 2 rooms, one for listening, another one for group activities” and specified that “all the centers meet these criteria.” Staff and focal points explained that there are separate rooms for “social assistants to listen to survivors” and for “embroidery and dancing activities” and that it was not possible for group activity participants to hear what was being discussed in the “listening” room. Focal points emphasized the confidentiality of the services, “even we, [focal points], did not know what they talked about” Some also emphasized that “participants were women seeking for group activities”, implying that the centers are not associated only with services for GBV survivors. Staff described leaving keys at the centers so that women can use the spaces to meet as they would like. However, staff also shared that youth and adolescents do not have their own space, but would benefit from spaces separate from adult women: “You see women and girls are afraid of each other. If there was a center for women and a center for girls this would be good. It would allow younger girls to attend services. Actually, most of beneficiaries are older survivors.”

Respondents specified that in addition to providing services in the safe spaces, focal points sometimes visit beneficiaries' homes when beneficiaries are unable to leave home, or in emergency situations. In other cases, focal points may host beneficiaries with emergency needs in their own homes; e.g., “Sometimes, the violence survivor who is seeking help is very hungry, doesn't have clothes or is afraid to go back to her household and then she asks to stay with us because she knows we are [focal points] and she trusts us.” In these cases, focal points reported providing food and other supplies to survivors and their children until they can arrange other options.

In Iraq, staff were moderately satisfied with the safety of spaces for PSS activities, as were focal points. Staff were also satisfied with the spaces for case management services (see Figure 4). Staff explained that they are “quiet and isolated spaces from men” which helped women to feel comfortable. They emphasized that spaces are not associated with GBV services: “there's no one who might think that this is a place for GBV or for case management; we just talk to women there in general and that is the thing that we publish in the community.”

Staff described particular challenges with the hussainiya (mosque) spaces used to house IDPs and the caravans used for services there. For two months of the year, during Shia religious ceremonies, hussainiyas are filled with pilgrims, streets are closed, and safe spaces are not accessible. IDPs are also affected in other ways; as staff explained: “during [religious] ceremonies, the owners of the hussainiya ask the people to leave it to host the visitors of the shrine. And the [IDP] woman host the people in their homes and the owners of the hussainiya ask the IDP men to work with them and to help them to host those visitors.” In addition, staff shared that landlords prohibit leaving furniture and equipment in some hussainiya caravans, impeding usability of spaces.

When asked about ways to improve safe spaces, staff mentioned need for renovations, including splitting spaces into two rooms, one for case management and the other for group activities; and for air conditioning in the summer. Some suggested that designated budget for safe spaces would allow them to rent spaces, rather than depending on rent-free spaces in the hussainiyas. However, some respondents acknowledged that if services were only provided by one office (presumably located outside the hussainiya), it would present transportation challenges for some women.

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55 In reviewing this report, IRC Myanmar noted that none of the official safe spaces used by mobile teams are next to the road but that these passages may refer to the occasions when group activities are delivered in schools or common halls in the camps in order to increase access.

56 In reviewing this report, IRC management noted that feedback in this passage indicates potential violation of best practice guidelines. It is a safety concern for focal points to both go to survivor’s homes and have survivors stay in the homes of the focal point. See Section III. Discussion: A Response from IRC for further discussion.
Respondents also shared that in some cases it is not possible for women to come to safe spaces for case management services, often due to family-imposed restrictions on her movement or childcare responsibilities. In these cases, staff and focal points will sometimes visit women at home, but will “ensure that there is privacy” when meeting with her there. In other cases, they reported calling her, or providing a number for her to call (e.g., when her husband is not home).

F. Transportation

Beneficiary input

In interviews, beneficiaries were asked to rate how challenging it is to get from their homes to the location of services using a 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely), and then to explain why in an open-ended item. Beneficiaries were also asked to share if there had ever been a time they felt unsafe traveling to or from the mobile services site, and to explain if so. See Staffing section for information about transportation needs for staff and focal points.

In Myanmar, adult women indicated that it was only minimally challenging to get to the location of services (M = 1.6). Most indicated that the space is close, within walking distance; when this is not the case transportation support has sometimes been provided. However, a few people mentioned concerns about traveling back home at night (e.g., around 9pm), after the activities are finished (“during the daylight, people have to go out to work so the events are often organized at 7pm in the evening. But when the event is finished, travelling back to one’s home in the dark is not safe, especially in the time of political instability”). For adolescents, travel to the location of services was perceived as moderately easy (M = 3.2) because the services were delivered at a nearby location (e.g., school). Although not a typical response, one adolescent indicated, “It takes about 30 minutes for a return trip, walking from my place to the safe space. Since it's walking along the busy road, I am worried about my safety.”

Some adult women participants provided additional information that illuminates transportation challenges that (potential and actual) beneficiaries may face in accessing services in Myanmar: “Participants cannot come due to long distance or transportation hardship”; “IRC should provide transportation for those that live far away”; “isolated communities away from Manton” (can’t attend without transportation assistance); “some women don’t stay in the camp (they stay in their farms)” and have transportation difficulties; “Elderly men and women have difficulty with transportation.” One person also shared, “It would be very good if the transportation allowance was arranged before the activities so that everyone interested can participate because I know women with children who wanted to come to the activity but they couldn’t.”

In Burundi, adult beneficiaries reported that it was only slightly challenging (M = 2.1) to get from their home to the location of services. Some reported that the site is close to their home. Others reported that it is far but that they manage to come, some walking for 1 to 1.5 hours or taking a bus or motorcycle taxi. A woman explained: “yes it far, but because I know the importance of this program, I come.” A few women identified challenges associated with “getting old”, and with managing childcare. Six (10%) of women shared that they had felt unsafe when traveling to or from the mobile services site, with most sharing fears related to being seen by their husbands or other community members. One stated, “As a gender based violence survivor, I fear that it happens again on my way.” Adolescents found it minimally challenging (M = 1.9) to travel to the site of services, with most explaining that it is quite near to their homes. Two (17%) reported feeling unsafe during travel (e.g., “when it rains and we go home late, we are scared because of what can happen to us”).

57 In reviewing this report, IRC management noted that this feedback indicates potential violation of best practice guidelines. See Section III. Discussion: A Response from IRC for further discussion.

58 See limitations section for implications of potentially non-representative sampling for over representing beneficiaries living closer to the service area.
In Iraq, participants likewise reported that it was slightly/moderately challenging to get to the location of services (M = 2.7). Whether the transport was challenging or not was primarily related to how close the participants’ home is to the site of the services, though some participants mentioned children or disabilities as additional barriers (e.g., “the place is far from my home and I couldn’t walk because I have problem in my back”). One woman reported feeling unsafe traveling to or from the site, “I was moving alone and felt unsafe”. Adolescents reported a similar level of challenge in traveling to service sites (M = 2.5), also attributing challenge to proximity/distance of the site from home. No adolescents reported feeling unsafe during travel.

G. Group activities (PSS activities / Information sessions)

Beneficiary input

In interviews, beneficiaries were first asked to share what they liked and disliked about group activities using an open-ended format. They were then asked to report whether group activities were helpful in the following domains: creating friendships and opportunities for social support; increasing knowledge about GBV; identifying coping skills; increasing knowledge about services to meet potential needs; increasing knowledge of safe and unsafe spaces in the community; and reducing stigma against GBV survivors (yes/no response options) (see Figure 5).

In Myanmar, in open-response items, women emphasized that they liked the following components associated with group activities (PSS activities/information sessions): educational content of information sessions; emotional support provided in a group setting; various types of skill training (soap, balm making, flower decoration), the fact that the sessions are open, anyone is invited to participate. Adolescent girls especially liked learning about available services, GBV education, and learning new skills. Participants did not mention any dislikes although a few adolescents indicated that at times the content of GBV information sessions was difficult to understand.

In Burundi, women mentioned liking skill building and income generating activities: “I liked embroidery because it was a new skill for me and my family economic situation improved” and trainings focused on GBV: “I liked when they taught us how to help a survivor and where to go for services and support.” Many women emphasized the social support provided: “I appreciated everything, this way of talking to each other and getting support” and the friendly environment: “When you come to the center with some worries and they start talking using jokes, you feel relaxed.” A few women mentioned the need for additional capital and resources (e.g., “we lacked pillows when making sheets”). Adolescents were positive about the services and emphasized liking information sessions, which “helped us to know our best attitude.”

Whereas in other countries PSS activities consisted of ongoing group activities in which participants could engage on an ongoing basis, in Iraq, PSS activities were often stand-alone outings or workshops that most beneficiaries were only invited to once, or very sporadically. When asked what they liked about group activities, many women mentioned social support – “exchange of experiences between women”, “the gathering of people, learning new stuff, and talking to each other”. Some women described learning useful skills, especially sewing, and some described useful information, including about early marriage and parenting. Women also appreciated the opportunity to engage in “recreation” and “reduce stress and change the daily routine”, and “trips to religious places.” When asked about dislikes, one woman described a perceived age cap – “I'm not allowed to participate in many activities because I’m 40+ age.” Another shared that needs were not met, “the staff asked about our needs but there was no good response, and I received a dress as assistance only.”
Learning associated with information session services

In interviews, beneficiaries were asked two sets of questions to assess learning in GBV-focused information sessions. First, they were asked 1) do you know what a safety plan is?; 2) if yes, describe a safety plan; and 3) if yes, do you have a safety plan? Next, they were asked: 1) do you know what medical interventions can help a rape survivor within 72 or 120 hours? and 2) If yes, describe.

In **Myanmar**, just over half (57%) of participants reported knowing what a safety plan was, and 34% of these reported that they had a safety plan. However, follow up questions suggested that many of these individuals were not able to explain a safety plan clearly (e.g., when asked please describe a safety plan a respondent answered, “avoid having argument with people”). Of the adolescents, only a few knew what a safety plan was. However, 6 (50%) of adolescents reported that they knew about medical interventions that can help a rape survivor within 72 or 120 hours (all 6 of these provided accurate fairly detailed explanations).\(^{59}\)

In **Burundi**, half of participants (50%) reported knowing what a safety plan was, and 70% of these reported that they had a safety plan. When asked to describe a safety plan, several mentioned plans for how to call for help and leave dangerous situations, while many described knowing “the best attitude” to adopt to avoid violence. No adolescents knew what a safety plan was. All adult women reported that they knew about medical interventions that can help a rape survivor within 72 or 120 hours, 35% provided accurate qualitative responses describing protections against undesired pregnancy and HIV/AIDS and other STIs. All adolescents also reported knowing about medical interventions, but none provided accurate qualitative responses.

In **Iraq**, 4 women (13%) reported knowing what a safety plan was but only two of these were able to give correct qualitative responses. Two (7%) reported having a safety plan. Five (83%) adolescents reported knowing what a safety plan is, and four (67%) were able to give accurate qualitative descriptions of a safety plan. Four (67%) reported having a safety plan themselves. Five (17%) adult participants reported knowing what medical interventions can help a rape survivor in 72 or 120 hours, but none were able to give accurate responses. Only one adolescent (17%) reported knowing about medical interventions; she did not provide a qualitative response.

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\(^{59}\) This question was erroneously excluded from adult survey in Myanmar.
Beneficiary reactions to staff facilitating PSS activities

In interviews, beneficiaries were asked to rate their satisfaction with the warmth and relatability of staff facilitating group activities, and the extent to which they trust IRC staff to share experiences with them, both using 5-point scales (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely).

In Myanmar, women were generally satisfied with staff facilitating group activities, indicating that they were very satisfied with staff warmth and relatability (M = 4.0); they also found them to be very trustworthy (M = 4.0). In Burundi, women were positive about staff facilitating group activities, reporting that they were extremely satisfied with staff warmth and relatability (M = 4.9), and found them extremely trustworthy (M = 4.9). In Iraq, women were also highly satisfied with warmth and relatability of staff (M = 4.4) and found them very trustworthy (M = 4.1). Adolescents were equally positive.

Suggestions to improve group activities

In interviews, beneficiaries were asked to share “suggestions about how to improve/change the group activities, staff, or spaces to better meet your needs” using an open-response format.

In Myanmar, the following themes/ideas emerged:

- IRC should expand the type of activities offered, including activities that are likely to generate income.
- Group activities could incorporate more useful content, such as more general health information.
- Participants indicated that it would be useful for IRC to provide additional resources such as a travel allowance (as some women don't have the means to get to the activities), meals (depending on time of activities), and on-site childcare.
- Several women mentioned that activities should take place without children present as they can be disruptive.
- Additional outreach should be provided to young women/adolescents who may feel shy and young/new mothers.
- Additional suggestions were made about the importance of providing sessions for men designed to reduce male perpetration of GBV and to enlist men as advocates: “Awareness raising and information session on GBV should also include men as women’s well-being is related to the men’s understanding of GBV. We should also teach men how to sympathize and understand. They should learn how to be fair when treating a woman/wife. They should know gender equality. Now, its like women cannot avoid men’s orders.” Others commented on the importance of sessions to improve men's understanding of IRC activities: “Some men even think that women are gathering to talk bad things/gossip about their husbands. So, if they participate in the activities, they will understand.”
- Others emphasized that scheduling of activities could be problematic/inconvenient: “IRC should give advance notice about day and time of activities, activities need to be held at a convenient time”.
- Some indicated that the location of activities and privacy is not always ideal, “activities need to be in a women-only large public space” (emphasizing that this should also be a place where others will not always be walking by).
- Adolescents suggested that girls and boys receive separate information sessions in a public (but private) space, and that knowledge should be shared with those who can't participate.
- Others indicate that translators are needed, and that activities should be organized by both language and ethnic group so people will feel more comfortable attending and sharing.

In Burundi, participants:

- Most frequently suggested increasing capital, economic opportunities, and vocational trainings (e.g., provide sewing machines and more sheets for embroidery, capital for bread-making, rice trading, livestock, funds to start a VSLA).
- Some suggested extending services to new areas and putting focal points in additional villages.
- Some women also suggested increased aid such as food and clothing and soap, especially for GBV survivors, and transportation means as needed.
Adolescents also suggested more income generating activities “to make sure that we are no longer a burden for our parents”, and more materials for activities (music player for dancing, sewing machines and sheets for embroidery, uniforms for dancing, drums, whistles).

In Iraq, beneficiaries suggested:

- Livelihood training and opportunities (“start haircutting lessons and equip me with the tools to work later”; “teaching women to read, write, and sew”)
- Increasing other activities (“I suggest increased activities, mainly cooking as it is much fun”).
- Some suggested increasing financial aid
- Targeting groups perceived to have been underserved (“Including people from Mosul…there was a bias for the people of Tar Afar. Including women over 40. Including widows”).
- Most women suggested that it was most convenient to do activities in the morning or early afternoon, while children were still in school and so that there would be time for cooking and household tasks later in the afternoon.
- Adolescents in Iraq offered suggestions about ways to empower and educate girls, e.g., “forming teams of girls and train them to do projects on their own to help other girls”, “giving awareness to girls about the importance of study and valuing learning”, “increasing awareness sessions and train us on giving lectures to our families and relatives about early marriage”.
- One adolescent respondent advocated for involving younger girls – “including younger girls (those in 7th grade) with the awareness sessions since it is the age of girl’s maturation and they should have basic information on GBV.”

**Staff, focal point, and other stakeholder input:**

In surveys, staff and focal points were asked to rate the effectiveness of group activities across nine domains using a 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely) (see Table 12). They were then asked to identify the most and least effective elements of services in open-response items. Staff, focal points, and other stakeholders (community leaders, service providers, community men) were also asked to comment on effectiveness and ideas for improvement of group activities in FGDs and interviews.
Table 12. Top 5 areas in which group activities (PSS and information sessions) are effective, staff and focal point input, by country (surveys)

<table>
<thead>
<tr>
<th>Myanmar</th>
<th>Burundi</th>
<th>Iraq</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff, n = 27 (mean)</strong></td>
<td><strong>Focal points, n = 10 (mean)</strong></td>
<td><strong>Staff, n = 6 (mean)</strong></td>
</tr>
<tr>
<td>Increasing knowledge about GBV (4.1)</td>
<td>Improving well-being/reducing distress (3.1)</td>
<td>Improving well-being/reducing distress (4.7)</td>
</tr>
<tr>
<td>Improving social support (3.9)</td>
<td>Knowledge about GBV (3.0)</td>
<td></td>
</tr>
<tr>
<td>Increasing knowledge about how to access other services to meet needs (3.8)</td>
<td>Increasing ability to keep selves safe (3.0)</td>
<td>Providing an entry point to case management services (4.8)</td>
</tr>
<tr>
<td>Increasing ability to keep selves safe (3.7)</td>
<td>Improving social support (2.9)</td>
<td>Increasing participant ability to keep themselves safe (4.6)</td>
</tr>
<tr>
<td>Reducing stigma against GBV survivors (3.6)</td>
<td>Entryway to case management (2.9)</td>
<td>Increasing use of coping skills (4.0)</td>
</tr>
<tr>
<td>Improving use of coping skills (4.0)</td>
<td>Improving participant well-being/reducing distress (4.6)</td>
<td>Improving social support (4.3)</td>
</tr>
<tr>
<td>Improving social support (4.3)</td>
<td>Reducing stigma against survivors of GBV (4.0)</td>
<td></td>
</tr>
</tbody>
</table>

Note: Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely

In *Myanmar*, when asked about the most effective element of PSS activities staff mentioned: group activities are “fun and relaxing”, group activities attract women because of the link to livelihoods (through soap making and other initiatives), activities allow for social support and “provide a safe space for women to share emotions and experience”, “the process helps build trust, and friendship in addition to the information shared”, “It makes them happy to be with other women facing similar challenges”, group activities allow for information exchange (“people get to share their knowledge, such as sharing the knitting skill, flower decoration, as well as sharing educational information”). Similarly, focal points indicated that education sessions are useful (“domestic violence - in rural areas, people want to receive more educational information to learn about various issues”).

When asked about least effective elements of PSS activities staff mentioned that too many resources are used for the activities, shyness impedes discussion, lack of private space, women don’t have time to participate, lack of interest in anything other than income generating activities, staff don’t have enough time to focus on such activities, and poor facilitation by those leading the group activities. Focal points mentioned the following areas in need of improvement: space is not adequate or safe, recruiting process for activities could be improved, lack of free time, lack of interest, no money for travel, and many participants experience shyness/discomfort and are therefore not willing to speak up.

In *Burundi*, when asked about the most effective elements of PSS services, staff emphasized the role of PSS activities in decreasing stigma about help-seeking from IRC, and increasing confidentiality and safety for those seeking and providing GBV-focused services. One explained, “About discrimination in the community, I would say that it is now decreasing thanks..."
to the activities organized in the centers where survivors are received. When the community or the perpetrators see people attending our centers, they think that they are coming for embroidery or basket weaving activities. This also ensures safety for [focal points]. Before the listening centers were set up, perpetrators could threaten our [focal points]."

Many respondents emphasized the value of social support. Most focal points mentioned that activities facilitated "women gathering together", so allowing opportunities for women to "comfort each other". A community leader commented, "being with others was comforting for survivors because they found friends to talk to and realized that they were not alone. They also found something to do so as to generate some income."

Focal points emphasized the value of dancing activities, embroidery, and basket-making. Many stressed that activities with potential to create income were most valued. A community leader explained: "I found that IRC has already understood that violence done for women does not come from the abuser only also from poverty. In the community where I live, IRC has taught us how to start some income generating activities like sewing and others. As the bad relations between wives and husbands may be a consequence of poverty they live, these activities will help to generate some income. Once they get out from such poverty, they live in harmony because poverty is a source of abuse." Likewise, male community members shared that the "most useful IRC intervention was setting up women associations; they can now make soaps and have income in the household."

Respondents also discussed the value of information sessions and counseling. Male community members shared that "information sessions helped us to fight against GBV. Households are now in peace thanks to IRC teachings." Community leaders emphasized the importance of, "listening to couples and counseling them. This helped spouses in conflicts to get united again."

Focal points shared that IRC activities have resulted in decreased violence in their communities: "following IRC's activities, violence has decreased a lot. Now, husbands are afraid to ill-treat their wives because they think: "If we abuse of these wives, the people from IRC will denounce us." They also shared that activities have helped in the personal lives of focal points: "The situation has changed for [focal points]. We were among women whose life was endangered by many problems but we now know how to behave thanks to the training we receive."

When asked about least effective elements and areas for improvement, staff cited need for increased economic and legal support. "In fact, survivors most of the time are abused because they depend on their husbands in everything. A wife cannot divorce from her husband because in that case she could not be able to take care of the children. The legal support was not successful because violence perpetrators bribe justice institutions and this brings in impunity." Focal points identified the need for more activities for adolescents. Many cited insufficient material resources associated with group activities, such as dancing costumes, sheets for embroidery activities, meaning that many women could not participate in group activities.

Male community members and community leaders emphasized the need to expand group activities to men. Specifically, community men advocated for awareness raising and training sessions to train men to act as role models for gender equality: "We have an adage that a skin whitening disease starts from the ruling class and spreads all over the country. We need to practice it ourselves, that freedom or openness, for that mum or sister, to get enough freedom of speech, we need to start from ourselves." Community leaders suggested income generating activities for men and boys, specifying that they perceived lack of income as contributing to GBV perpetration: "Violence has many causes, some boys who have stopped schools and who spend the whole day in cinemas or drinking alcohol, if we could get some activities like weaving, carpeting, wood work, etc. for them so that they can get money, security in the household could be improved and violence may decrease."

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60 In reviewing this report, IRC management noted that feedback in this passage indicates a common misconception about the root causes of violence against women and girls.

61 In reviewing this report, IRC management noted that feedback in this passage indicates potential violation of best practices. Mediation between couples is not a recommended practice, as indicated in the Interagency GBV Case Management Guidelines.

62 In reviewing this report, IRC management noted that feedback in this passage indicates a common misconception of the root causes of violence against women and girls.
In Iraq, both staff and focal points mentioned that GBV awareness sessions are especially useful, since many women are “already experiencing GBV but most of them don’t know that.” Staff shared, “at the beginning of the program the idea was so new that nobody else was working on it and the concept of abuse and GBV was unknown. So we introduced to the community the concept of GBV what is the abuse what is harassment and we were able to enlighten those people”, “I think that many women says it’s a great thing to do to have such knowledge in their life.” Focal points shared that PSS activities “gather women and take them away from their daily stressful habits.”

When asked about less effective components and how to improve, staff shared that the location of the sessions create issues, as some women would prefer to leave their own community for services. Lack of transportation fees are also problematic. Male community members emphasized need for “programs that involve small loans* and literacy classes “because it's not enough to have sessions on sewing and handmade crafts and cooking, the priority should be for learning how to read and write” (including learning Arabic for those who do not know it).

H. Case management

Awareness of case management services (non-case management participants)

In interviews, beneficiaries were asked if they had participated in case management services; if not, they were asked whether they were aware that it exists and if so, where they had learned about it.

In Myanmar, only 1 adult woman, and 1 adolescent interviewed had received case management services. For adult women not receiving case management, the majority (74%) were aware that case management exists. Five of the seven adolescents (71%) asked about case management were aware that it exists. Most learned about case management from focal points, case workers, or women neighbors. Qualitative survey responses suggest that many respondents did have a relatively clear understanding of what case management entails (e.g. participants mentioned confidential discussions about GBV, importance of a safe space, connection with various service providers and more).

In Burundi, 26 adults and two adolescents reported using case management services. Of those who had not received case management services, almost all (97% of adults; 90% of adolescents) were aware that case management services exist. Most reported that they learned about services during IRC trainings/information sessions by IRC staff and/or focal points, with a few people stating that they had learned about it through friends.

In Iraq, four adults and no adolescents reported using case management services. Of adults who did not use these services, 44% reported being aware that case management services exist. Those that did report knowing about case management indicated that they heard about it from awareness sessions and IRC staff. Only 1 adolescent (17%) reported being aware of case management services (through IRC staff).

Case management participant input

This section focuses primarily on responses from the case management participants in Burundi, with brief discussion of results and monitoring data in Iraq and monitoring data from Myanmar. In interviews, case management participants were asked 1) whether they were informed of their rights in case management sessions, 2) to identify tasks completed during case management sessions from a list of potential tasks (see Table 12), and 3) to identify case manager activities in facilitating referrals, also from a list of potential activities. They were then asked 4) to rate to what extent services met

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63 As described in the methods and limitation section, case management samples are small for Myanmar and Iraq. In Myanmar and Iraq, it was not considered practical or ethical to do any targeted recruitment of case management beneficiaries. Instead those participating in any IRC services were invited to engage in the research, resulting in only two participants that had engaged in case management in the Myanmar sample (1 adult women, 1 adolescent girl, out of 35 case management beneficiaries reflected in monitoring reports). In Iraq, only 4 case management participants were sampled, out of 321 case management beneficiaries in monitoring data. Instead, some routine monitoring data has been included to illuminate beneficiary experience. However, in Burundi adult beneficiaries were purposefully recruited who had participated in case management activities (based on existing case management logs), resulting in 26 case management participants.
their needs and 5) how satisfied they were with the warmth and relatability of staff, both using a 5-point scale (1 = not at all, 2 = slightly, 3 = moderately, 4 = very much, 5 = extremely). Finally, all were asked 6) about ideas for improving case management services using an open-ended format. During routine monitoring, case management participants in all settings were invited to provide feedback on services received. Using a 5-point scale (1 = not at all, 2 = not, 3 = somewhat, 4 = mostly, 5 = very), participants were asked to rate 1) the extent to which their needs were met and 2) their level of satisfaction with the service. Using a different 5-point scale (1 = very poor, 2 = poor, 3 = average, 4 = good, 5 = excellent), participants were also asked to rate 1) their social worker’s communication skills and 2) their social worker’s knowledge and helpfulness. Additionally, unique supplementary questions were asked in each setting according to what the team felt would be most useful to maintaining program quality.

In Myanmar, all case management participants are invited to provide feedback on services after 3 months or at the time of case closure. To date, 15 of the 35 case management participants (response rate = 43%) have agreed to do so. Per monitoring data, on average, participants reported feeling as though staff had excellent (M = 4.7) communication skills and good to excellent (M = 4.5) knowledge and helpfulness. They reported feeling that their needs were mostly met (M = 4.1) and that they were mostly to very satisfied with the services (M = 4.5). Of the services received, psychological support (73%) and legal assistance (53%) were commonly cited as most helpful. A subset (8, 53%) reported how they were referred to case management; of these, half were referred by NSSWON, a quarter by focal points, and the others by the hotline and self-referral. Some mentioned challenges receiving help such as cultural disapproval of divorce, lack of availability of a case worker on a certain day or poor phone reception in their villages.

In Burundi, 26 adults reported participating in case management services. A comparison of research sample data and case management monitoring data on the few demographic variables available suggests that the research sample appears to be generally representative of case management beneficiaries overall, with slightly larger populations married and from Makamba in the research sample (see Table 13).

Table 13. Comparison of demographic variable for case management programming beneficiaries and case management research sample beneficiaries, Burundi adults.

<table>
<thead>
<tr>
<th>Sample size, n</th>
<th>Case management beneficiary sample (monitoring data)</th>
<th>Case management research sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size, n</td>
<td>179 (January 2017 – March 2018)</td>
<td>26</td>
</tr>
<tr>
<td>Location, %</td>
<td>54% Bujumbura; 46% Makamba</td>
<td>46% Bujumbura; 54% Makamba</td>
</tr>
<tr>
<td>Residency status, %</td>
<td>96% community residents; 3% returnees; 1% IDPs; 1% refugees.</td>
<td>92% community resident; 4% IDPs</td>
</tr>
<tr>
<td>Marital status, %</td>
<td>47% married or cohabitating; 34% divorced/separated/widowed; 19% single</td>
<td>58% married or cohabitating; 31% divorced/separated/widowed; 12% single</td>
</tr>
</tbody>
</table>

Most adult beneficiaries in Burundi (88%) reported that they were informed about their rights as participants in IRC services, with many spontaneously sharing that they signed a consent form. They reported that services met their needs (M = 4.7) and were highly satisfied with the warmth and reliability of staff (M = 4.9). This is corroborated by monitoring data in which 64 out of 179 case management participants (response rate = 36%) responded to client satisfaction surveys, reporting that staff communication skills (M = 4.7) and knowledge and helpfulness (M = 4.7) were excellent.
Of the 26 women who had received case management services in Burundi, most reported having developed a safety plan, having identified and prioritized needs and developed an associated action plan, and having learned coping strategies (see Figure 6). Fewer than half (42%) reported that they had received referrals to other services, most commonly police/security-related services, medical services, and PSS group activities. Of those receiving referrals, 3 women (27%) reported that case worker had provided them with contact information or contacted services ahead of time to let them know she was coming, 4 (36%) reported that they were accompanied to services, but all 11 (100%) were contacted later to find if they had received services.

When asked about suggestions for improving case management services, some beneficiaries provided responses that were not specific to case management, but rather concerned services more generally, or were ambiguous about the specific services addressed. Participants described need for increased capital to fund projects, and for more frequent services (e.g., “if the program could concern more days in the week, like 5 days, that would be fine). Many respondents mentioned extending the service to additional people and places. Some requested increased support due to poverty, “we wish they could continue supporting us, especially those like me who are in the street because of lack of food and shelter.” Adolescents receiving case management services suggested increasing staff and expanding the services to help more people.

In Iraq, of the four participants who reported using case management services, all reported that they were informed about their rights. Three reported that appointments entailed identifying and prioritizing needs, one reported developing an action plan, and one reported discussing coping strategies. One participant reported receiving a referral to another organization, and stated that the caseworker providing contact information, contacted services to let them know she was coming, accompanied her to services, and contacted her later to find out if she received services. No participants reported developing a safety plan. Participants reported that case management moderately/very much met their needs (M = 3.8); when asked to explain, one participant said, “I can’t trust them completely and talk about everything.” Participants reported that they were moderately/very satisfied with the warmth and relatability of staff (M = 3.5), and that they moderately trusted staff enough to share their experiences with them (M = 3.3).

These findings reflect slightly lower satisfaction than the monitoring data in which 213 out of 321 case management participants (response rate = 66.4%) responded to client satisfaction surveys, reporting that staff communication skills (M = 4.9) and knowledge and helpfulness (M = 4.9) were excellent. All (100%) of respondents reported that they felt comfortable when speaking with the social worker and that they felt as though the social worker supported their decisions. On average, participants reported that they felt their needs were mostly to completely met (M = 4.7) and that they were mostly to very satisfied with the services (M = 4.8). Reporting participants most commonly said they heard about the case management services through friends or family (54%), community discussions (23%), and neighbors/community members (9%).
Staff input about effectiveness of case management services

In surveys, staff were asked 1) to rate how effective case management services are across five domains, using a 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely) (see Figure 7), and 2) to rate their confidence that confidentiality is maintained during case management sessions, using the same scale.

Figure 7. Staff rating of effectiveness of case management services, by domain, by country.

Note: Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely

In **Myanmar**, staff (including those facilitating case management services) were generally moderately confident that case management services are effective across domains. In addition, staff were (moderately to very) confident that confidentiality is maintained during case management sessions (M = 3.5).

In **Burundi**, staff (including those facilitating case management services) were very/extremely confident about the effectiveness of case management services across domains. Staff were also highly confident that confidentiality is maintained during case management sessions (M = 4.7).

In **Iraq**, staff (including those facilitating case management services) were generally very confident that case management services are effective and were highly confident that confidentiality is maintained during case management sessions (M = 4.5).

I. Help-seeking for case management related needs

Scenarios were used to elicit beneficiary input about help-seeking for case management-related needs from beneficiaries who may not have used case management services themselves. Beneficiaries were presented with community member scenarios (see Table 13) and asked 1) Would she seek help/tell someone what happened (yes/no) (see Figure 8); 2) why/why not? (open-response), and 3) who would she tell? (open-response). In regard to the rape scenario, women were then asked, 1) would she seek help from IRC’s WPE program?; 2) Could she get help from the IRC WPE staff without everyone in the community knowing; 3) would she trust the IRC WPE staff to keep her information confidential?; and 4) do you think that if she was seen talking individually to an IRC WPE staff member that others would assume that she is a survivor?, all with yes/no response options (see Figure 9). For each yes/no item, beneficiaries were also asked to share why/why not (open-response).
Table 14. Rape and domestic violence (DV)/Intimate Partner Violence (IPV) scenarios used with adult and adolescent beneficiaries

<table>
<thead>
<tr>
<th>Scenario Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rape scenario - adults</strong></td>
<td>A 21-year-old woman is raped by a man while… sleeping in the forest trying to escape conflict (Myanmar); washing clothes at the river (Burundi); she was walking to the market (Iraq). She is concerned about getting pregnant.</td>
</tr>
<tr>
<td><strong>Harassment scenario – adolescents</strong></td>
<td>[fictional name] is 16 years old and is just a typical girl living here. Every day when she walks outside, her neighbor makes catcalls, pokes or touches her, and insists that she have a relationship with him.</td>
</tr>
<tr>
<td><strong>DV/IPV scenario – adults</strong></td>
<td>If a woman in this community was being abused by her husband/partner, do you think she would tell someone/seek help about the abuse?</td>
</tr>
<tr>
<td><strong>DV scenario – adolescents</strong></td>
<td>If an adolescent girl in this community was being abused by a family member, do you think she would tell someone/seek help about the abuse?</td>
</tr>
</tbody>
</table>

Figure 8. Adult beneficiary input about whether a community woman would seek help when exposed to rape or IPV, by country
In **Myanmar**, most respondents said that the woman in the rape and IPV scenarios would seek help (see Figure 8). However, qualitative data associated with these vignettes provides additional context for understanding why some women might not seek services. A woman might not seek help if raped because: (adult women) she doesn’t want others to know, she is scared/worried, doesn’t know where to go; (adolescents) she is shy, doesn’t want her parents to know, others will find out and treat her badly. If experiencing domestic violence, respondents might not seek help because: (adult women) she is afraid of her husband, she is financially dependent on her husband, she wants to protect her husband, doesn’t want to be forced to leave her children if she gets a divorce; (responses from adolescent girls) to maintain her family’s dignity; doesn’t think seeking help will change anything.

In **Burundi**, almost all women said that the woman in the rape scenario would seek help, primarily to “get comfort” and “medical services” (see Figure 8). Most said that she would seek help from a focal point, IRC staff, or a trustworthy friend of neighbor. Likewise, almost all women said she would seek help from IRC’s WPE program (see Figure 9), for health services and support (e.g., “Advise her, comfort her so that she may not think about suicide”). Almost all said she could get help from IRC without everyone in the community knowing because IRC “work in confidentiality.” Of those who said that she could not, one specified “at hospital people may talk about cases, it is not easy that people keep silent on things they know.” All women said that they would trust IRC to keep her information confidential (e.g., “I know in IRC, if you are a staff you are committed to confidentiality”). Finally, most women reported that a woman seen talking individually to an IRC staff member would not necessarily be seen to be a GBV survivor, explaining “they know that different people with different problems come to the center, even those who come for singing and dancing” and “we are so many women coming to the center and no one can guess what issue we are talking about.” Women gave similar feedback about the intimate partner abuse survivor scenario, though a few shared additional reasons that women may not seek services: “If she depends on him on everything, she is obliged to keep quiet because she is afraid he will not provide for the needs anymore.”

In response to the harassment scenario, all adolescents reported that they would seek help in general and from IRC and could trust IRC to keep information confidential. Most (8, 67%) reported that a girl seen talking individually to an IRC staff member would not necessarily be seen as a GBV survivor, explaining that “people know that IRC doesn’t receive only people who are survivors of violence, but also other people” and “people think the center is only for weaving activities.” Regarding the domestic violence scenario, most girls (9, 75%) said that they would seek help, and most said that they would tell IRC staff or focal points.
In Iraq, 63% of adult respondents said that the woman in the rape scenario would seek help; however, several qualitative responses provided reasons why she would not seek help (e.g., “being afraid of people talk”, “keeping it a secret is better than scandals”; “so that she won’t be ashamed and a man will marry her”). Likewise, women who reported that she would not seek help, explained that she would be “afraid of shaming by the community” and of having a “scandal”. One woman explained, “her parents would kill her if she didn't kill herself.” Those who said that she would seek help from IRC explained that she would do so if she had needed information and can’t talk to family members. Fewer women (47%) stated that the women in the IPV scenario would seek help, citing similar reasons.

In response to the harassment scenario, all adolescents in Iraq reported that they would seek help in general (primarily from family members) and all also said that she would go to IRC. All said that she could get help from IRC without everyone in the community knowing, and all said that could trust IRC to keep information confidential (e.g., “because staff keeps secrets”). Most (5, 83%) reported that a girl seen talking individually to an IRC staff member would not necessarily be seen to be a GBV survivor. In response to the domestic violence scenario, half of girls (3, 50%) said that she would seek help, from her mother or friends of family. Those who said she would not seek help mentioned shaming herself and her family, e.g., “She should not tell anyone since she might disgrace her family.”

**Barriers to case management use and suggestions to increase use**

Following scenario items, beneficiary women and girls were then asked to identify reasons why women/girls in their community might choose not to receive case management services from a list of potential reasons (yes/no) (see Table 15). They were then asked, what changes do you suggest to increase the likelihood that women/girls will use case management services? (open-response).

Table 15. Top beneficiary-reported reasons that community women may not use WPE case management services, by country (adults and adolescents)

<table>
<thead>
<tr>
<th>Myanmar, n (%)</th>
<th>Burundi, n (%)</th>
<th>Iraq, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>Adolescents</td>
<td>Adults</td>
</tr>
<tr>
<td>Concerns about accessibility for disabled service users: 46 (77%)</td>
<td>Concerns about accessibility for disabled service users: 10 (83%)</td>
<td>Belief that violence is normal/should be accepted: 51 (85%)</td>
</tr>
<tr>
<td>Stigma/honor: 43 (72%)</td>
<td>Stigma/ “honor”: 10 (83%)</td>
<td>Opinions of family and friends: 39 (65%)</td>
</tr>
<tr>
<td>Concerns about cost: 40 (67%)</td>
<td>Not comfortable sharing in front of adult women (which might include their mothers or mothers-in-law): 8 (67%)</td>
<td>Concerns about confidentiality: 38 (63%)</td>
</tr>
<tr>
<td>Concerns about confidentiality: 37 (62%)</td>
<td>Concerns about safety: 7 (58%)</td>
<td>Concerns about safety: 36 (60%)</td>
</tr>
<tr>
<td>Opinion of family and friends: 36 (60%)</td>
<td>Concerns about cost: 7 (58%)</td>
<td>Lack of confidence that services will be helpful: 35 (58%)</td>
</tr>
</tbody>
</table>
In Myanmar, adult women suggested the following to increase the likelihood that women/girls will use case management services: more awareness raising to address social norms suggesting the GBV is ‘normal’, keep working to connect with community members, promote services, and ensure that all know that services are free and confidential, more emphasis on peer-support activities so women can encourage one another, greater outreach efforts to support those in remote areas. Adolescents suggested: expand services to those in isolated villages, hold meetings in very private places, invite more girls for fun activities such as flower making, separate sessions should be help for adolescents and adult women, those who have used services should help to recruit those who have not used services.

In Burundi, women primarily suggested to increase sensitizations/information sessions. Some women also suggested to increase number of focal points, set up centers in more communities, and make announcements in churches and through radios. A few suggested information sessions for community leaders and asking community leaders to “organize a meeting for everyone.” Some suggested providing transportation means, more vocational training, and material support such as clothes and food. Adolescents suggested more training sessions, setting up “youth centers” to inform students about activities, and enlisting other girls to spread the word (preferably with IRC t-shirts and bicycles).

In Iraq, women suggested more awareness raising sessions to clarify services, providing transportation means, following up on women “on a constant basis”, and raising awareness of mothers, fathers, men, elderly people, and the community in general so that they can support women who need help. An adolescent suggested to “increase awareness on the available services through training a group of girls, so every girl will spread awareness to others at their schools or in the community.”

### J. Referral pathways

Staff, focal points, and other stakeholders were asked about strengths and challenges regarding the referral pathways in interviews and FGDs. See Case Management section above for beneficiary experiences with referrals made in case management sessions.

In Myanmar, referrals are often made through the hotline network in the context of comprehensive case management for GBV survivors. Referrals may include medical and other supports, as described by one focal point: “IRC provides direct services or provides referral pathways to survivors to meet their needs.” Common themes from stakeholder input about referral pathways are detailed below.

- Inadequate resources and unrealistic expectations were mentioned several times. “The difficulty part for us as service providers is that after women report to us about these violence and we helped, they tend to be expecting a lot from us”, “We lack sufficient resources to help. A survivor comes and tells you: ‘I and my children have not eaten for 2 days’ and you find you can’t help.” Several staff indicated that it is very challenging when participants and service providers have unrealistic expectations about what IRC and referral pathway partners can provide as many services do not exist.

- Legal support is often needed, but there are limitations on what IRC can provide. Respondents explained that IRC utilizes a lawyer affiliated with a partner organization who has limited time to devote to IRC-referred cases. In addition, the partner has put a new pre-screening system in place, resulting in participants needing to see another contact at the partner agency before they can meet with a lawyer – a process that has proved frustrating for some participants. Several IRC staff indicated that a lawyer dedicated to IRC referred cases is needed.

- A reliable shelter or safe house is needed. Stakeholders mentioned that survivors may be given counseling by IRC, but this is often not enough when they really need access to a safe house (that is close by and they are comfortable using). A few respondents specifically mentioned that women who are survivors of GBV in rural areas are often victimized by armed actors or other villagers and need to be taken out of the community and put up at a safe house immediately when they seek help.

- Concerns were raised that referral pathways are limited in remote/rural areas. Several stakeholders were concerned that survivors have to go to Lashio to access services, noting that this can be problematic. Referral
pathways in rural areas are limited; stakeholders suggested redoubling efforts to identify potential resources in various locations outside of Lashio.

- The phone signal is poor in some areas, making connecting with the hotline and associated referrals very difficult in those regions.
- Lack of responsiveness from authorities is problematic. The police are not reliable and there is a lack of responsiveness from other authorities (e.g., social welfare staff seem to blame victims for trafficking).
- Referral pathway members, especially authorities, need GBV training. This was mentioned by several stakeholders, especially in the context of concerns about referral pathway partners maintaining confidentiality and having a compassionate approach to survivors (instead of victim-blaming).

In Burundi, staff explained that there is a referral process but it is “not very formal”. Although staff can easily make referrals with external organizations, these organizations typically do not provide follow-up information to IRC about the outcomes of referrals.

- Respondents emphasized the need for additional referral options for legal support, including for women who want to press charges against perpetrators of GBV (including locating a lawyer, paying fees for lawyer, transportation, and medical reports). Service providers also identified need for support with other legal needs and related fees: “If IRC could help vulnerable couple to pay for marriage legalization...or for children who have not been registered at their birth.” Community leaders echoed the need for support for official marriages, explaining, “Polygamy is one of the reasons why husbands ill-treat their wives.”
- A second major need is shelter. Staff explained that there are some shelter referral options in Bujumbura, but none in Makamba. Even in Bujumbura, shelters require material “contribution” which IRC does not provide: “When a wife is chased from her home, even if we refer her to other partners who can provide a shelter service, they ask for IRC’s contribution (food for example).” Staff explained that they would like to set up local “host families” to take in women and their children. However, financial support would be needed for host families, and confidentiality of survivors and safety of host families is a concern (hence plans to connect survivors with host families in different areas). Respondents shared that lack of current shelter options has resulted in focal points sometimes allowing GBV survivors (who have left their husbands and have no place to go) to stay in their own homes.
- Finally, respondents identified a lack of referral options for financial and material support, and for economic empowerment and vocational training services: A staff member explained, “the women in recreation activities (dancing) ask us, could you organize an income generating activity for us? Like a small business so that we may not continue being economically dependent? Most of the women include GBV survivors. As they economically depend on their husbands, it is difficult to set up a sustainable safety plan.”

In Iraq,

- Staff also cited need for legal support; although some referral options exist, they are “loaded down with cases” and do not always accept new referrals.
- Staff identified a lack of referral options for people with disabilities.
- In addition, staff shared that recently, free medical services for IDPs have been discontinued and services are now not easily available, and often charge fees. IRC does not pay fees for health services.

In reviewing this report, IRC management noted that this feedback indicates potential violation of best practice guidelines. See Section III. IRC Discussion for further discussion.
K. Hotline

Awareness of support call/hotline services

In interviews, beneficiaries were asked if they had used support call or hotline services; if not, they were asked whether they were aware that it exists (yes/no response options) and if so, where they had learned about it (open-response). Service providers and community leaders were also asked about awareness of hotline services during FGDs.

In Myanmar, only two adult women had used the hotline/support call center (none of the adolescents had used the hotline). Of the adult women that had not used the support call center, nearly all of the 54 women that were asked (94%) indicated that they were aware that the hotline exists, having learned about it from IRC focal points and case workers. Less than half (44%) of the nine adolescents in Myanmar who were asked about the hotline were aware that such services existed; those that were aware learned about it from information sessions, friends and case workers.

In Burundi, nine adults and two adolescents reported using support call services; of participants who had not used support call services, most (86% of adults; 90% of adolescents) reported that they were aware that call services existed. Again, most reported being given the number by staff or focal points, during trainings or group activities, and a few mentioned seeing it displayed in the office. One participant reported being informed by a “neighbor who benefitted from the program.” Some service providers, but not all, were aware of support call services; those that were shared that IRC had distributed the support call line number in trainings and in coordination meetings.

In Iraq, three adults and no adolescents reported using hotline services. Of adults, 6 (22%) of those who had not used hotline services were aware that they exist. Those that did know about hotline services reported learning about the hotline from IRC staff or family members. Two (33%) adolescents were aware of hotline services, also either from staff or from family members. Service providers were not aware of hotline services and requested an increase in awareness raising about it, as “all people can benefit from it.”

Reasons for not accessing hotline services

In interviews, beneficiaries who were not using hotline services were then asked to identify reasons that they did not use the hotline from a list of potential reasons (yes/no response options) (see Table 16).

Table 16. Top beneficiary-reported reasons for not accessing hotline services (among those not using services), by country (adults)

<table>
<thead>
<tr>
<th>Myanmar, n = 54, n (%)</th>
<th>Burundi, n = 21, n (%)</th>
<th>Iraq, n = 26, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefer to speak to someone in person: 32 (59%)</td>
<td>Was concerned it would cost money/require phone credit: 37 (74%)</td>
<td>Was not aware that this service was available to me 15 (58%)</td>
</tr>
<tr>
<td>Was not aware that this service was available to me: 23 (43%)</td>
<td>Don’t have access to a phone: 27 (54%)</td>
<td>Did not need this service/feel it would be helpful to me 5 (19%)</td>
</tr>
<tr>
<td>Concerns about someone overhearing the call: 22 (42%)</td>
<td>Did not need this service/feel it would be helpful to me: 27 (54%)</td>
<td>Was concerned it would cost money/require phone credit: 5 (19%)</td>
</tr>
<tr>
<td>Don’t have access to a phone: 17 (31%)</td>
<td>Concern about someone overhearing me or monitoring me when I call: 23 (46%)</td>
<td>Did not feel I could connect with someone over the phone/preferred to speak to someone in person: 3 (12%)</td>
</tr>
<tr>
<td>Did not need the service/did not feel it would be helpful to me: 15 (28%)</td>
<td>Did not feel I could connect with someone over the phone/preferred to speak to someone in person: 7 (14%)</td>
<td>Don’t have access to a phone: 2 (8%)</td>
</tr>
</tbody>
</table>

As noted in the limitations section, beneficiaries involved in this evaluation may not constitute a representative sample. Considering this, it is possible that awareness of the hotline services would be lower if sampling had been representative of residents of the larger target areas.
In Myanmar, in addition to reasons reported in Table 16, some participants that had not used the hotline previously (22%) indicated that they were concerned about hotline use because they did not know if IRC would keep information shared on the call confidential. Adolescents reported similar reasons for not using the hotline: they prefer to speak with someone in person (6, 66%), they have concerns about confidentiality/someone overhearing the call (7, 78%) or that information shared would not be kept confidential by IRC (4, 44%), and/or they don't have access to a phone (3, 33%).

In Burundi, only one participant (2%) was concerned that IRC would not keep information confidential. Women in Burundi emphasized that they trusted IRC to keep confidentiality, “I know that they listen and keep confidentiality”, though one woman mentioned prior fears, “At the beginning, when I didn’t have a phone, I thought phones could record what we are saying”. Others shared that they did not have phones or that lack of a private phone is a barrier; one woman shared: “Yes I have a phone but it’s always in the hands of my husband.” Among adolescents, top reasons for not using the call center were: concerns that it would cost money/require phone credit (7, 70%), not having access to a phone (6, 60%) and not needing this service/feeling it would be helpful (3, 30%). No adolescents were concerned that IRC would not maintain confidentiality.

In Iraq, only one participant was concerned that IRC would not keep information confidential. Most explained that they did not know about or understand the hotline, and that more awareness raising was needed. Among adolescents, top reasons for not using the hotline were lack of knowledge that it was available (3, 50%), concern it would cost money/require phone credit (3, 50%) and not needing this service/feeling it would be helpful (3, 50%).

Experience with hotline services

In interviews, beneficiaries who reported using the hotline/support call center were asked 1) what made you decide to use this service (open-ended), 2) overall, how easy is it for you to access/use the hotline? (5-point scale), and 3) to identify factors which enabled their ability to access the hotline from a list of potential factors (yes/no response options). Next participants were asked about 4) confidence that their call would not be monitored by others in their environment (e.g., family members), 5) confidence that information shared on the call would be kept confidential by IRC, 6) level of satisfaction with warmth and relatability of staff on the hotline, 7) ability to form a personal connection with them, and 8) satisfaction with availability of staff on the hotline, all using 5-point response scales (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely). During routine monitoring, all callers, except those who are distressed or have emergency needs and cannot stay on the line, in Myanmar and Iraq were invited to provide feedback on the hotline. Using a 5-point scale (1 = not at all, 2 = mostly not, 3 = somewhat, 4 = mostly, 5 = very), participants were asked to rate 1) the extent to which their needs were met and 2) their level of satisfaction with the service. Additionally, callers were asked 1) if they felt supported and listened to, 2) if the call helped to increase their ability to make decisions about their safety, and 3) what, if any, challenges they faced in calling the hotline.

In Myanmar, only two of 61 adult participants and 1 adolescent reported using the hotline/support call center. Both reported using the hotline to call on behalf of others and were therefore atypical callers. Given this small number, participant user experiences are not reported here. However, monitoring data reveals general satisfaction with the hotline services. To date, 14 out of 60 unique callers (response rate = 23%) have agreed to do so. All of these individuals (100%) have reported that they felt supported and listened to and that the call helped to increase their ability to make decisions about their safety and to address the consequences of violence in their lives. On average, respondents reported that the needs they called about were mostly met (M = 4.1) and that they were mostly to very satisfied with the service (M = 4.8). The primary challenge with using this service was cited as poor connections from rural areas (63%) but one woman mentioned that she initially was worried about connecting with the person on the other side of the line: “At the beginning time, [I] didn’t dare to call, concerning about, ‘oh do they understand/accept me.”

In Burundi, nine adults and two adolescents reported using the hotline. The most common reasons for deciding to use support call services were because it was an “emergency situation” (e.g., “it was an emergency situation and I wanted someone to comfort me”), because of living or being far from the center (e.g., “sometimes I have a problem while I’m

66 Beneficiary feedback for this service was not collected in Burundi due to the informal nature of the support line.
not near the center, and I have the possibility to call them and inform about what happen”), and due to ease of reaching someone (e.g., “sometimes, when I don’t know when they will come, the phone becomes an easy way to communicate”). Some women also used the line to confirm appointments before traveling to the center (e.g., “it was necessary to make sure she is available before I go because I’m pregnant). Participants reported that calls consisted of receiving “comfort,” listening and talking, scheduling follow-up visits, and connecting with a focal point to assist (e.g., “she talked to me, informed me the day she would come, but meanwhile she sent me to a [focal point] who accompanied me to the health center”). The two adolescents who had used the support call line shared that calls entailed “listening to my problems” and scheduling appointments.

When asked about factors enabling access to the support call center, the most commonly endorsed reasons were that it offered a wider timeframe and more flexibility during which one can access support (100%), was easier logistically than physically accessing services (78%) and that the service is free (67%). Overall ease of access was high (M = 4.2). Participants were extremely confident that information shared on the call would be kept confidential by IRC (M = 4.9), and just slightly less confident that the call would not be monitored by family and others in the environment (M = 4.1). Participants were satisfied (very much or extremely satisfied) with the availability of staff, warmth and relatability of staff and felt that they could form a personal connection with them (M = 4.7 – 4.9). Adolescents provided similar input, with top reasons for use being that the support call line was easier logistically and offered a more flexible timeframe than physically accessing services. Adolescents were very or extremely satisfied with staff in the support call center.

Suggestions for improvement focused on making sure that all women knew the phone number, keeping the phone line open at night, and increasing access to phones and credit (e.g., “we wish they could [make available] people who respond quickly at night when there is a call and plan to have a free phone number because sometimes we lack credits.”) Although focal points currently hold phones for use by other community members, one respondent suggested distribution of phones to other women as well: “they could select some trustworthy women, give them phones so that they can use them to call for help in favor of survivors”.

In Iraq, three adults reported using the hotline. When asked why, one stated: “I need help, especially I am a widow with 4 children”; and a second stated, “I need residence” (suggesting potential misunderstanding of the purpose of this hotline). Ease of hotline use was moderate (M = 3.3). Two of the three respondents endorsed all of the potential factors contributing to hotline use: easy access to a phone, free service, easier logistically than physically accessing services, allowed for more confidentiality than physically accessing services, and offers a wider timeframe during which I can access support. Respondents were very confident that their call would not be monitored by others in their environment (M = 4.0) and would be kept confidential by IRC (M = 4.0). Participants were very satisfied with the warmth and relatability of staff on the hotline (M = 4.3), and with the availability of staff on the hotline (M = 4.3) and moderately felt that they could form a personal connection with them (M = 3.3). Suggestions for improvement entailed broadening the hotline to serve “all needs of women not only GBV.”

These findings are reflected in the monitoring data as well with 4 out of 15 total hotline callers reporting on client satisfaction surveys (response rate = 27%) that their needs were mostly met (M = 4.0) and that they are mostly to very satisfied with the hotline (M = 4.8). Additionally, all respondents (100%) said that they felt supported and listened to and that the call helped to increase their ability to make decisions about their safety and to address the consequences of violence in their lives.

Staff, focal point, and other stakeholder input about hotline effectiveness

In surveys, staff were asked 1) to rate the effectiveness of hotline/support call services in a list of provided domains, using a 5-point scale (1 = not at all, 2 = slightly, 3 = moderately, 4 = very much, 5 = extremely). They were also asked 2) to rate confidence that privacy is maintained on the calls and 3) to rate how comfortable community members are using phone-based services, also using the same 5-point scale (See Figure 10). Focal points were asked how helpful hotline/support call center is for their work, also using the 5-point response scale. Staff, focal points, community leaders, service providers, and community men were also asked to comment on hotline use in FGDs and interviews.
Staff input regarding hotline/support call center effectiveness, by country.

Note: Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely

In Myanmar, staff rated the hotline/support call center as moderately to very effective across domains (see Figure 10). Focal points reported that they sometimes use the hotline and that when they do, it has been extremely helpful (M = 4.8). They explained that the “emergency phone line can help a survivor to seek the help they need in a timely manner,” and one focal point indicated, “I was always called back every time I called.” They shared that some people prefer to use the hotline, “survivors often don’t like to talk to us in person, so phone conversations are better for them to seek help”. However, some indicated that not everyone can use the hotline, “due to a very poor phone signal in our area, I have difficult accessing the phone line”.

In FGDs and interviews, staff, focal points and other stakeholders also indicated that the phone may be an especially useful tool in working with adolescents: “even if her parents forbidden her from coming, we can use phone and do whatever we can just to reach her and give her the help that she needs”, and emphasized “people who are suffering violence and who are in difficulty to escape from where they live can call the phone and ask for help”. However, some service providers raised concerns about not being able to access the hotline when they needed it, “limited hotline hours is problematic,” and explained, “some IRC staff (on the hotline) need more experience, need to be able to make immediate decisions in terms of what resources they can and can’t provide for a survivor”. Lastly, a few people raised concerns about women not having access to phones, and men monitoring any calls women make on the phone. There has been at least one incident of a man calling the hotline to ask, ‘what is this number for?’

In Burundi, staff rated the support call center as very/extremely effective across domains (see Figure 10). in: Improving participant safety (M = 4.7), facilitating referrals to essential services (M = 4.6), and improving participant well-being/reducing distress (M = 4.2). Staff were very confident that privacy is maintained on the calls (M = 4.2) and that community members are comfortable using phone-based support call center services (M = 4.3). In FGDs and interviews, staff emphasized the importance of phone services in providing a quick response: “You see if someone can talk to you on the phone, the services are given quickly. In our culture, it is not easy for people to talk about bad things which have happened to them...so if people can receive services on the phone this can be a sustainable solution especially if the incident is still fresh. After some days, the survivor can say okay, that’s how marriage is. So it is good to intervene when the situation is still fresh.”
In Burundi, focal points reported that they often use the support call services and that it has been extremely helpful (M = 4.7). They described using the support call system to contact social assistants (staff) on behalf of GBV survivors. They reported that this system increases the speed that they can respond to survivors needs (e.g., “Social assistants quickly respond to our calls. Like that, survivors quickly get help”), and allows for emergency and night-time response (e.g., “when a victim is abuse at night, you can call the social assistant and she tells you what you can do while she is not around”; see Figure 11 for timing of calls in each country). Focal points shared that IRC has given them phones and credit to use to call social assistants and to lend to community members as needed, which has been helpful. However, they requested stronger batteries as electricity for charging is not always available.

Community leaders shared that the hotline allows focal points to coordinate about how best to address local problems, especially when social pressures or conflicts of interest may complicate things. One explained, “a hotline is very useful because the [focal points] can call another [focal point] from another village.” Others shared that a primary barrier is lack of phones, and that a system is needed to allow all community members to have access to phones: “They cannot be able to call unless they use someone else’s phone (like a [focal point’s). There is need for setting up communication structures in the community so that they can help in reporting rape cases quickly.”

Figure 11. Timing of Hotline calls

In Iraq, staff rated the support call center as moderately/very effective across domains (see Figure 10). Staff shared methods that they use to protect the confidentiality of callers: “So we made a scenario and I told her…if someone else pick up or if someone from your side call, what should I say? She said, “Okay, tell him you’re my son’s teacher.” Focal points in Iraq reported that they do not use the hotline as part of their work.

Staff shared that a primary challenge with the hotline is lack of space to run it in the central office in Baghdad; because the room used for the hotline is also a meeting room, it is not always possible to guarantee confidential space. A second challenge is insufficient staff; currently two staff members share the hotline responsibilities, but a third is needed to fill-in
when the hotline gets busy. Staff also shared that the hotline is primarily reaching host community members and not IDPs. Calls to the hotline have increased significantly since staff began advertising it using Facebook; however, staff acknowledge that this medium is likely not reaching IDPs. Mobile team members distribute posters and cards to IDPs, but staff reported that IDP women have shared that they prefer to speak to staff face to face rather than by phone. Service providers in Iraq suggested that a primary challenge in women using the hotline in Iraq is “ignorance”. One explained that “about 70% of women who don’t know how to read and write in this community,” and only about “40% can reach the hotline.”

L. Staffing in mobile teams (including training/supports)

In surveys, staff and focal points were asked to rate satisfaction with 1) the quantity of staff of the team, 2) the training received, and 3) supervision received, all using 5-point scales (1 = not at all, 2 = slightly, 3 = moderately, 4 = very much, 5 = extremely) (see Figure 12). In addition, staff were asked to 4) explain staffing, training, and supervision needs, as well as “any recommended changes to better support you and your team to do your job” in open-ended items. Staff and focal points were also asked to share about staffing, training, and supervision needs in FGDs and interviews. See Table 16.

Figure 12. Staff and focal point satisfaction with quantity of staff, training, and supervision, by country

![Staff and focal point satisfaction with quantity of staff, training, and supervision](chart)

Note: Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely
Table 17. Staff and focal point suggestions for staffing, training, supervision, and other recommendations to allow us to do our jobs better, by theme, by country.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Myanmar</th>
<th>Burundi</th>
<th>Iraq</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing needs</strong> (i.e. quantity of staff on the team)</td>
<td>More staff needed for hotline and to supervise growing number of caseworkers and focal points; due to unpredictable nature of hotline calls and rapid response needs (due to new short-term displacement), hard to predict how many staff are needed; IRC legal resource person/lawyer needed; Staff with right background/education to engage with high level stakeholders</td>
<td>More staff are needed because there is too much work for the current number of focal points, and to provide timely support as emergency needs arise</td>
<td>Additional staff needed on hotline; recommend one designated staff in charge of case management, another “separate staff in charge of recreation activities” and “mass sensitization”</td>
</tr>
<tr>
<td><strong>Training needs</strong></td>
<td>More advanced case management training, including how to manage challenging cases (e.g., ghost calls - complex ambiguous situations, specific vulnerable groups such as men as survivors of sexual violence, LGBT+), trainings in leadership and facilitation skills; emergency response training, advanced TOT skills</td>
<td>Skills for working with adolescent girls; vocational/livelihood skills; conflict resolution; GBV IMS for social assistants; vocational/livelihood skills; entrepreneurship; training on CommCare and Rosa</td>
<td>Family code (laws governing family); GBV laws; GBV training (types of violence); gender equality; family planning/reproductive health; outreach strategies for reaching women who are afraid to seek services; skills for working with youth/adolescent girls</td>
</tr>
<tr>
<td></td>
<td>Reproductive health, human rights and case management; technical skills to provide emotional/mental support</td>
<td>Family protection services; working with adolescent girls; case management concepts at different stages; facilitation skills; outreach skills – “creative ways of attracting people and building trust with them”</td>
<td>GBV core concepts; PSS support; English classes; skills to work with “a nervous person, a person who is very angry, those with special needs”</td>
</tr>
<tr>
<td>Themes</td>
<td>Myanmar</td>
<td>Burundi</td>
<td>Iraq</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Supervision needs</td>
<td>Much closer supervision is required</td>
<td>More structured supervision (including regular time set aside for each staff member); action plan for case management clients developed with supervisors; Field visits by supervisors; coordination/information exchange meetings</td>
<td>Challenges with working remotely: More field visits needed by senior officers and management team to ensure quality programming.</td>
</tr>
<tr>
<td>Staff support/self-care</td>
<td>Staff welfare is needed, staff need more opportunities to process experiences, decompress, that are sanctioned by the office</td>
<td>Staff support/self-care activities; stress management/relaxation exercises. Retreat scheduled every 3 months.</td>
<td>Need for staff support/self-care</td>
</tr>
<tr>
<td>Transportation</td>
<td>Travel in unmarked taxis can be problematic but necessary at times due to challenges coordinating vehicles, it is preferable to travel in marked IRC vehicles</td>
<td>Focal points should travel in pairs (for safety reasons)</td>
<td>Need for project car, not shared with other projects \ Increased transportation means to visit women who live faraway; bicycles</td>
</tr>
<tr>
<td>Technology for communi-</td>
<td>Focal points would like their phone numbers added to hotline cards</td>
<td>Telephone/tablet</td>
<td>Smartphones, to take pictures of injuries and have Whatsapp group with other focal points; chargers for phones and/or extra batteries; solar panels for charging</td>
</tr>
<tr>
<td>Themes</td>
<td>Myanmar</td>
<td>Burundi</td>
<td>Iraq</td>
</tr>
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<td>------------------------</td>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Financial/material needs</strong></td>
<td>More financial and materials support for participants; more dignity kits</td>
<td>Stationary and other materials for PSS groups; birth control pills for women and other health needs; more brochures and other educational materials</td>
<td>Better salary; petty cash for immediate field needs</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Operation team should have decentralized management process to reduce staff contacting headquarters all the time. Need to review staff TORs - over time staff workloads have become inequitable</td>
<td>Those answering the hotline should have delegated authority so they can allocate resources quickly</td>
<td>Knowledge exchange with other IRC programs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IRC identification</td>
</tr>
</tbody>
</table>

Staffing, training, supervision, and other needs shared by staff and focal points are summarized in Table 16. In addition, some primary themes are discussed in more detail below.

**In Myanmar,**
- Respondents emphasized the need to hire more staff to focus on outreach, coordination and GBV trainings for high level stakeholders (e.g. police, authorities). These staff should have appropriate background/education in order to ensure that they are given respect by high level stakeholders.

**In Burundi,**
- Staff highlighted supervision and self-care needs. In surveys, staff suggested: “Visiting us on field; organizing a monthly coordination meeting for us for experience exchange and one day in every three months for stress management.” In FGDs and interviews, staff and focal points described similar needs: “We need relaxation activities to fight against stress related to our everyday work”; we should “meet every three months to exchange about our experience; talk about hard times we went through and that should occur in relaxed place, kind of retreat.”
- Staff also requested opportunities to exchange knowledge with other IRC programs: “We also would like to visit other countries to see how they are running this project and see if we follow the same principles. It would also be an opportunity to increase our knowledge.”
- Both staff and focal points also emphasized the need for emergency food and material aid for survivors, or petty cash that can be used to buy food and other kinds of aid as needed in the field. One explained: “For example, if we...
receive a survivor who has spent three days without eating, we need to give her food before we talk with her. Or a woman comes with her children who keep on crying because they are very hungry, in that case it is difficult to talk with her. Focal points shared that if IRC does not provide these goods, focal points end up providing it themselves, which stretches their already limited resources.

In Iraq,

- Staff identified significant challenges regarding supervision and monitoring of service delivery, explaining that management and supervisory level staff often do not go into the field to provide support to field staff or make sure that activities are implemented correctly. Insufficient field visits were explained by staff being “stretched quite thin,” as well as a sense that “we haven’t heard anything that’s gone wrong so things must be going okay.” However, staff explained that field staff may not be reporting difficulties or asking for support because they don’t want to appear as if they don’t know what they’re doing, or may not realize that what they are doing needs improvement because they haven’t been provided with needed support.

- Staff emphasized challenges associated with high levels of staff turnover among coordination and management level staff, resulting a “cascading effect” in which staff face “a lot of instability and they’re trying to figure out what’s going on and trying to piece things together.” Staff explained that frequent new hires result in “staff feeling overwhelmed because you have to prove yourself again to the new manager” Policies designed to support staff welfare and increase staff retention are needed.

- Staff also highlighted staff support and self-care needs, associated with work with highly difficult and distressing cases. A staff member explained, “[staff] had a lot of stress, they work in the camp where a few women experience ISIS practice and they hear them all and we need to take care about them.”

- Focal points emphasized the need for badges and/or other evidence of affiliation with IRC. One shared that when a man asked her for an ID at a beneficiary’s house, “I didn’t have one which was very awkward and I felt very small and shy and I had to leave”. A second shared: “We need to have a badge to differentiate us from other organizations because there are other types of organization that come, take information, take photos, and do not provide any help at all.”

### M. Technology

**Beneficiary use of tablets**

In interviews, beneficiaries were asked “how comfortable were you with the use of a tablet during this interview”, and “would you be comfortable with staff using a tablet when providing other services?”, both with a 5-point scale response options (1 = not at all, 2 = slightly, 3 = moderately, 4 = very much, 5 = extremely). They were also asked to explain “why or why not” in open-ended items.

In Myanmar most adults were slightly to moderately comfortable with the use of tablets during interviews (M = 2.98) and moderately to very comfortable with the use of tablets for providing services (M = 3.82). They went on to explain that tablets are “faster”, “more efficient”, “safer” and “a good tool to communicate to the outside world”. Some preferred tablets to paper, stating: “tablet is safer than papers in storing information. We don’t need to worry that it will be damaged” while others had concerns, “you can lose data in the device. We can press delete unintentionally”.

Among adults in Burundi, adults were extremely comfortable with use of tablets during interviews (M = 4.97) and for providing other services (M = 4.9). Many stated that they were comfortable because the interviewers explained the use of the tablet to them, and because they trust the interviewer. Participants were generally familiar with use of tablets, “its not the first time I see someone with such a device”; “it’s like using a pen”. Some appreciated the use of technology so that “you will be able to remember what we talked about”; “you write down all our conversation and it can get to your supervisors and that can be beneficial to us”. Many were in fact enthusiastic about use of a new technology, “it’s a sign of progress”; “it is interesting to see and it is easy to use it”. Adolescents were also comfortable; “I’m used to this because my sibling has a smartphone.”
In Iraq, participants were also comfortable with the use of the tablet in the interview (M = 4.1). When asked if they would be comfortable with staff using a tablet when providing other services, participants were generally positive (M = 3.7), with some observing that tablets help to feel listened to (“help me in problem solving as he will hear me”). However, others shared concerns about being voice-recorded or photographed and specified that tablets were only acceptable if it was confirmed that there would be no photography (“no harm as long as there is NO photographing”).

**Beneficiary use of phones and internet**

In interviews, beneficiaries were asked 1) “do you use a phone?” (yes/no response options). Those who responded yes were asked to specify 2) if the phone was “mine”, “shared”, or “borrowed”. If “shared” or “borrowed,” respondents were asked to specify 3) with who from a list of potential persons. Beneficiaries were also asked 4) “does anyone check what you do with the phone?” and 5) if yes, “who?” Finally, beneficiaries were asked 6) to identify barriers faced by women and girls in using phones, smart phones, and internet, using a list of potential barriers (yes/no response options) (see Table 17).

In Myanmar, the majority of respondents (80%) indicated that they use a phone. Of these, 92% stated that the phone belonged to them, with the remainder stating that it was shared or borrowed (with/from spouse-3, children-1). Most (79%) beneficiaries using phones reported that no one checks what they do with the phone, but others (20%) reported that others checked (sometimes 9, 90% or often 1, 10%). For those who had their phones checked, they were typically checked by husbands (90%).

In Burundi, more than half (58%) stated that they use a phone, and of these, 57% stated that the phone belonged to them, while 37% stated that it was borrowed and 2 (6%) reported that it was shared. Phones were most commonly shared or borrowed from neighbors (5, 38%), spouses (4, 25%) and in-laws (4, 25%). Most (62%) beneficiaries using phones reported that no one checks what they do with the phone, but others (37%) reported that others checked (sometimes or commonly checked). Phones were most commonly checked by spouses (5, 38%), the neighbor or others person who lent it (5, 38%), or children (3, 23%).

In Iraq, more than three quarters (77%) of women stated that they use a phone, and of these, 65% stated that the phone belonged to them, while 8 (35%) stated that it was borrowed and 2 (6%) reported that it was shared. Phones were most commonly shared with children (4, 50%), spouses (2, 25%) and parents (1, 12%). Most (74%) women using phones reported that no one checks what they do with the phone, but the remainder (6, 26%) reported that others sometimes or commonly checked. Phones were most commonly checked by spouses (3, 38%), children (2, 25%), parents (1, 13%), or siblings (1, 13%).

Table 17. Top beneficiary-reported barriers to use of phones, by country (adults)

<table>
<thead>
<tr>
<th>Myanmar, n (%)</th>
<th>Burundi, n (%)</th>
<th>Iraq, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of phone: 50 (89%)</td>
<td>Access to a phone: 60 (100%)</td>
<td>Cost of credit: 25 (83%)</td>
</tr>
<tr>
<td>Cost of credit on phone: 45 (80%)</td>
<td>Cost of phone: 59 (98%)</td>
<td>Disapproval from family, friends, community: 22 (73%)</td>
</tr>
<tr>
<td>Access to phone: 44 (80%)</td>
<td>Cost of phone credit: 59 (98%)</td>
<td>Lack of privacy/confidentiality: 20 (67%)</td>
</tr>
<tr>
<td>Comfort using the phone or internet: 30 (55%)</td>
<td>Disapproval from family, friends, community: 44 (78%)</td>
<td>Cost of phone: 20 (67%)</td>
</tr>
<tr>
<td>Disapproval from others: 21 (39%); lack of privacy: 21 (39%)</td>
<td>Lack of privacy/confidentiality: 39 (65%)</td>
<td>Access to a phone: 18 (60%)</td>
</tr>
</tbody>
</table>

Note: Participants also commonly endorsed barriers associated with familiarity/comfort in using the phone (45% in Burundi; 40% in Iraq) and charging phone batteries (43% in Burundi).
Safety risks due to phone use

In interviews, beneficiaries were asked “What are the safety risks of using phones/internet for women and girls?” using an open-ended format.

When asked about safety risks associated with phone use, many women in Myanmar expressed concerns about “men preying on women online” and the potential for marital discord if women meet men online: “I heard husbands often do not let their wives use internet too much because there were many problems after married women got online and started affairs causing problems in their marriages”, “for some girls, they might get cheated by old men online. Someone older than her can pretend to be young and become her boyfriend.” One woman, explaining the poor phone signal in her area, stated, “I just worry that there might not be phone line when I make a phone call when I really need it.”

Many women in Burundi emphasized controlling and violent reactions from husbands, associated with suspicion that women are using phones to engage in relationships with other men, e.g., “husbands become angry because they see other men’s phone numbers in their wives’ phones, and the man beats his wife, takes her phone and breaks it.” Women explained that phones can increase risk of sexual exploitation and violence, e.g., “even people who want to rape or do sexual violence can call the victim on the phone and if she responds and goes, she is going to get in troubles”. Women shared that use of phone by girls can lead to distraction and exploitation: “Using phones can be a source of laziness for young girls who spend a lot of time using them instead of doing domestic work”; “parents think phones allow their girls to be involved in bad relationships.”

In Iraq, participants reported safety risks associated with establishing illegal or prohibited relationships with men, and associated stigma (e.g., “the fear of the people of stigma if the girl to establish suspicious relationships”). Some participants noted that girls and women may be “exploited and deceived”, presumably by men met online. Many participants emphasized concerns about online use of photos (e.g., “misuse and fear of photos leakage”) and some mentioned concern about pornography sites. In some cases, use of phones overall may be stigmatized (e.g., “people bad talk about girls who use phones, so we forbid it”). Adolescent girls shared similar concerns, emphasizing family concerns, especially around misuse of photos (“our uncle doesn’t allow us to open Facebook for example, because he is afraid our photos will be spread or our accounts will be hacked”).

Staff, focal point, and other stakeholder input: phone and internet use

In FGDs, stakeholders, specifically male community members and community leaders, were asked to share input about use of phone and internet by women and girls. In surveys, staff and focal points were asked to rate how likely community members are to use services provided by internet using a 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely) (see Figure 13).

In Myanmar, many community men shared concerns about phones, “a lot of family problems appears because of using Facebook and WeChat. Mostly it is women”, “usually, phone signal is good in downtown area but it is not usually good in far places. Sometimes, signal goes down here when we are in urgent need”, “(phones) weaken the solidarity of family members. They chat with other people through Facebook or WeChat. It brings unhappiness to families”, “men will want to say their wives to stop using them in the long periods if women do not listen and just keep using them. It can also lead to domestic violence.”

In Burundi, some male community members shared that women frequently have phones and can make calls; one stated, “not only women; young girls have phones too…Here, most people, roughly 60%, can use phones very well, simple phones of course.” Men acknowledged that women may want phones with access to internet as well; one stated “I consider a lady who wants to get such kind of phone as an honor and a sign of development”, but cited poverty as a primary impediment. Likewise, community leaders shared that “very few women (1%) have access to smart phones but if they had them, they could use them”; “not men only should use smart phones; women also have rights to be informed and to share information.” However, other community men shared that “most the people who have phones are men. Some men tell their wives that it's not necessary to have a phone” and that “phones are also a source of conflicts in the household. A husband may check in his wife’s phone. If he finds that there are some men phone numbers, he starts suspecting his wife.”
In Iraq, male community leaders shared that approximately 95% of women in their community can use regular mobile phones and about 65% have access to the internet. Several participants stated that they support the use of websites to provide information about women’s health, childcare, and how to resolve marital problems.

Figure 13. Staff and focal point input: Beneficiary internet use

![Chart showing internet use by country and role]

Note: Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely

**Staff use of technology for remote supervision**

In surveys, staff were asked about tech-based approaches that they may use in their work. For each approach, they were asked to rate 1) how often they use it, and if they use it at all, they were asked 2) how helpful it is using a 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely). Staff were asked to explain their responses in open-ended items.

Across countries, staff shared that ROSA Skill Building and Assessment App for self-learning is moderately to very helpful in their work (see Table 19). ROSA is a remote supervision and skill-building application available offline on tablets/smartphones that facilitates capacity building and GBV skill assessment for frontline workers, creates a community space for peer learning and coaching, and connects workers to tools for GBV rapid assessments and advocacy resources. Staff in Myanmar shared that Rosa, “Allows us to make assessment, to read and learn about GBV information; allows us to choose languages that we feel comfortable and learn interesting subjects (but not convenient in Myanmar language).” In Burundi, staff shared that “Rosa has helped me to do the evaluation of the social assistants’ work in an easy way.” However, another staff person stated, “I don’t have time. When I come back from the field I feel very tired.”

In regard to the CommCare App for Programming and M&E (see Table 19), staff in Myanmar shared: “phone and internet communication provide a faster communication, better than in-person meeting when urgent help is needed.” Likewise, staff in Burundi explained that CommCare, “helps to work in confidentiality, not to forget some data, to know some useful information when we are talking with a survivor” and “helps us to save time; wherever I am I can enter data.” Staff in Iraq agreed: “It’s simple and easy to use.”

The Primero WEB App for case management documentation was used only in Iraq. PRIMERO (Protection Related Information Management System) is a web application that was developed to enable GBV humanitarian actors to safely collect, store, manage and share data for incident monitoring and case management. It combines field proven tools, global best practices, and the latest open source technology to bring a user-friendly and scalable solution for data management. The system utilizes technology enhancements with an on/offline data collection platform through a web page or mobile application. All staff surveyed had used it and on average found it very/extremely helpful (M = 4.5). Staff most valued that
Primero allowed for “speed and accuracy in storing information” and “more secrecy”, but cited need to improve issues with the program “not closing at the required time” and glitches when entering the birth year of participants.

The Primero MOBILE App was considered equally useful (M = 4.6) and also allowed for “speed and accuracy compared to paper forms.” Staff identified need to improve “shutdown speed (app closes too fast when not entering information).”

Table 19. Staff input about technology applications

<table>
<thead>
<tr>
<th>Application</th>
<th>Myanmar, n = 27</th>
<th>Burundi, n = 6</th>
<th>Iraq, n = 6</th>
</tr>
</thead>
</table>
| *ROSA Skill Building and Assessment App for self-learning,*  
  n = number of staff reporting use,  
  M = mean level of helpfulness | n = 15, M = 3.3 | n = 2, M = 4.0 | n = 3, M = 4.3 |
| *CommCare App for programming and M&E,*  
  n = number of staff reporting use,  
  M = mean level of helpfulness     | n = 21; M = 3.8 | n = 6, M = 4.7 | n = 5, M = 4.4 |

Note: Means use a 5-point scale: 1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely

N. Safety/security

*Beneficiary input about safety and security concerns*

In interviews, beneficiaries were asked 1) to identify safety and security concerns facing women and girls in their community from a list of potential concerns (see Table 20). They were then asked 2) to rate the extent to which IRC services address these concerns, using a 5-point scale (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely). Please see Safe Spaces and Transportation sections for content about participant perceptions of safety while receiving services and traveling to and from service sites.
Table 20. Top 5 safety and security concerns facing adult women and adolescent girls in their communities, country (adult beneficiaries)

<table>
<thead>
<tr>
<th></th>
<th>Myanmar, n (%)</th>
<th>Burundi, n (%)</th>
<th>Iraq, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adults</td>
<td>Adolescents</td>
<td>Adults</td>
</tr>
<tr>
<td>Violence in the home</td>
<td>54 (89%)</td>
<td>58 (97%)</td>
<td>Sexual violence/abuse</td>
</tr>
<tr>
<td>No safe place in the community</td>
<td>9 (75%)</td>
<td>13 (75%)</td>
<td></td>
</tr>
<tr>
<td>Sexual violence/abuse</td>
<td>9 (75%)</td>
<td>12 (90%)</td>
<td>Unplanned pregnancy:</td>
</tr>
<tr>
<td>Alcohol abuse:</td>
<td>46 (77%)</td>
<td>46 (77%)</td>
<td>Polygamy: 46 (77%)</td>
</tr>
<tr>
<td>Prostitution:</td>
<td>11 (92%)</td>
<td>11 (92%)</td>
<td>Being made to marry by their families:</td>
</tr>
<tr>
<td>Not allowed to move around:</td>
<td>16 (53%)</td>
<td>17 (40%)</td>
<td></td>
</tr>
<tr>
<td>Unable to access services and resources:</td>
<td>28 (46%)</td>
<td>45 (75%)</td>
<td>Violence in the home:</td>
</tr>
<tr>
<td>Unintended pregnancy:</td>
<td>45 (75%)</td>
<td>6 (50%)</td>
<td>Dropping out of school; teacher violence:</td>
</tr>
</tbody>
</table>

Note: In Iraq, women also mentioned ISIS as a significant challenge facing women.

**Extent to which IRC services address beneficiary safety and security needs**

In **Myanmar**, women reported that IRC moderately met their needs (M = 4.0). Adolescent girls indicated that IRC very much met the needs of girls in the community (M = 4.2), adding, “all IRC services are essential. Domestic violence often occurred in the past. But when CW said IRC is helping with this issue, violence reduced”.

In **Burundi**, most women reported that IRC “extremely” met stated needs of women in the community (M = 4.7). Girls also reported that IRC “extremely” met the needs of girls in the community (M = 5.0). They emphasized the “support” and “advice” provided by IRC, as well as knowledge gained through trainings.

In **Iraq**, most women reported that IRC moderately met needs of women in the community (M = 3.3). When asked to explain why or why not, some women shared that services were helpful (“when we talk to them our fear fades”). However other women emphasized unmet medical/health, and financial/aid needs. Some noted that services lacked follow-up or tailored support, “they just collect cases with no follow-up”; “just talking, no actual help.” Like women, girls reported that IRC moderately met the needs of girls in the community (M = 3.7). A few noted, “we can’t talk about everything in our minds”; “we need more support on the PSS level.”

**Staff and focal point safety and security**

In surveys, staff and focal points were asked: 1) How safe do you feel at work/when traveling for work? and 2) How satisfied are you with IRC’s current safety/security knowledge and policies?, both using 5-point scale response options (1 = not at all, 2 = slightly, 3 = moderately, 4 = very much, 5 = extremely) (see Figure 14). They were also asked to share what more is needed to improve their safety and security in surveys, and to elaborate on security risks and related suggestions during FGDs and interviews.
In Myanmar staff indicated that they feel moderately safe at work/safe when traveling for and are moderately satisfied with IRC's safety knowledge and policies (see Figure 14). Staff shared some safety related concerns such as, “safety (is needed) for residential areas where staff live”, “staff are to follow the security policies strictly”, it would be useful to “issue staff ID cards”, and to “test drivers before hiring.” A few staff also shared concerns about sometimes needing to travel in local taxis to project sites (due to a shortage of vehicles), which they felt could compromise their safety compared to riding in clearly marked IRC vehicles.

Focal points reported feeling slightly safe and slightly to moderately satisfied with safety policies. In FGDs, focal points mentioned several safety concerns, such as fear of GBV perpetrators, especially abusive husbands. At times they are visiting survivors in their homes, possibly helping them to leave an abusive situation (this may happen in the evening, and police are not reliably available to provide security for victims). When asked about ways to improve safety for focal points, several mentioned that more staff are needed so focal points can travel in pairs. Others mentioned that GBV training for local authorities and police would be useful in hopes that they might provide safety escorts.

In Burundi, staff reported feeling moderately safe at work, and are moderately satisfied with IRC's safety knowledge and policies (see Figure 14). Several staff shared transportation concerns due to staff on different projects using the same car, necessitating getting dropped off and picked up later. As a result, “if ever a staff gets a problem, he or she cannot get help easily.” Several responses also concerned need for cash to use in the field, and better salaries to increase overall sense of financial security.

In surveys, focal points reported feeling very safe and very satisfied with safety policies. However, in FGDs, focal points mentioned safety risks, including fear of retaliation from GBV perpetrators, sometimes associated with GBV survivors staying in the home of the focal point, “in the case a wife has been beaten and comes to you and stays because she knows you are a [focal point], and her husband knows his wife is staying with you, the husband comes and threatens everybody, and says it is you who is destroying my marriage, it is you who is destroying my household.” Focal points shared that such cases have not in fact arisen, because focal points have been well-trained about how to maintain safety and confidentiality. When asked about ways to improve safety for focal points, several mentioned the need for more training; one specified: “Organize a training for us and our husbands to inform them that our work has to be confidential.”

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67 This is identified by IRC as an unsafe practice that is not recommended by the Interagency GBV Case Management Guidelines and the Guidelines for mobile and remote service GBV service delivery.

68 ibid
Iraqi staff and focal points reported feeling “very” safe at work, though staff were only moderately satisfied with IRC’s safety policies (see Figure 14). Staff explained that Karbala is relatively safe (is considered one of the safer areas in South Central Iraq), but security issues do arise, and that field office in Karbala does not have a security focal point. Staff advocated for a clearer policy/approach for assessing and responding to security risks. When asked what is needed to improve safety/security, focal points emphasized the need for organizational IDs and certificates of employment which can “explain the work of the focal points to the community. They also requested sim cards to facilitate communication.

O. Participatory opportunities

In interviews, beneficiaries were asked 1) have you and other community members had opportunities to contribute your ideas about the kinds of services needed in your community and/or contribute to the development of services?, using 5-point scale response options (1 = not at all; 2 = slightly; 3 = moderately; 4 = very much; 5 = extremely). They were then asked 2) if yes, how so? (open response). Next, beneficiaries were asked 3) if they know members of their community who serve as IRC employees or volunteers, and 4) if yes, how this has influenced their experience receiving services.

In Myanmar women indicated that they have ‘moderately’ had opportunities to contribute ideas about the kinds of services needed in the community (M = 3.3). They went on to explain, “during meetings or activities organized by the Focal Point, we can openly and freely talk.” Most (72%) of women respondents said the members of their community serve as IRC employees or volunteers. They indicated that this has influenced their perspective of services in the following ways, “due to the information sessions and training on security issues delivered by the case worker, I feel more confident now to speak up about it than I did before,” and “our advocacy skill has improved since learning about women issues.” Others emphasized, “because she is our villager, she looks forward for our benefit…She also speak to us sincerely.” In Myanmar, adolescent girls also reported moderate levels of opportunities to contribute ideas about services (M = 3.3), “for community meetings, we are invited to participate and to discuss about issues that concern us.” Most (8, 67%) girls reported that members of their community work with IRC and shared that “it is better actually to have a member of the community as IRC staff because this helps her to facilitate more information sessions for us” and “she can take village responsibility, she can lead us.”

In Burundi, women reported that they “very much” had opportunities to contribute ideas about the kinds of services needed in the community (M = 4.3), primarily in training sessions and group discussions associated with PSS activities such as embroidery. Moreover, some groups of women started their own activities, beyond those implemented by IRC; at one site in Bujumbura, beneficiaries independently developed a VSLA. Most (83%) reported that members of their community work with IRC, and many noted that these were the individuals who introduced them to the services in the first place. Adolescent girls reported similarly high levels of opportunities to contribute ideas about services (M = 4.1). They reported being invited to share ideas during their “first meeting” with IRC, and during information sessions. One girl explained that dancing is their contribution to the services. Like adults, most (9, 75%) of girls reported that members of their community work with IRC and shared that these individuals encouraged them to participate in IRC services.

In Iraq, women reported that they “slightly” had the opportunity to contribute ideas about services needed (M = 2.2). Some noted that they were asked to share ideas about outings as PSS activities. Others stated that they were asked about needs but have not received services in line with those requests “They ask about needs but have received nothing but refreshments”. Almost half (43%) knew members of their community who serve as IRC employees or volunteers. Girls also reported that they had slight/moderate opportunity to contribute ideas (M = 2.5); one shared that staff had asked their opinion of new services; a second shared that she had been asked about the types of services she wanted to be a part of; and a third shared that no one asked her to share her opinion. Four (66%) of girls knew members of their community who were IRC employees or volunteers and shared that this increased their knowledge about activities and made it easier to reach IRC.

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69 As discussed in the limitations section, in light of potentially non-representative (convenience) sampling, it is possible that beneficiaries with close ties to focal points and staff are overrepresented in this sample.
P. Services for male survivors of sexual violence

Staff, focal points, community leaders, service providers, and male community members/leaders were asked about the need for and suggestions for services for men and boy survivors of sexual violence in interviews and FGDs. Content about other services for men and boys (e.g., activities that focus on prevention and/or increase men's willingness to facilitate women's involvement in services) has been integrated into prior sections.

In Myanmar, respondents shared the following:

Need for services

- Stakeholders shared examples of sexual violence men have experienced, including “men are sodomized by authorities while in detention, and they are afraid to even seek medical care”, “men have been sexually violated in conflict areas when detained by armed actors”, and “boys have been sexually abused by adults.”
- Some participants in men-only FGDs shared personal examples with male facilitators of having experienced other non-GBV forms of violence (e.g., being beaten by armed actors/soldiers, resulting in broken bones; being burned with a candle by soldiers; seeing other men tortured; forced to witness women being assaulted).
- Many men struggle with drugs and alcohol. Respondents indicated that this may also be true of men and boys who have survived sexual and other forms of violence. In order to reach such men and boys, they suggested that more services be provided for those struggling with substance abuse.\(^{70}\)
- Discrimination against men who are gay and gender non-conforming: “we can't even talk about gay men in information sessions or other trainings, people wouldn't understand and it would undermine all the other content”, “community members sometimes don't understand the difference between sexual abuse and sexual orientation”.
- Some stakeholders noted that male survivors of sexual violence would not seek services because they feel others will judge them.

Suggestions for outreach and services:

- Conduct pre-planning discussion meetings with various stakeholders about men and boy survivors of sexual violence (service providers, community leaders, camp committee members, etc.) “to avoid confusion and misunderstanding.”
- Craft specific messaging about IRC services aimed towards reaching men and boys who are survivors of sexual violence and promoting understanding and awareness about the topic (e.g. poster campaigns in the camps; radio programming).
- Reach out to LGBT civil society groups to collaboratively provide support and case management-related referrals.
- Men who are survivors of sexual violence need support from other men: “I think it will be good if there is a male focal person to support men just like women have. Men do not dare to speak out their cases to their friends. They just suffer themselves.” Men experiencing distress, including survivors of violence, need understanding male role models in the community: “We can make comparisons, for example, comparing him to yourself. You can say you have the same problems and show sympathy.”
- Several stakeholders also indicated that the current hotline could be a good resource for men and boy survivors of sexual violence.

\(^{70}\) This is out of the scope of IRC's services.
In Burundi, the following themes arose:

**Need for services:**

- Stakeholders reported that men and boys are survivors of violence, including sexual violence, e.g., community leaders shared: “some boys (14-16 years old) are frequently sexually abused by the people who say they are going to offer them a job”, “a primary school boy was raped by a 16 years old girl.”

- Service providers shared that, “if men and boys are abused, they need services exactly like women and girls.” Likewise, a male community member shared, “I think that the supporting and help process remains the same regardless of gender, violence doesn’t have a gender. The most important is to address the violence, no matter the kind.”

- While acknowledging need for services, stakeholders also emphasized particular cultural barriers impeding men from seeking help: “if he decides to talk about his violence case as a survivor, he thinks this diminishes his dignity. That is why it is not easy to help men. They rarely talk about their cases;” one explained, “Men do not dare talk about sexual violence they undergo. Indeed, men think that, if they talk about that, they would lose their self-esteem.” Others noted, “You cannot ask men to regularly come to a place for an activity which doesn’t generate an immediate income.”

**Suggestions for outreach and services:**

- Service providers emphasized the need for male service providers to work with men: “Considering the [focal points] who are [working with IRC], it seems they are all women and men cannot trust women and tell them what happened to them. So, it would be good if we had men among [focal points].”

- Male community members emphasized the need for services for men that allow opportunities for social support, similar to those provided for women: “The listening centers help women only. But as there are also men violence survivors, there should be services for men so that men can come and meet others at the center. It is easier for men to open themselves to other fellow men.”

- Male community members emphasized the potential role of men as “change promoters”, dedicated to reducing stigma. One shared, “we used to play the role of change-promoters (Abakangurirahinduka), IRC stopped these activities, we don’t know the reason...we suggest the project be reactivated so that victims of violence can continue having people to talk to about their cases.

- Respondents also supported use of a hotline for men: “if one knows he can hide in his bed and talk, knowing that no one is listening, he can talk freely. But, we need to sensitize about the existence of the free hotline.”

In Iraq, the following themes arose:

**Need for services for male survivors of sexual violence:**

- Staff and other stakeholders acknowledged that men and boys may experience sexual violence, but recognized massive cultural stigma about the topic: “There is a need yes, totally, 100%. Its there, everywhere in society, in our society, in other society but is there anyone who will you tell you about this? I didn't hear about it ever”, “In our society, the men should be the strong part and not get something like that, it's shame on him.”

**Suggestions for outreach and services:**

- When asked about services for men and boys, some staff emphasized the need for male service providers: “We cannot talk to them. The legal team [who are male] can talk to them. Because of being women, we can't talk to men.” However, others emphasized the need for female service providers trained to speak to male survivors, explaining that in the past, a related program had hired male social workers but found, after checking with male survivors, that they actually preferred to speak to women: “So, when they switched over to it being a female social worker then they had more male survivors come...I think maybe it might been more traumatizing or more stigmatizing to talk about this situation to a male.” Respondents shared that in some cases, service providers have “conservative beliefs” and the idea of working with male sexual violence survivors may make them uncomfortable,
and that this may explain why some women service providers are discouraging about the possibility of women speaking to male survivors. Ultimately, staff suggested: “So maybe if we can give them the choice, if you want to speak to female or male and you can decide.”

- Staff suggested that mental health and PSS services are needed for male survivors. One shared an example of a man “who burned the house on his family, locking them inside and burning the house and then killing himself. That's a huge sign of depression. He needed lots of PSS support and social support.”

- Respondents were generally positive about the idea of a hotline for men, due to the privacy it affords: “it’s easier to talk to someone one you did not see him, he cannot judge you, he cannot tell others about you.” However, others continued to stress the need to build a reputation for confidentiality: “you need to work into building a trust of that service first because they will be afraid of, “okay what if I called but then they told everyone about what I talked about?”

### Strategies for disseminating information about hotline services to men

In surveys, staff and focal points

71 were asked, “How could information best be provided to men and boys about hotline services for male sexual violence survivors?”, with two potential options: providing IEC in health clinics and holding group awareness raising sessions (see Figure 15), as well as an open-ended option to share additional ideas.

Figure 15. Staff and focal point endorsement of strategies for disseminating hotline information to male sexual violence survivors, by country.

As evident in Figure 15, across countries, staff and focal points generally supported use of both dissemination of IEC information in health clinics, and group awareness raising sessions, though the second approach was somewhat more popular. In Burundi, staff also suggested distributing flyers with call center numbers during mass sensitization sessions, and “providing a web platform.”

71 Focal points were not asked this question in Iraq due to potential sensitivities.
Q. Transitioning to local partners and program sustainability

Stakeholders (staff, focal points, community leaders, service providers, and community men) were given opportunity to speak about transitioning IRC services to local partners and about overall sustainability of programming in FGDs and interviews.

In Myanmar, respondents explained that IRC works with local partners in 19 long standing IDP camps, and also links with various civil society affiliates to coordinate response to short-term emergency displacements. In addition, IRC works with NSSWON-affiliated focal points in nine townships in Northern Shan. As a respondent shared, NNSWON, a multi-ethnic consortium of local women’s groups, provides an interesting model for consideration of opportunities and challenges associated with transitioning to local partners. IRC staff indicated that a clear benefit of this collaboration is that IRC has significantly expanded the reach of programs by working with the community-based NSSWON affiliated focal points. They emphasized however, that this type of model may only be possible where there is a strong civil society presence. IRC staff also underscored challenges associated with such a model, such as the need to ensure adequate GBV-related training for local partners, both to increase skills and to emphasize the importance of adherence to best practice standards (including safety and confidentiality protocols). This may be more challenging than it seems on the surface, as local partners may be engaging in practices that directly contradict internationally-recognized best practice. It is difficult to convince local partners that they should change their existing practices when they believe what they are doing is right and necessary (e.g., assisting women to flee an abusive situation by picking her up at her home when her husband may be present, with an absence of police response). Staff also indicated that any local partner organization (or consortium such as NSSWON) could function more effectively if there was a governance committee (such as board), in charge of decision-making. This may also help to avoid over-reliance on any one individual linked to a local organization, minimizing difficulties for partners during staff transitions, and limiting the potential for conflict between and within organizations.

In interviews focused on the topic of ‘working with and transitioning to local partners’, IRC’s civil society partners in Myanmar were grateful for the opportunity to work with IRC to support women and girls at risk for GBV, but they also reflected on the challenges. Specific advice for IRC about working with and transitioning to local partners in Myanmar included: (1) organizations such as IRC need to be careful not to undermine fragile pre-existing networks; concerns were raised that when IRC, or other similar ‘outside’ organizations become involved with local networks they may inadvertently upset fragile inter-ethnic, inter-religious alliances, fostering resource competition between historical collaborators. In addition, (2) IRC needs to be aware that while technical skills associated with GBV programming (including case management) are required and useful, local organizations often need organizational skills (e.g. HR, finance) if they are to sustain programming over the long-term. Finally, (3) local organizations often have limited funding. IRC and their donors need to consider long-term budgetary support to key local organizations to ensure sustainability of GBV services (e.g., hotline/support call center). In addition to budgetary support for key program initiatives, a flexible approach to budgeting is needed to ensure ‘surge capacity’ given the ever-changing needs associated with the ongoing humanitarian crisis.

In Burundi, while most respondents provided limited input about transition to local partners, a few shared concerns about IRC’s “sustainability problems”. Non-IRC service providers shared that several years earlier, IRC closed a series of safe spaces when funding ended. Staff members based there were transferred to a local partner, but this partner did not have sufficient resources to pay them. Community members were left without sufficient services. Respondents explained that “most projects start without a baseline discussion with partners and interveners to discuss sustainability” and rather just “haphazardly start.” Respondents emphasized need for sustainability planning, ideally through coordination groups, from the very start of programming.

In Iraq, respondents shared recent experiences associated with handing over WPE services to a local partner when funding ended for part of the programming. Staff shared that they were given three months in which to close down nine sites (transitioning from 11 sites originally, to three remaining sites) and to handover many open-cases to a partner organization. Challenges were associated with the short time-line and with lack of clarity about the capacity of the partner: “at the very last moment [another organization] provide us with the name of the partner to hand over the cases for, but we are still not sure about the quality of the case management services they are providing.” Others also shared that the organization selected for handover was a protection organization with potentially limited understanding of GBV
and case management, and that the capacity concerns, combined with the quick timeline, left limited opportunity to do a structured handover of cases.

Staff shared that capacity concerns are not limited to this single partner: “across the board one of the struggles is that the technical knowledge of global partners and how they do their programing.” However, benefits of working with partners were also emphasized: “WPE currently, in the Iraq team is the only department that uses local partners. And despite the challenges that we face with them, we really rely on them because they give us access to places that we don’t have access to.” Staff shared that “it’s unrealistic for us to come in and expect them to know everything about GBV...when it’s relatively new here.”

Regarding lessons learned, staff emphasized the importance of being prepared for sudden changes in funding and need to transition services to partner organizations: “it’s a gap from our side because the Karbala situation wasn’t stable from the beginning...so we should have considered having the idea of the sudden closure so that we prepare ourselves ahead of time instead of doing more harm, let’s say, for the survivors.” Staff suggested the need to focus not only on increasing services, but also on efficiently serving and closing existing cases to avoid leaving many open cases were services to end: “we should prepare ourselves for plan B all the time because we are dealing with sensitive cases.”

Other strategies include a comprehensive approach to building organizational capacity of local partners: “we’re not going to be here forever and we need to ensure that the local partners have the knowledge and skillset, not only in GBV but also the financing and procurement and whatever it may be.” Respondents shared that IRC has a comprehensive model for organizational capacity building, including development of a “sub partner working group internally within IRC”, which provides not only technical capacity building, but also “supply chain, operations, HR, finance...and grants.” Despite a strong model, some respondents shared challenges: “the departments are really busy so the problem we’ve had is that some of the departments will come and do their one-day training…but then there’s not any follow up and there’s no coaching or mentoring.”

### R. Beneficiary feedback about interview process

At the end of interviews, beneficiaries were asked to rate agreement with a series of statements adapted from the Reactions to Research Participation Questionnaire Revised (RRPQ), using a 5-point scale (1 = strongly disagree (no); 2 = disagree; 3 = neutral (maybe); 4 = agree; 5 = strongly agree (yes)). See Figure 16.

Figure 16. Adult and adolescent beneficiary feedback about the interview process as measured using the RRPQ, by country

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As depicted in Figure 15, beneficiaries were largely positive about the experience of participating in the interviews (with Burundi adults and adolescents slightly more positive than others). Despite the length of the interviews, beneficiaries generally did not find them to be boring. Participants understood that they had the right to stop participating at any time, implying that informed consent information about voluntary participation had been understood.
III. Discussion: A Response from IRC

This section, written by IRC staff, aims to interpret and contextualize findings with attention to constraints and other considerations associated with remote and mobile programming. Overall, the findings highlight that mobile and remote programming is challenging but both feasible and acceptable to local communities when appropriate and well supervised.

A. Feasibility, acceptability and challenges associated with mobile programming

Unfortunately, due to the nature of cyclical displacement in Myanmar, it was not possible to truly assess the short-term rapid response from a beneficiary perspective. Therefore, the results of the study reflect the longer term mobile programming in protracted contexts. This model is designed to meet the needs of survivors with limited case management services in remote insecure locations which lack static programming and is characterized by its rotating teams, meaning that there is much less staff time in each site. While this model was clearly feasible and acceptable for many beneficiaries as evidenced by uptake and satisfaction rates, a number of associated challenges were highlighted by research participants, primarily related to: 1) stakeholder expectations of mobile and remote teams, 2) location of services, 3) misconceptions about access to services, 4) community focal point roles and safety concerns, 5) need for on-going assessment and continuous service mapping, 6) access for particular vulnerable groups (particularly male and LGBTI survivors), and 7) sustainability. Despite these challenges, this pilot of mobile programming increased access for beneficiaries who otherwise would not have had GBV services. This is particularly true when mobile services are combined with remote programming, such as a hotline.

→ **Stakeholder expectations of mobile and remote teams**

Beneficiary, community member and staff responses reflect expectations that mobile teams can provide much more comprehensive programming than is realistic. Such expectations include a desire for longer term interventions that are usually associated with static programming (economic interventions such as IRC’s EA$E model or prevention programming such as IRC’s EMAP), full multi-sectoral responses to GBV where there are more referral options, and influencing other actors such as the government or the military. This is understandable, however such interventions require far more (and distinct) staff as well as time to carry out. While IRC can empower women and girls to meet in safe spaces and organize activities on their own, mobile programming does not allow for time intensive training and staff to provide these types of programs while meeting the emergency case management needs of survivors in all mobile sites across vast operational areas. For these reasons, the Guidelines for Mobile and Remote Gender-Based Violence Service Delivery state “Consider a mobile response only when a static response cannot be implemented or when mobile support to a site can be provided until static services are established either directly or through building the capacity of a committed local partner.”

Similarly, responses indicate that community and staff have expectations that mobile and remote teams can provide a full multi-sectoral response to GBV when there are actually very limited referral options in the majority of these contexts. GBV case management service providers cannot meet the comprehensive needs of survivors without links to other available services including health, legal, protection and security. Survivors may call the hotline when in immediate danger because of the lack of existing security response nearby. Staff feel pressure to respond to these immediate security concerns but cannot be expected to act as defacto police and intervene. Additionally, since mobile programming aims to provide services in areas where survivors would not otherwise have access, the population accessing mobile services may include not only conflict- or emergency-affected communities but also host communities. Such communities, struggling with a lack of needed services in the setting prior to the

73 See limitations section for more information.
74 [http://gbvresponders.org/empowerment/ease-approach/](http://gbvresponders.org/empowerment/ease-approach/)
75 [https://gbvresponders.org/prevention/emap-approach/](https://gbvresponders.org/prevention/emap-approach/)
humanitarian crisis and displacement, may also seek support from the mobile team, as well as the hotline, thus raising expectations further.

Finally, while working with other actors is necessary and important, mobile teams do not have the time or resources to gauge risk and determine appropriate methods for influencing the individuals and groups suggested by many stakeholders. For example, there may be little engagement about services for survivors with any actors associated with the military in conflict-affected areas as it would be associated with significant risk. Where there is intercommunal conflict and identity politics, engaging local leaders is necessary but still needs to be informed by a strong contextual understanding of community politics. Mobile teams who become aware of certain community needs should therefore communicate those needs to their supervisors who may be able to bring them to coordination meetings in order to advocate for more influential actors to engage.

Location of services

Another challenge identified by participant responses relates to where services should be located in order to facilitate access. Responses highlight a need for stronger consultation with women and girls and community members regarding best locations for services. As GBV case management services cannot be provided in isolation but rather need to be positioned within broader services to avoid stigmatizing survivors, it is necessary to identify appropriate community places to use as temporary safe spaces or to link with other services that have a private room for GBV case management. While mobile GBV services “move” as close as possible to a site convenient for a targeted population, there will likely still be populations outside of catchment areas that will not be able to safely or easily travel to be within the area where mobile services are provided. Partnering with another organization may greatly expand reach to a region where it would not be feasible for IRC to establish, monitor and supervise services independently. For instance, in Myanmar, locations from which mobile services are provided are near the residence or office of a focal point from a local umbrella women’s organization, NSSWON. However, even when operating with partners, mobile teams will be limited to providing services where those partner members reside and act as focal points. Therefore, mobile teams may engage in consultation with women and girls and community members regarding best locations for services while recognizing that there will continue to be unserved populations on the boundaries of catchment areas.

Misconceptions about access to services

A number of comments throughout the findings highlighted lack of consistency between staff and beneficiary understanding of services and access (e.g., beneficiaries believing there are age caps, that services cost money, etc.) which need to be addressed. This may be particularly important for mobile programming because there are often barriers associated with accessing services in the host communities (e.g., fees for services). Beneficiaries may erroneously associate these same barriers with mobile services because they are happening in the same geographical area. It is also possible that staff and focal points do not have a clear understanding of when and how survivors can access services and are therefore unable to respond to beneficiary concerns and encourage access for all survivors. Clarifying these policies and having clear messages will be essential to increasing acceptability of and accessibility to both mobile and remote programming.

Community focal point roles and safety concerns

Community focal points are clearly an element of the mobile model that increases its feasibility and acceptability. Because IRC staff spend less time in each site during mobile response, this programming relies heavily on community focal points to support mobile teams when they are off site. Across all three countries, most beneficiaries identified community focal points as their entry point to group activities, in-person case management and hotline services. However, respondents described a number of safety concerns related to focal points’ actions. When designing the approaches to service delivery, the intended role for the focal points was to conduct outreach in the community about the group activities in safe spaces, appropriately respond to disclosures of GBV in their community, and refer survivors to IRC caseworkers over the hotlines for sustained access to services when the
mobile teams are not on-site. It was not the intention that they provide case management or other types of services directly. However, the research findings highlighted that focal points sometimes go beyond their intended role, including seeking out survivors, going to the homes of survivors, and using their own home as a shelter. As community focal points are chosen due to their leadership and survivor-centered attitudes, it is understandable that they want to assist survivors to the highest degree possible. It may also be that due to their leadership role in the community they were already providing such support to survivors. Yet, IRC must be concerned with the risks such actions pose for the safety of survivors, staff and focal points (particularly because they live in the communities in which they work). Although findings highlighted IPV as the main concern for respondents, community focal points should not try to rescue survivors in unsafe security situations, especially given that women are at greatest risk when they choose to leave an IPV situation. In-home case management for active IPV cases with staff or focal points is never recommended and survivors should never be taken to the home of anyone associated with the program due to very real safety risk that their homes and families will be targeted by perpetrators and supporters of the perpetrators. Similarly, focal points should not attempt mediation for IPV as this is recognized as a harmful practice for both survivors and staff in addressing IPV cases in Interagency Case Management Guidelines. Though all focal points have been thoroughly trained on GBV guiding principles and are able to explain them in detail to others, some of their actions discussed throughout the findings demonstrate that community focal points struggle to put these principles into practice. This demonstrates a clear need for significantly more training, specifically utilizing common scenarios from each context to practice skills. Additionally, there needs to be more emphasis and training on boundaries and self-care in order to minimize risk of harm to community focal points.

→ Need for on-going assessment and continuous service mapping

Analysis of participant responses also indicate the importance of on-going needs assessment and feedback mechanisms. Ongoing consultations with beneficiaries are required to identify “entry points” for case management and where to locate services in order to reach the most potential beneficiaries. In Iraq, the mobile teams have shared that the location of sessions is problematic because some women would prefer to leave their own community for services which challenges our assumptions about the best locations for services being those that are close as possible to where beneficiaries live. In Myanmar, many activities are in the evenings because women are working during the day and are sometimes only available at night. However, this can create discomfort for some with respect to traveling at night, making it nearly impossible for mobile teams to meet the needs of every single individual. Even so, awareness of all barriers to access and concerns, can assist program design. Feedback must be captured during initial rapid needs assessments and during on-going feedback and then analyzed so as to tailor mobile programming to meet the unique needs of each community. Simultaneously, it is important to manage expectations, as discussed above, through continual trust building and outreach.

While service mapping is always important for GBV response, it requires additional staff time and effort for mobile and remote programming. Where static programming operates in a single space with defined boundaries (such as a refugee camp), mobile teams move to a broad range of sites that do not always have clear borders. In order to provide case management services, mobile teams must map services in each and every site where they operate, meaning that a mobile team going to four sites must do four times the service mapping as a static team. Similarly, because anyone with the phone number can call a hotline, it is difficult to narrow down a specific area in which to map services for remote service delivery. Additionally, because many of these contexts change regularly with new displacements and responders, there is a need to continuously gathering information about services available.

→ Access for particular vulnerable groups (particularly male and LGBTI survivors)

It is necessary to carefully consider other vulnerable populations when conducting outreach and designing services. While this pilot established hotline services as an entry point for case management for male survivors of sexual violence and LGBTI populations, programs have continually struggled to identify safe and effective ways to communicate about service availability. Given the taboo nature of talking about sex and sexual violence involving men in all of the piloted contexts, staff have been reluctant to disseminate information about the existing services.

76 http://gbvresponders.org/response/gbv-case-management/, module 15B Intimate-Partner- Violence and Mediation
These concerns indicate a need for more program time to create appropriate outreach messages given the cultural context to ensure that male survivors of sexual violence (and male and female–identified LGBTI survivors) know that services exist. In time, as these outreach messages are created in static programming in these countries, they can more easily can be adapted for mobile programming cultural context. Additionally, some stakeholders suggested that programming for men, boys, or LGBTI populations is difficult because of stigma and social norm–related fears which supports the need for a confidential hotline.

Related to services for male sexual violence survivors, there were suggestions from respondents to have male staff and focal points to be able to respond to such cases. There are often assumptions that male survivors will want to speak with men, however anecdotal evidence suggests that male survivors of sexual violence are more comfortable talking to female caseworkers. Nonetheless, each program will have to determine, based on the cultural context and the emerging needs, whether hiring specific male response staff is necessary.

B. Feasibility, acceptability and challenges associated with remote programming

While this study explored the potential for programming using other means of technology, the pilot primarily focused on hotlines as the model of remote GBV programming. According to the findings, remote GBV hotline programming is both feasible and acceptable to local community, so much so that there is a demand for more active hours. However, challenges relating to 1) stakeholder expectations in contrast to lack of services along the referral pathway, 2) need for extensive service mapping and 3) social and cultural norms related to women and girls' technology use were highlighted.

→ Stakeholder expectations in contrast to lack of services along the referral pathway

Despite clear desire for additional open hotline hours, there are concerns that adding additional hours to the hotline may be setting up false expectations that the hotline team can provide emergency safety (e.g. a survivor calling to be rescued in the middle of an active abusive incident). Staff have raised significant concerns about how to manage these limitations. Hotline staff can guide survivors through safety planning to identify their own resources and consider their safety, but cannot physically intervene to remove a survivor from a violent situation. Physical intervention to remove a survivor from a violent incident would require police or local security to be on call which is most often not the case in any country of operation. On the other hand, staff have reported cases of a potential beneficiaries calling when the hotline was closed, thus being dissuaded from calling again. It may be a matter of investing in staff capacity to better manage expectations of the community and callers as well as manage their own expectations about their capacity to respond in such cases of immediate danger, particularly for their own mental health and wellbeing.

→ Need for extensive service mapping

Similar to the need for on-going service mapping in mobile programming, remote teams need extensive knowledge of services across a vast space in order to sufficiently respond to survivor needs. Because anyone with the phone number can call a hotline, it is difficult to narrow down a specific area in which to map services. Therefore, to truly be responsive to referral needs, it is necessary to map as much of the surrounding area as possible, which requires considerable staff time and effort. It is also important to map which referral partners are accessible via phone in order to connect beneficiaries to services remotely.

→ Social and cultural norms related to women and girls’ technology use

When exploring the potential for scale up of the hotline or other technological platforms for service delivery, stakeholder responses reflected potential barriers to access related to certain social and cultural norms. Participants described husbands checking in on wife’s phone usage, fears about women and girls “getting into trouble” or into
bad relationships online, and even cited use of technology as potentially increasing violence. These responses indicate controlling behaviors by men in the community, using the ‘excuse’ of potential sexual exploitation and abuse as a way to control women’s behaviors as is commonly done in many other realms (e.g. women and girls’ mobility). Such social and cultural norms would need to be assessed in the initial design phase of remote-based services delivery and subsequently addressed during outreach and implementation (e.g. discussing safety protocols from the outset with hotline callers).

**IRC efforts to address challenges**

IRC WPE Teams have already begun responding to participant responses and recommendations within the pilot country programs. Such efforts include: designing a training for staff and focal points on safety, boundaries and self care; clarifying what money is available in the budget to support survivors needs; clarifying some misconceptions about availability of services; strengthening transportation support for staff, beneficiaries and focal points; developing other means of garnering consistent feedback from beneficiaries (anonymous feedback boxes in Burundi and Myanmar); developing some key messages around service provision for male sexual violence survivors and, where available, strengthened relationships with LGBTI service providers; and creating times and activities that are more responsive to the expressed needs of women and girls in safe spaces including separate activities for adolescent girls. Additionally, the outcomes of this study have significantly influenced the Guidelines for Mobile and Remote Gender-Based Violence Service Delivery which will be published and shared with the humanitarian community in September 2018.
IV. Recommendations and Conclusions

This section, co-authored by IRC and research advisors James and Welton-Mitchell, summarizes key conclusions and provides recommendations resulting from the feasibility and acceptability study/evaluation of IRC’s mobile and remote GBV programming in Myanmar, Burundi, and Iraq. Recommendations are geared towards an external audience of practitioners, researchers, policy makers and donors. A separate set of internal recommendations was provided to IRC by the evaluators/research advisors, building on detailed suggestions provided by participants (and as highlighted throughout the findings section).

Information in this section is complimented by IRC’s Guidelines for Mobile and Remote Gender-Based Violence Service Delivery. Guidelines were developed in tandem with this evaluation, through an iterative process. Successes and challenges that have arisen across the three very distinct settings (Myanmar, Burundi, and Iraq), are likely typical in mobile and remote GBV service delivery in humanitarian settings. As such, we hope that the recommendations below will be broadly applicable for humanitarians working in a variety of settings.

A. Recommendations for practitioners:

Staffing for mobile and remote programming. Several recommendations related specifically to staffing emerged from this evaluation. For additional information about staffing requirements see the IRC’s Guidelines for Mobile and Remote Gender-Based Violence Service Delivery, section on minimum standards for human resources.77

- Data from the study indicates that across countries, more staff overall are needed for mobile and remote service delivery, especially to enable scale-up and rapid response to unpredictable (and typically growing) numbers of service users. Organizations considering mobile and remote models should conduct thorough assessments of staffing needs on a regular basis and budget accordingly.
  » Specifically, dedicated staff are needed for hotline/support call services, allowing for expanded hours of operation, especially when the mobile team is not present at certain sites.
  » As with static programming, consider dedicated staff for working with adolescent girls, who may benefit from programming that is separate from adult women and scheduled around school hours.

- Staff and focal point composition should be reflective of the community. To ensure this is the case, it is useful to assess what ethnic group representation and languages will be necessary to meet beneficiary needs. It is also important to assess the appropriateness and potential need for male team members according to context (e.g., to provide services to male beneficiaries and/or to coordinate with community and religious leaders in contexts in which being male may facilitate outcomes).

- More technical supervision and on-going coaching and training is required for both staff and focal points. Not only is it essential to have highly skilled supervisory staff located in offices from which mobile teams deploy but it is also crucial that supervisory staff visit mobile sites to observe the practices of both mobile staff and community focal points. Scale-up of remote supervision, including technical support phone lines and case management applications, can allow for increased technical oversight when mobile teams are on the move. Focused, consistent supervision and ongoing training is required for focal points to ensure quality of services and compliance with safety protocols. Training must include scenario-based exercises to allow focal points the opportunity to practice skills.

- Staff support and self-care approaches are needed for staff and focal points. All staff working on the issue of GBV require support and self-care approaches. However, with mobile and remote programming because the context requires ongoing intensive, crisis intervention work and staff and focal points do not always have access to consistent in-person supervision and peer support, building strategies and resources for this into this programming

77 Available on GBV Responders: www.gbvresponders.org. Note to designers – we will have the address of the landing page before design is finished.
is critical. Approaches will need to be tailored to the context but programs can draw from the guidance and tools on staff supervision and care available in the Interagency GBV Case Management Guidelines.

Community focal point component of mobile service delivery:

- Clear MOUs and JDs for the role of the focal point are needed. Specifically, the parameters of focal point roles in regard to providing direct service case management should be clarified. Although it may be possible to increase the capacity of focal points to take on case management services over time, clear capacity building plans are needed to equip focal points with necessary skills to do so, as are criteria with respect to the resources and infrastructure required to support such services.

- Focal points should be thoroughly trained on outreach strategies and involved in ensuring access for all populations in the context. Focal points are critical to inform beneficiaries about services, help access vulnerable populations and highlight barriers to accessing services as mobile teams are infrequently on-site. Focal points need to be trained on meaningful access, how to do safe and non-stigmatizing door to door. To facilitate this, mobile teams should develop outreach scripts for community focal points.

- In addition, focal point MOUs, training, and supervision for focal points should prioritize confidentiality and safety protocols related to outreach and community engagement (e.g., importance of focusing outreach on group activities and not solely on GBV case management; conducting outreach for communities as a whole, rather than targeting known survivors; alternatives to home visits). It is key to facilitate dialogue with focal points about challenges associated with adherence to safety protocols (e.g., scenarios in which focal points feel obligated to break protocol) and strategies for addressing such challenges. Strategies for consistent supervision—even if remote—are needed to support focal points in following safety protocols.

Financial resources and infrastructure:

- As highlighted throughout the findings section, an adequate budget is necessary to ensure high-quality mobile and remote programming. Specifically, it is important to consider budget lines for adequate transportation support for staff, focal points, and beneficiaries (including for those with disabilities), costs associated with meeting the basic needs of survivors during case management (e.g., emergency food, NFIs), securing safe places for service delivery, set up and maintenance of the hotline, and other information communication and technology (ICT) equipment.

- Aim to strike a balance among various priorities when selecting spaces for mobile service provision. Although a low-cost or free space may be more easily shifted to community ownership, some level of mobile team control over spaces is beneficial (e.g., ability to use spaces when needed, to furnish appropriately, and to renovate/organize spaces to promote confidentiality). Central, safe locations are also key. Designated budget and local ‘fixers’ (staff who can effectively coordinate with landlords) may be needed to rent, furnish, and renovate spaces, especially when there is a lack of appropriate community space or service provider space associated with static services in the site.

Additional recommendations:

- Mapping of services in each mobile site requires extensive staff time in order to develop thorough referral pathways that are responsive to the changing nature of these contexts. It is also important to strengthen coordination and advocate for support of referral partners to ensure sustainable high-quality services for survivors. Referral policies and procedures should be clear, documented, and updated regularly, so that staff can contact organizational focal points when services for survivors are needed. Referral pathways need to be phone-based so that services can be arranged remotely by mobile and remote teams.

  » Payments or a voucher system should be arranged in advance to support costs incurred by referral pathway partners (including covering costs of survivor transport).

  » The roles of police and security actors and consequences of their involvement should be assessed for safety and then clarified (e.g., can local police be enlisted to pick up survivors and transport them to safe locations without the expectation of arrest).
• Given the short term, transient and emergency nature of mobile and remote programming, there is often limited time to conduct a thorough assessment before programming needs to begin. Because of this, it is particularly important to ensure that there are mechanisms to collect routine feedback from beneficiaries, focal points, and community leaders so that the mobile team can adjust to the changing needs of the community. Mechanisms should be developed for ongoing consultation with beneficiaries and other community members about content of activities and how to improve services, as well as determining the regions in which mobile teams should work, the specific spaces in which services will be provided, and the times of day that services should be implemented.

• Ongoing dialogue between staff, focal points, and beneficiaries should be conducted to identify safety risks and trainings and safety measures should be put in place to address these issues according to the best practices outlined in the guidelines. Safety risks highlighted through the findings and discussions sections related to conducting home visits and to inviting participants to stay in focal point homes and transportation (including lack of designated vehicles and insufficient transportation funds for staff) may threaten the feasibility of mobile and remote programming.

• Communicate clearly and consistently with beneficiaries and focal points about how beneficiaries can access services in order to mitigate potential misconceptions (e.g., that services cost money), and clarify scope of mobile services in order to address potentially unrealistic expectations given its limitations.

• Improve targeted outreach to vulnerable groups including development of appropriate outreach messages given the cultural context to ensure that male survivors of sexual violence and male and female–identified LGBTI survivors know that services exist.

• Focal points and community members should be encouraged to develop a sense of ownership over activities and spaces, both because mobile teams are not always present to lead services, and to facilitate sustainability when mobile teams move out. Consider mechanisms for systematically shifting ownership of activities and spaces to community groups throughout service provision, including by empowering community members to develop their own activities and use spaces as they desire.

• Facilitate thoughtful expansion of hotline and other technology, with an awareness of associated challenges regarding both technological limitations (e.g., phone signal, battery charging), and social norms that may discourage or create risks associated with phone and internet use by women and girls. This includes adequate training for staff working the hotline, mapping of referral pathways in all areas that the hotline reaches, procurement of necessary equipment, and routine awareness raising with community members designed to introduce available services and as appropriate, shift attitudes discouraging women's use of technology. ICT assessments could be used to explore ways to enhance access to phone/internet-dependent services for those with limited phone access and an unreliable phone/wifi signal. Finally, creative methods for broad advertisement of hotline services are needed. In particular, consider use of hotline programming for vulnerable groups facing particular stigma regarding help-seeking, such as men, boys, or LGBTI populations.

• Several stakeholders identified the lack of and need for safe shelters. While this is not unique to mobile programming, in areas where shelters do not exist, it may be useful to explore what other options may be available for short and longer-term safety should a survivor need such support.

• Plan for sustainability by including local partners from the outset of programming Thoroughly assess the potential to work with civil society and community-based groups, taking care not to undermine preexisting relationships and foster resource competition. If the plan entails eventual handover to local organizations, engage in ongoing capacity building, including technical trainings and organizational development. In addition, plan for a gradual handover of services while continuing to provide either on-site or remote supervision and technical support.
B. Recommendations for researchers and monitoring and evaluation practitioners:

• Include perspectives from non-service using members of the community. To better understand the need for and barriers to engagement in mobile and remote services, it would be beneficial to conduct further focus group discussions with non-service using members of target populations, including specific vulnerable subgroups. This includes those residing in the area but not using services and particular vulnerable groups as identified by stakeholders. Discussions about associated ethics should frame such work, including adherence to established guidelines.78

• Include perspectives from those experiencing short term displacement. Acknowledging logistical challenges and ethical considerations, develop innovative ways to collect feedback while engaging in emergency response for those experiencing short term displacement. Mobile teams should be trained to use specific tools to facilitate this process.

• Collect information about what kinds of cash programming could potentially support survivors with economic needs and what links to livelihood programming might be feasible and beneficial within mobile programming. Respondents indicated that economic barriers for survivors contribute to ongoing risk of GBV and many requested expansion of vocational skill-building initiatives such as those currently integrated into some PSS activities. While this association and request is not unique to mobile programming contexts, the nature of many mobile contexts presents considerable challenges to incorporating such interventions. Any such efforts should take into account guidance about use of cash in GBV response such as that available from the Women’s Refugee Commission.79 Information should also be collected about the potential use of cash to pay providers for referrals and transport when the mobile teams are not on-site.

• Further piloting of innovative programming to better support survivors would allow humanitarians to provide better care. Findings indicate that there is potential for more remote service provision through technology (such as SMS, chat, etc.), voucher or mobile cash programming associated with case management, and joint sectoral mobile deployments, such as with health or legal actors. Any piloting should involve contextual analysis to assess needs and whether such interventions are appropriate.

C. Recommendations for policy makers and donors:

• For donors, consideration of staffing and budget needs outlined above is critical. Although mobile and remote services may sometimes be perceived as less expensive alternatives to static programming, comprehensive programming entails myriad associated costs.

• Related to the above, consider that host community populations will also access programming especially if GBV services don’t exist in host areas (remote or otherwise). Resources must also reflect this need as it would be unethical and could increase tension between communities to only target IDPs when there is a need within host communities.

• UN agencies, donors and other stakeholders should prioritize advocacy for stronger referral options. It is crucial to advocate for responsive government services (which are important for mobile programming as populations are dispersed in urban and rural settings rather in centralized refugee camps with more access to referral partners). Specifically -
  » Functional police response is needed to ensure safety, especially for those experiencing IPV. Regardless of laws around IPV, and assuming consent from the survivor is secured, police could provide security to support a survivor at risk of bodily injury when attempting to leave her home.

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Access to safe and confidential shelters is critical.

Ministry of Health policies are needed that don’t require mandatory reporting of GBV cases so survivors can access critical health services for Clinical Management of Rape (CMR). It is important to ensure availability of medications and trained staff for CMR in government health posts.

- Donors should facilitate and require sustainability planning and responsible handover to local partners as appropriate, including sufficient funds for capacity-building.

We are hopeful that these recommendations, resulting from lessons learned, will be used to strengthen programming for GBV survivors and women and girls in emergency and other humanitarian settings.