



GBV Emergency Preparedness & Response

FACILITATOR'S GUIDE

THE INTERNATIONAL RESCUE COMMITTEE: *Since 1996, the IRC has implemented targeted programs to promote and protect the rights of women and girls in contexts affected by acute and protracted emergencies. The IRC has earned a reputation as a global leader with unique knowledge, expertise and capacity in GBV response and prevention programming.*

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Introduction

The problem of gender-based violence (GBV) in humanitarian settings has gained traction in recent years, with increased attention to the risk and severity of violence women and girls face in crises such as Syria, Pakistan, Haiti, Libya, and Côte d'Ivoire. Gradually, this has led to recognition of how conflict and natural disasters can also weaken social structures and, as a result, increase women and girls' exposure to abuses in the long term.

The development of international guidelines, most prominently the Inter-Agency Standing Committee (IASC) Guidelines for Gender-Based Violence Interventions in Humanitarian Settings, has been critical in helping to keep women and girls on the emergency agenda¹ These guidelines have also promoted greater understanding of GBV response priorities and standards. Despite this, many humanitarian actors and policymakers do not yet view violence against women and girls as an issue that warrants urgent response during emergencies. There is a failure to prioritize the needs of women and girls, leaving GBV largely unaddressed for weeks, months or years after emergency onset and resulting in long-term consequences for individuals, families and communities. This also means a more limited allocation of resources for GBV programming and a dearth of GBV experts who are prepared to lead effective response efforts.

NOTE: For the purposes of this handbook, the terms emergency and crisis are used interchangeably and apply to both conflict and natural disasters.

This curriculum and the accompanying GBV Emergency Preparedness & Response Participant Handbook are part of a broader International Rescue Committee (IRC) commitment to equip field-based practitioners with the skills and knowledge necessary to effectively and rapidly respond to GBV in emergencies. The content of this curriculum is designed to complement existing training materials and resources developed by other agencies and experts, and operationalize key guidelines, including those from the IASC.

This package is designed to provide the theoretical knowledge and practical skills necessary to:

- Adapt and use appropriate information collection tools to lead GBV-specific rapid assessments in emergency settings;
- Generate and prioritize recommendations for action, in line with international best practices;
- Design and implement interventions to prevent and respond to GBV in emergencies;
- Adapt existing activities and support for women and girls to emergency contexts and constraints;
- Tailor non-GBV-specific sectoral activities to include and prioritize women and girls in emergencies;
- Enhance the preparedness of organizations in emergency-prone contexts to respond to the needs of women and girls by preventing and responding to GBV.

TARGET AUDIENCE

The primary target audience for this training package is organizations responding to the needs of women and girls, in emergency-prone regions, including direct GBV practitioners.

In particular, the IRC's experience training and supporting practitioners in GBV emergency response has shown that in many instances, the first responders are local, established organizations – from

¹ Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*, 2015.

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grassroots community-based organizations to larger national organizations - rather than large, international non-government organizations. This experience has also shown that many of the organizations that are able and willing to respond to the needs of women and girls in emergencies are not necessarily large, international NGOs; rather, they may be organizations that already respond to the needs of women and girls and/or survivors of GBV in static contexts with limited emergency experience. Indeed, the humanitarian system as a whole is increasingly recognizing the need to support and develop local organizations as the best-placed actors to respond to crisis.² Therefore, this revised version of the GBV Emergency Response and Preparedness (ER&P) training and implementation package is specifically targeted at such local organizations, which may operate in contexts of low resources and may also have only partial training or 'qualification' in GBV-specific work.

Addressing GBV requires dedicated resources and the commitment of all humanitarian actors. Until all actors recognize their obligation to women and girls, interventions to prevent and respond to GBV in emergencies will remain an afterthought.

This training does not cover all aspects of GBV response and prevention; this is a complex and challenging field of work, of which all aspects cannot be covered in one training. It may therefore be necessary to provide preparatory or supplemental materials to participants. The recommended number of participants is 25 per training; a group of up to 30 participants is possible but will affect the training experience.

PRINCIPLES OF THE TRAINING

All content within this training, and by extension GBV-related programming in emergencies, is guided by several interconnected sets of fundamental principles.

GBV Guiding Principles³

1 - Safety

The safety and security of the survivor and others, such as her children and people who have assisted her, must be the number one priority for all actors. Individuals who disclose an incident of gender-based violence or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them.

2 - Confidentiality

Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment. In the context of this training, respecting this principle means setting a strong ground rule about confidentiality (see Section 5, Session 1 for more information on ground rules) with all participants, respecting this rule as a facilitator and reminding participants not to share any personal information that may be revealed within the training room.

3 - Respect

² World Humanitarian Summit, 'Commitments to Action', https://www.worldhumanitariansummit.org/sites/default/files/media/WHS%20Commitment%20to%20Action_8September2016.pdf.

³ United Nations High Commissioner for Refugees, *Sexual Violence against Refugees: Guidelines on Prevention and Response*, Geneva, 1995.

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All actions taken will be guided by respect for the choices, wishes, rights, and dignity of the survivor. It is essential to maintain a climate of respect for women, girls and survivors within the training room – see information below on managing harmful statements.

4 - Non-Discrimination

Survivors of violence should receive equal and fair treatment regardless of their age, race, religion, nationality, ethnicity, sexual orientation, or any other characteristic.

Protection Mainstreaming Principles⁴

Protection mainstreaming, an imperative in all humanitarian action, ensures a protection lens is incorporated into operations. It is a way of designing and implementing all programs so that protection risks and potential violations are taken into account, which is promoted in a number of other tools and guidelines, including the Sphere Humanitarian Charter and Minimum Standards in Humanitarian Response.⁵ The GBV Guiding Principles are strongly related to, and complemented by, the following set of Protection Mainstreaming elements.

1 - Prioritize safety & dignity, and avoid causing harm

Prevent and minimize as much as possible any unintended negative effects of your intervention which can increase people's vulnerability to both physical and psychosocial risks.

2 - Meaningful Access

Arrange for people's access to assistance and services – in proportion to need and without any barriers (e.g. discrimination). Pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services. – i.e. any GBV response must analyze and mitigate against any cultural and social, economic and physical barriers that might prevent survivors accessing treatment.

3 – Accountability

Set-up appropriate mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints.

4 – Participation & Empowerment

Support the development of self-protection capacities and assist people to claim their rights, including – not exclusively – the rights to shelter, food, water and sanitation, health, and education.

Core Humanitarian Principles⁶

Lastly, both the GBV Guiding principles and Protection Mainstreaming Principles are underpinned by the core humanitarian principles, originally codified in the Fundamental Principles of the Red Cross and Red Crescent Movement and now used, in different forms, by a wide variety of actors across the humanitarian space.

1 - Humanity

⁴ <http://www.globalprotectioncluster.org/en/areas-of-responsibility/protection-mainstreaming.html>. Note that several different sets of standards exist that highlight similar information about protection in humanitarian action. For the purposes of this guide, we will refer to the protection mainstreaming standards outlined by the Global Protection Cluster.

⁵ <http://www.sphereproject.org/handbook/>

⁶ https://docs.unocha.org/sites/dms/Documents/OOM_HumPrinciple_English.pdf

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Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.

2 - Neutrality

Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.

3 - Impartiality

Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class, or political opinions.

4 - Independence

Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.

These sets of core principles are interdependent and complementary, and should all be respected in GBV preparedness and response work.

HOW TO USE THIS GUIDE

Read through the entire guide at least once before using it. Note down questions and areas that are not clear; these may become clearer as you progress through the guide. If not, discuss with your co-facilitator or supervisor.

Symbols

You will notice various icons used throughout the guide to help navigate activities and discussions:



The objectives of the session.



The time required to facilitate the session. This icon and the accompanying information can be found at the beginning of each session, as well as before each section of the session.



The materials needed for the session.



Preparation that should be completed before the session.



Notes to the facilitator. This icon indicates things that you should keep in mind while facilitating the session.



Information that is included in accompanying presentation slides. The number within the symbol indicates the relevant slide number(s). Where the symbol also includes an F after the slide number, this indicates that this is key information that should be written on flipcharts if you are not using slides.



This icon indicates where the corresponding information can be found in the Participant Handbook.



Additional Resources. Content accompanied by this symbol can be further explored using resources in Annex 10.



The diamond bullet point indicates actions the facilitator should take (e.g. explain, highlight)



The plain bullet point indicates lists of information

PARTICIPANT HANDBOOK

The Participant Handbook that accompanies the training is structured to follow the sessions of the training. Each session of this Facilitator's Guide indicates the corresponding pages in the Participant Handbook. Key information is provided within each session of the Participant Handbook so that participants are not required to take notes of all discussions and presentations; in addition, questions and space for reflection are also included so that participants effectively generate their own learning guide as they move through the course, which they will keep after the training.

SLIDES

A slide presentation has been developed to accompany and support this training - the slide symbol indicates where an accompanying presentation is available, and the corresponding slide number. You can adapt and change slides as needed.

Given that most of the sessions are highly participatory, you may choose not to use the slides, or to use them only as backup or to support the review of sessions. Similarly, you may be working in a context where projectors or other materials necessary for using slide presentations are not available. For this reason, all information provided in the accompanying presentation is also included in this guide. If you are conducting the training without using slides, look for the F within the slide symbol – this highlights essential information to be written on flipcharts or otherwise highlighted with participants.

PREPARATION

This training will be most successful if well organized in advance. This section provides some key elements to consider when preparing for the training; however, depending on your location and context, other issues may need to be considered.

LOCATION

You will need a space large enough to accommodate 25-30 people, seated at desks. You will also need additional space for small group discussions, and for participants to move around during exercises. In selecting your location, pay attention to safety concerns – Can women safely access the location? Is it a space where they will feel comfortable participating? – as well as its appropriateness for activities and learning. Natural light helps participants stay awake and alert, as does the right temperature - pay attention to heating and ventilation. Your location should also be accessible for those with reduced mobility, if applicable.

The room should be organized so participants are comfortable and can clearly see the facilitator at all times. Given that open participation is required for this training, it is important to set up your training room in a way that encourages open interaction - each facilitator has their own preferences, but a U-shaped set-up, or small groups seated around tables, are often helpful. Rows of people with some participants behind others can block participation. If this is the only option, ensure that participants in back rows get particular attention in plenary discussions, and where possible, change the seating arrangement each day so that different people sit in locations that get more attention.

PARTICIPANTS

For this kind of training, smaller groups are easier to manage, and ensure a smoother training flow. A group of up to 25 participants is ideal; more than 30 participants is not recommended. Participants should ideally have some prior GBV knowledge and experience.

TIMING

This training package is based on a four-day agenda of 9am-5pm work days. If your situation does not allow for four days of training – or conversely if you have time and resources for additional days – you can streamline or increase content by following the indications in this guide, or by adjusting based on your context. It may also be preferable to hold multiple shorter trainings if participants cannot manage a full four-day period in an emergency.

In some locations, and depending on the security context, it may not be safe for women to travel to or from certain locations at these times of day. If this is the case in your location, you can adjust the training to start later or finish earlier (adding an extra training day as needed).

MATERIALS

You will need a variety of materials for this training, including:

- Projector and screen
- Flip charts & easel/stand
- Markers

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- Tape (for flip charts)
- Post-it Notes (preferably of four different colors)
- USB keys (if possible) for sharing additional materials

The particular materials needed for each activity are noted within the session descriptions.

PRE-TRAINING PARTICIPANT MATERIALS

As this training covers a large number of topics in a limited period of time, it is essential that participants have some prior knowledge - particularly of gender-based violence - before they attend. The below package should be sent to participants at least two weeks before the training to allow each individual to read the relevant information, fill out the expectations and experience table, and complete any relevant online trainings.

Pre-training materials:

- Participant Agenda (see Annex 1);
- Background reading (see Annex 3);
- Managing Gender-Based Violence Programmes in Emergencies, UNFPA, <https://extranet.unfpa.org/Apps/GBVinEmergencies/index.html>;
- Managing Gender-Based Violence Programmes in Emergencies E-learning Companion Guide, <http://www.unfpa.org/publications/managing-gender-based-violence-programmes-emergencies>;
- **The following table concerning participant experience and expectations for the training:**

| Question | Participant Answer |
|--|--------------------|
| What do you hope to gain from this training? | |
| Have you completed any previous trainings in the following (or related) areas? If yes, please describe the length and general content of the trainings. <ul style="list-style-type: none"> • Gender-based violence • Emergency preparedness and response (e.g. understanding conflict, natural disasters and their impact on humanitarian needs and programming) • Humanitarian action (including Sphere Guidelines, for example) • Gender in humanitarian action • Humanitarian Coordination Systems (i.e. the Cluster system) | |
| Please describe the coordination system in your context, and if/how you and/or your organization interacts with it. | |
| Do you have any questions about Gender-Based Violence Programming in Emergencies? Are there any topics you would specifically like to focus on? | |
| Do you have any concerns about implementing a Gender-Based Violence Programming in Emergencies? If yes, please describe. | |

** You can use this information to tailor the session on Coordination & Advocacy. If participants do not mention, or do not clearly explain, the Cluster system, ensure that this information is emphasized in your session.

Remind participants that the expectations and experience table should be completed and returned to you no later than one week before the training.

ELECTRONIC MATERIALS

Most of the information discussed during the training is included in the Participant Handbook. However, it can be useful to also provide materials in electronic format, if possible - for example on a USB key, or via email. This can include the Participant Handbook, presentation slides and any other resources that have been discussed during the training. If you have the option to provide materials in an electronic format, prepare the basic package before the training, then add to the materials as the training progresses, if necessary.

CERTIFICATES

Training certificates are often important to participants, both as a symbol of what they have learnt during the training and as proof of having attended the training. They may also be useful for employment in the future. If you have decided to give certificates, make sure they are prepared in advance, ready to provide to participants at the end of the training.

PRE- & POST-TESTS

This training package does not include prepared pre- and post-tests for participants. This is based on previous experience that such tests do not always capture the understanding or learning of participants, depending on levels of comfort with written tests, different styles of learning and the quality of translation in different contexts. Therefore, this training includes some interactive ways of gauging the understanding of participants. If your particular context or program requires 'data' from pre/post-tests, such tests can be developed from the content in the training – alternatively, contact wpe@rescue.org or through the link at gbvresponders.org for support.

Facilitation

This training should be co-facilitated by two people who are experienced GBV staff and have previously implemented GBV programs in emergency settings – where possible, this should include experience working with the assessment tools detailed in this training manual, as well as logical framework approaches. The facilitators should be familiar with international legal frameworks related to conflict, displacement and women as well as other standards and guidelines used to guide humanitarian response in emergencies. In areas affected by ethnically-driven conflict, the ethnicity (of the facilitators and expected participants) should be taken into account when deciding on facilitation teams.

As a facilitator, you are responsible for building a safe, participative and dynamic learning environment, based on mutual respect and collective responsibility between participants. The curriculum uses participatory approaches, allowing you as a facilitator to guide the group, while at the same time encouraging participants to play an active role. This also allows you to draw on the wide range of strengths and experiences among participants, inviting dialogue and collective problem-solving.

FACILITATION TIPS & SKILLS

Spoken and unspoken communication - communication includes what people say out loud, what they do not say, and the way they use body language. Be mindful of how people interact with each other, and with you. It is also important to be comfortable with silence - it can indicate that people are thinking, that they haven't yet decided what they want to say or that they do not feel comfortable contributing at this stage. Often, if you allow a silence to continue, one of the participants will step in.

*Active listening*⁷ - Use body language to show that you are listening to participants when they speak - for example, be careful not to cross your arms, or turn away from participants (though sometimes you might need to do so when writing on flip charts, etc.). You should also monitor that other participants are not making an uncomfortable space for anyone who is contributing (e.g. by speaking at the same time). Repeating participants' answers out loud, summarizing what you have understood from their contributions and rewording their phrases can help both to demonstrate that you are listening and also help to reinforce ideas for other participants. Asking for specific examples to illustrate points can also be useful.

*Effective questioning*⁸ - Ask open-ended questions (ones that cannot be answered with yes or no). For example - How do you understand the term GBV? What does it mean to you? Avoid questions that might imply judgment such as 'Why do you think that?'. Instead, you can say something like 'Can you explain what you mean by that?', or 'What might be the reasons behind that?'. Ask probing questions, and return questions back to the group by saying things like 'What would be your answer to that?', 'What does the rest of the group think about this?'. You can also reframe or reword a question to create a different context and help the group move to through a complicated conversation. Concrete and straight-forward questions, without multiple parts, are the most effective with groups of people.

*Boundaries and self-care*⁹ - While this training covers sensitive topics, it is not designed to elicit personal disclosures of violence and abuse. If participants do disclose experiences of violence, that information

⁷ Adapted from International Rescue Committee, Core Concepts in GBV: Facilitator Manual, 2008, <http://gbvresponders.org/response/core-concepts/>.

⁸ Adapted from International Rescue Committee, EAŞE Discussion Series: Facilitator Guide, 2012, <http://gbvresponders.org/empowerment/eae-tools-resources/>.

⁹ Adapted from International Rescue Committee, Core Concepts in GBV: Facilitator Manual, 2008, <http://gbvresponders.org/response/core-concepts/>.

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should remain confidential to the group (see Dealing with Disclosure, below). Equally, both participants and facilitators must pay attention to their own needs during the training - if it is too difficult to participate in a particular exercise, participants should feel free to step out of the training for whatever time they need. If they need to speak one-on-one with the facilitator, a specific time should be made for this rather than trying to do so during training sessions. As a facilitator, it is also important to maintain your own boundaries and feelings, and keep participants focused on the content and objectives.

Managing energy, time and flow - Group dynamics and energy are important elements of this training process. The agenda and exercises described in this guide should be used as a framework, but you will need to adapt the timing and details to your group and how they are feeling. Use energizer exercises as needed, and adapt the length of discussions to suit the energy in the room. Managing the timing of group discussions is one of the most challenging aspects of facilitating trainings, as some participants will want to respond to every question, whether others have already made similar contributions or not. You will need to use your judgment in deciding how to keep conversations centered on relevant discussions, and where to draw the balance in allowing discussion while keeping to time. Remember that not every question can be answered at the exact moment it is asked - every participant will take their own learning path throughout the training, and may be thinking about other issues that are not part of the current discussion. In this case, make active use of the Parking Lot, which helps to validate questions by making them visible and reassuring participants that they will not be lost or forgotten. It also allows you to tailor later sessions to include questions and concerns that have been raised.

Co-facilitation - Facilitating a training such as this one is intensive and requires high levels of preparation and energy. Co-facilitation, while helpful and recommended, requires particular preparation – both facilitators need to agree on how to manage the sessions, who will lead which activities and discussions, how to respond to questions and how they can support each other during sessions. Before the training, go through the sessions and choose a lead facilitator for each; when you are not the lead facilitator, you should support your colleague by noting main discussion points on flipchart paper if needed, putting presentations on the screen, handing out materials, etc. It is important to note that where male and female facilitators are sharing roles, you should ensure that there is a fair and equal distribution of tasks; that is, female facilitators should not be expected to take on more or most of the support roles while male facilitators do more or most of the main presentations and discussions. Additionally, pay attention to the dynamic between facilitators during discussions, ensuring that both female and male facilitators have active roles in answering questions from the group, and that neither facilitator undermines the other. This will help to model the full engagement of women in an empowering training process.

*Challenging Harmful Statements*¹⁰ - Below are examples of Common Resistance Responses that facilitators should be prepared to identify (within themselves and others) and respond to. All of these reactions:

- Are learned; they are taught by our society in order to reinforce norms and ultimately, patriarchy.
- Prevent men from having to take responsibility for their or other men's actions.
- Allow women to distance themselves from victims of violence.
- Involve minimizing, denial, and justification.
- Are not right and perpetuate violence against women.

¹⁰ International Rescue Committee, Engaging Men Through Accountable Practice Resource Package, 2013, <http://gbvresponders.org/prevention/emap-tools-resources/>.

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1. **Denial:** Asserting that something is not true or not a problem - “That is not an issue”, I do not know where she got the bruises on her face, she must have fallen”, “There is no problem here – nothing happened”
2. **Minimizing:** Making something smaller or less serious than it is - “I don’t know why women make this such a big deal”, “I’ve been hit before – it’s not that serious”, “It was only a slap”, Joking about GBV, “Violence is a normal part of any relationship – stop making an issue of it
3. **Justification:** Stating that something is right or reasonable - “Women need to learn to stay in line and listen to their husbands”, “She deserved it”
4. **Victim Blaming:** Stating or implying that the victim is at fault for the violence that she experienced - “Well if she had listened to her husband, this wouldn’t have happened”, “She asked for it by (behavior)”, “She provoked me, I had no choice”
5. **Comparing victimhood:** Changing the focus of the discussion/situation by stating that another group also experiences the same problem - “Men experience violence too”, “Both men and women are victims of violence – why is it always about women?”, “Women can be abusive to men too”
6. **Remaining silent:** Choosing to keep quiet or not speak up in the face of an injustice or problematic act - Not speaking up when violence/disrespect occurs, ignoring something or pretending you didn’t notice
7. **Reinforcing Norms:** Engaging in behaviors that support power inequality and harmful beliefs and attitudes - Taking control of women’s work in the community around GBV, perpetuating violence/discrimination
8. **Colluding:** Men supporting harmful beliefs and attitudes of other men - Agreeing with any of the above responses – by verbal expression or silence, believing or supporting excuses and justifications for violence, laughing at harmful attitudes and beliefs that other men express

The following are some suggested steps to challenge common resistance reactions, such as those described above.

- Ask for clarification / Learn why they have that opinion
 - » Summarize back the statement or comment
 - » Identify to yourself which of the “Common Resistance Reactions” is being expressed by the harmful statement or action
 - “Thank you for sharing your opinion with us.” Can you tell us why you feel that way?”
 - “So it sounds like you are saying...is that correct?”
 - “How do you think it might feel to your female colleagues in the room to hear that statement?”
- Seek an alternative opinion / Involve Others
 - » Send the question back to the group using an open method. For example:
 - “What do the rest of you think of that phrase (or this attitude)?”
 - “To me that sentence sounds like victim-blaming. What do the rest of you think?”
 - “You say that your religion supports this kind of violence against women. Would all those of the same religion/all religious leaders agree with that interpretation?”
- If nobody offers an alternative opinion, provide one.
 - “I know that a lot of people would not agree with that statement. Many of the men and women I know feel that the rapist is the only person to blame for a rape and that we all have a

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responsibility to respect other people's right to say "no" to sexual activity."

- Offer facts that support a different point of view and emphasize a helpful perspective. For example, statistics support the view that many more women experience GBV than men, and that the consequences are much more serious for women. Sometimes there are laws that can support a position but the law may not be recognized within the country or community. If you are going to reference a law, please ensure it is recognized in the community:
 - "The law says that every person has right to say "no" to sex, and the rapist is the only person to be blamed. I agree with this and as a man, I think it is important that we respect a woman's choice to make her own decisions about sex. It does not matter what a woman wears or does, she has the right not to be raped."
- Return to the underlying discrimination, oppression and power imbalance that is the basis of violence against women and girls, to explain the focus on these groups – putting aside the question of statistics (which can often provoke claims that violence against men is highly under-reported because services are focused towards women), we focus on violence against women and girls because of the way these groups are systematically oppressed, excluded from decision-making roles and considered as 'less than' men in societies across the world. This power differential is the basis of gender-based violence, and is the reason why men's violence against women (violence committed by a more powerful group of people against a less powerful group of people) is not the same as men's violence against men, or women's violence against men. Similarly, if the question of under-reporting arises, you can remind participants that women face consequences that are just as serious – up to and including death, e.g. honor killings – as those experienced by male survivors for reporting violence committed against them.

It is important as a facilitator not to reinforce negative or harmful statements by letting them go unchallenged. Raising the issue shows respect to women in the room and challenges the existing dynamic.

MANAGING GENDER DYNAMICS

Gender dynamics that exist in communities also exist inside training rooms. Women may find it difficult to express themselves openly in front of men, and men may (consciously or subconsciously) think less of women's contributions. Men are often accustomed to speaking first, speaking more, and being more forceful with their opinions - this can play out in both obvious and subtle ways within the training. For example, if men are the first to put their hands up when a question is asked, they will often be the first called on, with the result that women may not then contribute if they feel that either their thought has already been expressed or that they disagree with what their male colleague has said, but do not feel comfortable enough to openly contradict him. These dynamics are often not intentional; nonetheless, they can be detrimental to the learning process of the whole group, and in particular that of women participants.

In addition, women often have a deeper, lived understanding of GBV and the challenges faced by women and girls in their community. Even if they have not previously analyzed or named these experiences, once a discussion begins you will often find that these issues resonate very deeply with women who have either lived through them, or know someone who has. For this reason, such discussions can feel quite personal and emotional for women; this is not always the case (though it can be) for men, who may not have as much personal experience of, or connection to such limitations and/or violence. In addition, it can also feel quite uncomfortable for men to be faced with the kinds of abuses that men perpetrate; men (and women) may respond to this discomfort by making jokes,

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minimizing GBV and the issues that women face, and defending men, or pointing out that not all men perpetrate violence. They may also point out that men experience violence as well.

One of the most challenging aspects of facilitating mixed training groups is managing these dynamics in such a way that women are supported and empowered to learn and grow to their full potential, while at the same time men are encouraged to question their own beliefs and actions and those of other men. The suggestions below can support the framing and maintaining of a positive learning environment for both female and male participants.

- Pay attention to the set-up of the room - i.e. you can put women together so they feel more powerful and are not physically intimidated by male colleagues (even where men are not intending to intimidate female colleagues, this can be the result if a smaller woman is sandwiched between two large and vocal men, for example).
- In small groups, it can be helpful to have women-only groups for certain exercises, but otherwise ensure that there are women in every group, as no discussion about women should happen without women involved.
- Purposefully invite women to answer first when you ask a question.

DEALING WITH DISCLOSURE

It is highly likely that women participants will have either experienced, or know someone who has experienced, some form of violence. While this training does not require or expect participants to talk about their own personal experiences of violence, it is possible that such disclosures may happen - as a facilitator you should be prepared to manage such situations. It is not your role to provide counseling or detailed psychosocial support; however, the way you respond to a first disclosure can be very important.

A survivor-centered approach to GBV seeks to empower the survivor by putting her in the center of the helping process. A survivor-centered approach embraces each individual survivor's physical, psychological, emotional, social and spiritual aspects. This approach also considers a survivor's cultural and social history as well as what is happening in her life that could support and facilitate recovery. GBV is a manifestation of power inequalities and limited choices. If service providers—who are in a powerful position relative to the survivor—impose their perspectives, opinions or preferences on the survivor, they may unintentionally create a situation where the survivor feels further disempowered or abused. The survivor-centered approach recognizes that:

- Each person is unique
- Each person reacts differently to GBV and will have different needs as a result
- Each person has different strengths, resources and coping mechanisms
- Each person has the right to decide who should know about what has happened to them and what should happen next

Remember that this may be the first time she has talked about her experience. Be kind, and show support. Do not rush her, overwhelm her with questions or force her to tell you details. If the disclosure happens in a group setting, ask if she would like to speak with you privately at another time.

Know what resources are available, including health, psychosocial services and legal services, if applicable. If possible, source or prepare a referral list in advance of the training so that you can easily and quickly share with any participants who need it. It is not your role to provide counseling (unless you have specialized training to do so and can provide this support in a safe, confidential and sustained

manner outside of the training). If you do not feel comfortable in a situation involving disclosure, seek support from your supervisor.

SELF-CARE

Participants in your training are likely to be working in difficult contexts, or at the very least are expected to do so at some point in the future. It is therefore important to equip them with techniques to manage stress and take care of themselves in the field – this is also a helpful way to break up heavy sessions (they can be used together with, or instead of, energizers) and ensure the well-being of your participants throughout the training. This section lists some short exercises that you can weave throughout the training; suggested locations are included in the agenda, but you can insert them whenever needed in the flow of your sessions. If you have any psychosocial support experts among your participants, you can ask them to be responsible for some (or all) of the self-care and relaxation exercises.

Chair Yoga

Seated Neck Rolls

Sit up straight in a chair. Gaze up to the ceiling, keeping your neck long. Bring your left ear down toward your left shoulder and hold. Roll your head down toward the ground and bring your chin to your chest and hold. Roll your head to the right and bring that ear to your right shoulder. Inhale and exhale through the nose in a slow and controlled manner. Repeat twice.

Seated Mountain Pose

Sit up straight in a chair. Roll your shoulder blades up, back and down, arms relaxed at your sides. Pull your belly button in to your spine to engage your abdominal muscles, and keep your feet flat on the floor, if possible. Inhale through the nose and raise your arms overhead. Keep your arms shoulder width apart, and relax your shoulders. If you feel your shoulders creep up around your ears, relax them. Gaze in between your hands, to the ceiling. Stay here for five breaths.

Seated Eagle Arms

Sit up straight in a chair. Roll your shoulder blades up, back and down, arms relaxed at your sides. Pull your belly button in to your spine to engage your abdominal muscles, and keep your feet flat on the floor, if possible. Extend your arms out in front of you at 90-degree angles, palms facing each other. Place your right arm under your left and press the backs of your palms together. Inhale and sit tall, then exhale and tuck your chin to your chest to stretch the back of the neck. Hold the pose for five breaths, then switch arms and stay for another five breaths.

Seated Forward Fold

Sit up straight in a chair. Roll your shoulder blades up, back and down, arms relaxed at your sides. Pull your belly button in toward your spine to engage your abdominal muscles, and keep your feet flat on the floor, if possible. Spread your legs slightly wider than hip distance apart. Exhale and hinge from the hips, slowly lowering your hands to the floor (or in contact with your thighs or shins). Slowly round your upper back, lowering your chest in between your legs and relaxing your head and neck down. Allow your shoulders to relax and round. Stay here for five breaths. Inhale and slowly roll up, lifting your head up last.

Seated Cat/Cow

Sit up straight in a chair. Roll your shoulder blades up, back and down, arms relaxed at your sides. Pull your belly button in to your spine to engage your abdominal muscles, and keep your feet flat on the floor, if possible. As you inhale, arch your back (leading with the chest) and look up toward the

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ceiling. Lift the chin and allow your arms to relax next to you. As you exhale, round your spine and let your head drop forward. Tuck the chin and allow your shoulders to roll. Repeat five times, moving fluidly from cat to cow with each breath.

Standing Forward Fold with Chair

Begin by standing about an arm's length behind a chair. Your feet should be directly under your hips; your shoulders should be back and down, with your abdominal muscles engaged. Inhale and reach for the chair, allowing your body to roll down. Bend your knees slightly to prevent locking them, and allow the head to hang. Stay for five breaths, and then roll up slowly.

Seated Forward Bend with Chair

Sit on the floor in front of your chair with your legs extended in front of you, under the chair. Keep the chair close enough to your body that you can touch it with your hands when the arms are outstretched. Pull your belly in to your spine to engage your abdominal muscles and flex your feet to engage your legs. (Bend your knees if you cannot straighten them.) Hinge from the hip to place your hands/forearms onto the chair, and then allow your chin to drop toward your chest and your upper back to round slightly forward. Stay here for five to 10 breaths, then slowly roll your chin and chest up

Deep Breathing

Imagine you have a balloon inside your stomach. Place one hand below your belly button, and breathe in slowly through the nose for four seconds, feeling the balloon fill up with air – your belly should expand. When the balloon is full, slowly breathe out through your mouth for about four seconds. Your hand will rise and fall as the balloon fills and empties. Wait 2 seconds, then release. Repeat a few times. When belly breathing, make sure the upper body (shoulders and chest area) is fairly relaxed and still.

Visualization

Find a quiet place and close your eyes. Think of the most calm, peaceful place you have ever been. Picture yourself in that place. Describe what it: Looks like, Sounds like, Smells like, Feels like. Think of all the small details, like the breeze, the feeling of the grass or whatever else might be in your space. Imagine yourself in the place and breathe deeply for several breaths. Return here when you are feeling stressed or worried.

Muscle Relaxation

Make a fist with each hand and squeeze each hand tight. Squeeze... Squeeze... Squeeze...and Relax. Now, while you squeeze your fists again, tighten your arms to squeeze your body, Squeeze... Squeeze... Squeeze... Relax. Now, this time also squeeze your legs together while making a fist and squeezing your arms together, Squeeze... Squeeze... Squeeze... Relax. Repeat. Shake out your hands, arms and legs.

If you have the time, you can do this exercise by individual muscle group – i.e. starting with the left foot, left calf, left thigh, left buttock, moving to the right leg, then left hand, arm, shoulder, right arm, then then back, face, etc.

Writing it Out

Divide into pairs or small groups. Explain that you'll be asking them to write about a difficult or stressful experience in your work, and then they will read what they wrote to their partner/others in the group. They will not need to hand in what they wrote, and can choose not to read out what they wrote if they choose. Ask them to spend 5 minutes writing about a difficult work situation and what helped them to manage the situation.

After 5 minutes, ask them to spend 5 minutes reading what they wrote to their group. Listeners should not give advice or analyze what is said, they should only listen. After everyone in the smaller groups has had a chance to read, return to the full group. Debrief - what was the experience like? Did anything surprise you? What was difficult, what was useful?

Success Stories

When suffering is so pervasive and the needs so enormous, it can seem as though no matter what we do, it is never enough. This exercise is designed to help staff recognize even small accomplishments.

At the end of a work-day, gather staff together and ask each person to talk about one success they had during that day or that week – no matter how small. If someone is unable to come up with a success, other team members should help them. Doing this on a regular basis can begin to help staff recognize what they are accomplishing, rather than focus exclusively on what still needs to be done. This can be a helpful – and simple – strategy against burnout.

Sculpting

One group member volunteers to be the sculptor, while several other group members volunteer to be the “clay.” The “Sculptor” is asked to sculpt their image of a particularly stressful situation. The Sculptor does not tell the story, but rather asks the volunteers to assume positions that represent the stressful experience. The Sculptor can then join in and become part of the sculpture. Other group members are invited to gather around and view the “sculpture” and describe what they see. The leader then asks those serving as clay to break the position.

The Sculptor is then asked to “sculpt” their image of “freedom from the stress” – using the same volunteers. The Sculptor can then enter the sculpture, as well. Once again, other group members are invited to gather around and describe what they see. The leader then asks the volunteers to break the position.

Finally, the leader asks the volunteers to assume the original position (of stress), and – as the leader slowly counts to 10 – slowly transform the original sculpture of stress into the second sculpture of freedom from stress.

The leader asks all to return to their seats, and de-briefs the experience with participants, asking what it was like for them to assume the original position, how it felt in their bodies, etc. and how it then felt to move into the freedom from stress position.

Sharing

Finally, a simple yet effective way of supporting the self-care of participants is to take some time as a group (or smaller break-out groups) to discuss and share the techniques they use to relieve stress and look after themselves for others. You can prompt discussions with questions such as the following:

- What makes you stressed, or takes away your energy?
- What do you do to relieve stress, or recharge your emotional/mental/physical batteries?

Ask participants to share some strategies or techniques they use, and discuss.

Training Content

AGENDA

| Day 1 | |
|---------------|--|
| Time | Session |
| 9:00 – 10:00 | 1 - Welcome, Outcomes & Expectations |
| 10:00 – 10:15 | Tea/Coffee Break |
| 10:15 – 12:35 | 2 – Women, Girls, and Gender-Based Violence in Emergencies |
| 12:35 – 14:00 | Lunch Break (including 25 mins self-care/energizer) |
| 14:00 – 15:15 | 3 - Assessments – Introduction & Ethical Considerations |
| 15:15 – 15:30 | Tea/Coffee Break |
| 15:30 – 16:45 | 4 - Assessments – Tools & Practice |
| 16:45 – 17:00 | Wrap Up |

| Day 2 | |
|---------------|---|
| Time | Session |
| 9:00 – 9:30 | Introduction to the Day (including 10 mins self-care) |
| 9:30 – 10:30 | 5 – Introducing the Program Model |
| 10:30 – 10:45 | Tea/Coffee Break |
| 10:45 – 12:00 | 6 - Case Management |
| 12:00 – 13:20 | 7 - Psychosocial Support |
| 13:20 – 14:20 | Lunch Break |
| 14:20 – 15:30 | 8 - Health Response |
| 15:30 – 15:45 | Tea/Coffee Break |
| 15:45 – 16:45 | 9 – Referral Systems |
| 16:45 – 17:00 | Wrap Up |

| Day 3 | |
|---------------|--|
| Time | Session |
| 9:00 – 9:15 | Introduction to the Day |
| 9:15 – 10:45 | 10 - Community Outreach |
| 10:45 – 11:00 | Tea/Coffee Break |
| 11:00 – 13:10 | 11 - Risk Reduction |
| 13:10 – 14:30 | Lunch Break (including 20 mins self-care/energizer) |
| 14:30 – 15:30 | 12 – Responding to Other Forms of GBV in Emergencies |
| 15:30 – 15:45 | Tea/Coffee Break |
| 15:45 – 16:45 | 13 - Information Management & Sharing |
| 16:45 – 17:00 | Wrap Up |

| Day 4 | |
|---------------|---|
| Time | Session |
| 9:00 – 9:30 | Introduction to the Day (including 15 mins self-care/energizer) |
| 9:30 – 11:00 | 14 – Coordination & Advocacy |
| 11:00 – 11:15 | Tea/Coffee Break |
| 11:15 – 13:35 | 15 – Emergency Preparedness |
| 13:35 – 15:00 | Lunch Break (including 25 mins self-care/energizer) |
| 14:30 – 15:30 | 16 - Conclusion |

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This agenda is provided as a guide; you may need to adjust sessions and timing day-to-day based on participants' experience, knowledge, priorities and needs. For example, if you have two strong facilitators, you can run the Case Management and Psychosocial Support sessions concurrently (additional guidance is provided on this in the relevant session descriptions). Depending on your context, you may also need to change the start or end times of the training, or schedule breaks at certain times to cover participant needs such as prayer or additional protocols (security briefing, welcome from dignitaries). Check these requirements in advance if possible to avoid major changes at the last minute; however, it is likely that you will also need to adapt as you go. Stay flexible and remember that one training cannot provide every piece of information – nor will participants retain everything you discuss – so it is more important to focus on imparting the essential elements, principles and things to remember.

DAY 1

| Day 1 | |
|---------------|--|
| Time | Session |
| 9:00 – 10:00 | 1 - Welcome, Outcomes & Expectations |
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| 10:15 – 12:35 | 2 – Women, Girls, and Gender-Based Violence in Emergencies |
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| 15:15 – 15:30 | Tea/Coffee Break |
| 15:30 – 16:45 | 4 - Assessments – Tools & Practice |
| 16:45 – 17:00 | Wrap Up |

SESSION 1: TRAINING OUTCOMES AND EXPECTATIONS



Learning Objectives:

- Review expectations and training outcomes.
- Establish group ground rules.
- Review security guidelines for visitors to training location.



Time: 1 hour



Materials required: Projector, screen, flip charts, markers, tape.



Facilitator Preparation:

- Review relevant slides.
- Prepare flip chart with title 'Ground Rules' and affix in view of group
- Prepare flip chart with title 'Parking Lot' and affix in view of group
- Prepare agenda contents: Papers with Day 1, Day 2, Day 3, Day 4, 4 x lunch, and titles of each session. Attach to the wall, outlining sessions for the morning and afternoon of each day.
- Ensure that each participant has a copy of the Participant Handbook, as well as materials to write with
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.



PLENARY: Introductions – 20 min.

- ❖ Welcome participants. Introduce the facilitation team and the overall goal of the training: to strengthen capacity to prepare for and respond to GBV and the needs of women and girls in emergencies. Note their packet including the Participant Handbook. Encourage them to mark areas of interest in the Handbook, and to use it to take notes when needed.
- ❖ Explain that this training is part of an IRC initiative to strengthen the humanitarian community's ability to effectively and rapidly launch a response to GBV in emergencies. Explain that it focuses on local organizations as the most likely to be able and willing to respond to the needs of women and girls in emergencies.

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- ❖ Ask each participant to briefly say their name and where they traveled from to come to the training, and one fun or interesting thing about the context in which they work.

PLENARY: Review Training Expectations and Outcomes – 10 min.



- ❖ Remind participants that they were asked to share their expectations before the training, based on the information they received. Highlight some of the key expectations that participants shared.
- ❖ Review the training outcomes outlined below.



- Adapt and use appropriate information collection tools to lead GBV-specific rapid assessments in emergency settings; Design and implement interventions to prevent and respond to GBV in emergencies;
- Design and implement interventions to prevent and respond to GBV in emergencies;
- Adapt existing activities and support for women and girls to emergency contexts and constraints;
- Tailor non-GBV-specific sectoral activities to include and prioritize women and girls in emergencies;
- Enhance the preparedness of organizations in emergency-prone contexts to respond to the needs of women and girls by preventing and responding to GBV.

- ❖ Ask for any questions from participants.

PLENARY: Overview of training week – 10 min.



- ❖ Review agenda on the wall, outlining the main topics to be covered each day. Be sure to draw links between the agenda and the participant expectations already discussed, and to explain how the agenda will build toward the overall training goal. You can rearrange sessions in this agenda as needed.
- ❖ Introduce the Parking Lot – show where the flip chart is on the wall, and explain that this will be used to park questions until they can be addressed. Explain that participants should feel free to write their own questions here, or to ask facilitators to do so.

PLENARY: Ground rules – 10 min.

- ❖ Ask participants to contribute to ground rules to guide the training. Write their contributions on a flipchart.
- ❖ Add any that you feel are missing and ask if they agree. Ensure that each ground rule is clearly explained – for example, ask participants to explain what ‘respect’ would look like in practice. (The ground rules should remain visible for the full duration of the training.)
- ❖ If you have time, ask participants to sign the ground rules flip chart as a physical commitment to upholding the rules.

Depending on the group and the time available, you can make this exercise more interactive by asking participants to mime an example of a behaviour they want to see (or not see) instead of calling it out. Others in the group must then guess the behaviour.

PLENARY: Housekeeping – 10 min.



- ❖ Review information regarding the venue, transport, meals, security, etc.
- ❖ Ask if any of the participants have any questions regarding these issues or the training in general.

SESSION 2: WOMEN, GIRLS, AND GENDER-BASED VIOLENCE IN EMERGENCIES



Learning Objectives:

- Establish a common understanding of gender-based violence.
- Recognize characteristics of emergencies – natural and human-made disasters – and how these characteristics impact and present specific risks to women and girls.



Time: 2 hours 20 minutes

NB: If you have additional time, expand this session to include more discussion of how emergencies affect women and girls, and the consequences of GBV.



Materials required: Projector, screen, flip charts, markers, tape, blank note cards (or paper/post-it notes), scenario handouts (see Annex 4).



Facilitator Preparation:

- Review relevant slides.
- Print and cut up the GBV definition cards (Annex 7) – add translation, where necessary.
- Prepare two flip charts with titles 'Natural Disaster' and 'Conflict'
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.
- Choose relevant scenario and adapt. Note that two scenarios are provided in the facilitation package: one natural disaster and one conflict-based. These scenarios include fictional locations, names and armed groups; you can choose to use these scenarios as they are or to adapt them using content that is more relevant to your location and context. You may choose to use more than one scenario with your group; however, keep in mind that the more scenarios you use the more time you will spend sharing content between groups.



PLENARY BRAINSTORM: What is Gender-Based Violence? – 20 min.

- ❖ Distribute the GBV definition cards to participants (if you have a large group you may want to do this in two groups, with two sets of cards). Ask them to think about their understanding of Gender-Based Violence, and work with their colleagues to put the cards in order to create a definition (on the wall, a table, or the floor).
- ❖ Allow 10 minutes for participants to create a definition. If you have two groups, discuss any differences between the arrangements.
- ❖ If necessary, present the definition of GBV on a slide or flipchart (if your participants have arrived at the correct arrangement of the cards, you can move straight to the discussion from their work):



GENDER-BASED VIOLENCE is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. The term gender-based violence highlights the gender dimension of these types of acts; or in other words, the relationship between women and girls' subordinate status in society and their increased vulnerability to violence. GBV can be sexual, physical, psychological and economic in nature, and includes acts, attempted or



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threatened, committed with force, manipulation, or coercion and without the informed consent of the survivor.¹¹

A **SURVIVOR** is a person who has experienced gender-based violence.

- ❖ Explain that coming to a common understanding of GBV can be challenging during any situation because we all have our perspectives and see things slightly differently from each other; but in its absence, there is often confusion among those working to address it. During an emergency, it is essential to have this conversation as quickly as possible to ensure that there is a common understanding in order to avoid an ongoing unnecessary debate as you try to set goals, objectives and start to implement.



In some contexts, it might be more acceptable or relevant to use the term “violence against women and girls,” or VAWG. While there are many individuals and organizations who might use gender-based violence as a term to cover violence committed against both women and men in equal measure, it is important to recognize that this term originally arose out of the need to understand that violence against women and girls is based on gender roles – that is, it is socially-created, reinforced and perpetuated. So while men also experience violence and male survivors of violence are also deserving of care and support, GBV work maintains a strong focus on women and girl survivors of violence, because of the inferior status and power of women and girls in societies across the world.

- ❖ Note that because the vast majority of survivors of GBV are women and girls – and because of the power inequality, oppression and discrimination that women and girls experience - this training will focus specifically on them. We also recognize, however, that boys are vulnerable in emergencies and that emergency responders must understand the unique needs of men and boys who experience GBV.
- ❖ Note that GBV is not unique to emergency contexts, nor is it ‘created’ by conflict. GBV exists in all contexts at all times; however, it is exacerbated by emergencies, as you will now discuss.

PLENARY: Emergency? Crisis? Disaster – Understanding Emergencies – 30 min.



- ❖ Ask a volunteer participant to read the definition of emergencies:



EMERGENCY: Any situation in which the life or well-being of civilians affected by natural disaster, conflict or both has been or will be threatened unless immediate and appropriate action is taken, and which demands an extraordinary response and exceptional measures.



- ❖ Ask participants to name examples of natural disasters and conflicts. Write their responses on the appropriate flipcharts.

| Examples of Conflict Situations | Examples of Natural Disaster Situations |
|---|---|
| war | drought |
| political violence such as pre/post-election violence | floods |
| riots | mudslides |
| tribal/ethnic conflict | major storms |
| sectarian/religious violence | earthquakes |
| | volcanic eruptions and gas leaks |

¹¹ Interagency Standing Committee, Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, 2015.

| | |
|---------------|----------|
| rebel attacks | tsunamis |
|---------------|----------|



- ❖ Ask about the characteristics that different types of natural disasters have in common with each other. Then ask about the characteristics that the different types of conflict-related emergencies have in common:
 - Conflict often builds over time and can continue for a long time. It can start in specific areas but spread over time. It can target specific peoples.
 - Natural disasters, with the possible exception of drought and volcanic eruptions, devastates in a very short period of time. Generally, most people in the area are affected; however, the working poor, the poor and marginalized tend to suffer more and have the most difficulty recovering. In particular, women and girls are more likely to be killed by natural disasters (partly because they are often taking care of others – children and the elderly, for example – and partly because they may have had less opportunity to develop skills that can save them; for example, if women are unable to swim they will be less likely to survive a flood or tsunami. The effect of a natural disaster is often localized.
 - Conflict and natural disasters can happen simultaneously, making the situation more complex. During both there may be widespread displacement and a breakdown in social safety nets.
- ❖ Discuss the impact and time period of different types of conflict and natural disasters:
 - Emergencies are rarely linear – they may ebb and flow, get better then worse, or occur in cycles. In addition, different kinds of crisis may occur at the same time.
 - Emergencies can be categorized as acute, in which the situation deteriorates rapidly – for example, an earthquake, or a sudden outbreak of violence – or protracted, in which the situation may deteriorate more slowly, or may continue in the state of emergency for a longer period of time after the initial crisis. Protracted emergencies may be more stable (for instance, an established refugee camp) than acute emergencies, but both present elements of risk for women and girls. This training focuses more heavily on the acute emergency phase, when the context has changed dramatically, putting additional strain on structures and systems; however, the lessons also apply to protracted emergencies.

PLENARY: Introduction to Scenarios – 15 min.

- ❖ Explain that throughout the training, participants will work in a specific context, which is explained in the scenario handout.
- ❖ Hand out scenarios and allow a few minutes for participants to read them.
- ❖ Encourage them to ask any questions, and discuss.

SMALL GROUP: Case studies – 30 min.



If you can, select 3 groups, with each focusing on a specific child, adolescent or adult's story. However, if the groups are too large it might be necessary to have more groups. It is also possible that there are more than three emergency contexts and you want participants to be grouped by their context. Nevertheless, make sure that you have at least one story for child, adolescent and adult. If the emergency context has ethnic dimensions (e.g. ethnically driven conflict) or there are differences in treatment of survivors based on their ethnicity, make sure that groups consider the ethnicity of the survivor when developing their case study.

- ❖ Ask each group to think of the situation of an adult woman, a girl child or an adolescent girl in the scenario you have just discussed. (You may want to assign each group with a specific age to focus on, so that all three are discussed in the plenary.)



- ❖ Ask each group should develop a small case study based on their girl child, adolescent girl, or woman. Explain that they should give her a name and a story that is realistic for the context, including her experience of violence during or after the emergency.
- ❖ After this, each group will write on a flipchart what life was like for their girl child, adolescent girl, or woman for the first 12 weeks after the emergency. They should consider:
 1. Where does she live? With whom? Does this put her at higher risk?
 2. What are her daily responsibilities in order to sustain herself and her family? Does this put her at higher risk?
 3. Where does she go if she needs help? Does this put her at higher risk?



- ❖ You can also give an example case study.
- ❖ Give each group up to 30 minutes to answer the above questions. As each group finishes, put their flipcharts on the walls.

GALLERY WALK & PLENARY: Discussion – 25 min.



- ❖ Give participants five minutes to do a brief gallery walk and to see how other groups have developed their case studies of the girl child, adolescent girl, and woman.



- ❖ Wrap up and summarize what we know about risks to women and girls in conflict and in natural disaster.
- ❖ Transition from the discussion of what women and girls experience in emergencies into a brief reminder of the consequences of GBV; ask participants what the consequences of these experiences might be. Ensure the following points are highlighted:

- Physical consequences such as: bruises, open wounds, broken bones, internal injuries, permanent disabilities (up to and including death).
- Mental & Psychological consequences such as: depression, anxiety, panic disorders, sleeping disorders, flashbacks, low self-esteem, suicidal tendencies.
- Sexual and reproductive consequences: Sexually transmitted infections, unwanted pregnancy, pregnancy complications, sexual dysfunction, miscarriage
- Behavioral Consequences: Alcohol and drug abuse, sexual risk-taking, self-harm.
- Economic & Social consequences: Stigma, social isolation, rejection, loss of wages/earnings.
- Consequences for the family and community such as break-down of family and community structures, impacts on children of witnessing violence, loss of income for the family, etc.



- ❖ Explain that this training focuses on sexual violence, because it is an extremely prevalent form of violence in emergency contexts, because the risks of significant injury, permanent harm or even death are high, and because concrete actions can be taken to prevent these consequences from occurring. However, other forms of violence are also prevalent in - and exacerbated by - emergencies. If you are using slides, present the following quote from the IASC Guidelines. If you are not using slides, highlight the key terms (bolded below) on a flip chart:

*Because of its immediate and potentially life-threatening health consequences, coupled with the feasibility of preventing these consequences through medical care, addressing **sexual violence is a priority in humanitarian settings**. At the same time, there is a growing recognition that affected populations can experience various forms of GBV during conflict and natural disasters, during displacement, and during and following return. In particular, intimate partner violence is increasingly recognized as a critical GBV concern in humanitarian settings.*

*These additional forms of violence—including **intimate partner violence** and other forms of domestic violence, **forced and/or coerced prostitution, child and/or forced marriage, female genital mutilation/cutting, female infanticide, and trafficking for sexual***

*exploitation and/or forced/domestic labor—must be considered in GBV prevention and mitigation efforts according to the trends in violence and the needs identified in a given setting.*¹²

- ❖ Ask participants to share any questions, and discuss.

PLENARY DISCUSSION: Principles of GBV work and Interaction with Survivors – 20 min.

- ❖ Refer to the four guiding principles on the wall – Safety, Respect, Confidentiality, Non-Discrimination. Hand out example cards (Annex 7) to participants, and ask them to place their examples under the relevant heading. Each card may present an example of respecting or not respecting the principle – this will make participants think a little more deeply about the examples, and may prompt some discussion.



- ❖ Once all cards are on the wall, discuss as a group – make sure that cards are correctly identified as either respecting or not respecting the principle. Present the following information as an overview of the exercise.

- ❖ **SAFETY** - Make sure that the survivor is safe now, and avoid putting her in more harm
- ❖ **RESPECT** - Allow the survivor to make her own decisions and trust that she is capable of doing so.
- ❖ **CONFIDENTIALITY** - Do not share the survivor's case with anyone she does not give consent or permission to know. Do not tell your friend, mother, sister, or husband. If you discuss this case with your clinical supervisor, do not share identifying details.
- ❖ **NON-DISCRIMINATION** - Do not judge the survivor for what happened to her, do not ask her why she thinks it happened or what she could have done to cause it, do not limit the care that you provide her based on the information she tells you about her case. Do not limit care based on any characteristics of the survivor.
- ❖ Note that these guidelines apply to everyone interacting with women, girls, and particularly survivors of GBV.



- ❖ Explain that everyone interacting with survivors must do so in a positive, supportive, affirming and empowering way.
 - **Listen actively** to a survivor's story. Use gestures, eye-contact, sounds (e.g. uh-huh) and words (e.g. I see) to show you are listening.
 - Show that you **believe** her. Do not question or judge why she acted in a certain way - accept that she made the best choices she could in difficult situations.
 - When the survivor shares information, use **healing statements** to comfort her:
 - *I am sorry that happened to you.*
 - *It's not your fault.*
 - *You are safe right now.*
 - *I am here to support you.*
 - *I believe you.*
 - *I will do my best to help you.*
- ❖ Ask participants to keep these guiding principles and interactions in mind for the rest of the training.

¹² Ibid.

SESSION 3: ASSESSMENT INTRODUCTION & ETHICS



Learning Objectives:

- Understand why and how we gather information to inform GBV interventions in emergencies.
- Understand ethical considerations when designing and carrying out assessments.



Time: 1 hour 15 minutes



Materials required: Projector, screen, flipcharts, markers, tape.



Facilitator Preparation:

- Review relevant slides.
- If you are not using slides, prepare a flip chart with the WHO ethical and safety principles, as described in the session below.
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.
- Ensure participants have a copy of the scenario from the previous session.



PLENARY: Why gather Information? – 20 min.



- ❖ Open the session by asking the participants why it's important to gather information prior to starting a GBV response at the onset of an emergency. Highlight the following objectives:
 - To identify and improve understanding of:
 - the nature of violence against women and girls;
 - risk factors for violence;
 - available services;
 - gaps and needs for further intervention.

- ❖ Ask participants if we need to conduct an assessment to 'prove' that GBV is happening in the emergency context. Discuss.
- ❖ Explain that we should always assume a) that GBV is occurring in all contexts and that it is being exacerbated by an emergency, and b) that given the sensitive and taboo nature of GBV, we should assume that we will never get accurate data about the incidence of violence until quality, confidential services are established.



- ❖ If you are using slides, show the following quote from the IASC GBV Guidelines. If you are not, write the bolded sections on a flip chart:

*It is important to remember that **GBV is happening everywhere. It is under-reported worldwide, due to fears of stigma or retaliation, limited availability or accessibility of trusted service providers, impunity for perpetrators, and lack of awareness of the benefits of seeking care.** Waiting for or seeking population-based data on the true magnitude of GBV should not be a priority in an emergency due to safety and ethical challenges in collecting such data.*

*With this in mind, **all humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions ... regardless of the presence or absence of concrete 'evidence'**.*¹³

¹³ Ibid.

- ❖ Explain that GBV assessments are not about determining whether GBV is occurring, but rather about better understanding the context, dynamics of violence and the existing services to determine what kind of services and activities are appropriate and feasible. Moreover, a strong contextual understanding of the dynamics of violence is vital to ensuring that response services – and risk mitigation activities – do not inadvertently expose survivors to further harm, such as exacerbating tensions between ethnic or religious groups.
- ❖ Note that while these guidelines are internationally recognized and accepted, many NGOs and coordinating agencies will continue to press for incidence data to justify interventions – to address this, you will need to continue to advocate, explaining that this data is both unnecessary and impossible to get without quality service provision.



- ❖ Ask & discuss: if GBV assessments do not aim to find out *if* GBV is happening in the given context, then what is their objective? What might GBV assessments aim to do?
- ❖ Explain that rather than proving the existence of GBV in a given context, GBV rapid assessments aim to gather more information about the following:
 - **What is happening?**
 - *What is the problem and what are the priorities?*
 - *What type of violence is occurring? Why is it happening?*
 - *Do women and girls have other needs that are not being met?*
 - **What interventions will best address the problem?**
 - **What is already being done to address the problem and who is doing it?**
 - **What could and should we do to complement these efforts?**
 - *What is our capacity to implement these interventions?*
 - *What resources are available?*



- ❖ Ask participants why they think it might be important to conduct GBV-specific assessments. Highlight the following:
 - Multi-sector situational analysis often misses the gender/GBV perspective of the context. GBV response actors need to be proactive and advocate to be part of the situational analysis team to ensure that gender/GBV perspective is encompassed throughout the development, implementation and analysis.
 - Because of the complexities of GBV during emergencies it is necessary that additional information specific to the risks women and girls face as well as the available GBV response services is also gathered.
 - The best information about the safety and wellbeing of women and girls comes from women and girls.
 - Triangulate. Talking to a variety of key informants will provide a holistic view of the situation however; because women and girls are not always a part of the decision-making apparatus, GBV responders (and all humanitarian actors) should make a concerted effort to reach out to women and girls.



- ❖ Note that the approach is important when collecting information at the onset of an emergency:
 - Rapid assessments are necessarily limited because time is short and services must be established as quickly as possible.
 - In an emergency context, the urgency of the situation means that it is not possible or desirable to conduct thorough research or gather baseline data. The emphasis should be on rapid assessments, which will provide enough information to inform the beginning of essential, life-

saving programming while not overburdening staff or women and girls. Conducting rapid assessments will be an ongoing process as the context is rapidly evolving.

- issues that will help get the initial interventions started.
- Lastly, any assessment related to GBV must adhere to ethical standards, which you will explore more in the next part of the session.

PLENARY: Ethical Considerations When Gathering Information - Introduction to the WHO recommendations – 10 min.

- ❖ Ask participants what they think the safety or ethical issues might be when gathering information about GBV at the onset of a crisis and why.
- ❖ Explain that a necessary, initial question when considering information collection is whether the information sought is actually required. In some situations, there is a risk that sexual violence is being over-researched and over-assessed. In some cases, this has resulted in potentially avoidable harm to women and girls, while not yielding any new or additional information or understanding about the problem.
- ❖ Remind participants that **'all humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions ... regardless of the presence or absence of concrete 'evidence'**. This means that we do not need assessments to 'prove' that GBV is happening in any given context, so a lack of concrete data about the prevalence rate (the percentage of the population that has experienced sexual violence) is not a strong enough reason to start collecting data about sexual violence.
- ❖ Explain that the World Health Organization has developed a set of ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies (noting that although they were developed specifically for sexual violence, these rules can and should be applied more broadly to GBV in general). Present – or write on a flipchart – the WHO rules that must be followed when collecting information about violence:



While the WHO presents these as recommendations, you can describe them in whichever way makes the most sense in your context. This guide describes them primarily as 'rules' to ensure that participants understand their importance.

1. The benefits of documenting sexual violence must be greater than the risks to survivors and communities.
2. Information gathering and documentation must be done in the manner that prevents the least risk to survivors/participants, is methodologically sound, and builds upon current experience and good practices.
3. Ensure the availability of minimum services for survivor support before asking any questions about sexual violence in a community.
4. The safety and security of survivors, respondents, participants, the community and the information collection team is paramount and requires monitoring and attention in emergency settings.
5. Protect the confidentiality of all survivors, respondents, and participants.
6. Each survivor/respondent/participant must give her/his informed consent before participating in the data gathering activity.
7. All team members must be carefully selected and receive relevant and sufficient specialized training and ongoing support.

8. Additional policies, practices, and safeguards must be put into place if children – anyone under the age of 18 – are to be involved in information-gathering.

SMALL GROUP DISCUSSION: Connecting information collection rules to GBV Guiding Principles – 20 min.

- ❖ Divide participants into four groups and assign two of the rules to each group. If you want a particular focus on children in your training, assign one group to work exclusively on rule 8 and divide others accordingly – otherwise, group rules 1 & 2, 3 & 4, 5 & 6, 7 & 8. Give participants 10 minutes to describe how the rule relates to the GBV Guiding Principles (Safety, Respect, Confidentiality and Non-Discrimination). Ask them to give practical examples of how this rule helps to uphold particular principles.
- ❖ Feedback in plenary and discuss.
- ❖ If needed, use the following key points around involving children in information-gathering:
 - Children and adolescents face particular GBV risks. As well as those already discussed in the introduction to GBV, some children may have been forcibly recruited as combatants, and therefore be perpetrators and/or survivors of GBV. Child soldiers who have recently reunited with their family may face discrimination, which could affect their ability to access services.
 - However, while it is important to gather information about the problems facing children, and their needs and priorities, there are serious risks involved in interviewing children, and especially young children – their safety may be put at risk, specialized services for children are often not in place, and skilled interviewers are generally unavailable.
 - Other methods/approaches for gathering information related to sexual violence towards children may be used that do not involve putting them at risk, including the use of secondary sources of information (teachers, social service workers, health workers, leaders, concerned parent groups, women’s groups, etc.). In addition, you can ask women and older girls (if you can safely involve them in information-gathering) about the risks that younger girls face, where they can access services, and what the barriers might be to those services.
 - Determining acceptable and appropriate ages when adolescents may be able to give consent without parental involvement requires understanding of the applicable laws, culture, and context as well as careful evaluation of security and other issues in the setting - as a general guideline, consider children over 15 years old.



See Annex 10 for additional resources on ethics and safety in information gathering.

SMALL GROUP DISCUSSION: Applying information collection rules to our scenario – 15 min.

- ❖ Ask participants to remain in – or return to – their groups. Remind participants of the scenario used in the previous session (show on screen or make sure participants have their printed copy).
- ❖ Ask each group to think about the following questions, in this context:
 - What information is needed?
 - Can the information be gathered in a way that respects the ethical and safety rules they worked on in the last exercise?

PLENARY: Discussion & Wrap-Up – 10 min.

- ❖ Ask each group to briefly present their findings and discuss whether there is enough added benefit to put women, girls and your staff at risk in undertaking an assessment – and if an assessment went ahead, what its focus would be.

SESSION 5: CARRYING OUT AN ASSESSMENT



Learning Objectives:

- Introduce different types of assessments.
- Determine which assessment tools to use in diverse emergency settings.



Time: 1 hour 15 minutes



Materials required: Projector, screen, GBV Assessment Toolkit (Annex 6), cards for Assessment Toolkit Practice (Annex 7).



Facilitator Preparation:

- Review relevant slides.
- Put the headings (“Who”, “Purpose” and “What’s needed”) of the columns on the wall, and list the different assessment tools down a flip chart so it makes a blank outline of the table below.
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.
- Prepare handouts and cards (characters as well as those to attach to the wall) for assessment tool practice (See Annex 7)



PLENARY: Assessment Tools – Introduction – 10 min.

- ❖ Ask participants what kinds of tools they currently use to gather what kinds of information. Lead a brief discussion on these tools and how appropriate they are in emergency contexts.
- ❖ Introduce the GBV Emergency Assessment Toolkit, passing out samples of each tool.
- ❖ Remind participants of the scenario they reviewed in Session 2.
- ❖ Divide the participants into the following approximate sized groups.
 - 4 participants will do the Safety Audit case study
 - 9 participants will do the Service Mapping role play
 - 8 participants will do the Community Mapping role play
 - 6 participants will Key Informant Interviews role play



There are four exercises below. It is up to the facilitator to decide how many of the following exercises they would like to do concurrently during this session. If you have at least two facilitators, it is possible to have all four exercises happening simultaneously by having one facilitator supporting the safety audit + service mapping exercises and the other facilitator supporting the community mapping + the key informant interviews. When starting, the facilitators should ask all the groups to read the general scenario first. While they are reading, the facilitators should approach the safety audit group and the key informant groups first and explain the instructions. These exercises are relatively self-explanatory and they will need little monitoring once they start. This will allow the facilitators to provide more in-depth facilitation for the service mapping exercise and the community mapping exercise, which are more complicated and need ongoing guidance.

SMALL GROUP: Practicing the tools – 40 min.

The Safety Audit Exercise

Preparation:

- ❖ Cut the scenarios from the “Safety Audit Role Play Cards” handout into different sections.
- ❖ Post the different sections along the wall. Mix it up. There doesn’t have to a specific order.

Exercise:

- ❖ Ask the participants to go to a card and read it.
- ❖ After reading the card they can fill out their Safety Audit tool according to the information they learn from the card.
- ❖ They will proceed to the next card and continue to fill out the form.

The Service Mapping Exercise

Preparation:

- ❖ Cut the scenarios of the different roles from the “Service Mapping Role Play Cards” handout.
- ❖ Choose two participants. They will ask questions and fill in the Service Mapping assessment form.
- ❖ Give the other participants a card with a scenario of a service provider. They should read to understand the information that they need to give in their role play.
- ❖ Allow them 10 minutes to read.

Exercise:

Role Play: 30 minutes

- ❖ Ask the two participants to be “facilitators” from an NGO.
- ❖ They are responsible to conduct a Service Mapping meeting with other local service providers. They are to fill out the form as they facilitate the meeting. They will ask each “service provider” at a time questions that will allow them complete the form.
- ❖ The other participants will role play the “service provider” on their card.
- ❖ They will give information from the cards as the “Facilitators” ask them questions about their services.



Coach participants to probe for information. Suggest to the participants who are leading the meeting that they should start with the psychosocial service providers first. This will give “health workers” extra time to read through their scenarios which are a little longer.

Community Mapping

Preparation:

- ❖ Before the training prepare 3 identical maps based on the scenario.
- ❖ Cut the cards with information for the groups from the “Community Mapping” Handouts – where relevant and possible in the context, you can add additional information to your characters such as ethnicity, religion, LGBTI status, etc.
- ❖ Identify objects (like sticks, rocks, similar colored bottle caps, etc.) that can be used to signify safe areas in the locale for women and girls, unsafe areas in the locale for women and girls, and places that women and girls would go to seek help/support
- ❖ Explain to the participants that in actual community mapping exercise, the facilitator would ask the community members to make the map before going through this process. Often communities draw it in the dust or by using objects like sticks, leaves, pebbles, bottle caps, etc.
- ❖ Explain that in actual community mapping, you would conduct the discussions wherever possible with separate groups of women, and older girls.
- ❖ Divide the group into the following and give them name tags:
 - Two participants will be responsible for facilitating a Community Mapping exercise in a community
 - Two participants will play the roles of women in the community
 - Two participants will play the roles of community leaders in the community
 - Two participants will play the roles of service providers in the community
- ❖ From the objects you collected, ask the two “facilitators” to find objects that they can use to signify safe areas in the locale for women and girls, unsafe areas in the locale for women and girls, and places that women and girls would go to seek help/support. For instance, they could use

green caps for safe areas, red bottle caps for unsafe areas, and pebbles for places that women and girls would choose to get help/support. They should talk with each other about how they plan to conduct the mapping exercise to ensure that all participants can contribute equally.

- ❖ Give the “women”, “community leaders”, and “service providers” their corresponding cards that list what they might think are safe areas for women and girls, unsafe areas for women and girls, and places that women and girls would go to seek help/support

Role Play: 30 minutes

- ❖ The “facilitators” will ask the “women” to work on one map, “community leaders” to work on another map, and the “service providers” to work on the third map. For each group, they will ask them to place:
 - one type of object on areas on the map that women and girls feel safe; (5 min.)
 - Another object where women and girls feel unsafe; and (5 min.)
 - Another object on the places where women and girls would go to find help/support if they were harmed. (5 min.)
- ❖ The “women”, “community leaders”, and “service providers” will place the objects on the areas according to their cards and the scenario.
- ❖ Once they have finished, the participants will ask the groups to do a gallery walk and facilitate a discussion that notes the similarities and differences between the maps. (20 min.)

Key Informant Interviews

Preparation:

- ❖ Divide the group into pairs
- ❖ Give each participant cards from the “Individual Interview Role Play Cards” Handout. These are scenarios of key informants. Where relevant and possible in the context, you can add additional information to your characters such as ethnicity, religion, LGBTI status, etc.

Role Play: 30 min.

- ❖ The participants will alternate. One will fill out the Key Informant Form while the other participant will role play the service provider as illustrated on the card.
- ❖ Once the one participant has finished filling in a questionnaire, they will switch roles.
- ❖ They will continue switching roles until the practice session is over.

PLENARY: Report Back & Discuss – 25 min.

- ❖ Ask volunteers from each group to discuss their general impressions about filling in the assessment tools. What did they find difficult? What surprised them? Etc.
- ❖ Highlight that during an emergency information is needed quickly. The best way to get ready and be comfortable doing assessments in high pressured context like an emergency is to practice, practice, practice.
- ❖ Based on their experience in the practice exercise, facilitate a discussion with participants on the purpose, advantages and drawbacks of each tool (you can use the following table as an empty format to prompt discussion, or to summarize).



| Tool | Who/Where? | Purpose | What’s needed |
|--------------|--|--|--|
| Safety Audit | Women, older girls. Most useful in small, well-defined communities, camps, or | Want to determine where there are potentially unsafe areas for women and girls | Skilled team available, able to observe, remember and later record |

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| | | | |
|--------------------------|--|---|--|
| | other clearly delineated settlement areas | | |
| Service Mapping | Service providers, women, older girls | Want to determine who is doing what, where for assist women and girls | Setting with many actors / service providers Cluster system (or local-level coordination mechanism) activated and able to support |
| Focus Group Discussion | Women, girls, boys, men. Conducted in groups. Safe, private, confidential space | To understand the problems that women and girls face as perceived by different segments of the community, and particularly by women and girls | Skilled team available Participants from similar backgrounds Community expresses willingness to talk Safe for respondents to answer questions |
| Key Informant Interviews | Community leaders, camp managers, service providers, women's group leaders/representatives, individuals who may have specific information about the situation of women and girls or services | To get an in-depth understanding of the problems women, girls and GBV survivors face and to understand the extent that particular services are available in the area to help women, girls and GBV survivors | Services are available Respondents have the knowledge to answer questions Safe for respondents to answer questions |
| Interviewing survivors | Survivors | Trick question – we should not be interviewing survivors | ----- |



- ❖ Highlight the importance of triangulating information to ensure a wide range of perspectives. It is best to use a combination of assessment tools as they all have strengths and weakness.
- ❖ Note that some assessments (such as service mapping, for example) must be conducted regularly in order to remain current – particularly in conflict, where the situation may change rapidly and frequently.
- ❖ Explain that the tools are templates that need to be adapted to each emergency context. Adapting the tools should be a collaborative process, involving at minimum women staff, and ideally women from the location where the tool will be used. The simplest way to adapt tools is to bring together a small group of people and go through the tool together, looking for issues of language, relevance, appropriateness, contextual challenges, or whether the questions are appropriate to the setting (e.g. camp vs. urban displacement), what can be discussed and any risks it may create, and the process of using the tools (e.g. the time needed, flow of content, etc.).



See Annex 10 for additional support in adapting assessment tools to the context.

DAY 2

INTRODUCING THE DAY

- ❖ Ask participants in plenary to identify the key discussions from the previous day. This can be done popcorn-style with individual participants giving one element/answer each, or you can ask one participant to give a brief summary of the day's topics and key learning points.
- ❖ Present an overview of the Day 2 agenda
- ❖ Conduct a brief self-care activity.

| Day 2 | |
|---------------|---|
| Time | Session |
| 9:00 – 9:30 | Introduction to the Day (including 15 mins self-care/energizer) |
| 9:30 – 10:30 | 5 – Introducing the Program Model |
| 10:30 – 10:45 | Tea/Coffee Break |
| 10:45 – 12:00 | 6 - Case Management |
| 12:00 – 13:20 | 7 - Psychosocial Support |
| 13:20 – 14:20 | Lunch Break |
| 14:20 – 15:30 | 8 - Health Response |
| 15:30 – 15:45 | Tea/Coffee Break |
| 15:45 – 16:45 | 9 – Referral Systems |
| 16:45 – 17:00 | Wrap Up |

SESSION 5: INTRODUCING THE PROGRAM MODEL



Learning Objectives:

- Introduce the GBV Emergency Response Program Model a framework of interventions to address violence against women and girls during emergencies.



Time: 1 hour



Materials required: Projector, screen, PPT; Program Model Poster (if possible – where it is not possible to print a large version of the program model, participants can refer to it in their handbooks); flip charts with Program Model titles (see below), post-it notes.



Facilitator Preparation:

- Review relevant slides.
- Prepare flip charts with the goals and objectives of the Program Model, as described below, and attach them to a large wall. Ensure that the Program Model has been translated into appropriate languages for your location – even if you do not have a translation of all training materials, the Program Model is key.
- Print Safety, Respect, Confidentiality, Non-Discrimination cards (Annex 7) and attach to the wall next to each other, with space below. Print example cards (Annex 7).
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.



PLENARY: Introducing the GBV emergency response program model – 15 min.

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- ❖ Explain that you will now move on to looking at what kind of programming is appropriate and effective in responding to GBV and reducing risks for women and girls.
 - ❖ Explain that the IRC has developed a model for GBV programming in emergencies, based on years of experience in conflict and natural disasters. The program model has its foundation in the IASC GBV Guidelines, but operationalizes those guidelines by providing a framework for concrete action. The rest of the training will allow participants to examine each pillar of the model in greater detail.
- 4-8
- PH 44
- ❖ Present and explain the Goal and Objectives of the program model (the top two rows of the image below).



Some participants may be less familiar with the structure or function of logical frameworks. If this is the case, briefly explain the different levels of logic, and that these represent 'if, then' logic flows – e.g. 'If we achieve X, then Y will occur'.

Goal: Women, Girls & Survivors are Protected from Harm and Supported to Recover and Thrive

| Objective 1: Survivors of GBV access appropriate services in a safe and timely manner. | | | | | Objective 2: Women & girls face reduced risks of violence. | | | | Objective 3: Policies, systems, funding prioritize women, girls, and survivors. |
|---|--|---|---|--|--|---|---|---|---|
| Outcomes: | | | | | Outcomes: | | | | Outcome: |
| Survivors of GBV have safe access to health services, in line with WHO's guidelines for the clinical management of... | Survivors of GBV have safe access to emergency GBV case management services. | Women, girls, and survivors of GBV have safe entry points to psychosocial services. | Survivors of GBV safely navigate referral pathways and benefit from well-coordinated services | Communities know which GBV-related services are available and how to access them | Women and girls access material and cash-based support to help meet immediate needs. | Humanitarian actors across sectors identify and address risks to women & girls. | Communities support women, girls, and survivors of GBV and promote women's networks and spaces. | Communities are aware of the risks women and girls face and develop strategies to reduce those risks. | Decision-makers act to improve the protection of women and girls. |

SMALL GROUP WORK: Filling in the program model – 25 min.

- ❖ Divide participants into groups of three or four.
- ❖ Assign each group to one of the program model objectives (some objectives may have more than one group), and ask them to think about the key activities that the group deems necessary to ensure minimum response to and prevention of GBV. They should write each of the activities they choose on individual cards or post-it notes.
- ❖ Have them tape each activity under the appropriate outcome that is posted on the wall.
- ❖ Ask one or two participants to explain one of the activities that their groups listed. Ask other groups to complement and/or add activities that have not been mentioned.

PLENARY: Reviewing the full program model – 20 min.

- ❖ Ask participants to turn to the GBV Emergency Response Program Model in their Participant Handbook (Page 29).

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- ❖ Review each outcome and the key activities - ask volunteers to read activities and check for understanding. Guide a discussion of whether each activity is suited to the outcome in which it sits in this model, or whether it would be better suited elsewhere, and why. Note that the model is simply a way of organizing thinking and programming, and that in reality there may be overlap, activities may contribute to several different outcomes.



- ❖ Note that the IRC GBV ER&P Program Model is targeted at both women *and* girls. Even where this is not specifically highlighted in the model, all response and risk reduction activities should explicitly consider the different risks, needs, and priorities of girls as compared to those of women, and take steps to address them. Adolescent girls may be at particular risk in emergencies – Activities established for ‘youth’ (e.g. educational activities, safe spaces) may not specifically target them and as a result they may slip through the cracks.
 - Additional risks - for example, of sexual exploitation in exchange for access to economic or educational activities, or of early marriage as parents try to reduce the burden on families or attempt to protect their daughters from other forms of violence.
 - Reduced support structures & barriers to access – girls may feel unable to communicate with adults about their problems, particularly if those will be perceived with judgment (for example, if a girl experiences sexual violence she may be told it is her fault).
 - Different needs and priorities – adolescent girls face particular physical risks upon experiencing sexual violence due to underdeveloped reproductive systems, and may also have different priorities in terms of other services. For example, menstrual hygiene materials may be particularly important for this age group.
 - Increased responsibilities – In emergencies, girls may be tasked with more family and household tasks, such as collecting firewood or water which further expose them to risk.
 - Lack of targeted activities – Many activities are targeted towards children, youth or adults. Adolescent girls do not benefit from general ‘youth’ activities, which are often dominated by boys, but do not fit either in adult women or children’s services.



- ❖ Additionally, note that all services and activities, including in emergencies, must be inclusive of women and girls with physical and intellectual disabilities, as well as their caregivers. Supporting women and girls with disabilities means considering physical access when choosing or establishing locations for services (e.g. is there a steep hill or stairs that would block access for women with limited mobility) as well as considering how women and girls with speech, hearing, mobility, mental or intellectual difficulties will be able to access services and what kinds of resources may be needed. Specific issues for including individuals with disabilities are discussed in the relevant sections.



See Annex 10 for additional support on working with children, adolescent girls, and women and girls with disabilities.

- ❖ Introduce the additional Program Model guidance included in Annex 5 – explaining that this content has been developed to provide more information on activities in the program model, as well as how organizations can approach this work from the point of view of their existing programming.



It may be helpful to put a flip chart on the wall with a list of categories of women and girls who may be particularly vulnerable, need additional support, or who are often overlooked in programming – such as adolescent girls, women with disabilities, etc. Depending on the context, this may include ethnic or religious minorities or other demographic issues such as residency status (for example IDP or refugees will likely face different risks and require different inputs to static residents. You can add to the list as the training progresses and different groups are mentioned, using the list as a visual reminder to consider these groups in each session/discussion.

SESSION 6: CASE MANAGEMENT DURING AN EMERGENCY



Learning Objectives:

- Understand the key steps of case management in emergency contexts.



Time: 1 hour 15 minutes.

NB. If you have two strong facilitators, this session can be run concurrently with the previous session on case management, to build off and discuss the connections and similarities between the two areas – this will also save time, leaving you an extra cushion for discussion. If you decide to run the sessions concurrently, ensure that some participants from each organization are in each group. Use 1 hour 30 minutes for the core content (without the reflection activity) with each group, then bring both groups back together and have them present the key learning from their session to the other group (30 minutes). Lastly, use 15 minutes for the individual reflection activity.



Materials required: Projector, screen, Psychosocial Support & Case Management handout (Annex 7).



Facilitator Preparation:

- Review relevant slides.
- Prepare five pieces of paper with Assess, Plan, Implement Plan, Follow-up & Review, and Case Closure written on them.
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.



PLENARY: Introduction – 15 min.

- ❖ Explain that this session is not intended to teach participants how to do case management. Rather, it is intended either for participants who are already case management practitioners but need further information on how to adapt their services to emergency contexts, *or* for non-case management service providers who need an overview of the process to be able to provide effective information and referrals. Case management is a specialized discipline in which practitioners of the approach are specifically trained and supervised to do case management. If your participants are not case management practitioners, **they should not attempt to establish new case management services in an emergency.** This is not only ineffective but potentially harmful.
- ❖ Ask participants what they understand case management to be. Show the following case study (or if you are not using slides, read it aloud):



Anne is 19 years old. She was raped by a stranger when she was in the forest collecting firewood. Anne was frightened and told the story to her auntie. Her auntie had heard that an organization working in the area could help girls “who have problems.” With her auntie’s encouragement, Anne went to the INGO offices and shared her story with a GBV caseworker.

What will the caseworker do?

- ❖ Take a few suggestions from participants, and then use this to lead into the definition of case management:



Case management is a collaborative, multidisciplinary process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's needs through communication and available resources to promote quality, effective outcomes.



- ❖ Ask participants to remind everyone of the GBV guiding principles, which should guide all case management work:
 - Safety
 - Respect
 - Confidentiality
 - Non-Discrimination

PLENARY: Steps of case management – 40 min.

- ❖ Give out pieces of paper with Assess, Plan, Implement Plan, Follow-up & Review, and Case Closure written on them. Ask participants to collaboratively line the participants up in order according to the step of case management they are holding. Ask participants to outline the key elements of each step as you go to ensure that everyone has a general idea of the process. Use the following information to guide, if not brought up by participants.



- **Assess** - Why has the client come for help? What has happened? How does the client see the situation? What needs does the client have? What support does the client have? Listen to the client's story, help her to identify her needs
- **Plan** - What does the client want to happen next? To help a client plan how to meet those needs and solve problems, we give relevant information about available services. This step includes the identification of risks and safety planning around those risks, which are particularly important in emergency settings.
- delivery, referral for services not provided, advocacy on behalf of the client and supporting her throughout the process
- **Follow-up and Review** - Follow up to make sure the client is getting the help and services she needs to improve her situation and solve her problems. Is the situation better? Has the help been effective?
- **Case Closure** - This usually happens when the client's needs are met and/or her own support systems are functioning



- ❖ Explain that case management is normally a long-term process which can take many months. In emergencies, there are many elements of case management that may not be possible, given the security context, displacement, lack of staff, lack of dedicated spaces, increased caseload/overwhelming demand and other factors. Therefore:
 - You may only see a survivor once
 - Follow-up may not be realistic or possible
 - Case management may not happen within a formal structure
 - Transport or accompaniment may be very important
 - The focus is on the most essential needs or services that a survivor needs
- ❖ Ask participants to decide as a group which steps are prioritized in emergencies, and why. Discuss the participants' reflections in plenary, highlighting the first three steps. Emphasize the importance of the first interaction /engagement with a survivor in the case management process during the acute emergency. This is our opportunity to provide basic emotional support, to assess her needs, provide information and make a plan, and in some cases to accompany her to the first point of referral.

PLENARY: Review & Discuss – 10 min.



- ❖ Review and discuss the action points in the GBV Emergency Response Program Model on case management.
- ❖ Remind participants of the following key elements in case management:
 - The client is the primary actor in case management.
 - Action plans are developed in collaboration with the client and must reflect her wishes and choices.
 - The goal is to empower the client and ensure that she is involved in all aspects of the planning and service delivery.
 - Services should be appropriate and accessible for all women and girls. This includes ensuring that difficult-to-reach populations have safe access to services, and ensuring access for ethnic and religious minorities. It may mean integrating GBV activities into other services or locations (e.g. health centers) or using other activities to provide a discreet entry point to GBV-specific activities (e.g. generic women’s activities allowing survivors to access case management without showing that this is the case).
 - For work with girls, is it essential to ensure that communication is appropriate and that girls (and their caregivers) are able to give informed consent (or assent) in line with their level of development.
 - In order to ensure the inclusion of women and girls with disabilities, ensure that chosen sites for case management are physically accessible and that case workers are briefed in issues of communication and consent in relation to different disabilities.
- ❖ Ask for any questions and discuss.



See Annex 10 for additional support on working with girls and survivors with disabilities.



INDIVIDUAL REFLECTION – What Does This Mean for Me? – 10 min.



- ❖ Explain that now that we all understand the key elements of case management in emergencies, you are going to spend some time reflecting on what this means for each of them as individuals and for their organizations.
- ❖ Ask each person to spend 5 minutes filling out the relevant template in their Participant Handbooks:
 - Does my organization already do Case Management? If yes, how can I make sure my services are adapted to the emergency context? If no, what is my role in relation to Case Management (e.g. as an entry point/connector, sharing relevant information in communities, making referrals, working together with case management agencies or organizations, etc.)?
 - What steps do I need to take to ensure that this takes place?
 - Are there any risks for me as an individual and for my organization in taking these steps? How can I manage them?
- ❖ Remind participants that if they are not already case management practitioners, who have received relevant training, this particular training does **NOT** qualify them to begin to provide case management services, in an emergency context or otherwise.

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- ❖ After 5 minutes, ask participants to share with someone else from their organization and add or adapt as necessary. If there is no-one else from the same organization, participants can share with another individual. Encourage participants to ask questions or seek clarification from you as necessary.



This kind of self-reflection does not come naturally to all groups. It can be valuable to push groups who do not feel fully comfortable with it to do it anyway – sometimes, the discomfort can be a result of participants wanting to be taught what to do, rather than having to think for themselves about what they would do or how they would do it. If you know, or find during the exercise, that this will really not work for your participants, you can skip the individual reflection parts of each session and instead use the time at the end of the day to discuss key questions or fill out a table (see page 107 of the Participant Handbook) combining information from each session, which will provide a useful summary for the preparedness session later in the training.

SESSION 7: PSYCHOSOCIAL SUPPORT DURING AN EMERGENCY



Learning Objectives:

- Understand the psychosocial impact of GBV.
- Identify the most appropriate psychosocial approaches to ensure minimum response in diverse emergency settings.



Time: 1 hour 20 minutes

NB. If you have two strong facilitators, this session can be run concurrently with the previous session on case management, to build off and discuss the connections and similarities between the two areas – this will also save time, leaving you an extra cushion for discussion. If you decide to run the sessions concurrently, ensure that some participants from each organization are in each group. Use 1 hour 30 minutes for the core content (without the reflection activity) with each group, then bring both groups back together and have them present the key learning from their session to the other group (30 minutes). Lastly, use 15 minutes for the individual reflection activity.



Materials required: Projector, screen, colored labels/stickers/post-its, Case Management and Psychosocial Support Guidance Note (Annex 7).



Facilitator Preparation:

- Review relevant slides.
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.
- Prepare labels for the ecological model exercise – choose one of the women or girls discussed as case studies in Session 2: Women, Girls and GBV in Emergencies, and adapt numbers and titles as required (e.g. if it is a child survivor, include parents rather than daughter in family). (1 Blue label – “{insert name of survivor here}”, 4 pink labels – “Family”: Daughter, uncle, sister, father, 8 orange labels – Support group/peers: 4 friends, 2 neighbors, 2 classmates, 14 green labels – “Community”: 2 psychosocial workers, 2 community outreach staff, 2 community leaders, doctor, nurse, pastor, imam, 2 teachers, 2 police). Where relevant in the context, you can specify the ethnicity and/or religious background of characters, ensuring that different groups are represented.
- Prepare three flip charts titled ‘Individual/one-on-one support’, ‘group support with women’, ‘group support with girls’, and ‘interventions with family’.



EXERCISE: Effects of a Crisis on the Ecological Model – 20 minutes

- ❖ Explain that you are going to do an exercise based on the story of {insert name of survivor here} who was one of the case studies discussed in the earlier GBV and Emergencies session.
- ❖ Choose an individual to be the survivor. Give her a label with her name on it.
- ❖ Ask 4 participants to make a circle around her and hold hands. They get labels under “Family”.
- ❖ Ask 8 participants to make a circle around the “Family” and hold hands. They get labels under “support groups/peers”.
- ❖ Ask the rest of the participants to make a circle around the “support groups/peers” and hold hands. They get labels under “broader community”.

Part 1: Healthy Society

- ❖ Ask everyone to place a hand on the shoulder of someone in front of them.

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- ❖ Explain that in a healthy society, each ring of people (individual, the family, peers/support groups, and the broader community) helps each other. This is both the direct and indirect support that an individual receives. For a survivor, this support will help her rebuild trust, feel confident to make decisions for herself, and feel accepted.

Part 2: What happens when GBV happens in a stable situation

- ❖ Keep people in the circle as they are.
- ❖ Tell the participants that you will be tap some of them on their shoulder.
- ❖ When they feel the touch, they should turn to the survivor and make a common ugly remark that is often said in their community to shame a survivor, and then leave the circle.
- ❖ Touch 12-14 random participants on their shoulders except for the survivor and make sure that they are from each ring - family members, friends/colleagues and the broader community.
- ❖ Ask everyone who remains in the circle to place a hand on the shoulder of someone in front of them without moving.

- ❖ Discuss:
 - What is the difference from before?
 - How many of you are able to connect to the survivor either directly or indirectly through touching each other's shoulders?
 - Does the survivor have the same support as before?
 - Are there people to whom the survivor no longer has a link?
- ❖ Note that because of the stigma around GBV, in a normal situation she has less people to reach out to who will help her rebuild her trust, feel accepted again and know how to make the right choices for herself.

Part 3: What happens when there is an acute emergency

- ❖ Ask everyone to rejoin the group in the circles that they were in before.
- ❖ Note that for Part 3, you are returning to the point before Marie experienced a GBV incident
- ❖ Explain to the participants that you are going to say "boom". This will represent a crisis. After the "BOOM" all participants should jump 3 spaces in any direction (left, right, forwards, backwards, diagonal).
- ❖ Ask everyone to place a hand on the shoulder of the person that they touched initially, if they can do so without moving their feet.
- ❖ Discuss:
 - How many of you are able to connect to the survivor either directly or indirectly?
 - What changed and what does this represent to you?
 - As a teenager, what support does she have around her now?
- ❖ Note that during an acute emergency, the social networks and social support systems that an individual enjoyed begin to scatter, making it more difficult for individuals to find support. People who that individual once relied on or who could have helped may no longer be there for her – or in conflict situations where ethnic, religious or tribal delineations are part of the tensions, these social groupings make be an active source of conflict. Additionally, Marie is a teenager, which will affect her access to social networks. She may be reluctant to reach out to adults who she thinks don't understand her or because of their status.

Part 4: What happens when GBV occurs during an emergency?

- ❖ Ask participants to remain where they are from Part 3. Note that Marie has now experienced a GBV incident.

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- ❖ As before, tap random participants' shoulders. When they feel the touch, they should turn to the survivor and make a common ugly remark that is often made to shame a survivor, and then leave the circle.
- ❖ Touch 12-14 random participants on their shoulders except for the survivor and make sure that they are from family members, friends/colleagues and the broader community.
- ❖ Make sure that at least one NGO psychosocial worker, one NGO community mobilize, one doctor/nurse, one police, one teacher, one family member, one religious leader, and one community leader remain.
- ❖ Ask everyone who is left to place a hand on the shoulder of the person that they touched initially, if they can do so without moving their feet.
- ❖ Discuss:
 - How many of you are able to connect to the survivor either directly or indirectly?
 - What changed and what does it mean to you?
- ❖ Note that during an acute disaster, a survivor's support systems becomes even more distant and fragmented. It becomes harder for individuals to find support to heal, find acceptance, and feel empowered. A survivor may feel completely unsafe and alone. Therefore, it is important to find ways to reconstruct social networks and support survivors to access them. When planning and implementing psychosocial activities, it is important to look at the different levels of the ecological model (levels of support in a survivor's life) rather than focusing solely on the individual.

PLENARY: Understanding psychosocial response: Healing, Empowerment and Acceptance – 10 min.

- ❖ Explain the definition of psychosocial:



Psychosocial refers to the dynamic relationship between psychological and social effects of a traumatic event or violence on an individual. Both the psychological and social effects of emergencies continually influence each other.

- ❖ Note that there is often debate whether time and resources should be prioritized to start psychosocial services at the onset of an emergency when displaced people have urgent water, food, shelter and health needs. There is also growing consensus that psychosocial activities have real benefits to the emergency response and compliment the delivery of other urgent materials and services.



- ❖ Briefly show the diagram of the Ecological Model. Note that an individual's is supported by their families and friends, that the individual and family and friends are further supported by their close community (neighbors, social groups, etc.) who together are supported by the greater community. It is through this interlink that an individual will find belonging and self-confidence.
- ❖ Explain that you will have them do an exercise that will demonstrate the Ecological Model and how GBV and emergencies affect the social supports that are noted in the Ecological Model.



- ❖ There is often some confusion between case management and psychosocial support. If necessary, lead a brief discussion on the relationships between case management and psychosocial support. Case management, when done well, can support a survivor's psychosocial well-being, but psychosocial support also encompasses many other things. While the aim of case management is to provide direct psychological, emotional and referral support to a survivor of GBV, other psychosocial responses are aimed at strengthening the social support for a survivor and helping her reintegrate.

ROUND ROBIN BRAINSTORM: Psychosocial Support – 20 mins.

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- ❖ Put four flip charts up in different locations, with titles ‘individual support’, ‘group support with women’, ‘group support with girls’, and ‘safe spaces’. Divide participants into four groups and have them each start at one of the flip charts, brainstorming all of the activities they currently do that may benefit a survivor’s psychological or social well-being within each of those categories. After 5 minutes, ask them to move to the next flip chart and add anything that is missing (3 minutes). Repeat until all groups have addressed each category.
- ❖ Ask participants to do a gallery walk around the different flip charts to see everything that has been added, then return to plenary.

PLENARY: Review Psychosocial section of the Program Model – 20 min.



- ❖ Review the suggested psychosocial activities in the GBV Emergency Response Program Model:
 - Identify/establish safe spaces through which women, girls and survivors can access basic emotional support, accurate information about services and referral from trained staff/volunteers. Setting up safe spaces can be an important activity in the psychosocial aspect of emergency response. Safe spaces must be physically and emotionally safe for women, girls and survivors; they do not, however, necessarily need to be in formal locations such as women’s centers. Safe spaces can be established in informal and temporary locations – e.g. tents, health centers, a participant’s home, outside under a tree – as long as that location is recognized by women and girls as being safe and accessible.
 - Ensuring safe access may mean integrating GBV activities into other services or locations (e.g. health centers) or using other activities to provide a discreet entry point to GBV-specific activities (e.g. generic women’s activities allowing survivors to access case management without showing that this is the case).
 - Identify women’s groups/networks that can provide survivors with basic emotional support and a safe space through which to assimilate into community activities.
 - Train and mentor **psychosocial staff** and/or partners.
 - Provide individual and/or group **emotional support** activities for women and girls. Such activities can include: discussion and information-sharing sessions on specific topics relevant to women and girls (such as health and sanitation, violence or childcare); skill- and knowledge-building activities, including literacy and numeracy, health education, or sewing classes; and recreational activities such as sports, dancing, drama, arts and crafts, or story-telling.
 - Psychosocial activities may also include relaxation exercises, psychoeducation (explaining to a survivor what kinds of consequences she may experience as a result of violence – e.g. common signs of trauma, physical and emotional reactions, etc.), meditation, guided prayer groups, interaction with family members to help them to understand what survivors have been through so that they will be better able and willing to support her, etc.
- ❖ Note that activities must be tailored to both the context and the security situation – some activities may not be suitable for acute emergencies, but could be established in refugee camps, for example.
- ❖ Note also that activities should be structured in such a way as to ensure that all survivors can access them. This means ensuring accessibility for survivors with disabilities, as well as providing tailored activities for specific groups such as adolescent girls, and ensuring that characteristics such as ethnic and religious backgrounds do not block access.
- ❖ As you are discussing these activities, make sure any that were not previously captured in the exercise are added to the lists.
- ❖ In plenary, return to your lists and discuss which of these is a) feasible and b) a priority in an emergency. This should be based on several factors, including the security context, the length of the intervention and how often/frequently survivors are able to access the locations for services, as well as any other relevant factors for your context.

Handout the Case Management and Psychosocial Support Guidance Note (Annex 7) – participants can read these later.



See Annex 10 – and the Participant Handbook - for additional resources on psychosocial support, including detailed descriptions of activities.



REFLECTION: What Does This Mean for Me? – 10 min.



- ❖ Explain that now that we all understand the key elements of psychosocial support in emergencies, you are going to spend some time reflecting on what this means for each of them as individuals and for their organizations.
- ❖ Ask each person to spend 5 minutes filling out the relevant template in their Participant Handbooks:
 - Does my organization already provide psychosocial support in some way?
 - If yes, how would this need to change for emergency contexts?
 - If no, what is my role in relation to psychosocial support (e.g. can my activities be adapted to have psychosocial benefits? Can I serve as an entry point/connector, or share relevant information in communities, make referrals, work together with psychosocial support agencies or organizations, etc.)?
 - Does this pose any risks for me as an individual and/or for my organization? What about for women and girls?
- ❖ After 5 minutes, ask participants to share with someone else from their organization and add or adapt as necessary. If there is no-one else from the same organization, participants can share with another individual and discuss.
- ❖ Encourage participants to ask questions or seek clarification from you as necessary.

SESSION 8: SUPPORTING HEALTH RESPONSE DURING AN EMERGENCY



Learning Objectives:

- Identify healthcare priorities when launching a GBV-related response in an emergency.
- Recognize the appropriate roles of GBV and health actors in health response for adult, adolescent and child survivors.



Time: 1 hour 10 minutes



Materials required: Projector, screen, flip charts and markers.



Facilitator Preparation:

- Review relevant slides.
- Prepare timeline from time of sexual assault to 6 months, with 72 hours, 120 hours, 2 weeks, 6 weeks, 3 months, 6 months and Anytime marked (see exercise below). Prepare two sets of cards/post-its, with the key GBV-related health interventions (see Annex 7 for a printable set of cards) on each set. If possible, have each set on different colored paper or post-its.

PLENARY: Introduction – 5 min.

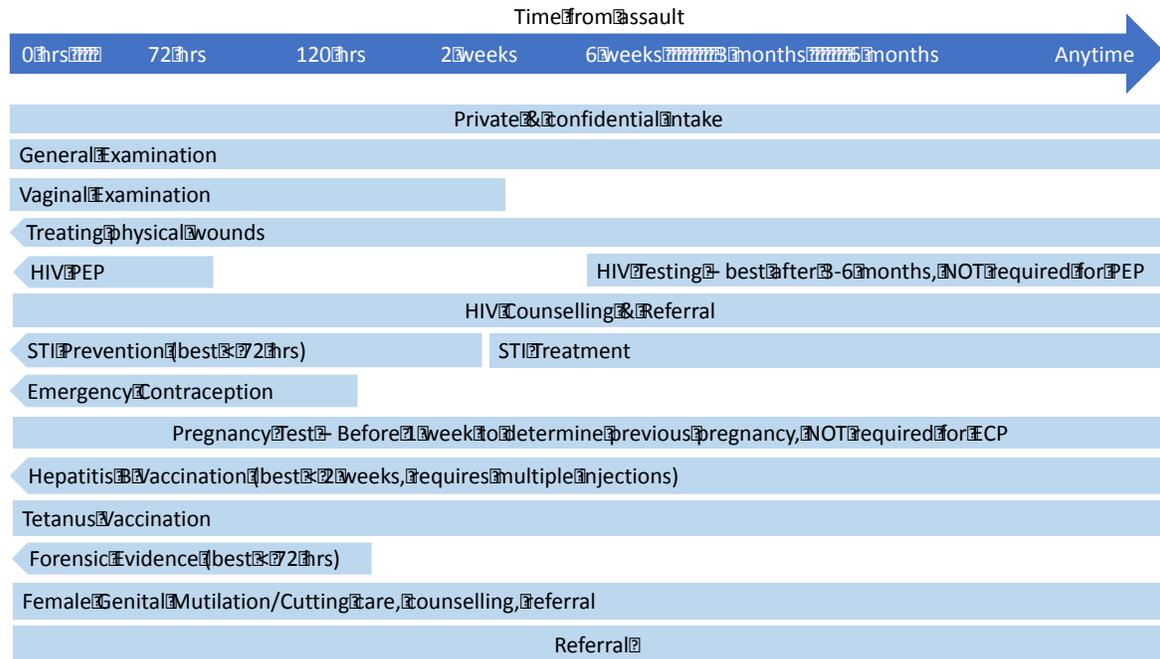
- ❖ Explain that in this session you are going to work together to understand the key healthcare interventions for survivors of gender-based violence. The focus remains on sexual violence but they should also keep physical violence (whether within or outside of intimate relationships) in mind for this session.
- ❖ Explain to participants that this training is NOT designed to enable them to provide healthcare; rather it aims to give them an overview of essential health interventions so that they can provide accurate information and referrals to survivors, and support healthcare providers to provide quality, survivor-centered care.
- ❖ Lead a brief plenary discussion of participants' prior or current interaction with healthcare systems for GBV. Have they worked with healthcare providers? How comfortable do they feel with the healthcare needs of survivors?

SMALL GROUP EXERCISE: What and When? – 20 min.



- ❖ Put the timeline up on the wall, divide participants into two groups, and distribute one set of cards describing health interventions to each group. Ask participants to decide as a group where the different interventions should go on the timeline. In plenary, talk through each of the terms/interventions to make sure participants understand them before starting the exercise, and explain that some of them may not know the answers if they have not worked closely with healthcare providers before, so they should make their best guess.

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PLENARY: Discussion – 20 min

- ❖ Bring participants back to plenary and discuss the different interventions and timelines decided by the group, arriving, through discussion and explanations, at something that looks like the timeline below. You can also show the timeline on a slide as a summary of the discussion.
- ❖ Next, lead a plenary discussion around the following key issues, asking participants what they think about the following points and making sure the key information is covered in the discussion:
 - Think back to the GBV Guiding Principles we have discussed. What would it look like to respect those principles in healthcare services?
 - Private, confidential spaces for intake, so a survivor does not have to say what happened in front of other people in a reception area/waiting room;
 - Availability of a female healthcare worker, or the possibility for a family member or friend to be present for any medical examination if the survivor wishes;
 - Giving information on examinations and procedures before providing them, ensuring compassionate care;
 - Collecting forensic evidence only if the survivor chooses, and considering risks of this in the context.
 - Children can receive the same treatments as adult survivors, but the dosage may need to be adjusted depending on weight
 - Emergency contraception does not cause abortion (as confirmed by the World Health Organization) and is safe for women who are already pregnant (therefore there is no need to wait for pregnancy testing to take ECP)
 - HIV testing is not effective until at least 6 weeks after contact with HIV, and prevention is only effective within the first 72 hours. PEP is safe to take, despite some unpleasant side-effects, and so it is important not to wait to start taking PEP, unless the survivor already knows s/he is HIV-positive.
 - Forensic evidence should ONLY be collected if it can be used in the context and if the survivor chooses.
 - It is never the role of a healthcare or GBV professional to determine whether rape has taken place. Healthcare professionals can only describe what they have physically seen and give their opinion – where possible – based on wounds or other evidence as to whether intercourse has

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taken place and the level of force used. Determining rape requires understanding whether or not the survivor consented to intercourse, which is firstly not necessary to provide services, and secondly never the role of either healthcare or GBV staff, who should always support and believe the survivor. A determination of rape is the role of legal/judicial actors, and requires a functional reporting and investigatory system, which may be compromised in emergency contexts.

- ❖ Use this last point to lead into discussion of which interventions are feasible in an emergency context.
- ❖ Explain that there are several key resources that they can go to for more information, and briefly introduce the following:
 - The **IASC Guidelines** provide a comprehensive overview of actions that healthcare providers should take across the program cycle (assessment, resource mobilization, implementation, monitoring & evaluation);
 - The World Health Organization's **Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons** and the International Rescue Committee's **Clinical Care for Sexual Assault Survivors: A Multimedia Training Tool** both outline key healthcare principles and actions; and
 - The **Minimum Initial Service Package (MISP)** for Reproductive Health is a priority set of life-saving activities to be implemented at the onset of every humanitarian crisis. The MISP prevents excess maternal and neonatal mortality and morbidity, reduces HIV transmission, prevents and manages the consequences of sexual violence, and includes planning for the provision of comprehensive reproductive health services.



See Annex 10 for additional resources on healthcare response for GBV in emergencies.

PLENARY: Roles and responsibilities in GBV health response – 15 min.



- ❖ Divide participants into two groups and have each group stand facing each other, with you in the middle. Designate one group as 'GBV staff' (including case management, psychosocial, community outreach, etc.), and the other as 'health staff' (including nurses, doctors – of state structures or NGOs). Ask them to spend a minute conferring with their group-mates about what their role should be in relation to the healthcare services for survivors that you have discussed.
- ❖ Discuss as a group. Ensure that the following activities from the GBV Emergency Program Model are considered:
 - Carry out service mapping of available, GBV-related health services
 - Advocate for action to improve identified gaps in health services
 - Work with health actors to identify and train GBV focal points in all health facilities
 - Work with health actors to identify private, confidential spaces within health centers
 - Train health facility medical and non-medical staff on GBV guiding principles for supporting a survivor and providing safe referrals
- ❖ Healthcare staff, on the other hand, should ensure that health staff are trained, that health facilities are equipped, and that appropriate treatment protocols are in place and followed

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- ❖ Emphasize that while all humanitarian actors play a role in ensuring that GBV survivors have appropriate care and safe access to health services, GBV staff do not provide any direct health services, procure or dispense drugs, or supervise health staff. Only trained health staff should be providing health care.



Training in Emergencies

Time is a luxury in emergencies. There is a need to implement but often staff don't have the pertinent skills to implement appropriate services. It's important to be flexible when designing trainings. They don't have to be formal 3-5 day trainings. For instance, set aside one hour a week to train staff on a topic that they've been facing that is particularly perplexing. Regard training as an on-going process that is integrated in their regular support and supervision.

Emphasize basic knowledge and encourage staff to seek assistance when handling complex situations. Include a learning component to on-site supervision and support during the response. Hold daily or periodic debriefs with staff to provide technical assistance with identified cases and emotional support to staff working in challenging and insecure environments.

- ❖ Emphasize that:
 - All humanitarian actors should be aware of these critical deadlines to ensure access to health intervention and that this information will help them refer survivors, on-time, to attain life-saving services.
 - It is because of these critical deadlines that a survivor's health needs are prioritized during an emergency. The need to find legal justice should never stop a survivor from receiving the full package of health services.

REFLECTION: What Does This Mean for Me? – 10 min.



- ❖ Explain that now that we all understand the key elements of healthcare in emergencies, you are going to spend some time reflecting on what this means for each of them as individuals and for their organizations.



- ❖ Ask each person to spend 5 minutes filling out the relevant template in their Participant Handbooks:
 - Does my organization already interact with healthcare systems in some way?
 - If yes, how can I make sure my services are adapted to the emergency context?
 - If no, what is my role in relation to healthcare (e.g. Can I serve as an entry point/connector, or share relevant information in communities, make referrals, work together with healthcare agencies or organizations, etc.)?
 - Are there any risks for me as an individual and/or for my organization? What about for women and girls?
- ❖ After 5 minutes, ask participants to share with someone else from their organization and add or adapt as necessary. If there is no-one else from the same organization, participants can share with another individual and discuss. Encourage participants to ask questions or seek clarification from you as necessary.
- ❖ Encourage participants to ask questions or seek clarification from you as necessary.

SESSION 9: REFERRAL SYSTEMS



Learning Objectives:

- Discuss the importance of clear, well-communicated referral systems in emergency contexts.
- Understand participants' role within the referral system



Time: 1 hour



Materials required: Projector, screen, flip charts, tape, post-it notes.



Facilitator Preparation:

- Review relevant slides.
- Print (Annex 7 – print double-sided if possible) or write out character information sheets (with the character written in large letters on one side and their instructions/script written on the other side so that they can read it while holding the title face out in front of them).
- Prepare one flip chart with images of services in a circle, around an image of a woman (see example below).
- Prepare separate flip charts for each service (two per service). Arrange each set of the individual service flip charts in two separate areas (e.g. one flip chart for health, one for psychosocial, one for safety, one for legal, etc. outside and one of each inside, or similar). Divide each flip chart down the middle with 'barriers' written on one side and 'supportive factors' on the other.
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.



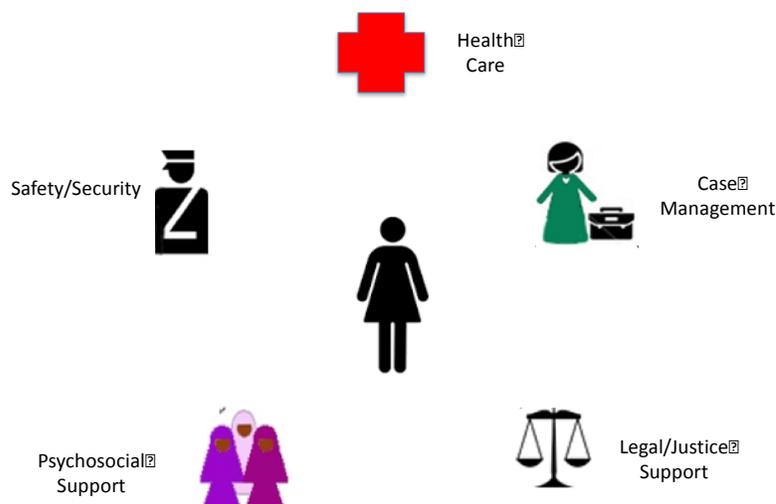
EXERCISE: Bouncing Around – 10 min.

- ❖ Ask for 10 volunteers from among the participants. Distribute character information and titles to each of the volunteers. Ask them to follow the instructions on their piece of paper. If necessary, facilitate the process of the survivor moving around to different actors.
- ❖ Ask the survivor how the process felt for them.
- ❖ Ask the rest of the participants (non-actors) what they observed. Highlight the problems, particularly noting that the survivor has not received any real support, and that she has been forced to re-tell her story multiple times, potentially creating additional trauma.

PLENARY: Discussion & Introduction to Referral Systems – 5 min.

- ❖ Affix a flip chart with an image of services (health, psychosocial, case management, legal, etc.) in a circle, with an image of a woman and/or girl in the middle (as below).

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- ❖ Introduce the concept of a referral system:

*A referral system is the process of connecting services in such a way that survivors can easily, safely and confidentially access them. A quality referral system should include trained GBV service providers, and should facilitate the access of survivors to services **without the need to retell their story multiple times. A survivor will likely experience some level of trauma every time she retells her story – our goal is to avoid as much trauma as possible while ensuring quality service provision.***

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- ❖ Explain that referral systems:
 - Coordinate service delivery and facilitate survivors' access to services.
 - Improve timely access to quality services for survivors of GBV.
 - Help ensure that survivors are active participants in defining their needs and deciding what options best meet those needs.
- ❖ Take any questions from participants and discuss.

FORCEFIELD ANALYSIS: Barriers to Effective Referral System Functioning – 20 min.

- ❖ Divide participants into two groups, and assign each to one of the areas where you have the flip charts for each kind of service. Within each group, divide them further so at least 2 participants start at each flip chart. Ask them to brainstorm on post-it notes (one idea per note) the things that might prevent the referral system from functioning (i.e. that would prevent services from working well together, and would prevent survivors from accessing the full range of services) and things that would support the referral system to function well, and therefore make sure survivors can access the full range of services safely, efficiently and confidentially. Give them 3 minutes to write down as many factors as possible, then clap your hands or blow a whistle to show that they should move to the next flip chart/service, adding anything that is missing (without duplicating).
- ❖ Ask participants to consider all groups of survivors in their discussions – e.g. children, adolescent girls, survivors with disabilities, survivors of different religious and ethnic backgrounds, etc.

PLENARY: Discussion & Presentation – 15 min.

- ❖ Bring the groups back together and discuss.

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- ❖ As a group, discuss the barriers and the facilitating factors that were identified. Do the suggestions from the second group respond to the barriers identified by the first?
- ❖ Outline the principles and key actions involved in supporting referral systems.



Principles:

- Ensure GBV guiding principles are followed. For example, ensure that individual information is shared only with the consent of the survivor and in support of her access to services. Establish systems to ensure that survivors' information is not accessible to others.
- Do not take action without permission of the survivor. Respect for the wishes and choices of the survivor are paramount in interacting with referral systems. Having multiple entry points to a system of services also helps to ensure that a survivor can access care and support where, when and how she chooses.
- Prioritize the safety and security of the survivor. This includes ensuring that difficult-reach-populations have safe access to services. It may mean integrating GBV activities into other services or locations (e.g. health centers) or using other activities to provide a discreet entry point to GBV-specific activities (e.g. generic women's activities allowing survivors to access case management without showing that this is the case).
- Keep the number of people informed of the case to a minimum.
- Provide a safe and confidential space.
- A trusted caregiver must accompany a survivor under the age of 18.
- At no point should anyone try to convince or coerce the survivor into reporting.



Key actions:

- Regularly engage **women and girls, the community, and service providers** to assess, update, and change the referral pathway, as needed.
- GBV actors need to **educate and motivate other sectors** about their responsibilities.
- Consult with **coordination bodies and working groups** to discuss relevant and emerging issues or concerns.



❖ Review key actions in GBV Program Model regarding referral systems:

- Carry out mapping of available services for survivors of GBV.
- Develop functional, context-appropriate referral pathways, with entry points fitted to the needs of different survivors (i.e., children, adolescents, adults, survivors with disabilities, etc.).
- Disseminate information on referral pathways among service providers and GBV focal points.
- Establish and/or advocate for regular meetings between service providers.
- Provide other sectors with information related to referral pathways and GBV guiding principles.

REFLECTION: What Does This Mean for Me? – 10 min.



❖ Ask each person to spend 5 minutes filling out the relevant template in their Participant Handbooks:



- Does my organization already interact with a GBV referral system in some way? How?
 - If no, can I serve as an entry point? Can I provide information to survivors? Should I be coordinating with other agencies/organizations?
 - What are the risks for me as an individual and/or for my organization? What about for women and girls?
- ❖ After 5 minutes, ask participants to share with someone else from their organization and add or adapt as necessary. If there is no-one else from the same organization, participants can share with another individual and discuss.
- ❖ Encourage participants to ask questions or seek clarification from you as necessary.

DAY 3

INTRODUCING THE DAY

- ❖ Ask participants in plenary to identify the key discussions from the previous day. This can be done popcorn style with individual participants giving one element/answer each, or you can ask one participant to give a brief summary of the day's topics and key learning points.
- ❖ Present an overview of the Day 3 agenda.
- ❖ Run a brief self-care activity.

| Day 3 | |
|---------------|--|
| Time | Session |
| 9:00 – 9:15 | Introduction to the Day |
| 9:15 – 10:45 | 10 - Community Outreach |
| 10:45 – 11:00 | Tea/Coffee Break |
| 11:00 – 13:10 | 11 - Risk Reduction |
| 13:10 – 14:30 | Lunch Break (including 20 mins self-care/energizer) |
| 14:30 – 15:30 | 12 – Responding to Other Forms of GBV in Emergencies |
| 15:30 – 15:45 | Tea/Coffee Break |
| 15:45 – 16:45 | 13 - Information Management & Sharing |
| 16:45 – 17:00 | Wrap Up |

SESSION 10: COMMUNITY OUTREACH



Learning Objectives:

- Discuss key messages and outreach mechanisms when raising awareness with the community about GBV during an acute emergency.



Time: 1 hour 30 minutes

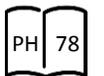


Materials required: Projector, screen, flip charts, markers, tape.



Facilitator Preparation:

- Review relevant slides.
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.



PLENARY: Introduction to Community Outreach/Awareness-raising during an emergency – 10 min.

- ❖ Ask participants – what is the objective of community outreach/awareness-raising in an emergency? Highlight that in an emergency, community information-sharing is not about changing community norms or preventing violence more globally. Information sharing in this context is about ensuring access to services as quickly and safely as possible.
- ❖ Discuss the importance of community outreach – even the best services are useless if communities – and especially women and girls – do not know how to access them. Community outreach is also essential in supporting risk reduction efforts.



- ❖ Review the Program Model on providing community awareness. They will find the community awareness activities in the “Access to Survivor Services” pillar and also in the “Risk Reduction” pillar of the Program Model.

GROUP BRAINSTORM: Finding the Appropriate Community Outreach Approaches – 20 min.

- ❖ Ask participants to form groups with others from their organization, and brainstorm answers to the following questions:
 1. *What are the different community outreach methods that you use/have used in your work?*
 2. *What are the key messages that you focus on in your community outreach?*
- ❖ Ask participants to return to plenary and present their lists. Create one master list as groups are presenting their brainstorming results.

PLENARY DISCUSSION: Prioritizing Approaches & Messages in Emergencies – 20 min.

- ❖ Distribute six stickers to each participant (three each of two colors or shapes) and ask them to use one color/shape stickers to identify the priority community outreach methods and the other to identify the priority messages in emergency contexts. They can put one sticker on each or several on one if they want to show its relative importance.



- ❖ Discuss the results as a group. Highlight the following key messages:
 - *Sexual Violence* - During the acute emergency, sexual violence tends to be reported more and has the high potential for life-saving support especially if they are able to get to a health clinic trained in the clinical care of sexual assault within the critical window.
 - *Access to services* (especially life-saving health services) - Survivors need to know where to find help. In addition, services - especially health services - are time-sensitive and we want survivors to get the best package of services that they can.
 - *Activities that can help reduce women and girls’ risk of sexual violence* - Provide ways in which the community can mobilize and prevent risks to GBV
- ❖ Highlight the following key outreach methods:
 - Wandering loudspeakers
 - Dissemination of Information, Education, Communication (IEC) materials – posters, pamphlets
 - Meetings (15-50 people) or small-group discussions (5-10 people) – including sharing information at other activities, such as distributions of materials or food
 - Social Media
 - Websites (e.g. www.refugee.info)
- ❖ Lead a brief plenary discussion on safety:
 - The safety of the women and girls that you talk with - people lose trust during crises, and families may not appreciate if a woman talks to a stranger, especially if staff are male. Just talking to a stranger can sometimes lead to confinement or physical violence.
 - Staff safety - when sexual violence is used as a weapon to humiliate the population, the belligerents will rarely be accepting of discussions around GBV.
 - Cultural attitudes towards different types of GBV
 - In many emergency situations, men will not allow women to meet together or mobilize. It is essential to consider and ensure the safety of women and girls when deciding on messages and means of sharing information with communities. Talk to women and girls!

PLENARY: Community Outreach Best Practice – 40 min.

- ❖ Explain the key attributes of effective community outreach messages. Ask participants to give concrete examples of each of the attributes below:



- **Clear** – keep the wording and meaning of the message simple.
- **Easy to read/hear/understand**, - images should be telling, big and culturally appropriate; the words used are big and common. Use the most common language that everyone understands.
- **Action oriented** – how is the message helping the community/women and girls/survivors know what to do to help themselves
- **Specific** – details are instructive
- **Positive** – illustrate positive action and attitudes. Don't patronize or vilify. Negative portrayals don't work. People rarely see themselves as the problem and nobody likes to be preached at. It's better to model positive behaviors that they can follow.
- Specifically, images of violence against women and girls should **NOT** be used in community outreach messaging. Showing images of violence can normalize this violence, and may also be a harmful trigger for survivors of violence.
- Topics should **inform the community** about the available GBV response services and risk reduction practices.
- Messages should be designed to **reach the most people** possible. Take into consideration the overall literacy rate.
- Messages should also be as **inclusive** as possible. Where possible, ensure that different groups of women and girls - including all age groups, all ability levels, all relevant ethnicities, etc. – are shown in community outreach images. Use outreach messages to highlight where specific services are available for relevant groups as well.
- Always consider **safety** of both staff and women and girls. How will certain messages be viewed by different members of the community or armed groups, and what will this mean for you, or for women and girls?



- ❖ Divide participants into three groups. Hand out the example packet (Annex 7) and ask groups to rate each poster on a scale of 1-3 (1 is poor, 2 is average, 3 is good) by considering a combination of attributes above.
- ❖ Return to plenary and discuss.



While the examples are shown are visual aids (poster, brochures and billboards) the same practices around messaging are transferable to other media used for awareness, be it theater, radio, pamphlets, TV, text messages, etc.



- ❖ Highlight different methods of sharing information, including websites (e.g. www.refugee.info), social media, and mobile apps. These will be particularly important in locations with more access to technology. Message types, lengths and formats will need to be adapted to suit the different media – e.g. messages shared on twitter will need to be short and text-based, while posters would contain more visual information.
- ❖ Explain that since it might be difficult to preconceive the specific messages that you'll need during the crisis, you can pre-arrange visual aids with the images ready but space to write in the message. Show an example from the blank posters.
- ❖ Explain that while it is ideal to have images that are culturally similar to the community, during the acute phase of an emergency it is ok to use pictures that give correct information even if they don't exactly represent the affected community (keeping account of major cultural taboos). When the emergency stabilizes and you have more time to make an accurate representation of the

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community, you'll have time to improve the message; however, during the acute phase it is better to make sure good information is shared even if it is not visually correct.

- ❖ When deciding when and how to share information in community outreach, keep in mind the barriers that women and girls may face in accessing information – for example, are women and girls in locations where visual media can be seen? It is important to use various channels and to consider how women and girls can be best access information.
- ❖ Safety is an essential element to consider in designing community outreach/awareness-raising messages and methods. In some cases, it may be safer to adapt your messaging to talk to small groups of women rather than conduct blanket community-level awareness-raising campaigns. In other situations, the opposite may be true. You will to discuss this with staff teams and women and girls to ensure no additional risks are created.



REMEMBER that these messages address suggested ways that women and girls can mitigate the GBV risks they face in very dangerous situations. They should never be used to suggest that it was the fault of a survivor if she is assaulted or raped while not following these suggestions. The person responsible for rape is always the rapist.

SESSION 11: REDUCING RISKS FOR WOMEN & GIRLS DURING AN EMERGENCY



Learning Objectives:

- Examine approaches to reducing risks and meeting women and girls' basic needs in emergencies.



Time: 2 hours 10 minutes



Materials required: Projector, screen.



Facilitator Preparation:

- Review relevant slides.
- Find out about the relevant reporting systems and requirements in the local context before this session. You can ask local teams, or get in touch with the relevant GBV sub-cluster or working group/coordination mechanism to find out how cases should be reported and what the investigation/response process looks like. Insert this information into Slide 19.
- Ensure that all participants have the scenario & camp map. Print Lanta camp descriptions for each group.
- Print or prepare risk & strategy matching cards (see Annex 7).



SMALL GROUP BRAINSTORM: Risks for Women and Girls in Emergencies – 40 min.



- ❖ Explain that during this session you are going to focus on the risks that women and girls face in emergency contexts, as well as risks involved in accessing humanitarian assistance. The aim of this area of work is to *reduce the risks women and girls face in the emergency / post-emergency context, and protect those who have already experienced violence from further harm.*
- ❖ Divide participants into the groups they were in for Session 2: Women, Girls and GBV in Emergencies, and remind them of the case studies of women and girls they developed. Ask participants to think about the emergency scenario they have been using since the beginning of the training, and to look at the included map of Lanta Camp, and to spend a few minutes reading the detailed scenario information (this is the same information as that used during the assessment practice session on Day 1).
- ❖ Ask each group to go through the information and identify the risks that their case study character faces in the scenario. They should assign the risks to one of the four categories below.
 1. Living space & physical camp/site layout
 2. Unmet needs
 3. Service delivery
 4. Information & Participation



Before this point, try to gauge the level of knowledge and experience of your participants in the 'humanitarian system'. If they are familiar with different sectors, such as Water and Sanitation (WASH), Shelter, etc. then the group break-down described above is fine. If, however, some of the participants have less experience in this system, try to put them in groups with others who have more experience. This may mean combining into different groups than those used for the 'Women, Girls & GBV in Emergencies Session'.

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- ❖ In plenary (keep groups sitting together), give pieces of different colored card to each group to represent their age group. Slowly read through the Lanta camp information, asking groups to raise their card(s) each time they hear a risk that they identified, of any category. If needed and you have time, ask a group to explain the risk as it is identified (and particularly if groups disagree). Ensure the following are highlighted, including particular risks for each age group:

| Category | Risks in Scenario |
|--|--|
| Living space & physical camp/site layout | <ul style="list-style-type: none"> - Lack of lighting - 'lodges' with multiple families living together provide no protection from sexual assault - some living areas are close to stream & bush - latrines are far from living areas, and close to bush areas - latrines are made of plastic, do not have locks, and not separated for men and women - some water points are in isolated locations - Some children have to pass through bush areas and market (where men are often drunk) to get to school - Overcrowded accommodation, close to bars when men are often drunk |
| Unmet needs | <ul style="list-style-type: none"> - lack of firewood means women and girls need to travel long distances through unsafe locations - lack of bathing facilities means individuals bathe in the stream, also leads to hygiene concerns - insufficient water points mean women and girls have to wait for long periods, are subject to physical assault from boys pushing to the front of the line - lack of menstrual hygiene materials, leading to women and girls hiding away from settlements during menstruation and being vulnerable to assault |
| Service delivery | <ul style="list-style-type: none"> - General confusion, and men hanging around at the entrance to the hall may present risks of women having rations stolen - Distribution staff are all male, have not been properly trained - Healthcare providers are mostly male, leading to risks of abuse or exploitation - The psychosocial NGO office is located close to the market, where men are often found drinking - security provided by government military, but many girls seen hanging around the camps, leading to risks of exploitation - no police presence in new sections of the camp, limited police presence at night - armed groups allowed into the camp - no feedback/complaints mechanism |
| Information & Participation | <ul style="list-style-type: none"> - lack of consultation leads to latrines being located far from settlement and women running risks while travelling, insufficient water points, lack of bathing facilities and menstrual hygiene materials, etc. - lack of consultation on ration type and amount leads to risks of women and girls being forced to engage in prostitution to supplement meals, as they are responsible for feeding their families - lack of information about which services should be provided for free means that women and girls are vulnerable to sexual exploitation and abuse by service providers |

GROUP BRAINSTORM: Matching Risk Reduction Strategies – 30 min.



- ❖ Now, divide into four groups, and distribute a set of matching cards to each group (Annex 7), as well as some blank cards. Each group should match the potential strategies with the risks that they would address, remembering that some strategies may address multiple risks (they can draw a line to each, in this case). Groups can also write additional strategies on blank cards and match them, as needed.
- ❖ Gallery walk and discuss – use the table below, as needed.

| Category | Risks in Scenario | Potential Strategies |
|--|---|---|
| Living space & physical camp/site layout | <ul style="list-style-type: none"> - Lack of lighting - ‘lodges’ with multiple families living together provide no protection from sexual assault - some living areas are close to stream & bush - latrines are far from living areas, and close to bush areas - latrines are made of plastic, do not have locks, and not separated for men and women - some water points are in isolated locations - Some children have to pass through bush areas and market (where men are often drunk) to get to school - Overcrowded accommodation, close to bars when men are often drunk | <ul style="list-style-type: none"> - Conducting frequent safety audits; - installation of lighting; - distribution of solar flashlights; - shelters, latrines and showers installed with doors and locks; - female-headed households located near/within the center of the camp/community; - placement of services, including those specific to GBV, guided by discussions and risk assessments with women and girls - safety or community (patrol) teams/groups (note that patrol or collection groups should be unarmed whenever possible – men with guns, no matter their group, clothing, or affiliation, can be dangerous for women and girls); - firewood/water patrols or collection groups; |
| Unmet needs | <ul style="list-style-type: none"> - lack of firewood means women and girls need to travel long distances through unsafe locations - lack of bathing facilities means individuals bathe in the stream, also leads to hygiene concerns - insufficient water points mean women and girls have to wait for long periods, are subject to physical assault from boys pushing to the front of the line - lack of menstrual hygiene materials, leading to women and girls hiding away from settlements during menstruation and being vulnerable to assault | <ul style="list-style-type: none"> - Hygiene or dignity kit assembly and distribution, based on discussions with women and girls; - Ration cards assigned to female heads of the house; - distribution of fuel or fuel-efficient stoves; - cash- and voucher-based assistance; - Codes of conducts for staff that are explicit about sexual exploitation. |
| Service delivery | <ul style="list-style-type: none"> - General confusion at distributions, and men hanging around at the entrance to the hall may present risks of women having rations stolen - Distribution staff are all male, have not been properly trained | <ul style="list-style-type: none"> - Ensure the presence of female staff in distributions - Organized distribution centers, special protocols for vulnerable people like people with disabilities, child headed households, elderly, |

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| | | |
|-----------------------------|---|--|
| | <ul style="list-style-type: none"> - Healthcare providers are mostly male, leading to risks of abuse or exploitation - The psychosocial NGO office is located close to the market, where men are often found drinking - security provided by government military, but many girls seen hanging around the camps, leading to risks of exploitation - no police presence in new sections of the camp, limited police presence at night - armed groups allowed into the camp - no feedback/complaints mechanism | <ul style="list-style-type: none"> - pregnant/lactating women, Single mothers. - Codes of conducts for distribution staff that are explicit about sexual exploitation, confidential reporting systems and strong consequences for infringement - Monitor design and implementation of activities to ensure they do not do harm; - Ensure quality services & referral systems to avoid retraumatization |
| Information & Participation | <ul style="list-style-type: none"> - lack of consultation leads to latrines being located far from settlement and women running risks while travelling, insufficient water points, lack of bathing facilities and menstrual hygiene materials, etc. - lack of consultation on ration type and amount leads to risks of women and girls being forced to engage in prostitution to supplement meals, as they are responsible for feeding their families - lack of information about which services should be provided for free means that women and girls are vulnerable to sexual exploitation and abuse by service providers | <ul style="list-style-type: none"> - women involved in dialogue and decision making - Establish confidential, accessible reporting mechanisms - Trainings and capacity building of community leaders or camp committees, ensure women's groups and leaders are involved in community outreach process - community meetings with security sector personnel |

PLENARY: Sexual Abuse and Exploitation – 30 min



Find out about the relevant reporting systems and requirements in the local context before this session. You can ask local teams, or get in touch with the relevant GBV sub-cluster or working group/coordination mechanism to find out how cases should be reported and what the investigation/response process looks like.

- ❖ Highlight elements of the previous discussion related to sexual abuse and exploitation, explaining that women and girls often face risks from the very organizations, activities and individuals who are supposed to support and protect them.
- ❖ Ask participants if they have heard of sexual abuse and exploitation. Ask volunteers to explain what the term means. Introduce the following definition:



Sexual exploitation is exchanging money, shelter, food or other goods for sex or sexual favors from someone in a vulnerable position.



Sexual abuse is threatening or forcing someone to have sex or provide sexual favors under unequal or forced conditions.

Even if appears that the survivor agreed to the sexual act, it is important to remember that true consent never exists unless there is a valid alternative choice; where an individual

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either does not understand their options or does not have other options, they cannot be said to provide informed consent to an act.



- ❖ Discuss the importance of recognizing sexual abuse and exploitation by humanitarian actors and the process to respond and prevent SAE, using the following questions:

- Do you know how to **report** a case?
- Do you have a system for **women and girls to confidentially report** a case, or any other concerns with interventions?



- ❖ Explain and discuss the correct reporting procedure in the location, highlighting the following key points:

- If you see something or hear something that makes you think there might be exploitation or abuse occurring, you **MUST** report it, even if you are not sure or do not have proof. It is not your responsibility to investigate or prove a case before you report it. Of course, you should only report cases in good faith.
- You must report the case to the designated focal point or your supervisor. Do not discuss any suspicions or allegations with your other colleagues or friends.
- Ensure that anyone who has experienced sexual exploitation or abuse has access to the appropriate services.



See additional resources for Preventing Sexual Exploitation and Abuse in Annex 10.

PLENARY: Summary - 15 min



- ❖ Highlight where risk reduction activities can be found on the GBV emergency Program Model. Promote risk reduction as a life-saving and immediate priority in emergencies.
- ❖ Explain that during the acute emergency, risk factors are continually evolving – therefore it is important to monitor risks on a regular basis. The frequency of your monitoring would depend on how quickly the context is changing. At the beginning when the situation is constantly fluctuating it may be necessary to monitor risks bi-weekly, but as the situation becomes more stable, monitoring risks once a month might be sufficient. You can use tools that have already been introduced, such as the safety audit and the community mapping tool, to assess risks and identify potential responses.
- ❖ Note that addressing the risks the women and girls face and putting in measures to reduce those risks is the responsibility of all humanitarian actors, authorities and community members. It is often necessary to advocate with other humanitarian actors, authorities and community members who have specific skill sets to address certain risks to take action (advocacy will be covered on Day 4).
- ❖ Explain that it can feel overwhelming to work on risk reduction, because we often cannot prevent violence from occurring in emergencies; however, we can put measures in place to reduce the risks that women and girls face. Remember that it is not a question of all or nothing – any reduction in risk is better than no action at all.
- ❖ Women and girls are the best source of information to learn about the risks that they face. However, because of their social status, capturing their concerns can be difficult. It is necessary to be proactive when asking women and girls about the risks factors – it is also important to have feedback systems, through which women and girls can easily and confidentially report concerns, or give feedback on the quality of services they receive.
- ❖ Ask for and discuss any other questions.

REFLECTION: What Does This Mean for Me? – 15 min.



- ❖ Explain that just as there are risks for women and girls, there may also be risks for you as an organization or individual.

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- ❖ Ask participants to spend 10 minutes considering the following questions, noting their responses in the reflection table (in the right-hand column):
 - Will the emergency change your activities in your personal or professional life?
 - Will your work put you at risk in an emergency context?
 - What strategies might you or your organization need to take to address this?
- ❖ After 5 minutes, ask participants to share with someone else from their organization and discuss. If there is no-one else from the same organization, participants can share with another individual and discuss.
- ❖ Encourage participants to ask questions or seek clarification from you as necessary.

SESSION 12: RESPONDING TO OTHER FORMS OF GBV IN EMERGENCIES



Learning Objectives:

- Understand potential responses to various forms of gender-based violence in emergencies



Time: 1 hour

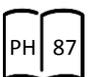


Materials required: Projector, screen, flip charts, markers, tape.



Facilitator Preparation:

- Review relevant slides.
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.



PLENARY: Introduction & Brainstorm – 10 min.

- ❖ Explain that although you have been focusing on the response to sexual violence in emergencies up to this point, it is also true that sexual violence is not the only form of violence that exists, either before or during crises. Emergencies exacerbate all forms of violence for a variety of reasons.
- ❖ Ask participants to turn to the person beside them and spend 5 minutes brainstorming ways in which emergencies might make women and girls more vulnerable to different forms of violence.
- ❖ Ask for a few examples from the group, then highlight the below.



- *Early/forced Marriage:* Economic hardship may lead families to force their daughters to get married earlier so they are no longer a financial burden on the family (note that this is not the same for boys). Many families will also try to ‘protect’ their daughters from other forms of violence by marrying them.
 - *Female Genital Mutilation/Cutting:* Families who are very focused on ensuring that their daughters will be able to find husbands may also renew their focus on practices such as female genital mutilation and cutting that, in the local cultural context, are seen as desirable for girls/women.
 - *Domestic Violence/Intimate Partner Violence:* Intimate partner violence runs the whole gamut of violence from sexual through physical and economic to emotional/psychological violence. All of these forms of IPV can be exacerbated in crises, during which men may use higher levels of stress & hardship as excuses to take out their anger and frustration on their wives (note that this does not excuse the violence, which is still a choice on the part of the perpetrator). Women may also lose the social networks and coping mechanisms that they have used to mitigate the violence in the past, leading to increased repercussions.
 - *Sexual Exploitation:* Economic hardship as existing systems break down in a crisis makes women and girls particularly vulnerable to exploitation by individuals in positions of power. Such individuals may force women and girls to provide sexual favors in exchange for goods, services, or access to opportunities such as employment. These individuals may include humanitarian professionals (see Session 11 on Risk Reduction for more on this issue).
- ❖ Ensure that participants think about particular kinds of violence that occur in their specific context – this is a good point in the training to focus on contextualizing emergency response.
 - ❖ Remind participants that many forms of violence, including intimate partner violence, may include – or be expressions of – sexual violence. For example, although we use the term

early/forced marriage in talking about the phenomenon of girls being forced to marry much older men, one of the key kinds of violence occurring in such a situation is rape.

SMALL GROUPS: How does our response look different for these kinds of violence? – 20 min.

- ❖ Divide participants into groups, depending on the number of key types of violence are identified in the brainstorming exercise (i.e. if you want to focus on early/forced marriage and IPV, split participants into four groups where two groups focus on each of the issues. If you have more types of violence to address, you can spread the groups out further).
- ❖ Ask each group to answer the following questions for their issue/type of violence:
 1. Are there different risks for survivors of these kinds of violence?
 2. How would the response services we have discussed (Case management, psychosocial support, health care) need to change to better address this violence?
 3. Are different entry points required to these services?
 4. What other interventions are needed to address this violence and/or reduce the risk of further violence for the survivor?
- ❖ Encourage groups to reflect specifically on their own context for this exercise. Note that, for many groups the go-to response will be to do ‘awareness-raising’ for all kinds of violence. If this might be an issue with your group, make a ‘no awareness-raising’ rule – that is, awareness-raising cannot be an answer to any of the questions (since we know that awareness-raising must accompany all services and interventions but is not in itself an intervention that is likely to change the situation for women and girls).

PLENARY: Debrief and Discuss – 20 min.

- ❖ Ask participants to briefly share their answers, trying not to repeat points that have already been shared.

- ❖ Highlight the following points:

- Issues such as early/forced marriage are complex and difficult to address, even in stable contexts where programming is established and can operate over a longer period. Therefore, it is important to recognize that they cannot always be ‘solved’ – especially in emergencies. Our focus will most often be on mitigating the immediate consequences or preventing further harm.
- *Mitigating immediate consequences:* While it may seem that early and forced marriage are very different issues to sexual violence perpetrated by an armed actor, for example, the consequences can look very much the same. Girls who are forced to marry at a young age may experience significant physical trauma from sexual intercourse and require health care, for example. Survivors of intimate partner violence will require psychosocial support to recover from their experiences. Case management, psychosocial support and healthcare services are therefore just as important for cases of early marriage or IPV as for other forms of sexual violence. What might be different is how these survivors can or cannot access services – in the context of early/forced marriage, will a girl be easily able to access services, or will her husband prevent her from doing so? How can we improve the information she receives, and her access?
- *Preventing further harm:* The other key aspect when dealing with such issues is to take steps to avoid further traumatization for the survivor, including by trying to mitigate immediate risk (how can you help a survivor to make her situation safer, are there places she can go or others who can help her) and by identifying individuals who can advocate on her behalf (e.g. can community leaders work with the families to try to delay marriage, is there some way in which the family can access economic resources that would reduce the need to focus on the marriage



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of their daughter, etc.). In situations of intimate partner violence, one of the key elements to recognize is that a survivor may be living in a situation of ongoing violence and risk. It is key to help her recognize and manage this situation.

- In situations of sexual exploitation, preventing further harm also involves reporting the perpetrator to the appropriate reporting mechanisms (See Session 11 on Risk Reduction for further information on this).
 - Issues such as early marriage are very closely intertwined with social and religious norms, which makes them complex and difficult to address. In emergency situations, we do not have the time or resources to address change of social norms on a broad scale; however, we can interact with local religious and community leaders to try to improve the situation for individuals, and to try to reduce risks for women and girls more generally.
 - *Recognizing our limits:* One of the key complicating factors here is that in these cases the violence is likely ongoing, and therefore the survivor will continue to experience trauma even as services are provided. It is important to recognize that response to **all** GBV cases may not be possible, particularly in the acute stage of an emergency – this means both that the caseload may be overwhelming and require prioritization of cases where lifesaving care is possible, and also that response to some more complex cases may not be feasible in an emergency (although this will of course depend on the context and the stage of the emergency). This is difficult to manage when we are interacting with survivors, because we want to make things better for them. It is important to recognize that we can most likely not ‘solve’ the problem, but that even the small act of listening to and believing a survivor when she shares her experience can have a significant positive impact on her life. Be guided by what the survivor wants and needs from you.
- ❖ Explain that you will spend time discussing risk reduction on Day 3 and advocacy on Day 4 – both of which will address these points again.

REFLECTION: What Does This Mean for Me? – 10 min.



- ❖ Explain that you are going to spend some time reflecting on what this information means for each of them as individuals and for their organizations.



- ❖ Ask each person to return to the table they have been filling out after each session, and spend 10 minutes going back to each of the completed sections and adding any ideas, priorities or actions that have come out of the discussions for this section in terms of support for survivors of other forms of GBV.
- ❖ After 5 minutes, ask participants to share with someone else from their organization and add or adapt as necessary. If there is no-one else from the same organization, participants can share with another individual and discuss. Encourage participants to ask questions or seek clarification from you as necessary.

SESSION 13: INFORMATION MANAGEMENT & SHARING



Learning Objectives:

- To refresh understanding of how to safely and ethically manage, share, and protect GBV data in an emergency setting.



Time: 1 hour

NB. If you have limited time, this session can be shortened to a few key points and combined with the Case Management session on Day 2, or the Referral Systems session at the beginning of Day 3. In this case, use slides 37-39 to lead a short discussion on the topline principles of GBV information-sharing.



Materials required: Projector, screen, chocolate or similar for prizes.



Facilitator Preparation:

- Review relevant slides.
- Write out the general best practices, hard copy best practices and soft copy best practices, as per the Family Feud game below. Cover each with a separate, removable, strip of paper so they cannot be seen by participants.
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.



PLENARY DISCUSSION: Introduction – 5 min.



- ❖ Ask the group to think back to the ethical guidelines for GBV-related assessments from the beginning of the training (the WHO guidelines). Ask participants to spend 2 minutes discussing with the person next to them the eight recommendations from the guidelines to see how many they can remember. Once time is up, ask if any groups want to give their answers – give a prize to any pair who can successfully name all recommendations, or alternatively to the pair who can name the most. Fill in any gaps.
- ❖ Explain to participants that these principles remain in place after the assessment phase – they all apply to all kinds of information collection. Gather some ideas on the different ways in which we might collect information about GBV, apart from assessments (i.e. from service providers, in hard copy (paper) or soft copy (electronic) form).

PLENARY EXERCISE: Best Practices Family Feud – 20 min.



- ❖ Refer to the three flip charts of General Best Practices, Hard Copy Best Practices, Soft Copy Best Practices. Set up two teams of 5 people each. Each person has to guess one best practice (from any of the three lists). If they get it right, the best practice is revealed (remove the strip of paper) and the next person from the same team can guess another best practice. If they get it wrong, the chance passes to the other team. Continue in this way until all best practices have been revealed.

General best practices in information management:

- Services should be in place first
- Survivors confidentiality must be protected
- Intake forms should not be shared
- Information sharing agreements should be developed
- Compiled and analyzed information should be shared back with implementing agencies
- Data should be kept securely

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Hard Copies of Documents

- Only print if necessary.
- Use a coding system
- Readers are accountable for documents.
- Destroy all printed material when it is no longer needed.
- Store printed material in a safe or other secure container (locked cabinet or locked drawer - or a plastic box in a locked room)

Soft Copies

- Avoid e-mailing information
- Store data on a single computer.
- Secure back-up copies.
- Control access to information.
- Using a coding system and/or data encryption.

PLENARY: Review of key principles of information management and sharing – 20 min.



- ❖ Transition into a discussion of general issues around data collection and information-sharing. Different actors from survivor, NGO's, UN agencies, Government to the donors have different objectives and access for the information they want. This makes sharing information complex. This is a good time to ask them to repeat the GBV response Guiding Principles. Highlight the need to protect the survivor's confidentiality and dignity.
- ❖ Present the basic principles of GBV information sharing:
 - All individual information about a survivor belongs to the survivor. It is her experience, to do with as she wishes. Any use of this information should be with the express (informed) agreement of the survivor, and in her best interests.
 - Aggregate (collective, de-identified) information is useful in designing services and knowing if they are functioning safely and effectively. However, the sharing and use of this data can present danger for survivors if it is not done correctly. Therefore, survivors should also have the choice of whether their information contributes to this aggregate data or not, and all information should ONLY be used in line with established information-sharing protocols and in the best interests of survivors.
- ❖ Use this as an opportunity for participants to share experience of challenges they've had with data storage during a deteriorating security situation in the field, and solutions they've found to keep information safe. This is also a good opportunity to discuss any experiences they have had with challenging conversations – with donors or other organizations - around which information should be shared. If needed, use the following questions to prompt discussion:
 - Should a donor have access to individual information about GBV survivors if they fund services, and the data collection process? (*No – no organization or donor, regardless of the services they fund, should have access to individual-level data unless this is directly required to provide a service which the survivor has chosen to access and consented to share their information for. Aggregate information (that is, group-level information about the number of survivors supported, the kinds of services provided etc. may be shared beyond direct service providers to support advocacy and policy-making, but this should be guided by an information sharing agreement. See the Additional Resources section for more information on this).*)
 - Do you or your organization have the right to refuse to share data about survivors? Under which circumstances? (*Absolutely. The survivor's confidentiality and safety are the primary considerations – if you suspect that these are at risk, you not only can but MUST refuse to share information, even with international NGOs or donors. If you're not sure, seek support before sharing).*)

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- ❖ Highlight that the following questions must be asked in order to cue all actors that the GBV guiding principles and especially respect for the survivor's safety, confidentiality, and dignity should be at the forefront of everyone's decision to collect information on GBV and when they ask for information to be shared about GBV.
 - How will the information be used? (To advocate for, or improve services for survivors; to improve protection of women and girls? NOT to provide reports; because a donor wants to know)
 - Who will have access to the data? (The smallest number of people possible; designated individuals)
 - Who will see it? (Only those who need to use the data for the specific purposes outlined above)
 - How will the information be reported and to whom?
 - For what purpose will the data be reported?
 - Who will benefit from sharing data, and when? (Survivors; women and girls – rapidly, i.e. not once a proposal is approved)

If these questions cannot be answered satisfactorily, information should **not** be shared. Remind participants that releasing sensitive GBV data (intentionally or unintentionally) in a manner that does not fully consider all possible implications can jeopardize ethics and put survivors, communities and program staff at risk.

PLENARY: What happens to data in a deteriorating security situation? – 15 min.

- ❖ Review best practices for storing information during emergencies. Divide participants into two groups and have each talk for 10 mins about ways to protect – or destroy - information if the security situation deteriorates and/or they have to flee. If both groups use both hard and soft copy data, you can assign one topic to each group. Return to plenary and discuss.



See Annex 10 for additional resources on information management and sharing principles and systems.

REFLECTION: What Does This Mean for Me? – Homework.



- ❖ Ask participants to fill out the reflection questions and/or table in their Participant Handbooks as homework before tomorrow's session.



- Does my organization already collect, receive or use individual GBV survivor data?
- What needs to change about our collection, management, use or sharing in an emergency context?
- Does this pose any risks for me as an individual and/or for my organization in taking these steps? What about for women and girls?

DAY 4

INTRODUCING THE DAY

- ❖ Ask participants in plenary to identify the key discussions from the previous day. This can be done popcorn style with individual participants giving one element/answer each, or you can ask one participant to give a brief summary of the day's topics and key learning points.
- ❖ Present an overview of the Day 4 agenda.
- ❖ Conduct a brief self-care activity.

| Day 4 | |
|---------------|---|
| Time | Session |
| 9:00 – 9:30 | Introduction to the Day (including 15 mins self-care/energizer) |
| 9:30 – 11:00 | 14 – Coordination & Advocacy |
| 11:00 – 11:15 | Tea/Coffee Break |
| 11:15 – 13:35 | 15 – Emergency Preparedness |
| 13:35 – 15:00 | Lunch Break (including 25 mins self-care/energizer) |
| 14:30 – 15:30 | 16 - Conclusion |

SESSION 14: COORDINATION & ADVOCACY



Learning Objectives:

- Understand how to leverage resources and support for women and girls and GBV programming in emergencies.
- Understand the importance of effective coordination and how to interact with the relevant systems



Time: 1 hour 30 minutes

NB: If you have additional time, expand this session to spend more time practicing advocacy strategies – i.e. choose an issue and follow the advocacy process from beginning to end.



Materials required: Projector, screen, flip charts, markers, tape.



Facilitator Preparation:

- Review relevant slides.
- If you are not using slides, prepare relevant flip charts as noted in the session notes below.
- Write the coordination and advocacy questions on flip charts.
- Invite, if possible, someone engaged in the humanitarian coordination system in your context (e.g. from the Protection Cluster, GBV sub-cluster/working group, or similar) to give an overview and answer questions. This would happen during the plenary and feedback discussion, or you can rearrange the session to suit.



PLENARY: Introduction to Coordination – 5 min.

- ❖ Explain that this session will discuss some of the challenges in coordinating and advocating for programs and actions that address GBV in emergencies.

- ❖ Facilitate a brief discussion in plenary on what the term ‘coordination’ means in the context of humanitarian – and specifically GBV – action. Invite some suggestions, then if necessary discuss the following simple definition and answer any questions:



Coordination consists of groups, systems or mechanisms that organize humanitarian actors and interventions to ensure that assistance is delivered in an effective and efficient way. This includes mapping interventions, strategic planning, managing information, mobilizing resources, ensuring accountability, avoiding duplication and filling gaps.

SMALL GROUP DISCUSSION: Understanding coordination – 15 min.

- ❖ Divide participants into three groups – try to have a mix of more and less experienced organizations in each group. Ask them to spend 15 minutes answering the following questions.



1. What kinds of coordination groups/systems/mechanisms exist in your context?
2. What role do you play? Do you do anything to contribute to assistance of women and girls within/through these coordination systems?
3. What do you find challenging?

PLENARY FEEDBACK & DISCUSSION – 20 min.

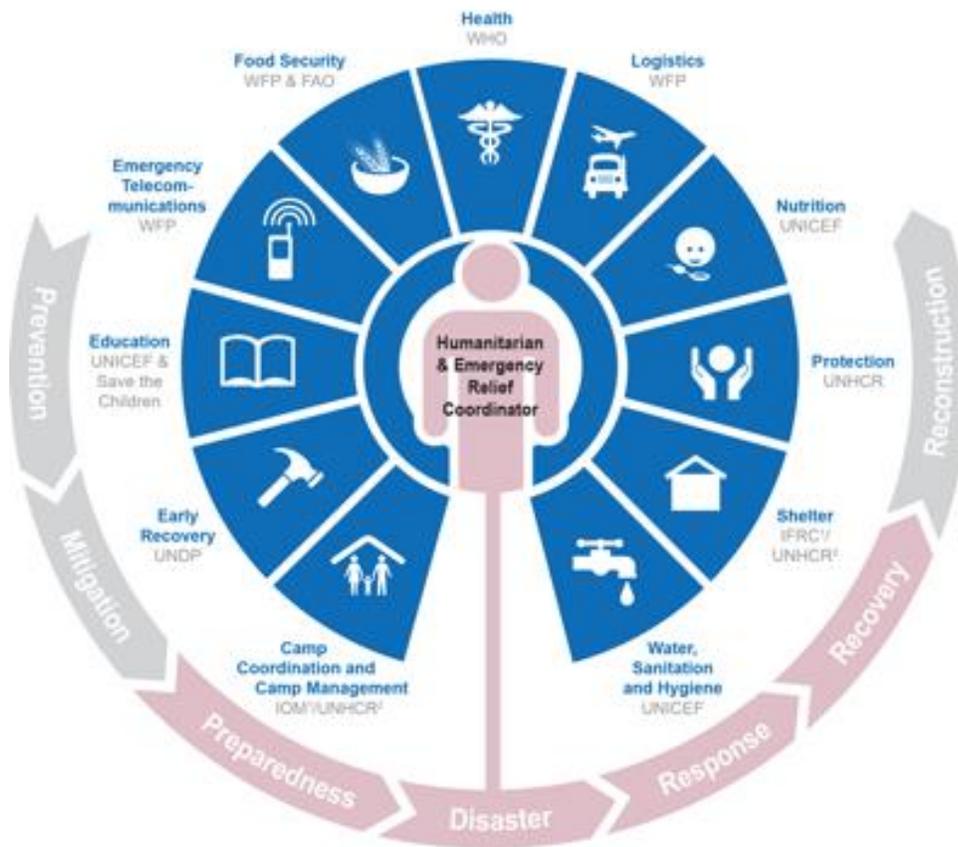
- ❖ Return to plenary for share-outs and discussion. Use the following points if not brought up during the feedback and discussion.



- Coordination can, and should, happen at all levels – from formal to informal, local to regional to national to international.
- In some contexts, formal ‘Cluster’ systems are active (see image below). Clusters are formalized groups of humanitarian actors (both UN & non-UN) in each of the main sectors of humanitarian action (e.g. water and sanitation, health, protection, nutrition, etc. The heads of each cluster, and their responsibilities, are standardized. GBV work is generally coordinated through the Protection Cluster or sub-groups within this known as GBV sub-clusters or GBV working groups. At the global level, GBV coordination is led by what is known as the GBV Area of Responsibility, within the Global Protection Cluster.
- Formal coordination mechanisms such as the cluster system are important and should be kept informed of your assessments, activities and plans so that they can understand and coordinate gaps in programming. However, these formal systems do not always reach the most community-based, grassroots levels – and coordination still needs to happen at those levels. Even where formal coordination bodies do not exist, ‘coordination’ itself can still happen – organizations or agencies in the same area can still meet bilaterally or convene meetings amongst each other.
- Coordination systems can allow you to understand what is happening and where, where the gaps are and where your organization can most effectively intervene. It also helps you to avoid duplicating what others are already doing. Importantly, coordination systems are a good forum to raise issues that you want other organizations to address – for example, if organizations are

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not responding to the needs of women and girls, or if you notice gaps in the field that need to be addressed.



The level of detail you present on coordination mechanisms will need to be tailored to your participants and their knowledge of/previous interaction with these systems. If this information is not provided in the questionnaire that participants fill out before the training, try to gauge it before this session. It may also be helpful to invite someone from the relevant local coordination mechanism to participate, as the system varies slightly in each location.



See Annex 10 for additional resources on humanitarian coordination systems.

PLENARY DISCUSSION: Introduction to Advocacy – 5 min.



- ❖ Use the advocacy role of coordination systems raised in the previous discussion to lead into the following piece on advocacy. Ask participants what they understand when you say 'advocacy', and take some ideas and examples. If it doesn't come out during the discussion, present and discuss the following definition:

The deliberate and strategic use of information – by individuals or groups of individuals – to bring about change. Advocacy work includes employing strategies to influence decision makers and policies, to changing attitudes, power relations, social relations and

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*institutional functioning to improve the situation for groups of individuals who share similar problems.*¹⁴

- ❖ Explain that you can undertake advocacy to improve the well-being of women and girls. This might mean increasing GBV-related services, improving protection for women and girls, or pushing for a change in policy or law at the national or international level. Advocacy involves identifying decision-makers (i.e. who has the power to make the desired change?) and leverage points (what will make decision-makers more likely to make the change?) and putting in place strategies to affect these. Advocacy can range from simple to complex and local to international.

SMALL GROUP DISCUSSION: Understanding Advocacy – 15 min.

- ❖ Divide participants into three groups – try to have a mix of more and less experienced organizations in each group. Give each group a flip chart with the prepared questions below.



1. Do you currently do advocacy? How? Who do you advocate to?
2. What kind of change are you trying to achieve?
3. What do you find challenging?

PLENARY FEEDBACK & DISCUSSION – 20 min.

- ❖ Return to plenary for share-outs and discussion. Use the following points if not brought up during the feedback and discussion.



- It sounds difficult, but doesn't have to be. Advocacy really means trying to make a change, and finding people who can help you to make that change.
- Let's think about a specific issue and how we might advocate around it. Let's choose one of the risks you identified in the risk reduction session and think through what advocacy might look like on that issue. (The following is an example – adapt it based on the content of the risk reduction session). Let's say that in your context, women and girls in IDP camps are at risk of sexual violence when they go to the toilet, because the toilets are far away from the houses in the camp. What is the change that we would want to see in this case?
- Now, choose your target(s). Who could make the change we want to see? Who can be an ally to you (someone with power and who cares at least somewhat about the issues of women and girls)? **Make sure that this discussion includes how coordination mechanisms serve as fora for advocacy.*
- Now, what change are we asking for (i.e. what is the advocacy message)? Be clear and specific on what you want or need. (For example, instead of saying 'toilets should be safer for women and girls', your message could be – toilets should be constructed within family blocks, or within X distance of housing, etc.)
- Explain that in emergency contexts, advocacy often (though not always) happens through coordination mechanisms. As well as official communication and requests, individual and informal communication is helpful. For example, you can ask the head of the coordination system the day before a meeting if they would be willing to introduce your point to the group if you do not feel it will get the attention it deserves.
- Be prepared to be persistent – some changes are easy, some are not. Follow up with individual conversations after making advocacy requests, and keep trying.
- Consider the risks involved in advocacy work – to you as an individual, to your organization, etc. Think about how you will protect your own safety and that of women and girls in the

¹⁴ Adapted from AWID, 2001 and FCR, 2003

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community – will you share information through other organizations or will you do it directly?
How will you keep yourself safe?

- You should not spend time ‘proving’ that GBV exists – as per internationally recognized GBV guidelines, all humanitarian actors should assume this is the case and act. Refer people to the guidelines.

REFLECTION & DISCUSSION: *What is different in emergencies? – 10 min.*



- ❖ Wrap up the discussion by asking participants what would be different about coordination and advocacy in an emergency from what they are already doing. What would they do differently? Would the focus change? What would the risks be? Take some suggestions & discuss (Highlight,



Cluster systems vs. other coordination mechanisms, frequency of meetings, focus of issues highlighted in coordination meetings might address more lifesaving advocacy issues, etc.). You can use the program model to highlight key actions.

- ❖ Ask participants to note down their answers/thoughts in the Coordination & Advocacy section of their reflection tables. If you do not have time before the end of the session, give this to participants as homework.

SESSION 15: EMERGENCY PREPAREDNESS



Learning Objectives:

- Understand the purpose of preparedness and the tasks that can enhance readiness
- Understand contingency planning. Practice using the Contingency Planning Worksheet.



Time: 2 hours 15 minutes

NB. If you have additional time, you can split this session into two and spend more time developing likely emergency scenarios (contingency planning) and developing detailed preparedness plans.



Materials required: Projector, screen, flip charts, markers (multi-colored), tape, stickers.



Facilitator Preparation:

- Review relevant slides.
- Prepare individual pieces of paper with Human Resources (recruitment and orientation), Transport, Procurement & Storage, Finance, Communication, Safety/Security and Staff Housing written on them, and place them in a hat/bag/similar.



- If you are not using slides, prepare relevant flip charts as noted in the session notes below.

PLENARY: Introduction to Emergency Preparedness – 10 min.

- ❖ Ask participants what they understand when we say the term ‘preparedness’. Take some thoughts from participants.
- ❖ Explain that considering and planning for what will need to be done in an emergency allows us to be ready to deal with uncertainty and quickly adapt when the situation around us is changing rapidly. It’s about being proactive and planning for potential situations that may occur. Being prepared will help ensure that the emergency intervention starts immediately and service delivery is of good quality.
- ❖ Explain that when an emergency occurs, people may be stressed, overworked, affected by conflict or natural disaster – including being injured, having to flee their homes, or having family, friends or neighbors who are directly affected – and, in general, less able to think clearly and logically about what needs to happen. Therefore, it is helpful to have thought through these questions in advance – then, if an emergency happens, you may need to adapt your response but you will at least have a framework within which to operate.

SMALL GROUP EXERCISE: Practice Emergency Preparedness – 1 hour 30 minutes.

- ❖ Divide participants into groups by organization. Ask them to list out on a flip chart all of the activities they currently do.
- ❖ Once the lists are complete, distribute stickers to groups and ask them to put a sticker next to each of the activities that could be done in an emergency (they should already have some idea of this from the reflection activities they have done throughout the training). As they are discussing, support groups to identify the adaptations that will be needed for activities to be feasible in emergencies – for example, if organizations do case management, you want them to identify that as an activity that can be continued in an emergency but will need to be adapted (e.g. limited to focus on first three steps).
- ❖ Once they have identified the activities that can be done in an emergency, ask them to choose only one of the activities to consider for the next part of the activity.



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- ❖ Ask participants to consider the scenario you have been using throughout the training (or alternatively they can consider their own emergency context). Explain that you will use this scenario to consider some preparedness actions that would help them to respond more quickly and effectively when the situation arises.
- ❖ Part 1: Explain that you would like them to plan as if the activity they have identified would need to be implemented in the fictional emergency scenario. Ask them to create a table as below.

14

| Existing Activity | What needs to change (i.e. what the activity will look like in an emergency) | Current Resources | Resources Needed | Person Responsible & Time Needed |
|-------------------|--|--|--|---|
| | | a) Staff (minimum number, roles) b) Materials | c) Staff (minimum number, roles) d) Materials | (To get/prepare the resources cited in the previous column) |

- ❖ Part 2: Next, move around to each group and ask them to select two operational/logistics considerations from a hat. They should go through the same process as before for these two areas.
- ❖ Part 3: Now, ask them to do a risk analysis for their chosen activity, thinking back to the session of risk reduction and answering the following questions:
 - What risks might women, girls, and particularly survivors face in this activity in an emergency context?
 - What risks might staff face in implementing this activity in an emergency context?
 - What strategies might help to mitigate these risks?
- ❖ Part 4: Ask participants to do a gallery walk around all the other preparedness plans, debrief and discuss.

PLENARY: Sharing examples of preparedness tasks, tools and actions – 30 min.

15

- ❖ Highlight some preparedness tasks that your team can do around staffing and programming:

Staff Security & Wellbeing

- Security protocols written
- Communication equipment purchased
- Security communication tree up-dated
- Communication and responsibilities matrix drafted
- Staff for “emergency team” are identified with clear roles and responsibilities
- Adjusted staffing schedule prepared to meet the stressful demands of an emergency

Programming

- Questionnaires, forms, and awareness materials are prepared and ready
- Post-rape kits and dignity/hygiene kits are compiled and pre-positioned
- Current map of GBV response services in the area updated
- Protocols to manage data and protect confidentiality developed
- Staff are trained in GBV emergency response

- ❖ Explain that this session is focused on preparing for a fictional emergency scenario. However, participants should take the time to develop contingency plans (emergency preparedness plans

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based on specific, potential emergency scenarios) in their own context. Content and additional resources to support this process can be found in the Participant Handbook, and amongst the tools that will be presented next.

- ❖ Explain that the transition to emergency programming (and out of emergency programming once a crisis has passed) is an essential element of preparedness planning. This includes both logistical and programmatic concerns – e.g. how financial, human resources and physical structures will need to change to allow for the emergency programming to take place, as well as considering exit strategies from the beginning of emergency programming, given that emergency funding is usually limited and short-term. For instance, establishing a large, complex program in an emergency when there is only 2 months of funding without considering the next steps may create expectations for staff and beneficiaries that cannot be fulfilled.
- ❖ Explain that during an emergency, time and resources are in short supply and priorities need to be made. Senior management determines where it prioritizes the organization’s time and resources. Management of different sectors also prioritize what they will address for their emergency programming and how it will be addressed. If they haven’t been sensitized to issues of gender and GBV before the emergency (therefore they don’t see their contribution to supporting women and girls needs and the GBV response), they are less likely to see it as a priority once an emergency strikes. Therefore, it’s important that you bring them on board before the emergency, if you want them to address issues of GBV from the onset.
- ❖ Introduce the following preparedness tools as additional resources:



- **Preparedness Plan Template** – The preparedness plan template outlined below is designed to support your reflection during the training on the actions that are most likely for you and your organization in an emergency, according to your current interventions and organizational strengths.
- **Scenario Development** – Guidance to identify the most likely scenarios in your context. The questions to guide your scenario development are included in the second tab of the same Preparedness Plan Template spreadsheet.
- **Communication & Responsibilities Matrix for Key Individuals at the Advent of an Emergency** - This is a simple map that outlines who should be contacting who and what their responsibilities are when a crisis occurs. It makes sure that the lines of communications are clear and that people know what to do when needed.
- **Emergency Deployment Tool Kit / Materials Check-List** - This is a list of the materials that a response team would need if they have to deploy into a crisis situation. It lists the types and quantity of the materials needed and who is responsible to have them packed and ready.

PLENARY: Feedback, Summary and Conclusion – 10 min.

- ❖ Summarize the key points of the session, highlighting the following:
 - Preparedness activities are most effective when concrete and specific, with one person assigned responsibility and a timeline.
 - Preparedness does not have to be done all at once. Spread out the tasks; do one or two tasks per week over a period of time. It is better to be partially prepared than not prepared at all because you kept pushing off all the little tasks as a “preparedness activity”.
 - Remember that you need to decide where your strengths lie as an organization and as individuals in deciding what you will take on in an emergency.

SESSION 16: CONCLUSION



Learning Objectives:

- Review and summarize learning and next steps.



Time: 1 hour



Materials required: Parking Lot Flip Chart, flip charts from the week, chocolates or similar to use as prizes, certificates, small ball or object to use for conclusion activity.



Facilitator Preparation:

- Review Parking Lot questions, source additional resources that can serve as support for participants if there are questions that cannot be answered on the spot.
- Arrange flip charts from the week around the training room.

PLENARY: Summary and Questions – 30 min.



- ❖ Ask participants to take a walk around the room, reviewing flip charts on the wall.
- ❖ Divide participants into small groups and give them each a pack including a blank agenda format, session titles and key session content (with content face down so participants cannot start early).
- ❖ Explain that this is a competition to see who can recreate an overview of the training the fastest. Participants should put their overview together, then raise their hands to have facilitators check their work. The group that gets the correct answer the fastest receives prizes.
- ❖ The following is the accurate list of sessions with key information to check answers (make sure you update this if you move sessions or content around during the training):

| Session | Key Points |
|--|--|
| Day 1 | |
| Women, Girls, and Gender-Based Violence in Emergencies | <ul style="list-style-type: none"> • Definitions of GBV and emergencies • Characteristics of natural disasters and conflict situations • The impact of emergencies on women and girls • Acute vs protracted emergencies • Consequences of GBV |
| Assessments – Introduction & Ethical Considerations | <ul style="list-style-type: none"> • Purpose of GBV rapid assessments in emergencies • Ethical considerations involved in GBV assessments in emergencies • Children and information-gathering |
| Assessments – Tools & Practice | <ul style="list-style-type: none"> • ER&P assessment toolkit (safety audit, focus group discussion tool, community mapping guide, individual interview tool, service mapping tool) • Advantages and drawbacks of different tools |
| Day 2 | |
| Introducing the Program Model | <ul style="list-style-type: none"> • Purpose of the IRC GBV Emergency Response & Preparedness Program Model • Goal, objectives and outcomes of the Program Model • Adolescent girls in ER&P programming • Survivors with disabilities in ER&P programming • Principles of GBV programming in emergencies • Supportive interactions with women, girls and survivors |

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| | |
|---|---|
| Case Management | <ul style="list-style-type: none"> • Essential steps of case management in emergencies |
| Psychosocial Support | <ul style="list-style-type: none"> • Distinction between case management and psychosocial support • Purpose of psychosocial support • Potential psychosocial activities |
| Health Response | <ul style="list-style-type: none"> • Key guidelines outlining health interventions (MISP, IASC guidelines for GBV Integration in Humanitarian Action, WHO Clinical Management of Rape, IRC Clinical Care for Sexual Assault Survivors) • Key health interventions and timelines for GBV survivors |
| Referral Systems | <ul style="list-style-type: none"> • Purpose and importance of referral systems • Barriers to effective referrals |
| Day 3 | |
| Community Outreach | <ul style="list-style-type: none"> • Purpose of outreach • Key topics • Creating effective messages (incl. not using images of violence) • Outreach methods • Safety in community outreach |
| Risk Reduction | <ul style="list-style-type: none"> • Definition and purpose of risk reduction work • Categories of risks for women and girls • Strategies to address risks • Principles of risk reduction • Preventing sexual abuse and exploitation • Do No Harm |
| Responding to Other Forms of GBV in Emergencies | <ul style="list-style-type: none"> • Different kinds of GBV that may be exacerbated in emergencies • Strategies to address these forms of violence • Service provider limits in acute emergencies |
| Information Management & Sharing | <ul style="list-style-type: none"> • Purpose of information sharing • Best practice in information management and sharing • Data storage/destruction in emergencies |
| Day 4 | |
| Coordination & Advocacy | <ul style="list-style-type: none"> • Definitions of coordination and advocacy • Key points of coordination and advocacy for GBV programming in emergencies |
| Emergency Preparedness | <ul style="list-style-type: none"> • Purpose and definition of emergency preparedness • Preparedness planning practice • Overview of preparedness tools |

- ❖ Review and discuss any questions in the Parking Lot. Highlight if there are questions that cannot be answered during this training, and provide additional resources, where possible. Ask participants for any additional questions or concerns, and discuss.

PLENARY EXERCISE: Final Quiz! – 20 min.

- ❖ Explain to participants that as a final exercise before you finish the training you are going to do a quiz to gauge understanding of different topics covered during the training.
- ❖ Divide participants into groups of 4, and ask each group to choose an animal noise to use as their buzzer sound. Test each group's 'buzzer'.
- ❖ Read out the following questions. The first group to make their 'buzzer' sound has 5 seconds to answer the question. If they answer it incorrectly, or fail to answer within the time limit, the chance passes to the next group that made their buzzer noise (or if no-one else did, ask the question again).

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and give the option to all teams to answer - except the one that already answered incorrectly). Give two points for a correct answer and 1 point for a partially correct answer – in that case, you can offer the option for another group to earn the additional point by completing the answer given.

- What is Gender-Based Violence? (Do not be too concerned about the exact wording – award the point if they include harm/violence (and particularly physical, emotional, sexual, etc.), consent, and gender roles/socially constructed expectations of men and women.)
 - Name three ways in which women and girls are particularly vulnerable in emergency contexts.
 - Name four of the eight ethical and safety recommendations for collecting data on sexual violence.
 - What are the priority steps of case management in emergencies?
 - A local NGO named {insert appropriate name here} is an expert in community outreach and awareness-raising. They have never done case management before. When an emergency strikes, should they start providing case management for survivors of GBV? Why or why not?
 - Name three types of psychosocial support.
 - Name three relaxation/self-care exercises.
 - Name two healthcare interventions for survivors of sexual violence, and the timeframe within which they must be provided to be effective.
 - Name two tools that can be used in GBV assessments in emergencies.
 - What is the Cluster Coordination system?
 - What is advocacy?
 - What is emergency preparedness?
 - Name two key ways in which we can share information about GBV services in emergencies.
 - Name three potential risk reduction strategies/activities/interventions.
 - What is a referral system/pathway and why is it important?
- ❖ Tally up the points and give prizes to the winning group and the runner-up. Use any incorrect answers as the opportunity to discuss the topic and ensure understanding.

PLENARY: Conclusion & Certificates – 10 min.

- ❖ If you are providing certificates, do so at this point. The following exercise is a nice way for participants to show their appreciation for each other: place certificates face down in a circle and ask participants to stand in front of any certificate. Select one participant to start by picking up the certificate in front of them, stepping to the center of the circle and reading out the recipient's name. The recipient should step forward to the center of the circle and receive their certificate, as participants show their appreciation for the recipient (the previous person returns to their place in the circle). Then ask the person who just received their own certificate to read out the name on the certificate they were standing in front of, and present it to the next recipient as they move to the center of the circle. Repeat until everyone has a certificate.
- ❖ Thank everyone for their participation.
- ❖ If you have time, you can do a brief conclusion activity: throw a ball to a participant and ask them to say one phrase about what the training experience has been like for them, then throw the ball to another participant. If you still have time, continue the activity by doing a second round where you ask participants to now say one word about how they are feeling at the conclusion of the training.
- ❖ Finish the session by highlighting any plans for follow-up with participants, and reminding them where they can find additional resources for support (see Annex 10).

ANNEXES

For ease of use, all annexes can be found in separate documents in the training package.

Annex 1: Participant Agenda

Annex 2: Facilitator's Agenda

Annex 3: Background Reading

Annex 4: Scenario

Annex 5: GBV Program Model (with additional guidance)

Annex 6: Assessment Toolkit (with adaptation and combination guidance)

Annex 7: Session Materials/Handouts

- Session 2 – GBV Definition Cards
- Session 3 – GBV Guiding Principles Example Cards
- Session 5 – Assessment Practice Role Play Scenarios & Cards
- Session 7 – Case Management and Psychosocial Support Guidance Note
- Session 8 – Healthcare Cards
- Session 9 – Bouncing Around Character Cards
- Session 10 – Community Outreach Materials
- Session 11 – Risk Reduction Handout
- Session 11 – Lanta Camp Description
- Session 11 – Risk Reduction Matching Cards

Annex 8: Templates

- Preparedness Planning Template (with scenario development guidance)
- Communication & Responsibility Matrix Template & Example
- Deployment Checklist Template & Example

Annex 9: Slides

Annex 10: Additional Resources

- GBV
- Emergencies & Humanitarian Standards
- Case Management & Psychosocial Support
- Health Response to Sexual Violence
- Prevention of Sexual Exploitation and Abuse
- Disability Inclusion
- Safe Spaces
- Monitoring & Evaluation/Information Management & Sharing