



Promising Practices, Lessons Learned Preparing for, Preventing and Responding to Violence against Women and Girls in Emergencies

Field-Based Learning in the Democratic Republic of Congo

October 2014



This document was developed with the support of the Department for International Development



Introduction

The International Rescue Committee (IRC) works toward a world in which women and girls are free from violence, and are valued, equal members of their communities. With this vision in mind, the IRC's Women's Protection and Empowerment (WPE) Unit has invested in emergency response and preparedness over the past 15 years, seeking to ensure that women and girls have access to lifesaving services during and after emergencies. The IRC developed an evidence-based program model and technical resource package, and has trained and mentored field-based practitioners since they are among the first responders in acute emergencies. Throughout 2013, the Department for International Development supported the IRC to scale up emergency preparedness and response in the North and South Kivu provinces of the Democratic Republic of Congo (DRC).

The IRC's experience in the DRC has highlighted the fact that despite the existence of multiple programmes working to prevent and respond to violence against women and girls, their needs are vastly underserved in the cyclical crises that strike the east of the country. Teams are rarely equipped to adapt their programming approaches and respond rapidly – within the critical timeframes necessary to prevent further harm and promote healing – to the needs of women and girls when conflict or displacement occurs. The IRC has therefore invested heavily in both increasing its own capacity to respond to these situations, as well as supporting local partners to do the same – and advocating for organizations in a variety of sectors to take the needs of women and girls into account in their humanitarian action.

This paper is based on program learning, IRC staff feed-back and an after-action review workshop conducted with IRC staff and a wide variety of agencies working in North and South Kivu.¹ While the submission and finalisation of this document was originally planned for early 2013, ongoing funding allowed for the analysis of lessons learned also to take into account the continuation of the project, allowing for richer, longer-term findings.

The paper is organized into the following key areas of analysis and learning:

- Preparedness
- Assessment specific to gender-based violence (GBV)
- Deployment and direct response
- Reducing and mitigating risks for women and girls
- Coordination and advocacy
- Focus on adolescent girls

The IRC's focus on GBV emergency preparedness and response is unique, and provides the opportunity for essential learning about how effectively to support and protect women and girls in conflict-affected contexts. This paper seeks to highlight the importance of organizational investment in preparedness, while also sharing lessons learned through this experience, with the ultimate goal of ensuring that survivors access life-saving services and are protected from further harm during crises.

Context

The volatility that has characterised eastern DRC for more than a decade has fostered an environment in which gender-based violence (GBV) is widespread. In particular, since the beginning of 2012, both North and South Kivu have been severely affected by the increased activity of armed groups and resulting displacement. In this setting, women and girls are vulnerable to various types of GBV, including rape, sexual exploitation and abuse, psychological violence and forced marriage.

¹ The after-action review workshop was designed to provide field teams with an opportunity to reflect on challenges and ways to improve future in-country GBV emergency response, as well as giving international and local organizations the chance to provide feedback on the quality and utility of GBV emergency programming. The AAR, held in North Kivu, was facilitated by the IRC WPE Technical Advisor and Senior Emergency Manager in DRC. Twenty local and international organizations from North and South Kivu participated. Where representatives from an organization were unable to participate, they were asked to complete questionnaires with key elements discussed during the workshop – the results of these questionnaires are also included in this paper.

The IRC's Women's Protection and Empowerment (WPE) programme has provided services to GBV survivors in the DRC since 2002. The programme design is based on assessments conducted in conjunction with experts from the IRC global WPE Technical Unit (TU). Ten years of monitoring and evaluation have since contributed a wealth of experience and learning that is used continually to update and adapt approaches. Since 2009, the IRC WPE TU has invested significant resources in developing, testing and implementing tools and training modules to enhance emergency GBV response capacity, efficiency and efficacy among humanitarian actors. The result of this investment is the Emergency Response and Preparedness (ERP) intervention model and technical resource package, which has been used for emergency GBV programming in both North and South Kivu.

The IRC's ERP model provides practitioners with a complete toolkit, adapted to the DRC context, which includes a comprehensive assessment form, a communication matrix to ensure rapid and efficient information sharing, a deployment checklist, as well as a matrix of roles and responsibilities for all individuals involved². More specifically, the consolidated assessment form consists of a safety audit, service provider mapping and key informant interview guides. Assessments prioritise discussions with women and adolescent girls as they are most knowledgeable of their needs. In addition, if safe to do so, the IRC undertakes community mapping exercises to obtain information on locations that pose particular risks to women³. The IRC ensures that assessments conducted by other actors – for example, multi-sectoral assessments conducted by the *Réponse Rapide aux Mouvements de Population* (RRMP – Rapid Response to Population Movements) program – are taken into account to avoid duplication of efforts in assessing available services. In South Kivu, the IRC WPE team conducts joint assessments with RRMP (co-led by the IRC) to enhance access to certain areas and increase complimentary action.



DFID has been supporting the IRC to respond to the urgent needs and priorities of women and girls in emergency situations in North and South Kivu since January 2013. This support has allowed dedicated Emergency Response Teams (ERTs) to be established in each province, which have carried out **nearly 170 deployments to date, supporting over 23,600 women and girls**. While this project was conceived to respond to short-term emergency needs over a six-month period, the current context in North and South Kivu is such that these urgent needs – and the risks that women and girls face – show no signs of abating, and the support has been extended through May 2015⁴. Fluid security situations and waves of displacement persist across both North and South Kivu; displacement in North Kivu increased in the first quarter of 2013, and there are currently nearly 913,614 internally displaced persons (IDPs) in North Kivu as of the end of July 2014, while there are over 554,981 estimated IDPs in South Kivu as of the end of June 2014⁵.

² This matrix includes members of the DRC Ministry of Public Health who would deploy with the IRC if possible.

³ The assessment toolkit was developed by the IRC WPE Technical Unit and specifically adapted to the eastern DRC context.

⁴ The most recent cost extension for the GBV emergency response program has been expanded to include Katanga province in order to respond to population displacement occurring since early 2014 as a result of increased armed group activity in an area called the 'Triangle of Death'.

⁵ OCHA, Nord-Kivu: Situation des personnes déplacées internes (PDI) au 25 juillet 2014, http://www.rdc-humanitaire.net/attachments/article/4870/Province%20du%20Nord-Kivu_Mouvements%20de%20population_25%20juillet%202014.pdf;

While the defeat of the M23 armed group in North Kivu has been touted by some as a major improvement in the security situation, the presence of dozens of other armed groups in North and South Kivu, and spikes in conflict caused by groups fighting to fill power vacuums left by the M23 and others, result in population displacement and will remain an important feature of the security landscape in these provinces in the near future. Indeed, the constant deployment of the ERTs even after the fall of the M23 illustrate that the situation in many parts of North Kivu remains extremely dangerous and volatile.

The link between displacement, conflict and increased risk of GBV for women and girls has been clearly established in a variety of contexts worldwide⁶, and this link has been corroborated by the high level of needs demonstrated among populations affected by violence in North and South Kivu. Since January 2013, wherever the DFID-supported IRC ERTs have deployed, survivors have come forward immediately to seek both psychosocial and medical services, which attests to the importance of this intervention. Experience from the project to date has shown that, while the rapid establishment of essential services is critical in the immediate aftermath of conflict or displacement, the crises in Eastern DRC are not one-off events; rather, they are cyclical and often ongoing emergencies, which in some cases necessitate longer-term support to services.

Over the period covered by this report, the IRC in DRC has fielded up to nine emergency response teams at any one time; while the structure of these teams has changed in response to varying needs and the availability of different funding support, the IRC has maintained a strong, dedicated GBV emergency response capacity throughout this period.

Promising Practices in GBV Emergency Response & Preparedness

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

Preparedness

What is it? Commitment to preparedness for GBV in emergencies was a cornerstone of the IRC's work in 2013. This means investing time and resources into building the capacity of IRC staff, partners and other organizations, to ensure that they are ready to respond when crises occur. It also means working with these field-based teams to identify likely emergency scenarios, and to develop and take action based on plans that outlined how GBV responders would ensure emergency response materials were pre-positioned, make quick decisions regarding deployment for immediate assessment and response, work with operational support teams to access affected sites with staff and supplies, communicate and work with other actors and coordination leads, and advocate for the prioritisation of GBV response at the height of emergency.

It is important to note that the goal of this investment in preparedness is not limited to planning for one, discrete event. It is, rather, a commitment to ensuring that IRC teams and partners are better equipped to react and respond to the urgent needs of women and girls in the context of cyclical conflict and displacement. Indeed, the structure of this project, with multiple deployable emergency response teams, was designed with a volatile landscape of cyclical and continuous violence in mind. The IRC has emphasised skill building and practice, tool development and adaptation, and internal and external relationship-building to facilitate stronger emergency response. In this way, the preparedness undertaken through this project represents a departure from a more traditional understanding of contingency planning for one anticipated event, such as an election.

OCHA, RD Congo – Sud-Kivu : Mouvements de population au 30 juin 2014, http://www.rdc-humanitaire.net/attachments/article/4860/Mouvements%20de%20populations%20au%2030%20juin%202014_07082014.pdf.

⁶ Inter-Agency Standing Committee 2005, 'Guidelines for Gender-based Violence Interventions in Humanitarian Settings: focusing on prevention of and response to sexual violence in emergencies', p.3.

What does preparedness look like? The IRC's GBV Emergency Response & Preparedness (ER&P) training, facilitated by members of the IRC WPE Technical Unit and in-country technical experts, introduced field teams to the approaches and tools that they would use to carry out preparedness planning and GBV-specific emergency response. This investment in people – the first responders and their support networks – was followed and made effective by a preparedness process that went far beyond the training.

Preparedness is critical to responding quickly to GBV when an emergency occurs. In the DRC, the IRC invested in preparedness by building skills and knowledge, positioning tools and materials, strengthening partnerships, and outlining operational procedures that would allow for a rapid response immediately when crisis occurred.

What preparedness means to the IRC:

- Establishing seven trained response teams who can assess GBV needs and provide immediate and lifesaving services in the acute response window of 72 hours. Pre-positioning of **post-rape kits** and other medical supplies for use in health centers;
- Ensuring there are materials to construct **spaces** for women to come together for support;
- Pre-positioning of **essential hygiene and safety items for women and girls**, combined in a 'dignity kit'⁷;
- **Assessment forms** adapted to the North and South Kivu contexts;
- Emergency client intake and consent forms for GBV caseworkers;
- Training of local field partners, including health care personnel, in best practices and key actions to take to prevent and respond to GBV in an emergency setting.

Impact of preparedness efforts:

- GBV response teams **provide lifesaving services in the vital response window of 72 hours**. Even in extremely challenging circumstances, the GBV teams have deployed to assess GBV needs and provide critical services. These **local and specialised response teams** include medical and psychosocial experts as well as community outreach focal points.
- **Services provided to 1,502 survivors** during emergency and short-term deployments since January 2013.
- Better response of humanitarian and community actors to GBV due to **training of 47 IRC staff, 425 community health workers, 1,363 psychosocial service providers, and 1,446 community animators for awareness-raising in displacement sites and host communities**.
- Women have been able to **access on-site case management, post-rape care and emergency shelter more quickly** due to pre-positioning of key materials in areas likely to be affected by conflict.
- **Congolese partners have a strategy to respond to GBV even during periods of insecurity and displacement**.
- In a context where women and girls have been constant targets of violence, no one organisation alone can respond to all needs. The IRC's GBV-specific emergency response

**Taking action before the crisis:
A case for proactive support**

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

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

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

⁷ Explained further below on page 11.

preparedness extended beyond the organisation, including engagement with partners, sister organisations, state actors and local communities.

- **More actors that support GBV response** in areas likely to be affected by conflict or natural disaster. For example, in one case, the IRC carried out a support mission in a territory targeted for upcoming military operations against local armed groups.⁸ The IRC met local service providers; discussed likely scenarios and needs; provided training on case management, crisis counseling and community outreach; and trained medical personnel on the clinical management of rape. When military operations took place, service providers were better equipped to handle the increased caseload of GBV survivors as a result of the preparatory training and support.
- Other humanitarian actors have a better understanding of the risks that women and girls face and **support risk mitigation** of GBV in their own work.
- **Quicker provision of services to women and girls** as there is increased ability to identify service gaps quickly. For example, the supply of medicines to health facilities is often an obstacle that significantly slows GBV response. In both North and South Kivu, work with state health actors prior to the crisis led to joint assessment missions and collaboration on the identification of ruptures in post-rape kits stocks.
- Better coordination and safe and ethical information sharing on GBV during emergencies due to ongoing discussion and advocacy around the importance of **confidential service provision**.

What was learned? Investments in preparedness had clear impacts on the IRC’s **ability to deploy and respond**, as is outlined in the next section. The preparedness measures taken also influenced **how confident staff felt in their ability** to put in place rapid programming that would improve protection of women and girls. Staff deploying to areas in which materials had been pre-positioned said later, for example, that knowing they had the ability to offer lifesaving solutions such as post-rape care and on-site case management reinforced their confidence and commitment when deploying to a new crisis. Community-based women’s organisations, with which the IRC works closely to provide case management and psychosocial support services to GBV survivors, were trained on emergency case management procedures, and how to **protect confidential information** if they were forced to flee or were threatened by conflict or armed forces. This training allowed CBOs to provide services extremely rapidly when emergencies occurred, as their members were already on the ground and ready to help from the first day of displacement or conflict, where NGO staff are often limited by stringent security procedures from responding immediately.

The existence of **dedicated response teams** removed the obstacle posed in the DRC by multiple contexts existing concurrently in one province. Previously, the IRC had asked existing program staff to respond to emergencies in another part of the province when they occurred; however, in many cases, the existing program areas remained stable, and staff were required to continue to support these activities. In this way, emergency and longer-term development needs often conflicted. Having multiple teams dedicated solely to emergency response removed this barrier, and allowed staff to dedicate the necessary time not only to assessment and response missions, but also to monitoring, follow-up, and ongoing support to trained volunteers, where possible.

Prepositioning of post-rape kits has allowed the IRC to fill gaps in stock rapidly where necessary, while also advocating for standard procurement procedures to catch up to demand.

PREPAREDNESS: Actions & Tools	
ACTION	NOTES, TOOLS & RESOURCES⁹
Train field-based staff and partners on GBV emergency response and preparedness	IRC GBV Emergency Response & Preparedness training presentations and participant handbook
Provide regular post-training practice sessions,	

⁸ These military operations were led by the Congolese army and the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO).

⁹ All of the resources and tools noted throughout this document are available through the IRC’s GBV Responders’ Network: www.gbvresponders.org. For specific tools, including the program model, indicators, preparedness planning templates, assessment tools and training materials, see the GBV Emergency Toolkit section of the web site: <http://www.gbvresponders.org/emergency-toolkit>.

through which GBV first responders use tools and build teamwork	
Establish a context-specific preparedness plan, outlining actions needed to ensure emergency readiness, and engaging with other sectors/actors to ensure commitment and support	IRC preparedness plan templates and the GBV assessment checklist
Develop emergency scenarios likely to unfold, and take pre-emptive action to pre-position materials – post-rape kits, medical examination forms and case management forms – and equip local service providers with skills and support	
Develop context-relevant assessment tools and checklists, and decision-making and communication matrices	IRC GBV assessment toolkit, including safety audit, service mapping, focus group discussion, community mapping and individual interview tools, as well as the GBV assessment checklist
Identify trained GBV first responders to be part of first-line deployment in crisis, or establish actual local GBV response teams	This is specific to each organization and program; suggested local response team composition includes medical, psychosocial and community education staff.
Train GBV staff on security and communication protocols, ensuring they have a direct line to supervisors for technical support during response	

GBV-specific assessment

What is it? Using the IRC’s emergency assessment toolkit, the IRC in the DRC has undertaken over 169 emergency assessment and response missions since January 2013. The IRC has also deployed GBV experts to participate in assessments conducted by other sectoral teams and organizations, ensuring that a focus on women and girls was present in the assessment.

What does GBV-specific assessment look like? The IRC uses an emergency assessment toolkit, composed of safety audits (observational tools for displacement zones¹⁰), focus group discussion guides, key informant interview guides as well as community and service mapping tools, to assess risks for women and girls, the presence, quality, and accessibility of services for survivors, and the presence and efficacy of referral networks. Such assessments undertaken by the IRC have identified various key findings across a range of displacement and conflict zones, including that:

- Only limited health posts and centres serving displacement zones are equipped with complete post-rape kits, or have staff trained to provide clinical care for survivors of sexual violence. Very few health centres are equipped with paediatric post-rape kits, which include drug dosages appropriate for younger girls;
- Case management services are either insufficient or lacking;
- Information dissemination is rarely in place in displacement zones, and community members have extremely limited information about services, even when these are available;

Gaps in information and understanding:

A case for specialised expertise and services

Assessments that did not specifically look at the needs of women and girls in North Kivu following the occupation of Goma by the M23 concluded that GBV was not happening or was not a primary concern.

Knowing that international best practices recommend assuming the presence of GBV in situations of conflict and displacement even without documented evidence, the IRC initiated service provision in displacement sites around Goma. In every camp, survivors began to report from the first day that services became available.

¹⁰ What is referred to in this document as displacement zone are the areas where the displaced population seeks refuge regardless if they would be staying within the host communities or in displacement sites. By displacement sites we mean camps official or spontaneous where the IDPs are staying.

- The lack of adequate shelter in zones means that many women and girls are sleeping outside at significant risk, in cramped communal housing, or being housed with host families, which often exposes them to risks of sexual exploitation and abuse;
- Firewood collection is identified by women and girls as a specific and on-going risk of GBV in most zones;
- Most sectors operating in displacement sites do not fulfill accepted IASC guidelines on GBV interventions in humanitarian settings – this lack applies to many sectors, including shelter, water and sanitation and distribution, and the gaps contribute to increased risks for women and girls;
- There is little to no lighting in sites which presents additional risks for women and girls at night;
- Adolescent girls are affected in different ways than adult women during conflict and displacement, and their needs are not taken into account in the current humanitarian response – for example, actors that can provide specific case management or clinical care services for adolescent girls are not present in the majority of settings where the IRC has deployed to date. In addition, adolescent girls are at increased risk of abduction and rape by armed actors, and must often resort to **survival sex**¹¹ to fulfill essential needs.

What was learned? This project has underscored a key area of learning for the IRC, namely that **GBV-specific assessments – or GBV-specific elements in general assessments – are essential** to identify risks that women and girls face, as well as the presence or absence of essential services for survivors. Where trained GBV staff are not present, these issues are not highlighted or prioritised in emergency assessments.

In addition, it is clear from multiple interventions throughout this project that **survivors do not report cases of GBV unless specialised services are available to support them**. This learning reinforces international standards, which state that humanitarian agencies should assume the presence of GBV in emergency contexts even where no evidence is available.

Deployment and direct response

What is it? Seven established emergency response teams have deployed a total of 169 times¹² since January 2013, conducting GBV-specific rapid assessments and either putting in place direct response services or working with existing actors and/or local volunteers to ensure capacity on the ground.

What does deployment and direct response look like? Upon receiving an alert of an emergency situation – most often information about population displacement – the IRC discusses with relevant coordination mechanisms to decide whether an assessment mission is warranted. When a decision is made to assess the crisis area, an emergency response team is deployed as soon as possible, within the constraints of physical access and security.



¹¹ Exchanging sexual acts for food, shelter, protection or other essential items.

¹² This figure includes assessment, response, and monitoring missions, though sometimes these are combined or overlap.

The IRC teams that had been trained and selected during the preparedness phase deploy to new crises and stay on the ground for an average of two to three weeks in each deployment¹³. They carry out rapid GBV assessments, provide direct services where other service providers are non-existent or unable to meet increased needs, and train and mentor local actors in case management, psychosocial care, clinical care for sexual assault survivors, and community outreach. This support at the peak of the crisis allows existing service providers to refresh skills, access technical supervision and understand how their service provision might change in order to accommodate increased caseloads during the emergency period. It also reinforces best practices in ongoing service provision and referrals. In addition, where no local actors are providing psychosocial services, the IRC trains local volunteers to implement basic case management and crisis counselling for survivors. The IRC maintains a stock of post-rape kits to provide to health centres if local stocks are insufficient.

During deployment, the IRC teams also collaborate with existing community-based mechanisms to conduct response activities, including community leaders as well as community-based organisations and health workers (*relais communautaires*). Community leaders are key players in any advocacy issues that need to be raised (see below), but they can also play key roles in transmitting messages within the community about available survivor services and knowing where to refer survivors if a survivor seeks a leader's assistance. Community-based organisations and health workers also play key roles in the provision of direct services to survivors and building an effective referral pathway among service providers. In many places, community-based organisations may already be providing services to survivors or to women and girls more generally and are in need of technical support to refresh their skill sets; if not, they are often a valuable resource for identifying potential service providers or volunteers in a community so that basic services may be established. Community-based health workers also play an important role in the referral pathway for survivors as they are already based in the community and linked directly with the local health care centers to do community outreach on health care-related services and information; they are thus a natural link in messaging about available survivor services.

What was learned? Many areas where the most intense needs were identified did not benefit from the presence of any local (or external) actors providing psychosocial support. To respond to this constraint, the IRC trained volunteers in many emergency response locations; where possible, these volunteers were part of local women's organisations, or had links to local health centres, to ensure ongoing support to trained volunteers. However, the lack of incentives and institutional structure for these volunteers has meant that, in many cases, services have functioned in the immediate term but have not continued in a sustained, focused way for many months after training was conducted. Key learning from this experience for the IRC has been that emergency response interventions, while laying the ground-work for increased capacity and service provision, cannot ensure the sustainability of quality service provision; **long-term service availability requires a continued investment of resources and support**. However, to address this challenge in the short- and medium-term, the IRC has worked to incentivise local volunteers through capacity building, providing small amounts of materials necessary for the work, creating groups and networks for mutual support, and ensuring regular contact and follow-up with trained individuals.

Strong logistical and security support is essential to the success of emergency response missions. In many cases, the IRC has responded in areas where other NGO actors are not present, and where the site may take two or three days to reach by road, or may be accessible only by helicopter. This experience has shown very clearly that strong logistical support is a crucial aspect of emergency response, and logistical preparedness is just as important as technical knowledge and capacity. Investment in sufficient staff and other resources for logistical and security support of emergency programs is an important way forward.

Emergency deployments also showed that while collaboration with other sectoral interventions is essential to ensuring the safety and well-being of women and girls in emergencies, not all

¹³ Under the most recent renewal of emergency funding, GBV emergency response teams could deploy for longer, up to 8-12 weeks to conduct a response mission in a particular zone, though average response time would likely be in the 4-6 week range depending upon the context.

emergency response organisations and initiatives are open to or supportive of GBV prevention and response activities. This project has highlighted many challenges in attempting to integrate aspects of this important work in existing projects, and in ensuring organisational commitment to responding to the needs of women and girls in the early stages of emergencies.

Lastly, challenges were also experienced in interventions that addressed displaced populations housed within host communities, particularly concerning the distribution of material but also concerning service provision activities. In terms of material distribution, the IRC ensured that host community members were also covered by distributions of risk reduction items, as they too experience heightened risk during displacement concerning their community. Concerning service provision, the IRC encountered the challenge that many survivors either wanted to receive case management and counselling services from someone within their community, or wanted exactly the opposite, depending on their perception of which group would provide the most confidential services. To address this concern, the IRC respected, where possible, the preferences of women and girls concerning service providers; in cases where this was not possible, the IRC ensured a strong focus on confidentiality in case management trainings.

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

Risk reduction and mitigation

What is it? The IRC uses a tailored assessment package (safety audits, focus group discussions, individual interviews, as well as community and service mapping exercises) to identify the risks faced by women and girls in emergency settings, then works with women and girls to identify strategies to mitigate these risks, including community-based strategies, to organise the distribution of key risk reduction materials where warranted, and to conduct advocacy to other actors.

What does risk reduction and mitigation look like? Using a combination of observation, discussion and participatory techniques, emergency response teams work together with women, girls and community members to identify GBV-related risks in each setting. Having identified risks, the IRC works with these groups to develop strategies that will help in mitigating or reducing risks and then supports women, girls, community members, community leaders, and emergency response organisations to carry out these strategies. Community-level strategies include 'firewood patrols,' where men travel with women and girls to collect firewood, or women and girls travelling in groups for this kind of task to increase safety. The IRC plays the role of intermediary, ensuring that strategies identified by women and girls are communicated to and supported by other community members and leaders.

In addition, the IRC distributes targeted risk reduction materials. To date, distributions have consisted of 'dignity kits'¹⁴, containing essential hygiene items for women and girls as well as torches to use while moving around at night and whistles to signal for help in case of attack. However, it must be noted that the risks of adolescent girls are often not taken into account in emergency response initiatives. The IRC has conducted distributions of dignity kits specifically targeting adolescent girls and will continue to conduct response and risk reduction activities to address their particular needs and ensure improved access to services and advocate for other emergency actors to do the same.

Over past months, the IRC has worked with the Women's Refugee Commission's 'Safe Access to Firewood and Alternative Energy' (SAFE) project¹⁵, to identify, source and distribute fuel-efficient stoves, which reduce the amount of firewood consumed and therefore the time women and girls spend collecting this firewood in unsafe conditions. Considerable advocacy has been undertaken during this period to ensure coordination and effective distribution of fuel-efficient stoves; in addition, the WRC and IRC have worked together to conduct a baseline and end line evaluation to assess the impact of this activity on the safety of women and girls in displacement sites. While the final report of the end line evaluation is being finalized for distribution, here are some preliminary findings from the initiative:

- Beneficiaries consumed less firewood with the fuel-efficient stoves, which gave them more time to conduct other income generating activities and sell more of the firewood they collected for income rather than household use, so monthly income increased.
- The introduction of the fuel-efficient stoves reduced the amount of money that beneficiaries spent on firewood. At the baseline, nearly all beneficiaries (97%) reported purchasing 7-21 bundles of firewood per week (at a cost of up to \$4.20) whereas 100% reported purchasing less than 12 bundles per week at the end line (at a reduced cost of up to \$2.40).
- Fewer beneficiaries reported using firewood as compared with charcoal, which is the preferred type of fuel since it does not smoke and is easy to use. Beneficiaries were pleased that they consumed less firewood and could sell more of it for income, which corresponded to a reported increase in use of charcoal at the end line.
- Over half of the beneficiaries (60%) were still using the fuel-efficient stove at the end line as compared with 87% of beneficiaries who used the traditional three-stone fire at the baseline. Those who were using the three-stone fire at the end line reported that either the fuel-efficient stove had been stolen or had to be sold for money to meet other urgent household needs, such as food and medicine.
- The fuel-efficient stoves had positive effects for the beneficiaries' environment where 38% reported in the baseline that they combined energy sources for fuel, such as waste, leaves, plastics, and clothing, and only 2% reported doing so at the end line.
- While the time of day at which the beneficiaries collected firewood did not change, there was a significant decrease in the number of beneficiaries who collected firewood every day and a corresponding increase in the number of beneficiaries who collected only a couple of times per week: 48% collected firewood every day at the baseline compared with 16% at the end line, and 26% collected one to three times per week at the baseline which rose to 57% at the end line.
- There was also a significant decrease in the



¹⁴ Dignity kits aim to meet the immediate and urgent hygiene needs of women and girls of reproductive age, and include sanitary material for women's menstrual periods, as well as a whistle and torch with batteries for security, buckets and soap to ensure private washing of clothes, etc.

¹⁵ Women's Refugee Commission, January 2012, 'Fuel and Firewood Initiative'. This project is supported by the WRC, <http://womensrefugeecommission.org/programmes/firewood>.

amount of hours per day beneficiaries spent collecting firewood: a majority of beneficiaries spent 4-8 hours per day collecting firewood at the baseline, which had reduced to 3-6 hours per day at the end line.

- Beneficiaries also traveled shorter distances to purchase firewood (57% traveled 30 minutes or more to purchase firewood at the baseline compared to 27% at the end line) or no longer needed to purchase firewood for household consumption at the end line (35% at the end line reported no need to purchase firewood compared to 16% at the baseline).
- While beneficiaries still reported rape as a primary risk associated with firewood collection, the reduced time per day and number of times per week spent searching for firewood reduced the exposure of women and girls, still the primary firewood collectors, to sexual violence.

Lastly, **advocacy** has formed an essential element of risk reduction activities during this project. The IRC's approach to advocacy and lessons learned from this aspect of the project are described in the following section.

What was learned? Distribution of risk reduction materials for women and girls represents an **intersection between traditional GBV and non-food item (NFI) sectors**, and requires significant adaptation and coordination to be successful. GBV programs are rarely funded at the kind of scale seen in NFI programs, and therefore often lack the logistical expertise needed for successful large-scale distributions of materials. On the other hand, NFI experts tend to assume that business-as-usual approaches are also applicable to distributions that are specific to either women or girls, given that these groups are usually those collecting rations or NFIs; however, the experience during this project has shown that considerations of safety and exploitation are not adequately taken into account during distributions, and women and girls are rarely consulted in the make-up of kits designed for them, or the set-up of distribution sites. Such consultation can help to reduce risks and ensure the 'do no harm' principle is respected. This intersection between sectors needs careful consideration and coordination to be successful.

Given that longer-term behaviour change activities addressing deep-rooted beliefs, attitudes and cultural norms are not feasible to undertake in this kind of emergency intervention, **risk reduction and mitigation activities represent the only true GBV prevention programming that is feasible in crisis contexts**. Risk reduction programming – whether through community-level strategy development, distribution, or advocacy – represents a large focus of the IRC's GBV emergency response activities, and yet it is often absent from other sectoral programming, as well as many GBV-specific interventions. IRC staff have heard time and time again from women and girls in emergency response sites that before such discussions, they had never been consulted on the risks they might face, and that they found the process to be a valuable one. In addition, women and girls have regularly stated that **attention to their hygiene needs – an activity largely missing from emergency interventions – has been essential in protecting their safety and dignity** in displacement zones.



Beneficiaries likewise responded positively to the distribution of fuel-efficient stoves, and the **preliminary results from the final evaluation reflect a reduction in the amount of time spent**

searching for firewood and the amount of money spent on firewood, corresponding to an increase in household income and time available for other economic activities as well as a decreased exposure to risk. Future fuel-efficient stove interventions, however, should take into account **other forms of income-generating opportunities** that might be developed alongside a fuel-efficient stove initiative. Displaced persons are typically far from their fields and usual sources of household income, and thus must find ways, usually at the expense of other essentials, to purchase cooking fuel, such as firewood, and food with almost non-existent resources; as a result, lack of food and income become preoccupying concerns for households in displacement, especially where food distributions are scarce. For this particular distribution, the stove was often perceived as a valuable household item, only to be used on special occasions or to be passed on as a special ‘family possession’ rather than an article for everyday household use, which meant the stove risked being stolen or not being used as frequently; in other cases, because of limited means, the stove was sold to cover other basic household necessities. **Future such stove initiatives should take into account locally made stove options**, which meet similar fuel efficiency requirements but which might be perceived as less ‘valuable’ and thus less likely to be stolen or sold and more likely to be used for regular cooking purposes.

RISK REDUCTION AND MITIGATION: Actions & Tools	
ACTION	NOTES, TOOLS & RESOURCES
Identify risks for women and girls	IRC GBV assessment toolkit, including safety audit, service mapping, focus group discussion, community mapping and individual interview tools
Together with women and girls, identify strategies that their communities, and they themselves, can implement to reduce risks	The IRC has used a focus group discussion format to identify these strategies with women and girls
Advocate for the respect of the IASC Guidelines on Gender-Based Violence Interventions in Humanitarian Settings	This requires relationship building and the development of strong advocacy messages. How advocacy is carried out and who is targeted is decided based on context, presence of other actors, and safety and security considerations for GBV staff, service providers and volunteers. However, advocacy activities and responses are tracked by emergency response and preparedness managers in each province. Also see the IRC GBV Emergency Response & Preparedness participant handbook.

Coordination and advocacy

In addition to the provision of lifesaving services, the IRC’s GBV emergency response program model outlines interventions in coordination and advocacy that are necessary to further reduce risks and harm for women and girls. The IRC’s ability to carry out and then share results from rapid assessments in North and South Kivu has given the organisation the information needed to advocate with other actors and sectors to address gaps in service provision and to promote action to reduce risks to women and girls.

What is it? The IRC’s GBV-specific emergency response and preparedness extends beyond the organisation, including engagement with partners, sister organisations, state actors and local communities. Establishing a wider net of actors ready to support GBV response allows the IRC to play a more proactive role in areas likely to be affected by conflict or natural disaster, and to have a wider geographic reach in response. How the IRC worked with other actors throughout the preparedness, planning and response phases is tailored to the role that they are equipped to play, as well as their own specific mandates and priorities. This requires a significant investment of time in relationship building, which continues to be a strong component of the IRC’s GBV prevention and response work. State actors and local service providers are included in IRC training on GBV Emergency Response & Preparedness, and wherever possible trainings are co-led – or at the very least coordinated – with the responsible ministerial actors. Building on these relationships, the IRC

has undertaken strong and sustained advocacy on key issues identified during assessment and response missions.

What does coordination and advocacy look like? As noted above, work with other actors was highly dependent on context and local capacities. Some of the strongest examples of collaborative actions taken were those addressing problems linked to the supply of medicines to health facilities and the sharing of sensitive information during emergencies. These are obstacles that can significantly slow GBV response. The IRC worked with authorities and communities during emergency preparedness planning and discussions, carrying out joint assessment missions with health authorities to identify ruptures in post-rape kit stocks.

Joint advocacy also played a role in the IRC's response. When humanitarian actors failed to prioritise GBV interventions, citing a lack of survivors reporting, the IRC worked with UNICEF and others to push for GBV-specific response despite the absence of "evidence."¹⁶ Advocacy for the prioritisation of GBV as a part of lifesaving emergency response in eastern DRC continues. The process of engaging allies and senior decision makers at the provincial, national and international levels laid a foundation for stronger messaging and support. Sustained advocacy has led to significant results – including ensuring gender-separated toilets in distribution sites, and the provision of clinical care for sexual assault survivors among IDPs where it had not previously been available.

Advocating for the best interests of women and girls in emergencies

The IRC advocated with an international medical NGO in the Fizi health zone in South Kivu to begin including and administering paediatric post-rape kits in their survivor care package as, to date, they had only kept in stock post-rape kits for adult women. The gap was observed during an emergency assessment to Fizi, and the NGO partner responded promptly and favorably to the IRC's recommendations.

The IRC also conducted successful advocacy with the Protection Cluster in South Kivu to request that an FARDC military camp, which had been established just next to the displacement site in Minova, be relocated to a more distant location. The proximity of the military camp to the displacement site was creating significant risks for women and girls at the site, and the FARDC ultimately agreed to relocate the camp.

While many organisations and agencies requested the IRC to share the number of survivors reporting GBV during emergency missions, the IRC developed a brief emergency mission report format for sharing with coordination mechanisms, which did not include details on the number or kind of cases received. This choice was motivated by the disproportionate focus on numbers of cases received as a justification of GBV-focused interventions (or lack thereof) – the IRC believes that GBV prevention and response activities should be an inherent part of all emergency response activities, whether or not cases have been reported or verified, and therefore does not justify need with case numbers.

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

IRC teams used safety audits and community consultations to help inform their understanding of risks to women and girls, and to gauge changes in the environment as the situation evolved. IRC teams using these tools sometimes struggled, however, **to engage other sectors successfully in reducing these risks.** Teams felt that risk mitigation continues to fall on GBV service providers, despite the fact that preventative approaches are clearly linked to the full range of humanitarian sectors, including camp management, security, shelter, food and NFI distributions, and WASH. As a result of this learning, the IRC has continued to adapt its approach to advocacy within the

¹⁶ "Evidence" or "proof" that GBV survivors are coming forward is frequently demanded by humanitarian decision makers, despite the fact that this contradicts best practice, as outlined in the Inter-Agency Standing Committee's *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*.

project, breaking concerns down into small, actionable recommendations and ensuring sustained follow-up with other organisations and agencies on each advocacy intervention.

A key learning point from ongoing advocacy efforts is that many similar issues are raised across organisations and geographical sites, and that the objectives of such advocacy initiatives cannot be achieved at the level of implementation; rather, such issues require **high-level buy-in and commitment from organisations and donors**. For instance, advocacy conducted towards some providers of emergency medical services noted that their mandate does not include clinical care for sexual assault survivors as part of their core package of services; therefore, these services cannot be provided to survivors despite the will and engagement of frontline staff. The IRC has learnt that these issues must be raised at a higher level to reach a successful conclusion, and often require the support of donors or others with institutional influence.

Lastly, the IRC has learnt that effective advocacy is time-consuming and human resource-intensive; expectations that field staff can perform this role as well as their other day-to-day duties are unrealistic. Such **sustained advocacy requires a longer-term and organizationally supported commitment** to advocacy responsibilities.

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

Focus on adolescent girls

What is it? The IRC's experience with the initial stages of this project, as well as many years of gender-based violence programming in the DRC and elsewhere, showed that adolescent girls are often neglected in humanitarian interventions, despite having specific and often elevated needs compared to other segments of displaced or conflict-affected populations. To respond to this, the IRC has worked to target adolescent girls much more actively during assessment, response and monitoring missions, ensuring that their voices inform all emergency response activities and that their needs are directly addressed in services and risk reduction interventions.

What does a focus on adolescent girls look like? A stronger focus on adolescent girls begins with emergency assessments, where IRC staff conduct focus group discussions with girls to ensure that their needs are taken into account in emergency response interventions. Information from these assessments informs the targeted activities that form part of response missions, including dignity kits whose contents are tailored for adolescent girls, as well as ensuring that service providers have the appropriate capacities and – importantly – attitudes to support adolescent girls effectively and provide safe entry points for them. IRC case managers have been trained on working with child survivors, and also train volunteer psychosocial assistants or focal points in these skills. Specific attention is also paid to messages and entry points that girls will hear and understand during community outreach activities. Dignity kits have been tailored for and distributed specifically to adolescent girls – this adaptation has varied in different contexts, but has, for example, included more absorbent material to correspond to heavier menstrual flows. Girls have also highlighted the need for materials to support their 'integration' into host families – such as footwear and clothing that can reduce the additional burden on the families they stay with and therefore the contribution in terms of household work that girls are expected to provide, as well as reducing the risk that girls will engage in survival sex to fulfill their basic needs.

What was learned? The most important element of learning from the stronger focus on adolescent girls during this project is that, simply put, **the needs and priorities of girls are neither the same as other groups, nor are automatically understood by them.** Many organisations and programs – including the IRC, before strengthening its investment in working with this important group – tend to conflate girls with women or youth, assuming that their needs and views are covered by information provided by others. However, girls are both particularly vulnerable and particularly invisible during emergency response, and emergency interventions that do not actively seek their input and work towards their safety often fail to create important opportunities to reduce risks for girls, or unintentionally create additional risks.

For many girls, focus groups conducted during emergency assessment missions by the IRC represented **the first time that anyone – whether from their own community or an external organisation – had asked their opinions.** Nonetheless, despite their inexperience in articulating their own needs, **girls successfully described the adaptations they would like to see in emergency interventions, and devised their own risk mitigation strategies.** The wealth of information gathered from such discussions with girls helped the IRC to adapt its emergency preparedness and response activities, including conducting distributions of dignity kits tailored specifically to the needs of girls and girl-centred service provision for survivors.

FOCUS ON ADOLESCENT GIRLS: Actions & Tools	
ACTION	NOTES, TOOLS & RESOURCES
Ensure that case management and psychosocial support activities are tailored to the needs of girls	Caring for Child Survivors – an IRC-developed resource that supports case managers to understand and work with child survivors, including adolescent girls
Support healthcare providers to serve girl survivors better	Clinical Care for Sexual Assault Survivors multi-media training curriculum, used by the Ministry of Public Health

Understand the needs and priorities of adolescent girls in emergency preparedness and response	Focus group guide for adolescent girls
--	--

Conclusion

This project represented an important and unique investment in GBV-specific emergency preparedness and response. The learning gleaned from this experience both reinforces and extends international standards and best practices, showing that despite many years of advocacy and the existence of strong tools, modules and training materials, the needs of women and girls are not being considered in the first phase of emergency response. The IRC's experience implementing this model, and the challenges that field teams sometimes faced, also brought to light the importance of having trained teams and organisational commitments to emergency preparedness specific to GBV. Without one or the other, quality GBV emergency response cannot be effective. Training and mentoring increased staff confidence and readiness to engage as crises emerged by creating a platform of knowledge, tools and support. Commitment at all levels of the organisation shored up the response by making resources accessible, and ensuring that women and girls were prioritised as part of direct GBV response. The IRC has seen how this commitment, particularly at senior levels, also has the potential for improving protection of women and girls through the emergency programming of other sectors.