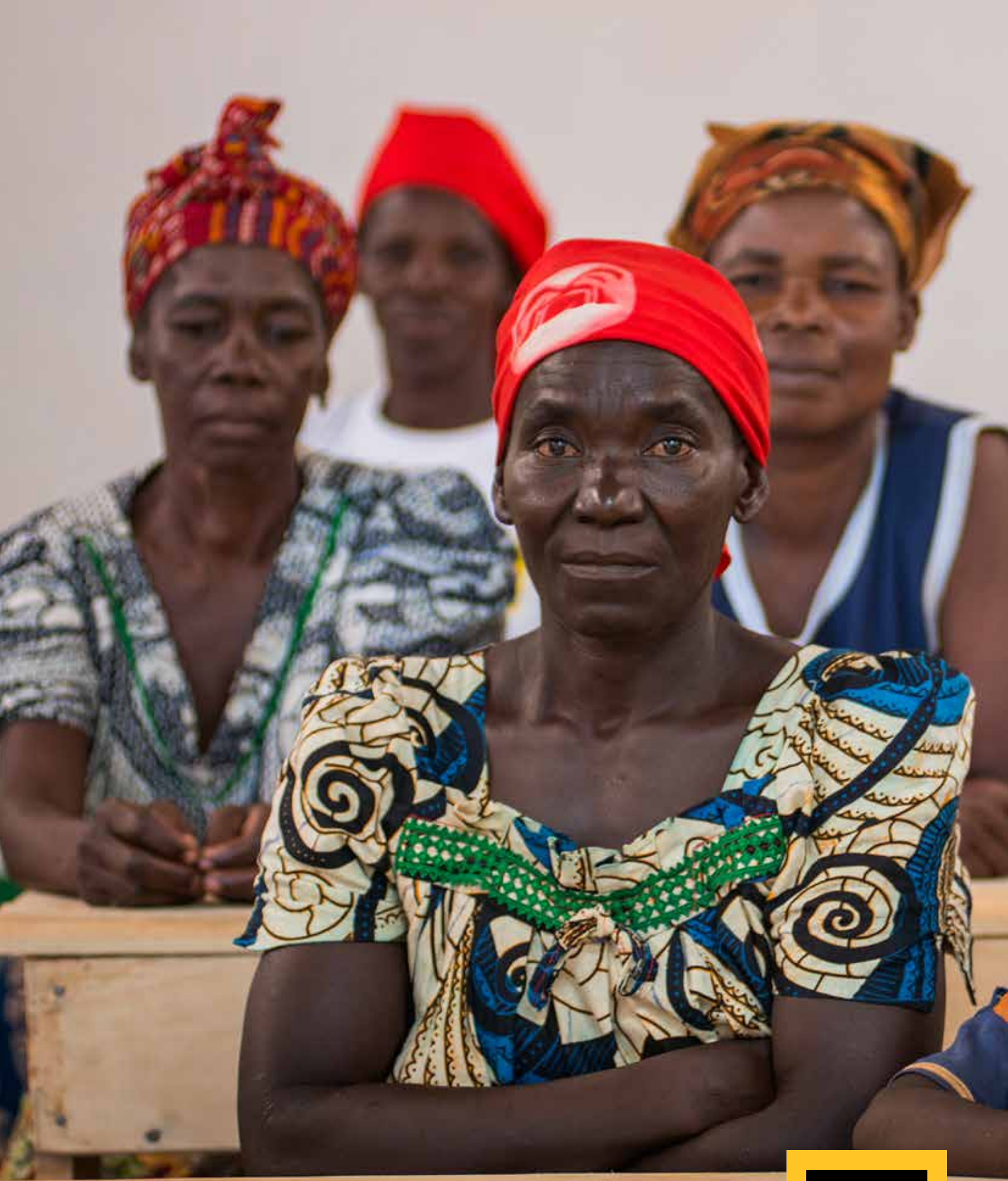
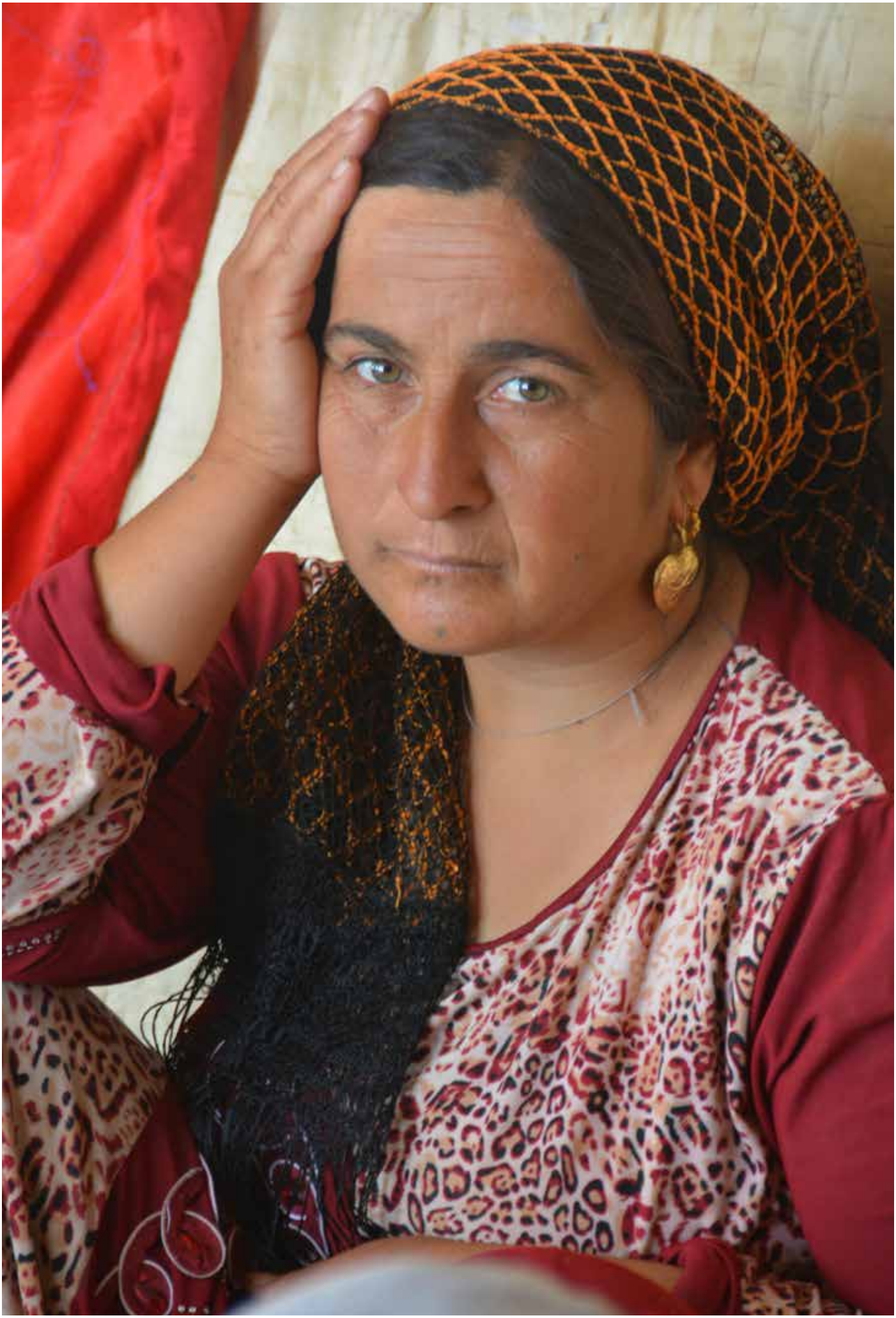


Are We There Yet?

Progress and challenges in ensuring life-saving services and reducing risks to violence for women and girls in emergencies

International Rescue Committee | SEPTEMBER 2015

INTERNATIONAL RESCUE COMMITTEE



Are We There Yet?

Progress and challenges in ensuring life-saving services and reducing risks to violence for women and girls in emergencies

International Rescue Committee | SEPTEMBER 2015

Table of Contents

FRONT COVER: Members of an IRC-organised saving and loan association near Ouandago, Nana-Grébizi district, Central African Republic (2014)

OPPOSITE PAGE: A woman sits in a communal hall, which has been used as shelter near Dohuk, Iraq, where families have been living in horrible conditions. The IRC has provided thousands with emergency kits containing plastic sheeting, cotton blankets, soap, undergarments and solar-powered lights with ports to charge cell phones. (2014)

3 Bloomsbury Place, London WC1A 2QL, UK | Rescue-uk.org | Rescue.org

INTERNATIONAL RESCUE COMMITTEE

Findings and Recommendations

In October 2012, the International Rescue Committee (IRC) launched the discussion paper, *Lifesaving, not Optional: Protecting women and girls from violence in emergencies*, which analysed the obstacles to effective responses to gender-based violence (GBV)[1] in humanitarian crises.

Lifesaving, Not Optional assessed the humanitarian community's response to GBV in four emergencies – in Haiti, Pakistan, the Horn of Africa and the Democratic Republic of Congo (DRC). The report evidenced a systemic failure to prioritise GBV in emergency response and surfaced the following lessons:

1. **GBV was not prioritised as life-saving in emergencies,** particularly during the acute phase of a crisis.
2. **GBV programmes were scarcely funded at the outset of emergencies,** accounting for less than 1-4% of the funding awarded in the four emergencies.
3. **GBV coordination and leadership within the UN system was weak**. Funding constraints and weak leadership prevented coordination bodies from having a major impact on practice in the field.
4. Donors, United Nations (UN) agencies and implementing **organisations interpreted, prioritised and implemented existing guidelines inconsistently**. There was a lack of consensus about what is urgent, and GBV was often considered too multifaceted or complex for concrete emergency response programming.

In an effort to examine progress in the field since our 2012 report, the IRC analysed four additional emergencies – in Central African Republic (CAR), South Sudan, Iraq, and the Ebola Virus Disease (EVD) crisis in Sierra Leone. This paper assesses the response to these ongoing emergencies in terms of how GBV has been prioritised in funding streams, the quality of GBV coordination efforts, implementation of GBV risk reduction guidelines across sectors,[2] and the delivery of specialised GBV services.

Progress: Where are We Today?

The launch of *Lifesaving, Not Optional* marked the beginning of a positive shift in high-level attention to GBV in emergency response. The world has never seen a stronger expression of commitment than there is today from key donors, UN agencies and practitioners to prevent and respond to GBV in emergencies, including through increased funding and strengthened accountability.

GBV services are life-saving.

When a woman is raped, she has:

72 hours to access care and prevent the potential transmission of HIV

120 hours to prevent unwanted pregnancy

A few hours to ensure that life-threatening injuries do not become fatal

Progress includes the launches of the United Kingdom (UK) -led *Preventing Sexual Violence in Conflict Initiative* (PSVI), the *Call to Action on Protecting Girls and Women in Emergencies* (Call to Action), the United States' (US) *Safe from the Start Initiative,* and the *Real-Time Accountability Partnership.* These initiatives have brought international attention to GBV in emergencies and secured high-level commitments from donors, UN agencies and non-governmental organisations (NGOs) in various areas, including to prioritise GBV as a life-saving intervention and to work with all humanitarian sectors on GBV risk reduction, with a focus on sector-wide accountability.

Preventing Sexual Violence in Conflict Initiative (PSVI), May 2012

PSVI builds on international declarations and other high-level initiatives[3] to bring focus to the issue of sexual violence in conflict.

> "We need to hold ourselves accountable for assuring that gender-based violence is… addressed in every single humanitarian response."
>
> —US SECRETARY OF STATE, JOHN KERRY, AT THE GLOBAL SUMMIT TO END SEXUAL VIOLENCE IN CONFLICT, JUNE 2014

Call to Action, November 2013

Call to Action aims to mobilise donors, UN agencies and NGOs to prioritise the protection of women and girls in first-phase humanitarian response. In its *Communiqué,* donors and humanitarian agencies adopted 12 global commitments to tackle GBV from the onset of emergencies.

Safe from the Start, January 2014

The US assumed leadership of the Call to Action and launched Safe from the Start, which frames US bilateral efforts on GBV emergency response. US leadership is focusing on establishing a Call to Action roadmap, with common objectives for the humanitarian community.

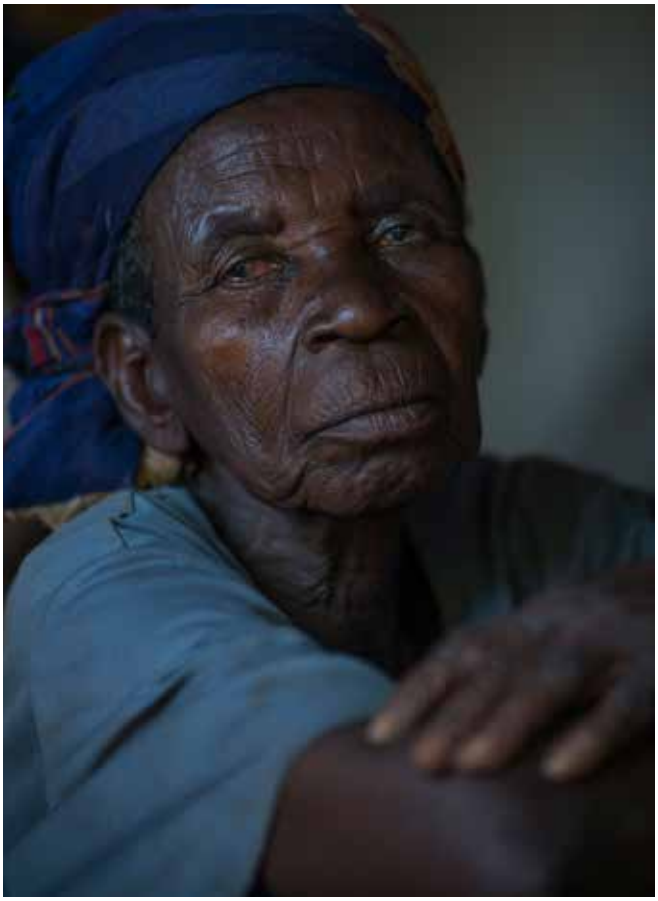
These objectives are:

1. to strengthen specialized GBV prevention and response services and programmes;
2. to implement actions to reduce and mitigate GBV risk across all levels and sectors of humanitarian response; and
3. to mainstream gender equality and the empowerment of women and girls throughout all aspects of humanitarian action.

Real-Time Accountability Partnership (RTAP), January 2015

Key humanitarian and donor agencies – United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the IRC and US Agency for International Development's Office of US Foreign Disaster Assistance (OFDA) – launched a partnership to promote accountability for the prioritization, integration and coordination of GBV efforts across all humanitarian action. The RTAP will develop and implement a model for strategic action to support this goal in emergencies. It will also evaluate the partnership's success in implementing the model.

> "The commitments made today mean… the safety of girls and women will be a major priority for all humanitarian agencies alongside delivering other essentials like food, water and shelter."
>
> —JUSTINE GREENING, UK SECRETARY OF STATE FOR INTERNATIONAL DEVELOPMENT, NOVEMBER 2013



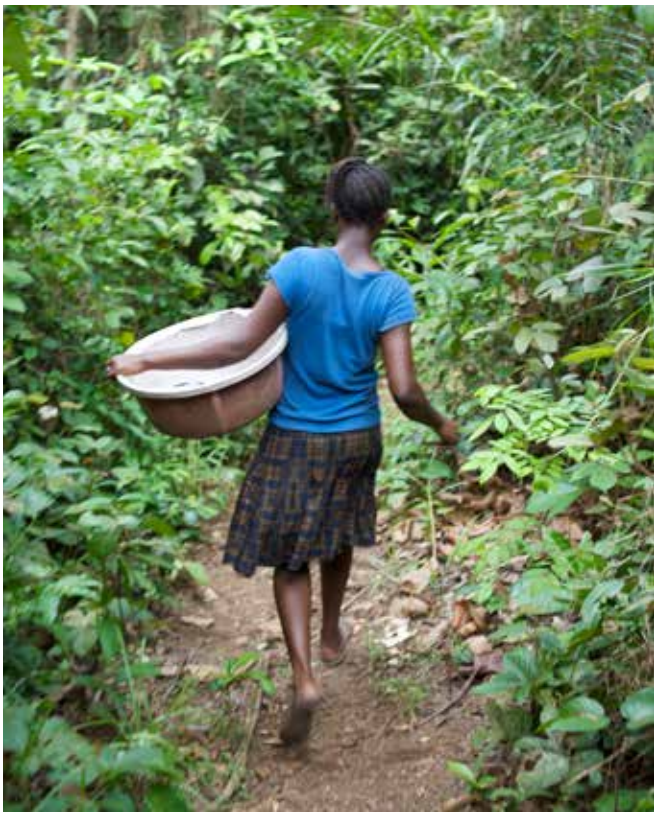
A woman in her shelter at one of several sites for internally displaced people in Kaga Bandoro, Central African Republic (2014)

As a result of these initiatives, donors and UN agencies have worked to strengthen GBV coordination, and there is greater consensus in the humanitarian community on how to interpret and implement guidelines for GBV response. A notable success was the creation of the GBV Area of Responsibility (GBV AoR) Regional Emergency GBV Advisors (REGAs) in 2014. REGAs provide regional and country-level support by deploying to Level Three (L3) emergencies.[4] They have supported response efforts in the field, including in South Sudan and Sierra Leone, as highlighted in this paper.

The GBV AoR has also revised the 2005 Inter-Agency Standing Committee *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* (IASC GBV Guidelines)[5] to reflect changes in the humanitarian architecture, the Transformative Agenda, and lessons learned from ten years of implementation of the Guidelines. The revised IASC GBV Guidelines outline minimum commitments each humanitarian sector must fulfil to reduce risks of GBV and facilitate women's and

girls' access to quality services. Defining these minimum commitments is a critical step toward promoting common approaches and buy-in on the importance of action across the humanitarian spectrum.

Increased funding for GBV research and specialised programming is also resulting in improvements in the evidence base on how the humanitarian community best delivers GBV emergency response programming. The UK government launched *What Works to Prevent Violence against Women and Girls in Conflict and Humanitarian Crises,* a multi-country, multi-study research initiative that seeks to advance learning on issues ranging from GBV case management to cash assistance for women in emergencies. The UK Department for International Development (DfID) also launched a research and programming pilot on protection of adolescent girls in fragile settings in DRC, Pakistan and Ethiopia. Irish Aid continues to prioritise GBV response on various fronts, in the Horn and East Africa; additionally by funding GBV programmes in new emergencies, and by advocating for GBV response towards the World Humanitarian Summit. The Swedish International Development Agency (SIDA) is supporting the Humanitarian Innovation Fund to pilot an initiative on GBV response in emergencies.



Marima, a girl attending an IRC-supported secondary school in Kenema District, Sierra Leone, fetches water from the river after school. (2009)

Conclusions and Recommendations

High-level commitments and processes such as those discussed above seek to protect women and girls from harm in emergencies and to support GBV survivors to recover and thrive. Progress should be measured based on whether this is happening for women and girls in current emergencies.

The analysis of the four emergencies in this paper shows that despite high-level commitments to strengthen the response to GBV in emergencies, the humanitarian community has yet to take effective and consistent action to address the protection concerns of women and girls in crises, especially those related to GBV risk reduction and GBV specialised services.

This section outlines the main conclusions from the analysis, and issues recommendations for humanitarian actors to improve response to GBV in emergencies. It is only by meaningfully monitoring our progress and holding ourselves accountable that the humanitarian community will be able to redirect efforts and resources to fulfil our obligations to women and girls in crises.

1. Humanitarian leadership does not prioritise or hold actors accountable for action on GBV in emergency response.

The case studies in this paper evidence how donors, humanitarian coordinators (HCs), humanitarian country teams (HCTs), and cluster leads are gatekeepers in the response to GBV; their decisions and actions are pivotal in determining the extent to which GBV is prioritised during emergencies. These actors are in a position to include GBV in initial assessments, activate and fund coordination bodies, influence the contents of Humanitarian Response Plans (HRPs), lead advocacy efforts, and require effective and timely GBV programming.

The Iraq and Sierra Leone case studies show a significant delay on the part of humanitarian leadership in including analysis of GBV in their emergency reports. In addition, in Iraq, the GBV sub-cluster was activated only seven months after the onset of the emergency,[6] and in Sierra Leone was not activated at all during the Ebola outbreak.

Furthermore, the near-absent response to GBV in Sierra Leone reveals that the humanitarian community's improved understanding of GBV as a priority issue in conflict-related emergencies has not extended to emergencies with a different profile, such as public health emergencies and natural disasters.[7] The focus on treating and stopping the spread of EVD in Sierra Leone was obviously needed. However, it should not have come at the expense of providing GBV life-saving services or of complying with the IASC GBV Guidelines. Without a GBV coordination mechanism in place and with very limited funding, GBV actors were unable to fill the gaps left by the overwhelmed health sector, leaving GBV survivors with nowhere to turn.

Without the commitment and follow-through of humanitarian leadership, progress in delivering GBV programmes will continue to be sporadic and inconsistent.

Recommendations

- Lead humanitarian agencies, HCTs, and HCs should commit to consistently include GBV in all emergency assessments and reports, response plans and funding schemes, including by hiring qualified staff to oversee these processes.
- Humanitarian leadership should require all humanitarian actors to be trained in GBV risk reduction and/or specialised services prior to deployment. To support this aim, humanitarian leadership should require the GBV AoR and sub-clusters to report on global and local capacity-building efforts through periodic reports.
- The GBV AoR should increase and improve its field and high level advocacy in order to bolster humanitarian leadership's awareness of GBV and encourage inclusion of GBV in all emergency response efforts.

2. Donors and common funding pools do not consistently fund GBV in emergencies.

All case studies show that GBV prevention and response activities in emergencies are in high demand, yet vastly under-resourced.

There has been a recent increase in bilateral funding for GBV emergency response efforts. However, the high levels of need in the face of multiple, ongoing emergencies, along with varying donor funding cycles and competing priorities, means that bilateral funds for GBV in emergencies, while an important contribution, can be unpredictable and inconsistent.

In pooled funds and HRPs, funding for GBV programmes is late to be prioritised if at all, leading to tremendous shortfalls in all the emergencies studied. The 2014 HRPs for CAR, South Sudan and Iraq, for example, only fulfilled 5.2%, 20.9%, and 5.5%, respectively, of what was requested for GBV programmes,[8] totalling minuscule percentages of the total HRP in each country. This results in insufficient and undependable resource flows, which then contribute to a shortage of effective and comprehensive response programmes.

Humanitarian leadership has the capacity to direct funds from these pools to various aspects of emergency response efforts on a 'needs basis'. Given that international standards such as the IASC GBV Guidelines require "all humanitarian personnel to assume and believe that GBV… is taking place and is a serious and life-threatening protection issue, regardless of the presence or absence of concrete and reliable evidence",[9] the need to fund GBV programming is easy to predict. Humanitarian leadership and decision-makers in common funding pools (including the Global Protection Cluster) should apply this accepted principle to the allocation process.

Recommendations

- Donors should make their contributions to common funding pools contingent upon allocations to GBV programmes, in compliance with IASC GBV Guidelines and in response to identified needs.
- Donors should require all entities seeking funding to explicitly address in their funding applications how they will respond to GBV, regardless of their sector or area of focus.
- The GBV AoR and in-country mechanisms must increase and sustain advocacy efforts for better and more immediate funding for GBV programmes, and report on these efforts in regular monthly calls, emergency-specific calls and periodic reports, and through the GBV AoR website.

3. GBV coordination continues to face capacity limitations, and local-level advocacy is ineffective due to weak support at higher levels.

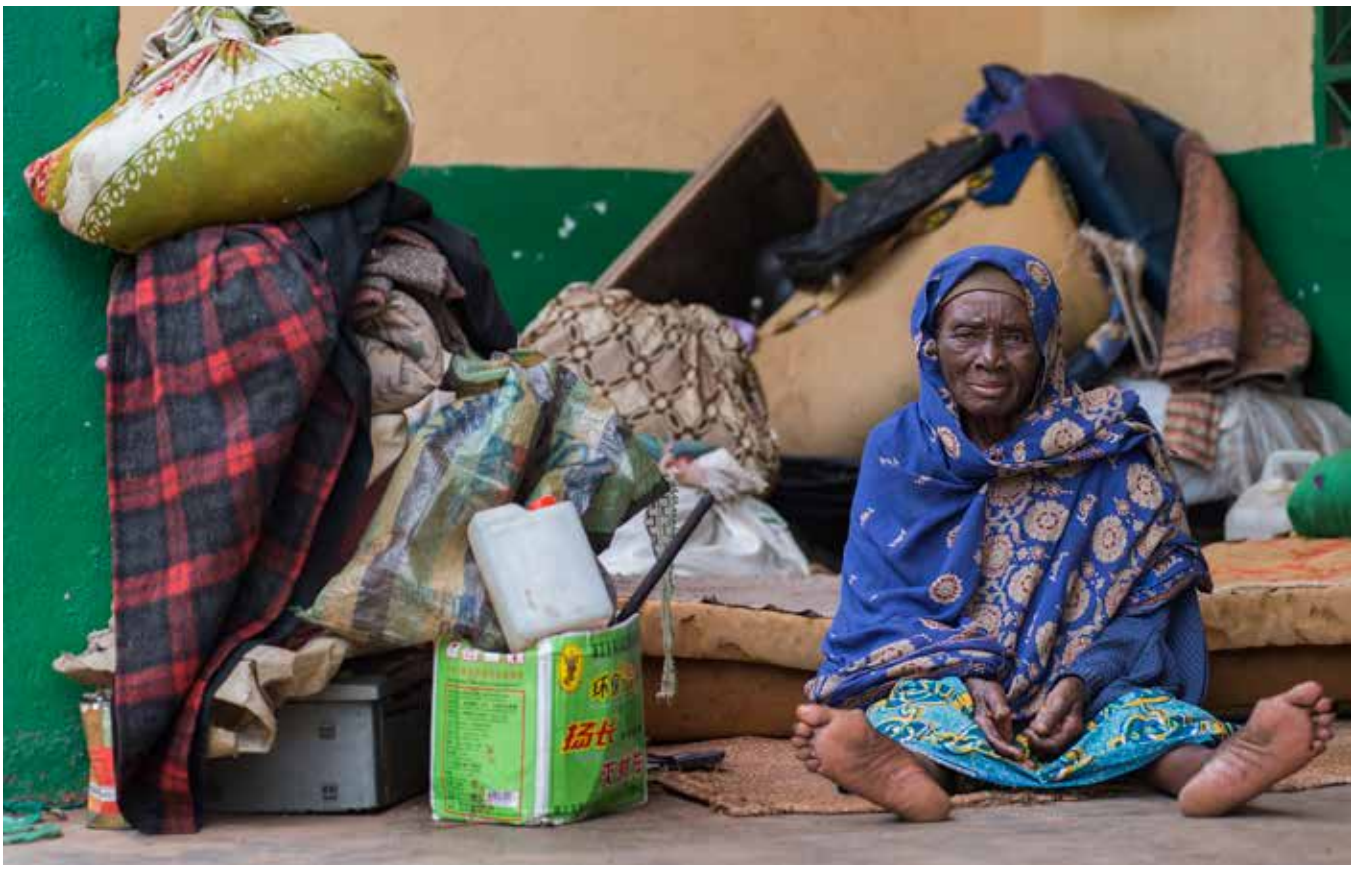
The case studies from CAR and South Sudan offer positive examples of GBV sub-cluster efforts to draw attention and funding to GBV. However, this advocacy did not always result in robust response to GBV, and the GBV AoR should seek to understand why. This could be rooted in the ways local humanitarian leadership – HCs, HCTs and Protection Cluster leads – do, or do not, elevate the messages of the GBV sub-cluster to help ensure its concerns are heard and acted upon. However, the GBV AoR also has an important role to play as a global body mandated to conduct high-level advocacy for increased action and accountability for GBV at global levels.

All case studies highlight challenges in capacity from GBV coordination bodies. Weak GBV leadership and coordination negatively impact GBV programming, including by impairing the ability to identify priorities, conduct robust and sustained advocacy, ensure adequate staffing, conduct service mappings, establish referral pathways, and support other clusters in implementation of minimum standards.

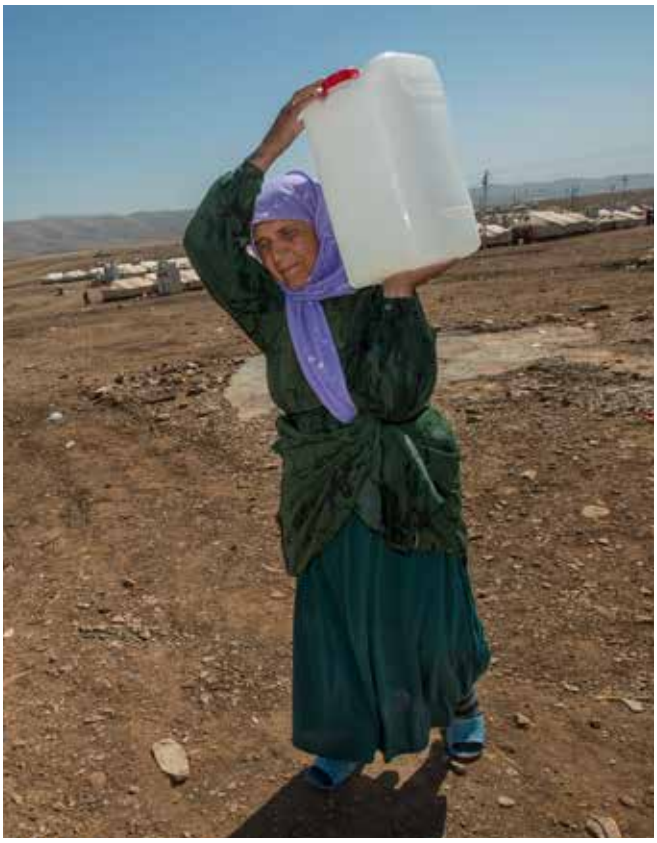
Recommendations

- Donors investing in GBV coordination must hold the GBV AoR and in-country mechanisms publicly accountable for effective coordination, information-sharing, awareness-raising and advocacy. Donors should require GBV AoR and sub-clusters to share their work plans, reports and accomplishments publicly on a quarterly basis with GBV AoR members and through the GBV AoR website.
- Humanitarian leadership should mandate deployment of interagency GBV coordinators within 72 hours of an emergency.
- The GBV AoR should commit to the timely recruitment of a permanent GBV Coordinator. A timeline for this recruitment process should be shared with AoR members without further delay.

An elderly Muslim woman, displaced by sectarian violence, sheltering at the main mosque in Bangui, Central African Republic (2014)



- The GBV AoR should require GBV sub-cluster coordinators to report monthly on their efforts and progress, and share these and REGA deployment reports with donors and GBV AoR members on a monthly basis, through monthly calls and publicly through the GBV AoR website.[10]
- The GBV AoR should invest in building the capacity of GBV coordinators, including by developing indicators to measure effective coordination within the first phase of an emergency,[11] encouraging GBV coordinators to shadow more experienced coordination leads from other clusters and by facilitating the exchange of best practices with other coordination bodies.
- The GBV AoR should report annually on the fulfilment of its mandate to the Protection Cluster, donors and GBV AoR members. This report should describe all sub-clusters and global cluster activities to promote enhanced GBV emergency response in all L3 emergencies, and respond to outcomes and actions in the Call to Action Roadmap, which is being finalised by the US in 2015.



An elderly woman brings water to her tent from an IRC-installed tap in Arbat, Iraq (2013)

4. Specialised GBV services are inadequate or absent in emergency response, and existing guidance on GBV risk reduction is not operationalised by all humanitarian sectors.

Although GBV coordination mechanisms were quick to draw attention to GBV concerns in two countries where they were already activated from previous crises (CAR and South Sudan), this attention did not translate into adequate set-up of specialised services at the onset of new crises. For example, only 19 out of 44 sites for internally displaced people in Bangui, CAR had essential GBV services during the first phase of the emergency response. In all cases, the establishment of essential programming was hindered by limited funding, insufficient availability and slow deployment of GBV experts, and in some cases, weak advocacy for GBV prioritisation from coordination mechanisms at strategic levels.

All case studies demonstrate lack of action from humanitarian actors beyond the Protection and GBV sectors to reduce risks for women and girls. They highlight examples of actors' limited response to identified GBV protection gaps within the purview of their sector – e.g., putting locks on sanitation facilities to increase women's and girls' safety or ensuring safe food distribution practices. These examples point to low levels of commitment to GBV minimum standards, limited understanding of how to operationalise the IASC GBV Guidelines, and lack of accountability to humanitarian leadership regarding compliance.

The rollout of the revised IASC GBV Guidelines should be seen as an opportunity for humanitarian leadership to strengthen understanding and compliance among all actors. In addition, through the RTAP, an interagency group will set forth standards for high-level action required to ensure the prioritisation, integration and coordination of GBV in emergencies. The commitment of a major donor and four UN agencies in this partnership indicates strong will to strengthen accountability to GBV response.

Recommendations

- Donors should require funding proposals from all sectors to outline planned GBV risk reduction activities and account for them in monitoring and evaluation plans and reporting.
- Humanitarian leadership of all L3 emergencies should conduct annual real-time evaluations of the implementation of the IASC GBV Guidelines.

- Cluster leads should mandate all agencies to disseminate, channel resources towards, and train staff to adequately implement the IASC GBV Guidelines. All cluster reports should include GBV risk reduction efforts and give specific recommendations to agencies that fail to comply with IASC GBV Guidelines.
- All clusters at field and global levels should identify GBV focal points to participate in GBV sub-cluster meetings and report on their sectors' actions on GBV risk reduction to the GBV sub-cluster.
- The GBV AoR and in-country mechanisms must:
  1. ensure that dissemination and training related to the IASC GBV Guidelines is widely undertaken;
  2. monitor the implementation of the Guidelines; and
  3. hold all clusters accountable through strong public advocacy at all levels and through their annual report.

5. GBV implementing agencies do not have the capacity to respond to the current levels of need.

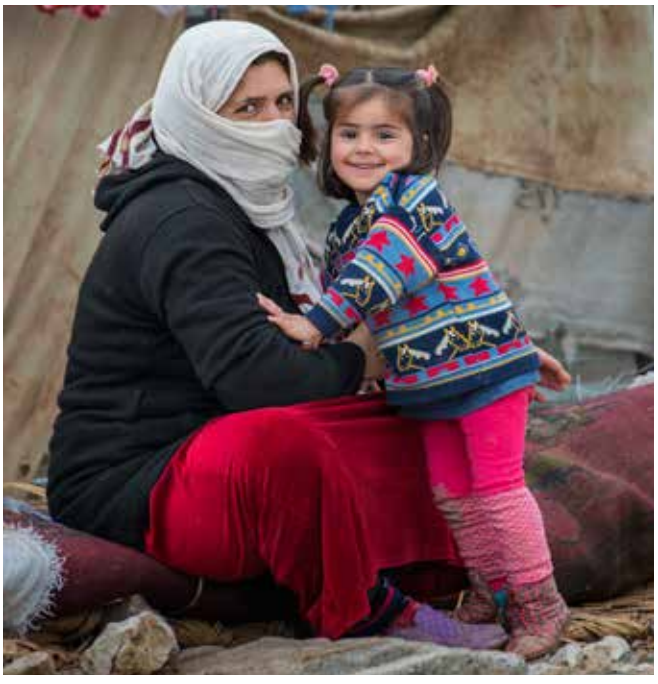
The case studies highlight a global reality: there is insufficient capacity to respond effectively and comprehensively to the levels of GBV in emergencies across the world.[12] On various occasions, donors have been prepared to disburse funds to support GBV programming, but did not receive proposals from qualified actors. GBV, as a sector, is still developing, and although donors have invested in individual capacity-building initiatives, these have not been global or system-wide.[13]

This lack of capacity and the heightened security and humanitarian access concerns in many emergencies underscore the crucial need for investment in building the capacity of local and international organisations to provide GBV services directly and in a timely manner. In particular, local actors are better placed to respond before INGOs are able to mobilise resources and deploy, or after international staff have evacuated due to security concerns. They have deep knowledge of the communities they work in and are trusted by them.

Recommendations

- Donors should create a pooled funding mechanism to resource the implementation of the actions and recommendations in the GBV AoR Capacity Building Strategy for 2015-2020. A global GBV capacity-building initiative should train, provide tools and ongoing-support to organisations interested in gaining or scaling up GBV expertise.
- Donors should make funding for agencies delivering GBV specialised services contingent upon having received GBV training and capacity building.
- The GBV AoR must work with its members to ensure capacity-building efforts reinforce a common, multi-sectoral approach to GBV response in emergencies.
- The GBV AoR and the Call to Action lead should create an annual audit process to evaluate agencies' efforts to build internal capacity to deliver GBV programmes (specialised services and risk reduction).
- INGOs must prioritise internal capacity building on GBV emergency response and preparedness and include a quota of local stakeholders/partners in these trainings.

It is time for humanitarian actors to shift from awareness and high-level commitments on GBV response in emergencies to concrete action and accountability on the ground. Donors, UN agencies and NGOs must hold each other accountable to actions that affect positive change and save the lives of women and girls.



LEFT: Mother and child in Domiz camp, Iraq (2014)

Case Studies at a Glance

	Central African Republic	South Sudan	Iraq	Sierra Leone
Onset of the emergency	December 2013	December 2013	January 2014	June 2014
Level Three emergency declared	December 2013	February 2014	August 2014	n/a
Number of affected people	837,245 displaced *(368,859 IDPs and 468,386 refugees)*	2,215,962 displaced *(1.6 million IDPs and 615,962 refugees)*	3,100,000 IDPs *	17,357 people affected *(13,406 Ebola Virus Disease confirmed cases and 3,951 deaths)*
GBV first mentioned in OCHA and other emergency reports	17 December 2013	23 December 2013	9 August 2014	31 December 2014
GBV sub-cluster activated	Activated before crisis	Activated before crisis	Activated August 2014	Not activated
Funding allocated for GBV in 2014 common funding pools (US$)	***HRP*** $313,396 / ***CHF*** $0	***HRP*** $15.8 million / ***CHF*** $3.9 million	***HRP*** $411,832 / ***CHF*** n/a	Undetermined
Funding (%) allocated to GBV against total amount requested in 2014	***HRP*** 0.9% / ***CHF*** n/a	***HRP*** 21% / ***CHF*** n/a	***HRP*** 9.4% / ***CHF*** n/a	Undetermined
Funding (%) allocated to GBV against total humanitarian funding in 2014 (HRP and CHF)	***Total*** 0.08% ***HRP*** 0.08% / ***CHF*** 0%	***Total*** 3.9% ***HRP*** 1% / ***CHF*** 2.9%	***Total*** 0.05% ***HRP*** 0.05% / ***CHF*** n/a	***Total*** 0% ***HRP*** $0 out of $547 million *(granted by the Regional Ebola Response)* ***CHF*** $0 out of $15.9 million designated for general protection *(granted by US, UK and Canada)*

* This does not include Syrian refugees or displacement related to the Syria Regional Response.

Four Emergencies Close Up: Successes and Challenges

Central African Republic

The current crisis in CAR began in March 2013, after the armed group known as the Seleka seized the capital city of Bangui and ousted then-President Bozizé, plunging the country into a new cycle of fighting and lawlessness.[14] In December 2013, an escalation of the conflict caused massive upheaval, displacing an estimated 370,000 people in Bangui and scattering 785,000 more across the country.[15]

GBV was acknowledged as a major problem from the onset of the crisis. Reports from Amnesty International confirmed that women and girls were systematically targeted by armed groups with a consistent pattern of abuses – including rape and other sexual violence, and other forms of GBV.[16] Various reports from OCHA drew attention to the need for increased GBV services.[17,18] In December 2013, the GBV AoR launched an urgent Call to Action, stating that most survivors were reluctant to access the limited response services available, given the pervasive stigma associated with GBV.[19] This advocacy helped draw the humanitarian community's attention to the issue early on.

As the crisis wore on, advocacy efforts continued.[20] A June 2014 report by the Gender Standby Capacity Project (GenCap) advisor, for example, detailed the significant, ongoing risks and challenges facing women and girls in CAR – including rape, sexual slavery and early and forced marriages.[21]

This early awareness-raising, however, failed to result in adequate programming to address the health and safety concerns of women and girls in CAR. Over-stretched coordination and leadership, insufficient funding and lack of cross-sectoral prioritisation of GBV meant that women's and girls' most urgent needs, including GBV services, have fallen through the cracks throughout the current crisis.

Coordination and Funding

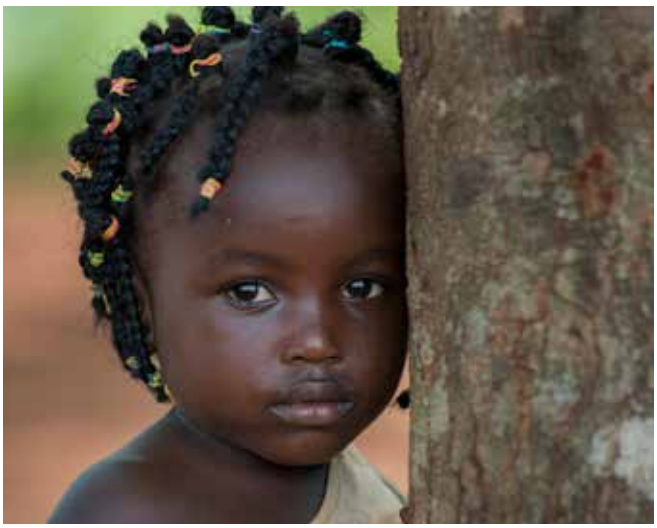
The GBV sub-cluster was already activated in CAR from previous crises, and GBV experts were quickly deployed once the new wave of violence broke out. The sub-cluster, however, was challenged by instability in its leadership: it had, for example, three separate co-chairs in the first four months of the emergency. Although the GBV AoR launched the Call to Action, early in the crisis the GBV sub-cluster did not regularly share data on GBV services and analysis with other clusters or humanitarian actors to support local level advocacy to draw attention to GBV.[22] This weakness in coordination may have contributed to the lack of prioritisation of GBV in the common funding pools, and thus the insufficient levels of funding to effectively respond to the violence taking place against women and girls.

> "Here, women had to bury the dead, were abandoned. Everything that happened in the country, women have been targeted."
>
> —LOCAL LEADER, BOCARANGA, CAR

The 2014 CAR HRP was 68% funded, only 9.2% of which went to the Protection Cluster. From this, only one GBV project was funded - representing less than 0.9% of the protection funding and 0.08% of the total budget, and covering only 5.2% of what was originally requested for GBV. Furthermore, not a single dedicated GBV programme was funded within the two Common Humanitarian Fund (CHF) rounds for CAR in 2014, although the GBV sub-cluster sent proposals to the Protection Cluster in both rounds.[23]

Bilateral donors provided most of the funding for GBV programmes during the crisis, though funds did not all come in a timely manner. DfID contributed $22,350,542[24] and $20,631,270 in 2014 and 2015, respectively,

A girl displaced by fighting in Bangui, Central African Republic (2014)



to programmes that included a GBV component, including psycho-social and medical assistance, income-generating activities and community-level prevention activities. The EU has set up a women's empowerment trust fund to support economic and social empowerment programming and build national capacity to provide GBV services. The US has also funded multi-sectoral GBV programmes. While these contributions have played a critical role in sustaining life-saving programming for women and girls in CAR, they alone are not enough to provide prevention and response services to match the need.

Specialised Services and Reducing Risks for Women and Girls

Violence against women and girls was well documented during the crisis, including gang rapes of women and girls by armed forces.[25] Despite this, by February 2014 there were only four GBV service providers operating in all of CAR, and by mid-2014 fewer than half of the sites for internally displaced persons (IDPs) in Bangui had specialised GBV services, referrals, and sensitisation efforts in place (19 out of 44 sites).[26]

In December 2013, a GBV sub-cluster update reported that UNFPA had rolled out the Minimum Initial Service Package for Reproductive Health in Crisis Situations (MISP),[27] and that the GBV sub-cluster had given guidance to all clusters on minimum GBV prevention and response actions to incorporate into their ongoing work, encouraging full implementation including in areas with low reporting rates, warning this could be due to the pervasive stigma around GBV.[28]

Despite these efforts, the IRC identified areas in which minimum standards to protect women and girls were not being met. Through safety audits, focus group discussions, and community mapping exercises with women and girls, the IRC documented persistent high-risk factors, including women's and girls' lack of access to money and resources, their role in the collection of water and firewood, lack of sex-segregated sanitation facilities, unsafe shelter, overcrowding and lack of privacy.

The failure to respond to the GBV sub-cluster's calls to implement minimum GBV risk reduction measures (especially by the water, sanitation and hygiene (WASH) and shelter sectors), and lack of follow-up action from other clusters in response to the documentation of persistent risks reflect non-compliance with minimum standards for GBV risk reduction and the absence of political will and action to tackle GBV.

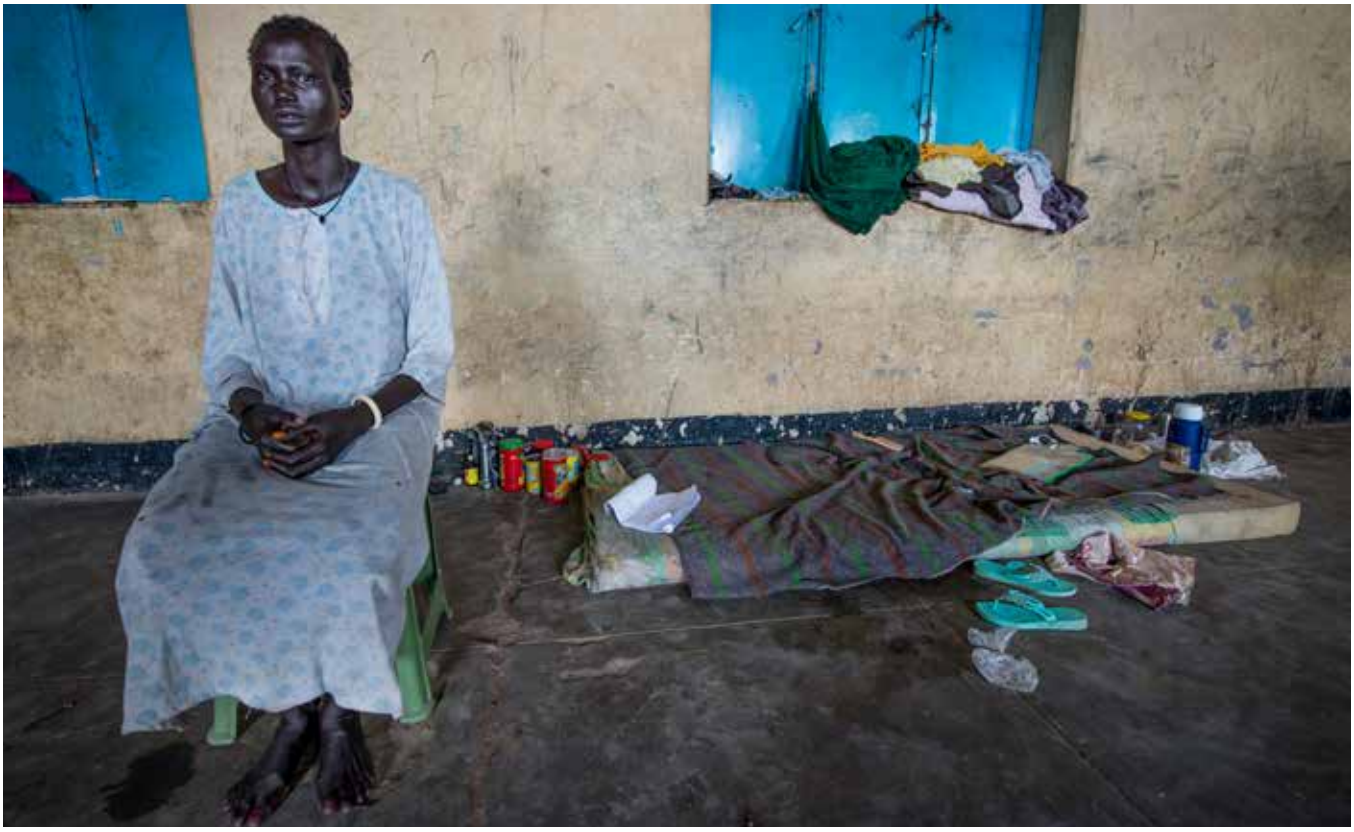
Lucienne Nouetou, 59, one of the thousands living in Moukassa displacement camp, Bangui, Central African Republic (2014)

The Future for Women and Girls in CAR

At the time of writing, the security situation throughout CAR remains volatile, with regular attacks on both civilians and humanitarian workers, and ongoing high levels of displacement.[29] The referendum on the new constitution planned for October 2015 could invite further violence. Meanwhile, dwindling resources[30] have forced GBV service providers, including the IRC, to continually cut back on essential programming.

The IASC GBV Guidelines mandate all actors to assume and believe that when an emergency occurs GBV is happening and will increase, and women and girls are amongst the first to be targeted. Donors and humanitarian agencies must increase and sustain support for life-saving GBV programming in CAR for the duration of the crisis and beyond. This support includes ensuring local actors have the capacity to implement the GBV Standard Operating Procedures launched in July 2015 during the visit of a GBV AoR REGA. Comprehensive initiatives that bridge humanitarian and development approaches, such as the EU trust fund, are welcome and should be expanded upon as part of ongoing efforts to address GBV.

> "From 7pm the girls do not even leave the tents. They do not even set foot outside the tent. The girls will not even urinate, because if they leave the tent, boys attack."
>
> —WOMAN IN IDP SITE, BANGUI, CAR



Ayom Aduit, 35, has lived inside a classroom in a Muslim school in South Sudan's capital, Juba, for six months. (2014)

South Sudan

Heavy fighting broke out in South Sudan in December 2013, following a political dispute between President Salva Kiir and former Vice President Riek Machar. This plunged the country into a civil war that has continued into 2015.[31] Tens of thousands of people have been killed, over 1.6 million people have been displaced inside the country, and 615,962 people have sought refuge outside the country's borders.[32] Insecurity and violence led some IDPs to seek protection inside UN bases. These sites became known as Protection of Civilians (PoC) sites, and by June 2015 were hosting more than 138,000 IDPs.[33]

GBV was a well-documented problem in South Sudan before December 2013, and, as in CAR, the GBV sub-cluster was already activated before this crisis. GBV was not reported by OCHA until its third situation report on this crisis;[34] further concerns about sexual violence targeting women and girls were published in January 2014.[35] Humanitarian actors, advocacy groups such as Amnesty International,[36] and the UN Mission in South Sudan[37] all reported increases in intimate partner violence (IPV), rape, sexual abuse and exploitation, and sexual slavery.[38] All women and girls who spoke to the IRC during a June 2014 assessment reported that rape was a common weapon wielded by both sides of the conflict, threatening safety both within and beyond the PoC sites.[39]

Restricted humanitarian access, overstretched coordination mechanisms, and scarce resources for GBV prevention and response – due to dwindling funding and weak institutional capacity – have long left most women and girls in South Sudan unprotected and without recourse in the face of extreme violence.

Coordination and Funding

Coordination efforts in South Sudan have lacked capacity to respond effectively to the particular risks faced by displaced women and girls. By September 2014, nine months into the conflict, only seven out of 18 locations identified as being of concern had a GBV lead agency to coordinate efforts.[40] The GBV sub-cluster, led by UNFPA, has not had an NGO co-lead since August 2014, in part because NGOs are overstretched and focused on service delivery, but also due to limitations within the sub-cluster's coordination and technical capacity.[41]

> "I was three months pregnant, but because I was raped by so many men, the baby came out. If I had refused those people, they would have killed me. Nine men raped me."
>
> —GBV SURVIVOR IN LEER COUNTY, SOUTH SUDAN (AMNESTY INTERNATIONAL)

South Sudan was allocated more funding for GBV than CAR or Iraq, in absolute terms and as a percentage of total funding, perhaps as a result of advocacy by the GBV sub-cluster. [42] In 2014, 30.7% of Protection Sector allocations and 1% of the whole HRP were for GBV.[43] However, this was insufficient to respond to the levels of need: only 21% of the requirement for GBV was funded by the HRP in 2014.[44] The 2014 CHF allocated $13,898,077 to protection projects, $3,943,483 of which was channelled to five organisations for GBV programmes, representing 28.4% of the CHF protection allocations and 2.9% of the whole CHF.[45] A good practice in South Sudan was the deployment of a GBV AoR REGA to inform the development of the 2015 HRP, which resulted in higher funding in the 2015 HRP.[46]

DfID allocated $4,845,222 to GBV programmes in 2014, channelled through NGOs; the US supported specific GBV programmes and Irish Aid has contributed to GBV specialised services in PoCs. In 2015, DfID also stepped in to fill the coordination capacity gap by supporting a Roving GBV Coordinator to act at state and national levels to improve information sharing and support efforts to mainstream risk reduction across all humanitarian sectors.

Specialised Services and Reducing Risks for Women and Girls

The majority of IDPs in South Sudan are women and children, yet services catering to their urgent needs are few and diminishing. Key obstacles to implementing high quality GBV programming include the limited number of actors with GBV expertise, insufficient funding, ongoing insecurity and limited humanitarian access, and weak coordination and leadership by the Protection Cluster and GBV sub-cluster.

During much of the crisis, GBV services were concentrated in the six PoC sites, despite the relatively small proportion of IDPs there, leaving fewer resources for the more remote, conflict-affected areas. Dwindling CHF funding has recently led agencies to close or downscale programmes in the PoC sites and across the country, however, leaving even fewer places to turn for women and girls subjected to violence.

Furthermore, where general medical services do exist, they are not always equipped to respond to the needs of GBV survivors. Not all health agencies, for example, provide the minimum clinical response in cases of rape, and where post-rape care kits are available, staff are not always trained to use them. In addition, a survey conducted by CARE International and UNICEF in May 2014 found that only 37% of respondents who reported GBV to hospitals or the police received counselling.[47]

There has been a general failure in South Sudan on the part of other humanitarian sectors to incorporate basic GBV risk reduction actions into emergency programming. An IRC assessment in February 2014 in the Mingkaman IDP camp and the PoC in Bentiu, for example, found that women and girls were being attacked, raped and abducted while collecting firewood, water and food. In most IDP and PoC sites, limited or no lighting in the settlements, overcrowding, lack of spaces to congregate safely, and no privacy or locks on toilets, tents or showers contribute to women's and girls' risks of violence. In one of the PoCs, it took protection actors more than three months of advocacy to get WASH actors to put locks on the toilets so women and girls could use them safely.[48]

Food scarcity in South Sudan,[49] including recent disruptions to food distribution programmes in parts of the country, have forced women and girls to forage in the forest or bush to gather food for their families, exposing them to risks of rape, exploitation and survival sex. Where World Food Programme (WFP) food distribution points are functioning, they can be harrowing experiences for women and girls, who may have to walk hours or days to reach them, and then sleep in the open before embarking on the long trek back – all of which render them vulnerable to exploitation and attack. In addition, many women have received unprocessed sorghum, forcing them to find ways to pay for milling, which also increases their risks of sexual exploitation. While WFP's ability to import alternative food sources is limited by security and logistical constraints, distributing mills to IDP sites would help reduce these immediate risks. Despite ongoing attempts by the GBV sub-cluster to draw attention to the links between food insecurity and GBV,[50] there has not been any effective action taken to curb the problem.[51]

The Future for Women and Girls in South Sudan

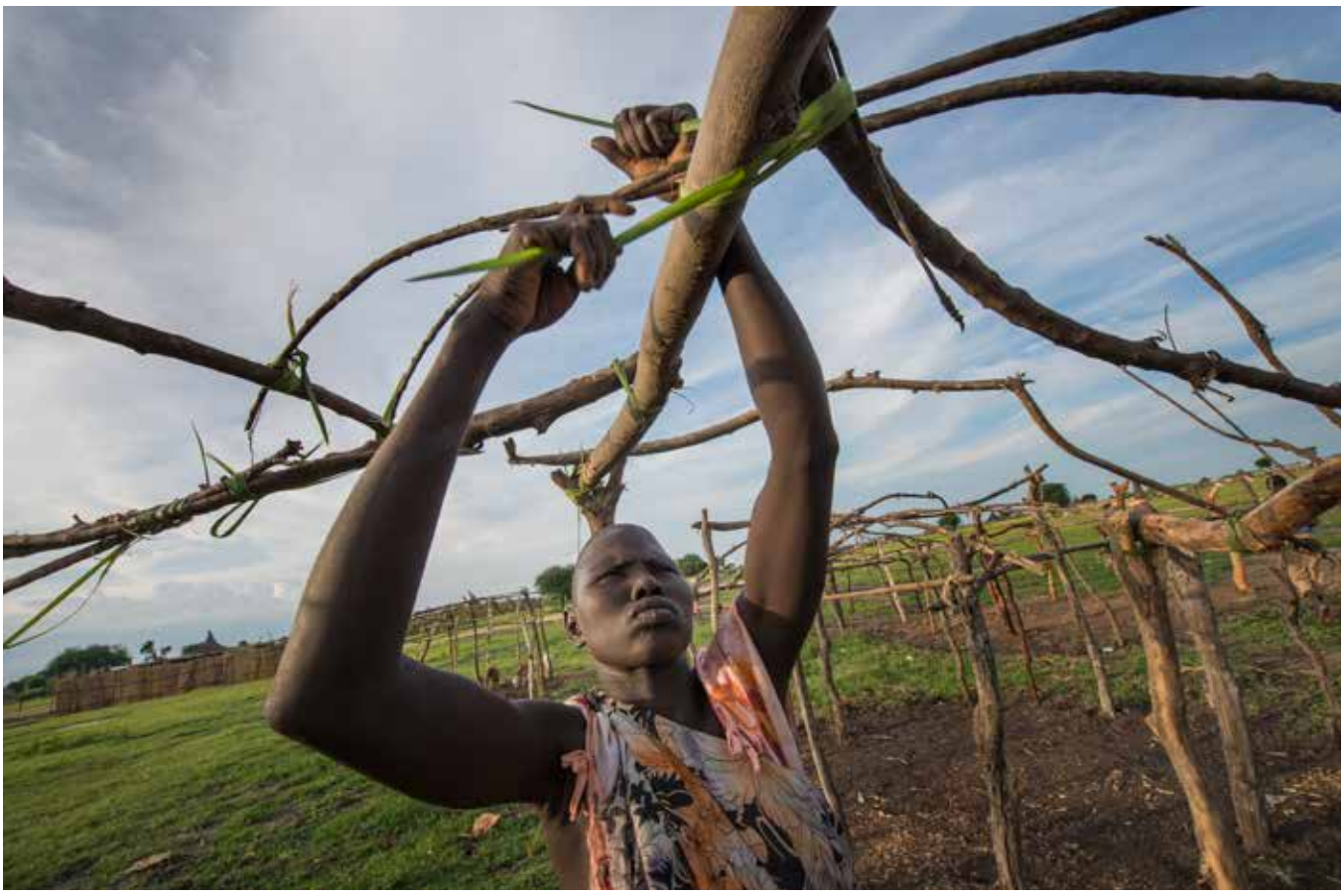
In response to the persistent protection gaps in South Sudan, a Global Cluster Coordination mission in August 2014 recommended the formation of a Protection Policy Group led by UNFPA, UNHCR and UNICEF,[52] though it remains to be seen whether and how this group might support increased attention to GBV.

Due to significant decreases in funding,[53] GBV actors across the country are struggling to meet emergency needs, while also working to strengthen local NGOs' capacity for service delivery and resource mobilization. Unless increased support for local capacity building is forthcoming, local structures and organisations will emerge from the crisis dramatically weakened.

The humanitarian community knows what the immediate GBV gaps are in South Sudan. In-country humanitarian leadership, including HCs, HCTs, and cluster leads, must now put experts in place to lead local coordination mechanisms, reinforce implementation of the revised IASC GBV Guidelines across all sectors, and ensure adequate funding to expand service provision. Heightened security concerns and humanitarian access challenges underscore the crucial need for investments in local organisations so they can better provide humanitarian assistance, including GBV response services.

> "Women venture into the forest to gather edibles and even walk for up to 10-14 days to bring back food for their families… In the process they are subject to violence attacks and rape from armed actors."
>
> —BETWEEN A ROCK AND A HARD PLACE, SOUTH SUDAN GBV SUB-CLUSTER

A woman displaced by fighting builds a makeshift shelter in Ganyliel, South Sudan (2014)



Iraq

The humanitarian situation in Iraq deteriorated rapidly after January 2014, when the Islamic State (IS) moved from its stronghold in northern Syria to assert control over Iraqi territory. During the first week of June 2014, a series of IS attacks in and around the city of Mosul triggered a sudden and serious worsening of the security situation in the central part of the country, expanding conflict between the Iraqi army, IS security forces, and Kurdish Peshmerga fighters.

For women and girls in Iraq, the current crisis takes place against a backdrop of pre-existing inequality and violence. Honour-based killings, domestic violence, rape, sexual exploitation, early and forced marriage, female genital mutilation, and social exclusion are all familiar types of violence for women and girls in Iraq.[54]

GBV, particularly sexual violence, spiked when the crisis hit in 2014. In August 2014, the UN Special Representative on Sexual Violence in Conflict and the UN Special Representative for Iraq confirmed reports of violence, including sexual violence, against women and children belonging to Iraqi minorities, and urged for their immediate protection. They also reported that some 1,500 Yazidis and Christians may have been forced into sexual slavery.[55] These concerns have been resoundingly corroborated by human rights organisations, which have noted that many of those abducted for sexual slavery by IS are children – including girls 15 years old and younger.[56]

An elderly woman sits outside her tent in Domiz camp, Iraq. (2014)

Coordination and Funding

GBV emergency response in Iraq has faced major challenges, owing largely to a complex and inefficient coordination system with separate mechanisms for addressing the needs of refugees and IDPs.

Since 2011, UNHCR had been leading a system of working groups to coordinate the humanitarian response for Syrian refugees in Iraq.[57] With the IS insurgence in January 2014 and the associated Iraqi IDP crisis, the cluster system was activated alongside the UNHCR-led system. This generated confusion with regard to resource distribution and coordination among different sectors, as well as differential treatment of groups with similar needs.[58,59]

Not surprisingly, the problems with these parallel coordination systems had a direct impact on GBV coordination. The Sexual and Gender Based Violence Sub-Working Group (SGBV SWG) in Erbil led by UNHCR was already activated for the Syria regional crisis before the current crisis in Iraq. In August 2014, a GBV sub-cluster was activated at a national level to lead both efforts, however its lead (UNFPA) only arrived in early 2015. As a result, the sub-cluster was severely delayed in getting off the ground and terms of reference were only circulated in May 2015.

This resulted in delayed advocacy efforts to ensure prioritisation of GBV as an integral part of response to the crisis. It took a year for OCHA situation reports to include information on GBV. One of the few activities that the SGBV SWG reported conducting were gender and GBV information sessions for other clusters. These were jointly run with the IASC GenCap advisor, who was deployed 11 months after the crisis hit.[60] A GBV AoR REGA was deployed only in October 2014. Moreover, IDP service provider mappings were not completed until nine months after the emergency started.[61]

In response to these coordination gaps, in 2015 donors have focused on improving the system-wide humanitarian response to GBV in Iraq. DfID, for example, has deployed two technical experts to the SGBV sub-cluster to strengthen coordination efforts, including improving information collection and sharing.

In addition to coordination challenges, funding for GBV programming was also woefully inadequate. The 2014 Iraq HRP was 74% funded, with support for only one GBV

> "This is a war that is being fought on the bodies of women… They kidnap and abduct women when they take [to] areas so they have – I don't want to call it a 'fresh supply' – but they have a new girl… Girls are sold for as little as a pack of cigarettes."
>
> —ZAINAB BANGURA, JUNE 2015 [62]

programme – GBV funding thus represented 0.6% of all Protection funding, 0.05% of the whole 2014 HRP budget,[63] and 9.4% of what was requested for GBV. The 2015 HRP has been 40% funded;[64] the Protection Cluster has been allocated 31% of its requested funding, 17.3% of which is for GBV.[65,66]

Bilateral funding for GBV from IrishAid and DfID has provided critical services for women and girls in select areas, though it is a drop in the bucket compared to the level of need across the country.

Specialised Services and Reducing Risks for Women and Girls

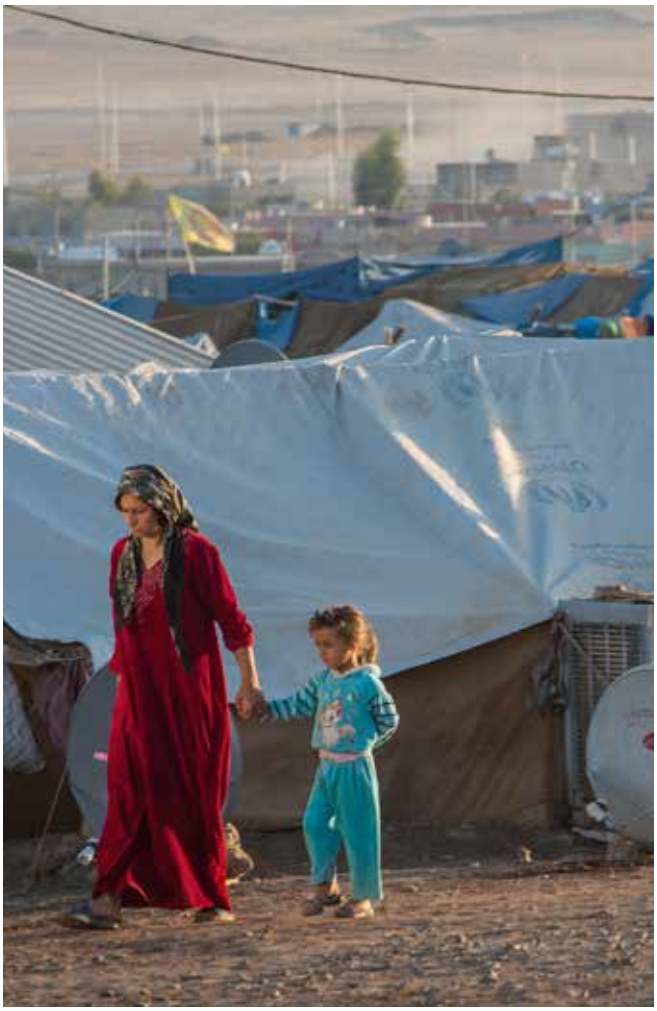
According to a Protection Cluster factsheet, GBV survivors in Iraq do not have sufficient access to quality, comprehensive multi-sectoral services.[67] At the time of writing, only 40,748 out of 3.2 million IDPs had received information about GBV prevention and response services in 2015.[68,69] GBV trainings, dignity kit distributions and the establishment of new women's centres are positive developments, though they didn't happen until well after the first phase of the current emergency.[70,71]

In September 2014, the IASC Gender Alert reported limited access to health services for GBV survivors and poor shelter arrangements for women and girls, including 'a lack of segregated living quarters, lack of security, inadequate WASH facilities and increasing rents'. While efforts by the GBV sub-cluster to strengthen risk reduction activities were welcome, they were also late and underwhelming:[72] for example, revised tools and trainings on safe GBV referrals by NGOs and UN partners were conducted one year after the crisis.[73]

The Future for Women and Girls in Iraq

Iraq is now contending with one of the largest IDP populations in the world,[74] making for a 'patchwork of displacement' with unique challenges to the multi-layered crisis that had already existed in Iraq.[75] Humanitarian access remains the principal challenge in the delivery of aid.

Women and girls continue to be targets of violence by armed groups, compounding the violence, harassment, harmful practices and discrimination they are already subjected to on a daily basis. As the crisis continues, donors and humanitarian leadership must implement the recommendations in the IASC's 2015 Operational Peer Review and do much more to prioritise GBV prevention and response, including through increased funding for GBV services and improved coordination across all sectors. Furthermore, they must work to strengthen the capacity of national NGOs and increase bilateral partnerships, while ensuring protection and support of women and girls and GBV survivors.[76]



RIGHT: Mother and daughter in Domiz camp, Iraq (2013)

Sierra Leone

The first cases of EVD in Sierra Leone were confirmed in May 2014.[77] The situation quickly became a widespread health emergency: 13,494 people were infected and 3,952 died in the country[78] (51% female, 47% male),[79] with cases reported in all districts. The crisis was overwhelming, and the focus of the humanitarian response was on saving lives directly threatened by Ebola.

This case offers a unique opportunity to look at how the humanitarian community implements minimum GBV risk reduction standards and services during a non-conflict-related emergency. Gender and GBV analysis was poor during the crisis: the lack of sex- and age-disaggregated data at the beginning of the outbreak made it hard to understand the different impacts EVD had on men, women, girls and boys and tailor prevention efforts accordingly.[80] It was not until December 2014 – five months after the government declared a state of emergency – that a Multi-Sectoral Impact Assessment of Gender Dimensions of the EVD in Sierra Leone was published.[81] This assessment highlighted how existing GBV prevention programmes had been disrupted by the EVD crisis, and how GBV risks had, as in all emergencies, increased:

- Women who survived EVD reported being blamed for bringing Ebola into the family and suffering stigmatisation, abuse and ostracism as a result, putting them at greater risk of GBV and exploitation.[82] Nurses working in EVD response, particularly women, reported facing similar stigmatisation, isolation and abuse.
- Women and girls quarantined in their homes remained responsible for fetching water and firewood, and were financially and sexually exploited by guards in exchange for permission to leave the house. More than 65% of female respondents reported manipulation and exploitation by guards stationed at their homes during quarantine.[83]
- Restrictions on movement to prevent the spread of EVD resulted in the suspension of cross-border trading, and consequently the closure of markets and a shortage of goods and services. While this economic disruption caused a threat to livelihoods generally, it was particularly detrimental for women, who are more likely than men to be employed in the informal and agriculture sectors.[84] This loss of income meant women lost savings in village loans and savings associations, incurred more debt, and were at further risk of sexual exploitation.[85]
- Increased rates of teenage pregnancy in Sierra Leone since the start of the Ebola crisis were reported by the police, government and humanitarian actors, pointing to a surge in both rape and consensual sex among teenagers.[86] Eighty-four percent of nearly 1,000 youth surveyed in January 2015 expressed the perception that teenage pregnancy had increased during the outbreak.[87] Given the health and social risks associated with teenage pregnancy – including being banned from or dropping out of school – such spikes were likely not only a signal of girls' increased vulnerability during the crisis, but also a contributor to heightened risks and greater disparities.[88,89]

The fragility of the country's institutions and systems meant that continued provision of social services that existed before the crisis became unsustainable during the outbreak.[90] GBV mechanisms mandated to provide life-saving services came to a near halt, exacerbating risks for women and girls and leaving GBV survivors with nowhere to turn, as health and other services were oversaturated. Sierra Leone GBV service providers struggled with similar challenges as those in neighbouring Liberia, where assessments indicated that more than 80% of GBV survivors were denied access to basic health services out of fear that health workers could contract EVD through contact with bodily fluids.[91]

In Sierra Leone, the Ebola epidemic was of catastrophic proportions, and the focus of the government and humanitarian actors on the mobilization of health personnel and infrastructure (treatment centres) was necessary. However, this response should not have precluded ensuring capacity and resources to also meet minimum emergency response standards, including those specific to addressing GBV – such as basic health services for survivors and meeting IASC GBV Guidelines on risk reduction.[92]

Coordination and Funding

Lead actors and funders in the response to Ebola in Sierra Leone gave little priority to the specific needs of women and girls, including their risks of GBV. Sierra Leone's Accelerated Ebola Outbreak Response Plan comprised six coordination pillars,[93] including one called 'Psycho-social support, Gender, Children', led by the Ministry of Social Welfare, Gender and Children Affairs (MSWGCA) and UNICEF.[94] This pillar did not have a specific GBV component. [95]

Though the cluster system was never officially activated in Sierra Leone, several entities mobilised to support the humanitarian community, particularly the logistics and the emergency telecommunications sectors; [96] protection and GBV coordination bodies were never activated.

Despite a lack of emphasis on GBV in reports and assessments,[97] the GBV AoR appointed a REGA to West Africa to support the Ebola crisis in December 2014. This REGA deployed to Sierra Leone only in April 2015.

Sierra Leone received $547 million from a total of $1.35 billion for the whole regional Ebola Response,[98] though information on funding for GBV, or protection activities in general, is impossible to identify, as all funding is earmarked as "sector not yet specified."

Bilateral funding has included more explicit focus on protection, including for GBV. Four projects funded by the US and Canadian governments, totalling over $12 million, include general protection activities. DfID and Irish Aid funded studies and surveys, including a UNDP study to assess GBV.[99] DfID has given $3,907,437 to provide support to seven INGOs and the MSWGCA to enhance access to a range of protection and other services for vulnerable people in eight districts, including GBV services. This initiative launched in May 2015 - one year after the outbreak began. DfID also supported the government and UNICEF to establish Protection Desks in Ebola response centres at the District Emergency Response Centres. These desks receive reports on GBV and other protection concerns, and provide case management and referrals.[100]

Specialised Services and Reducing Risks for Women and Girls

The breakdown of systems, failure to prioritise funding for GBV, and weak coordination efforts all negatively impacted the availability of services for GBV survivors during the Ebola crisis.

GBV services that had been provided through the public health system were severely disrupted, as resources and personnel were redirected to the EVD treatment units. This resulted in a shortage of doctors to provide medical attention for GBV survivors, including the necessary documentation for reporting rape to the police.

While many GBV service centres, locally known as Rainbo Centres, also ceased operations during the crisis, a handful did remain open or were able to re-open in new locations, thanks both to a level of flexibility and adaptability the government institutions did not have, as well as funding from the IRC.[101] Especially at the height of the crisis, these centres saw an increase in the number of women and girls coming to them for health services, counselling and case management: between June and December 2014, there was a 19% increase in the number of women and girls attending the Rainbo Centres of Freetown and Kono,

A girl farming with her hoe, Sierra Leone

compared to the months before the crisis. While these centres were able to sustain life-saving services for these survivors, there were only three of them in total – hardly enough to meet the needs of the at-risk population. This meant that for GBV survivors in most of the country, specialised services were weak or non-existent.

The unique and severe nature of the Ebola crisis meant that even minimum standards or measures to reduce risks for women and girls were often overlooked:

- In hospital wards, patients were grouped not by sex, but according to the type of Ebola case (suspect, probable or confirmed). Women and men were thus placed in the same wards, increasing women's risks of sexual abuse and harassment.[102] With health workers overwhelmed and no GBV experts to monitor risks and advocate for solutions, such issues went largely unaddressed.
- In addition to the disruption to basic and essential obstetric services,[103] early in the outbreak few EVD holding units and treatment centres catered to the needs of pregnant women suspected of having Ebola. Fear of contact with bodily fluids led to some women being denied access to treatment facilities if they were in labour, forcing some to give birth and/or die in the streets.

- In a context where pre-existing gender inequalities give women very limited decision-making with regard to sexual relations, the humanitarian community afforded little attention to women's and girls' elevated risk of contracting EVD through sexual relations or sexual violence,[104] contributing to their increased susceptibility to becoming infected.

Such breaches in upholding minimum standards to protect the safety and dignity of women and girls were not inevitable. Actors, including non-governmental entities, were available and willing to sustain life-saving risk reduction and response activities, including GBV service provision, to fill the gaps left by the overwhelmed health system. But in the absence of funding and any recognition of the need and role these organisations could play, their ability to act effectively was extremely restricted.

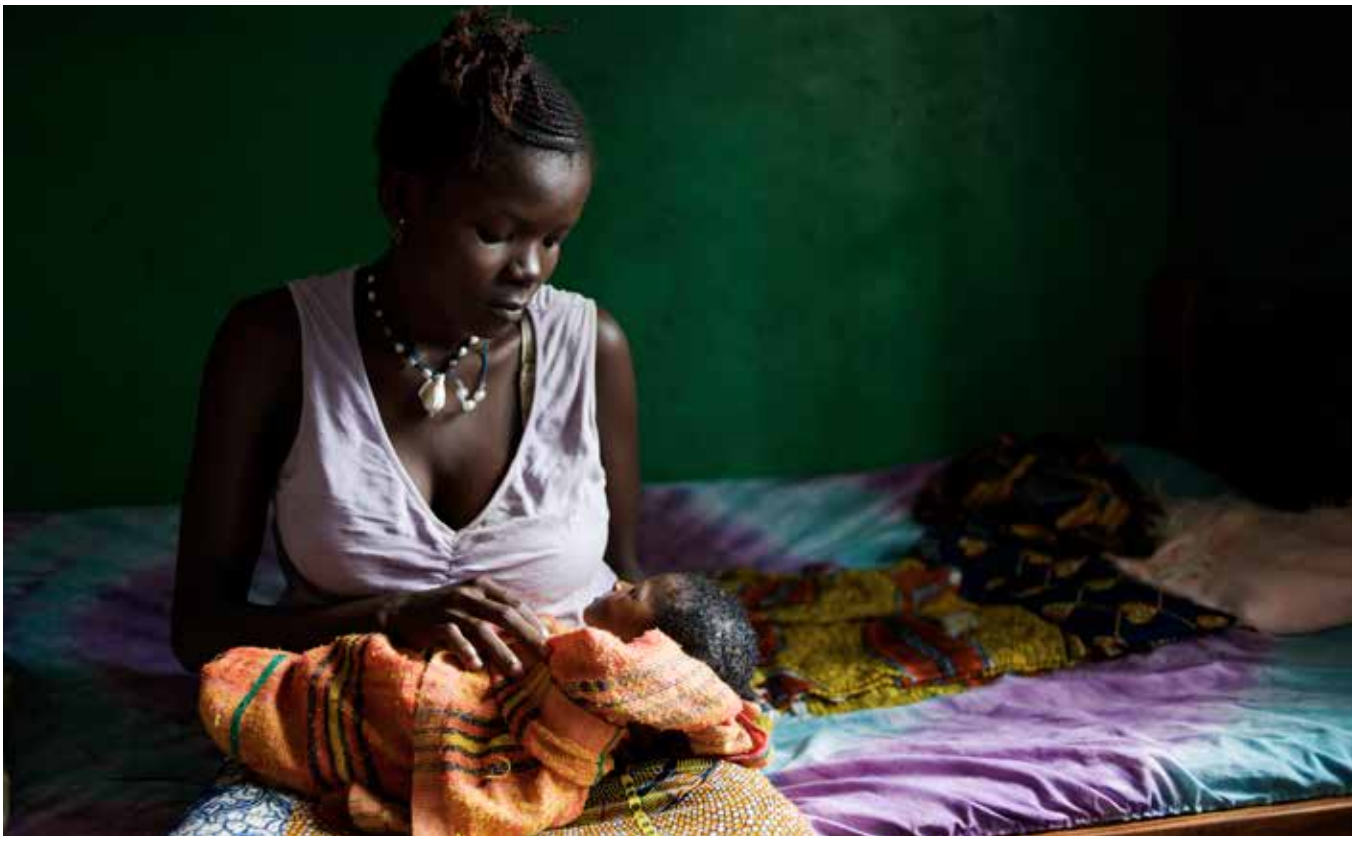
The Future for Women and Girls in Sierra Leone

Today, Ebola seems to be under control in Sierra Leone. Recommendations for the post-EVD recovery plans entail integrating efforts to contain the epidemic with action to address gender inequality and GBV.[105] This should include ensuring allocation of resources to re-establish GBV services along with all essential health services.

The government and humanitarian agencies should identify and address the full range of immediate and long-term material, social and psychological needs women and girls will have in the wake of the crisis. Many women have lost livelihoods, as well the social networks and safe spaces that once served as means of protection – leaving them more vulnerable to violence and exploitation. Connecting women with resources and income-generating opportunities, strengthening community-based women's groups and networks, evaluating and treating psychological impacts, and continuing girls' education will be essential to a robust recovery.

Importantly, local organisations should be included in recovery planning and monitoring, as they are best positioned to identify their most pressing immediate and long-term needs, and, as this case study has shown, civil society organisations in general have the flexibility to adapt services in a way that government entities often cannot, allowing them to fill critical gaps during both crisis and recovery.

BELOW: Lucy Lansana, 20, brought her two-week-old baby, Ibrahim, to the health clinic in Levuma when he developed a high fever and convulsions. He was delivered by C-section at Gondoma clinic after a referal from this clinic. Lucy's first child died from birth complications and she walked eight miles from her village to attend the clinic. (2009)



Acronyms

CAR	Central African Republic
CHF	Common Humanitarian Fund
DfID	UK Department for International Development
DRC	Democratic Republic of the Congo
EU	European Union
EVD	Ebola Virus Disease
FTS	Financial Tracking Service
GBV	Gender-Based Violence
GBV AoR	GBV Area of Responsibility
GenCap	Gender Standby Capacity Project
HC	Humanitarian Coordinators
HCT	Humanitarian Country Teams
HRP	Humanitarian Response Plan
IASC	Inter-Agency Standing Committee
IASC GBV Guidelines	Inter-Agency Standing Committee Guidelines for Integrating GBV Interventions in Humanitarian Action
IDP	Internally Displaced Person
IPV	Intimate Partner Violence
IRC	International Rescue Committee
IS	Islamic State
L3	Level Three
MISP	Minimum Initial Service Package for Reproductive Health in Crisis Situations
MSWGCA	Ministry of Social Welfare, Gender and Children's Affairs
NGO	Non-Governmental Organisation
OCHA	UN Office for the Coordination of Humanitarian Affairs
OFDA	Office of US Foreign Disaster Assistance
PoC	Protection of Civilians
PSVI	Preventing Sexual Violence in Conflict
REGA	Regional Emergency GBV Advisor
RTAP	Real-Time Accountability Partnership
SBGV SWG	Sexual and Gender-Based Violence Sub-Working Group
SIDA	Swedish International Development Agency
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
US	United States of America
UK	United Kingdom
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme

Endnotes

1 This paper will focus on GBV experienced by women and girls in emergencies. It will use the terms 'GBV' and 'violence against women and girls' interchangeably.

2 This paper will use the terms 'GBV risk reduction' and 'GBV mainstreaming' without distinction.

3 These include *2006 Brussels Call to Action to Address Sexual Violence in Conflict* and Beyond and the Commission on the Status of Women *Agreed Conclusions on the Elimination of all forms of Violence against Women and Girls* of March 2013. It followed and complemented the *G8 Declaration on Preventing Sexual Violence in Conflict* and the *UN Declaration of Commitment to End Sexual Violence in Conflict.*

4 This is the global humanitarian system's classification for the response to the most severe, large-scale humanitarian crises. See *OCHA Emergencies: http://www.unocha.org/where-we-work/emergencies*

5 See *IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings: http://www.refworld.org/docid/439474c74.html*

6 Although there was a GBV coordination body covering the Syria crisis in Iraq before the January 2014 Iraqi crisis, difficulties in parallel coordination systems meant the SGBV sub working group for the Syria response faced important challenges in responding to GBV in the Iraqi crisis. More details can be found in the case study.

7 See DfID, *What works in addressing violence against women and girls, lessons learned from Typhoon Haiyan: workshop report,* June 2015: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/432579/Violence_against_women_and_girls_Typhoon_Haiyan_workshop_report.pdf*

8 The lack of specification from the EVD funding mechanism makes it impossible to analyse relevant data for this specific emergency.

9 See *IASC GBV Guidelines,* supra note 5

10 Country-specific GBV coordination information should include:

- *a* whether a GBV coordinator is working in country and if so, time between activation of cluster and deployment of GBV coordinator, their objectives and how they are coordinating response in country;
- *b* whether and when a REGA has been deployed, their terms of reference, the results of their work, and reports;
- *c* expenditures on GBV programming per donor, per country and per funding mechanism (bilateral, pooled, emergency, etc.);
- *d* number of GBV actors present per country and the types of GBV programming they are implementing;
- *e* number and percentage of assessments that include GBV risk analysis;
- *f* number and percentage of HCs/HCTs that are monitoring the implementation of the guidelines;
- *g* number and percentage of proposals that require reporting on partners' adherence to the guidelines;
- *h* number and percentage of trainings on the guidelines carried out in country;
- *i* number of clusters with a dedicated GBV focal point responsible for advising on and monitoring implementation of guidelines.

11 This paper will consider the first phase of an emergency from the onset to the third month.

12 See *GBV AoR Capacity Building Strategy 2015-2020*, p7: *http://gbvaor.net/resource-topics/advocacy-policy/*

13 Ibid, p12

14 See *OCHA CAR Situation Report No. 52, Background on the crisis,* 14 April 2015: *http://reliefweb.int/sites/reliefweb.int/files/resources/OCHA%20CAR%20Situation%20Report%20No%2052.pdf*

15 See *OCHA CAR Situation Report No. 4,* 30 December 2015: *http://reliefweb.int/sites/reliefweb.int/files/resources/OCHA_CAR%20Sitrep%20No4%2030%20December%202013.pdf*

16 See *Amnesty International, 'CAR Human Rights Crisis Spiralling Out of Control',* 29 October 2013: *https://www.amnesty.org/en/documents/AFR19/003/2013/en/*

17 See *OCHA, CAR Flash Update 6 Armed Conflict,* 1 2 December 2013: *http://reliefweb.int/sites/reliefweb.int/files/resources/OCHA%20CAR%20Flash%20Update%206.pdf*

18 See *OCHA, CAR Situation Report No. 1,* 17 December 2013: *http://reliefweb.int/sites/reliefweb.int/files/resources/CAR%20sitrep_131217.pdf and OCHA CAR Situation Report No.11, 5 February 2013 http://reliefweb.int/sites/reliefweb.int/files/resources/OCHA%20CAR%20Situation%20Report%2011%2C%205%20February%202014.pdf*

19 See *Global Protection Cluster, GBV in CAR,* December 2013: *http://www.endvawnow.org/uploads/browser/files/car_final_formatted_brief.pdf*

20 See *Global Protection Cluster, GBV in a forgotten conflict recommendations for the CAR,* March 2013: *http://www.globalprotectioncluster.org/_assets/files/field_protection_clusters/Central_African_Republic/files/CAR_GBV_AoR_Advocacy_Brief_EN.pdf*

21 See *GenCap Gender Briefing Note on CAR,* June 2014: *http://reliefweb.int/sites/reliefweb.int/files/resources/CAR_RPT_140610_OCHA_Gender%20Briefing%20Note%20June%202014.pdf* see supra note 19; and IRC's *Bearing the brunt of violence, women & girls in the CAR: http://www.rescue.org/sites/default/files/resource-file/CAR%20advocacy%20sheet%20on%20women%20and%20girls_26March2014_0.pdf*

22 In 2015, cross-cluster data sharing was included in the 2015 CAR information-sharing protocol, and the GBV sub-cluster increased data-sharing efforts with other clusters and actors.

23 While there were no GBV programmes funded by the CHF in the first round of 2015, two GBV projects have been accepted in the second round, though details are not yet available. See *Financial Tracking Services (FTS) CAR CHF Funding and Allocations in 2015: https://fts.unocha.org/reports/daily/ocha_RPool2B_C41_Y2015___1508111433.pdf* and *OCHA Strategy Allocation Document, second allocation round,* 2015: *https://docs.unocha.org/sites/dms/CAR/CHF_%20Document%20de%20la%20strat%C3%A9gie%20de%20la%20deuxi%C3%A8me%20allocation%20standard_Juin%202015_final.pdf*

24 This paper will use US dollars as the principal currency, all figures containing this symbol ($) denote US dollars. All conversions are based on the 20 August 2015 exchange rate (£1=$1.56 US). All specific figures on bilateral funding in this paper have been provided directly by each donor.

25 1,015 GBV cases were reported by the GenCap advisor between January and March 2014 alone, approximately 20% of which were rape cases. 90% of reported rape cases between April 2013 to June 2014 were gang rapes of females by armed males. See supra note 21, *GenCap Gender Briefing Note on CAR*

Endnotes (continued)

26 See *CAR Protection Cluster Crisis Report No. 5*, 9 January to 9 February 2014

27 The MISP for reproductive health is a set of priority activities designed to:

a prevent and manage the consequences of sexual violence;
b reduce HIV transmission;
c prevent excess maternal and newborn morbidity and mortality;
d plan for comprehensive RH services.

See *MISP for Reproductive Health in Crisis Situations*, 2011: *http://misp.iawg.net/*

28 See *OCHA, CAR Flash Update 7 Armed Conflict*, 13 December 2013: *http://reliefweb.int/sites/reliefweb.int/files/resources/OCHA%20CAR%20Flash%20Update%207.pdf*

29 There are 30,186 IDPs across 32 sites in Bangui, and 368,859 across the rest of the country. See *OCHA CAR Humanitarian Bulletin*, July 2015: *http://reliefweb.int/sites/reliefweb.int/files/resources/HUMANITARIAN_BULLETIN_JULY_2015%20-%20FINAL.pdf*

30 The CAR HRP 2015 is only 36.1% funded and the Protection Cluster has only received 26.8% of its requested funds. See *FTS CAR HRP*, 2015: *http://fts.unocha.org/reports/daily/ocha_R32sum_A1071___19_April_2015_(03_01).pdf*

31 See *New York Times, New Estimate Sharply Raises Death Toll in South Sudan*, 9 January 2014: *http://www.nytimes.com/2014/01/10/world/africa/new-estimate-sharply-raises-death-toll-in-south-sudan.html?_r=0*

32 See *OCHA South Sudan Humanitarian Bulletin*, August 13 2015: *https://docs.unocha.org/sites/dms/SouthSudan/2015_SouthSudan/South_Sudan_13_August_2015_Humanitarian_Bulletin_1.pdf*

33 See *IOM South Sudan Humanitarian Update No. 49*, 4-11 June, 2015: *https://www.iom.int/sites/default/files/situation_reports/file/IOM-South-Sudan-Humanitarian-Update-49.pdf*

34 See *OCHA South Sudan Crisis Situation Update Report No. 3*, 23 December 2013: *http://reliefweb.int/sites/reliefweb.int/files/resources/South%20Sudan%20crisis%20-%20situation%20update%203_as%20of%2023%20December.pdf*

35 This was in New Fangak in North Jonglei State. *Inter-agency, Initial Rapid Needs Assessment Report*, 24-25 January 2014: *https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/assessments/24.01.2014_IRNA_New_Fangak_final.pdf*
and *CARE Emergencies, The Girl Has No Rights: GBV in South Sudan*, May 2014: *http://reliefweb.int/sites/reliefweb.int/files/resources/CARE_The_Girl_Has_No_Rights_GBV_in_South_Sudan.pdf*

36 See *Amnesty International, South Sudan: Civilians killed and raped as ethnically-motivated violence spirals and famine looms*, 8 May 2014: https://www.amnesty.org/en/articles/news/2014/05/south-sudan-civilians-killed-and-raped-violence-spirals-and-famine-looms/

37 See *UN Mission in the Republic of South Sudan, Conflict in South Sudan, A Human Rights Report*, 8 May 2014: *http://unmiss.unmissions.org/Portals/unmiss/Human%20Rights%20Reports/UNMISS%20Conflict%20in%20South%20Sudan%20-%20A%20Human%20Rights%20Report.pdf*

38 See *Amnesty International*, supra note 36

39 See *IRC Policy Brief, Turning Promises into Action? Addressing Gender-Based Violence in South Sudan*, September 2014: *http://gbvresponders.org/wp-content/uploads/2014/10/Addressing-GBV-in-South-Sudan-policy-brief-Sep-2014.pdf*

40 See *EU Roundtable on GBV in Emergencies – Summary Report*, 19 November 2014: *http://www.cooperazioneallosviluppo.esteri.it/pdgcs/italiano/Speciali/Semestre%20Ue/20141119%20Outcome%20report%20EU%20Roundtable%20on%20GBV%20in%20emergencies_FINAL.PDF*

41 See *Global Cluster Coordination, Mission Report South Sudan*, 5-9 August 2014

42 See *South Sudan Protection Cluster GBV AoR South Sudan Advocacy Brief*, 2014: *http://southsudanprotectioncluster.org/wp-content/uploads/downloads/2014/05/GBV-AoR-South-Sudan-Advocacy-Brief_V3-_2_DRAFT.pdf*

43 See *FTS South Sudan HRP Crisis Response Plan 2014*, 19 August 2015: *https://fts.unocha.org/reports/daily/ocha_R32_A1024___6_August_2015_(16_01).pdf*

44 21% of the same requirement has been funded in 2015. See *FTS HRP South Sudan 2015: https://fts.unocha.org/reports/daily/ocha_R32_A1062___17_August_2015_(03_01).pdf*

45 See *OCHA South Sudan, list of CHF supported projects*, 2015: *https://docs.unocha.org/sites/dms/SouthSudan/2015_SouthSudan/2014%20CHF%20Project%20List.pdf*

46 GBV allocations in South Sudan's HRP 2015: 36.9% from the amount allocated to protection, 1.35% of the total budget allocation and 73% of the requested amount. This sum includes two GBV projects out of 12 have over 100% funded. See supra note 44

47 See *CARE*, supra note 34

48 Such findings have also been echoed in *IASC, Humanitarian Crisis in South Sudan Gender Alert 2*, May 2014: *http://www.unwomen.org/~/media/Headquarters/Attachments/Sections/Library/Publications/2014/IASC%20Gender%20Reference%20Group%20%20Gender%20Alert%20South%20Sudan%20May%2013%202014%20Refo%20%20%20%20pdf.pdf*

49 The Integrated Food Security Phase Classification predicted some 4.6 million people would be food insecure by July 2015. See *South Sudan Map Detail*, 30 April 2015: *http://www.ipcinfo.org/ipcinfo-detail-forms/ipcinfo-map-detail/en/c/288396/*

50 See *South Sudan Protection Cluster, GBV Food Insecurity and GBV in South Sudan*, 2014: *http://southsudanprotectioncluster.org/wp-content/uploads/downloads/2014/06/GBV-SC-Food-insecurity-and-GBV-in-South-Sudan.pdf*

51 Unprocessed sorghum was still being distributed at the time of writing.

52 See *Global Cluster Coordination, Mission Report South Sudan*, 5-9 August 2014

53 CHF allocated just $1 million across all protection sub-sectors in 2015, greatly impacting the availability of funds for GBV. This scarcity has meant that only three partners received funding for GBV programmes.

54 See *IRC, Working Together to Address Violence Against Women and Girls in Iraqi Kurdistan*, 2012: *https://www.rescue.org/sites/default/files/resource-file/IRC%20Addressing%20Violence%20Against%20Women%20in%20Kurdistan%205-12.pdf*

55 See *UN News Centre, 'Barbaric' sexual violence perpetrated by Islamic State militants in Iraq*, 13 August 2014: *http://www.un.org/apps/news/story.asp?NewsID=48477#.VXa5Ts9VhHw http://www.un.org/apps/news/story.asp?NewsID=48477#.VdeMBvlViko*

56 See *Amnesty International, Iraq: Yezidi women and girls face harrowing sexual violence*, 23 December 2014: *https://www.amnesty.org/en/articles/news/2014/12/iraq-yezidi-women-and-girls-face-harrowing-sexual-violence/* and see *Human Rights Watch, Iraq: ISIS escapes describe systematic rape*, 14 April 2015: *http://www.hrw.org/news/2015/04/14/iraq-isis-escapees-describe-systematic-rape*

57 See *UNHCR Syria Regional Response Plan Iraq*, 2014, p13: *http://www.unhcr.org/syriarrp6/docs/syria-rrp6-iraq-response-plan.pdf*

58 See *IRC, Iraq Humanitarian Crisis: Aid must be directed accordingly to vulnerability, not status or geography*, March 2015: *http://www.rescue.org/sites/default/files/resource-file/Iraq%20policy%20brief-March%202015.pdf*

59 See *IASC Operational Peer Review Iraq*, 8 July 2015:

60 See *Protection Cluster*, Iraq Response Protection Cluster Factsheet, 28 February 2015: http://reliefweb.int/sites/reliefweb.int/files/resources/Protection%20Cluster%20Factsheet%20-%20Feb15.pdf

61 See *UNHCR SGVB Sub-Working Group Meeting Minutes*, 19 August 2014: *https://www.dropbox.com/sh/dxm94wh8leonuf7/AAAWwlZnZu5fsKhqb-nOSJHma/SGBV%20SWG/Minutes%20of%20meetings%20Duhok/SGBV%20Meeting%20Minutes%20August%2019%202014.doc?dl=0*

62 See *The Guardian*, June 2015: *http://www.theguardian.com/world/2015/jun/09/isis-slave-markets-sell-girls-for-as-little-as-a-pack-of-cigarettes-un-envoy-says*

63 See *FTS HRP Iraq 2014*, 19 August 2015: *https://fts.unocha.org/reports/daily/ocha_R32_A983___17_August_2015_(15_01).pdf*

64 See *FTS Iraq 2015*: *https://fts.unocha.org/pageloader.aspx?page=emerg-emergencyDetails&appealID=1097*

65 See *OCHA Iraq, 2015: http://www.unocha.org/iraq*

66 See *FTS HRP Iraq 2015*, 19 August 2015: *https://fts.unocha.org/reports/daily/ocha_R32_A1097___12_August_2015_(12_35).pdf*

67 See *Protection Cluster*, supra note 61

68 Ibid

69 See *OCHA Iraq Humanitarian Crisis Situation Report No.56*, 11 August 2015: *http://reliefweb.int/sites/reliefweb.int/files/resources/ocha_iraq_humanitarian_situation_report_56_5_-_11_august_2015.pdf*

70 *See Protection Cluster Dashboard Iraq Response 2015*, 18 June 2015: *https://www.humanitarianresponse.info/en/system/files/documents/files/protectionclusterdashboard-may2015.pdf*

71 This is based on a definition of the reproductive age as 12-45

72 See *IASC Humanitarian Crisis in Iraq Gender Alert*, September 2014: *http://www.unwomen.org/~/media/headquarters/attachments/sections/library/publications/2014/iasc%20final%20gender%20alert%20iraq%2019%20sept.pdf*

73 See *Protection Cluster, Iraq Response Protection Cluster Factsheet*, supra note 61

74 See *OCHA Iraq Humanitarian Crisis Situation Report No. 54*, 22-28 July 2015: *http://reliefweb.int/sites/reliefweb.int/files/resources/ocha_iraq_humanitarian_situation_report_54_22-28_july_2015.pdf*

75 As stated by Kristele Younes, IRC Director for UN Humanitarian Affairs, during the Tom Lantos Human Rights Commission Hearing on the Humanitarian and Human Rights Crisis in Iraq.

76 *IASC Operational Peer Review Iraq*, supra note 59

77 See *United Nations Emergency Appeal To Combat Ebola In Sierra Leone*, August 2014: *http://reliefweb.int/sites/reliefweb.int/files/resources/1st%20UN%20emergency%20ebola%20appeal%20-%20Sierra%20Leone.pdf*

78 See *World Health Organisation (WHO), Ebola Situation Reports: http://apps.who.int/ebola/ebola-situation-reports*

79 See *WHO, Ebola statistics*, 2015: *http://apps.who.int/gho/data/view.ebola-sitrep.ebola-summary-age-sex-20150610?lang=en*

80 See *REGA mission report*, submitted 24 April 2015, p2

81 See *Government of Sierra Leone, Ministry of Welfare, Gender and Children's Affairs (MSWGCA), Report of the MultiSectoral Impact Assessment of Gender Dimensions of the Ebola Virus Disease (EVD) in Sierra Leone*, December 2014: *http://www.mswgca.gov.sl/attachments/Documents/Multisector%20Assessment%20of%20EVD.pdf*

82 Ibid

83 Ibid

84 Women constitute an estimated 70% of cross-border traders in Sierra Leone's Mano River Union region, for example.

85 See *UN, World Bank, EU and African Development Bank, "Recovering from the Ebola Crisis"*, 26 March 2015, p90-94, 96: *http://www.undp.org/content/undp/en/home/librarypage/crisis-prevention-and-recovery/recovering-from-the-ebola-crisis---full-report.html*

86 As confirmed by the Assistant Director for Sierra Leone's MSWGCA in the eastern region in *IRIN News, "Sex Crimes up amid Ebola outbreak in Sierra Leone,"* 4 February 2015: *http://www.irinnews.org/report/101090/sex-crimes-up-amid-ebola-outbreak-in-sierra-leone* and see *Save the Children, "Children Report Increased Exploitation, Teenage Pregnancies in Ebola-affected Sierra Leone,"* 17 June 2015: *http://www.savethechildren.org/site/apps/nlnet/content2.aspx?c=8rKLIXMGIpI4E&b=9241341&ct=14736265&notoc=1*

87 An increase in pregnancies was also confirmed by Sierra Leone's First Lady. See *Africa Research Institute, Behind closed doors: Schools, teenage girls and Ebola in Sierra Leone*, 17 April 2015: *http://www.africaresearchinstitute.org/blog/behind-closed-doors-schools-teenage-girls-and-ebola-in-sierra-leone/*

88 See *UNDP Africa Policy Note, Confronting the Gender Impact of Ebola Virus Disease in Guinea, Liberia and Sierra Leone*, 30 January 2015: *http://reliefweb.int/sites/reliefweb.int/files/resources/RBA%20Policy%20Note%20Vol%202%20No%201%202015_Gender.pdf*

Endnotes (continued)

89 See *Plan International, Pregnant teenagers banned from school in Sierra Leone,* 16 April 2015: *https://plan-international.org/about-plan/resources/media-centre/press-releases/pregnant-teenagers-banned-school-sierra-leone/ https://plan-international.org/about-plan/resources/media-centre/press-releases/pregnant-teenagers-banned-school-sierra-leone/*

90 See *"Recovering from the Ebola Crisis,"* supra note 85, p25

91 See *UN, World Bank, EU and African Development Bank,* supra note 84, and *Front Page Africa, "Stop all forms of violence against women" Gender Minister,* 28 November 2014: *http://www.frontpageafricaonline.com/index.php/news/3816-stop-all-forms-of-violence-against-women-gender-*

92 See *ODI Humanitarian Practice Network, Ebola and Humanitarian Protection, Issue 64,* June 2015: *http://www.odihpn.org/humanitarian-exchange-magazine/issue-64/ebola-and-humanitarian-protection*

93 See *Sierra Leone Accelerated Ebola Virus Disease Outbreak Response Plan,* July to December 2014: *http://reliefweb.int/sites/reliefweb.int/files/resources/evd-outbreak-response-plan-west-africa-2014-annex4.pdf*

94 See *"Ebola Blog direkt aus Sierra Leone,"* 19 January 2015: *http://ebola-in-sierra-leone.de/tag/psychosocial/*

95 In the Phase II context of the Ebola Outbreak there was still no specific mention of a GBV component, although it does mention women's protection. See *National Emergency Response Centre, Guidance note to inform district level planning on the provision of child protection, psychosocial services with gender considerations in the EVD Phase II context,* January 2015: *http://www.nerc.sl/sites/default/files/docs/Guidance%20to%20districts%20on%20Child%20Protection%2C%20Gender%20and%20Psychosocial%20Jan%201....pdf*

96 See *Logistics Cluster Ebola Outbreak Situation Update,* 1 September 2014: *http://reliefweb.int/sites/reliefweb.int/files/resources/logistics_cluster_ebola_outbreak_situation_update_140901.pdf* and *UNICEF Sierra Leone Humanitarian Situation Report,* 15-21 September 2014: *http://www.unicef.org/appeals/files/UNICEF_Sierra_Leone_EVD_Weekly_SitRep_-_21_Sept_2014.pdf*

97 See *UNMEER Sierra Leone: Ebola Emergency Situation Report No. 21,* 16-29 March 2015: *http://reliefweb.int/sites/reliefweb.int/files/resources/No%2021%20-%20UNMEER%20%20NERC%20Situation%20Report%2016%20-29%20March.pdf*

98 Ibid

99 Irish Aid funded the study, "Assessing Sexual and Gender Based Violence during the Ebola Crisis in Sierra Leone," conducted by UNDP, and DfID funded a perception survey of GBV in EVD Context, conducted by Ground Truth.

100 See *ODI*, supra note 92

101 This specific programme is supported by Irish Aid and NoVo Foundation, who also sustained this support through the emergency.

102 *See Government of Sierra Leone,* supra note 81

103 See *ODI,* supra note 92

104 See *Huffington Post, Ebola: the overlooked sexually transmitted disease,* 26 May 2015: *http://www.huffingtonpost.com/mardia-stone/ebola-the-overlooked-sexu_b_7428342.html?utm_hp_ref=tw*

105 See *Recovering from the Ebola Crisis,* supra note 85

Authors: Gina Bramucci and Diana Trimiño Mora

Researcher: Virginia Zucco

Editor: Sarah Green

Designer: Ros Mac Thóim

Photos: All photos by Peter Biro/IRC except
Inside front cover: Paul Enkelaar/SV
p4: Aubrey Wade/IRC
p18: Jeffrey Austin/IRC
p19: Aubrey Wade/IRC

Thank you

A debt of gratitude to the IRC Women's Protection and Empowerment (WPE) Coordinators and Technical Advisors for their contributions to this paper and their tireless advocacy to highlight women and girls' needs in CAR, South Sudan, Iraq and Sierra Leone.

Thank you to Irish Aid who supported the writing of this paper and the Wellspring Foundation who contributed to the research for its analysis. Thank you to the many donors who have supported IRC's WPE work in the four emergencies in this paper.

The International Rescue Committee (IRC) responds to the world's worst humanitarian crises and helps people to survive and rebuild their lives. Founded in 1933 at the request of Albert Einstein, the IRC offers life-saving care and life-changing assistance to refugees forced to flee from war, persecution or natural disaster. At work today in over 40 countries and 22 cities, we restore safety, dignity and hope to millions who are uprooted and struggling to endure. The IRC leads the way from harm to home.

New York
International Rescue Committee
122 East 42nd Street
New York, NY 10168-1289
USA

Washington, DC
International Rescue Committee
1730 M Street, NW
Suite 505
Washington, DC 20036
USA

London
International Rescue Committee–UK
3 Bloomsbury Place
London WC1A 2QL
United Kingdom

Brussels
International Rescue Committee–Belgium
Place de la Vieille
Halle aux Blés 16
Oud Korenhuis 16
1000 Brussels
Belgium

Geneva
International Rescue Committee
7, rue J.-A Gautier
CH-1201
Geneva
Switzerland

Bangkok
International Rescue Committee
888/210–212 Mahatun
Plaza Bldg., 2nd Floor
Ploenchit Road
Lumpini, Pathumwan
Bangkok 10330
Thailand

Nairobi
International Rescue Committee
IKM Place
5th Ngong Avenue
Upper Hill
Nairobi
Kenya

Join the conversation

@IRCuk

facebook.com/IRCuk

Pinterest.com/IRCuk

From Harm to Home | Rescue-uk.org | Rescue.org

Irish Aid
Rialtas na hÉireann
Government of Ireland

International Rescue Committee
NEW YORK | WASHINGTON, DC | LONDON | BRUSSELS | GENEVA | NAIROBI | BANGKOK

From Harm to Home | Rescue-uk.org | Rescue.org