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Special feature
Making humanitarian action work for women and girls

WOMEN DELIVER

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Cover photo: In the informal tented settlements in North Bekaa, Lebanon.
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Left: *© WFP*

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Middle: Bocame local council.
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Bottom: Adolescent IDPs in Batu, East Shewa, Ethiopia.
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The theme of this edition of *Humanitarian Exchange*, co-edited with Women Deliver, is making humanitarian action work for women and girls. Despite gains, including commitments made at the World Humanitarian Summit, there is still much to be done to address the gendered impacts of humanitarian crises and improve gender-sensitive humanitarian action.

In the lead article, Jacqueline Paul advocates for feminist humanitarian action based on evidence that improvements in women's socio-economic status can reduce excess mortality among women after shocks. Jean Kemitare, Juliet Were and Jennate Eoomkham look at the role of local women's rights organisations in preventing and responding to violence against women and girls, and Marcy Hersh and Diana Abou Abbas highlight opportunities for more concrete action on sexual and reproductive health in emergencies.

Citing experience from Vanuatu, Jane Newnham explains how women will choose to use contraceptives even during a humanitarian response, when services and counselling are delivered in an appropriate and responsive way. Drawing on experience in Bangladesh, Tamara Fetters and colleagues challenge the belief that abortion is a non-essential service, or too complicated for humanitarian actors to provide. Darcy Ataman, Shannon Johnson, Justin Cikuru and Jaime Cundy reflect on an innovative programme using music therapy to help survivors of trauma.

Emilie Rees Smith, Emma Symonds and Lauryn Oates highlight lessons from the STAGE education programme in Afghanistan, and Degan Ali and Deqa Saleh outline how African Development Solutions is helping women and girls take on leadership and decision-making roles in Somalia. Fiona Samuels and Taveeshi Gupta explore patterns of suicide among young people in Vietnam, with a particular focus on girls, and Subhashni Raj, Brigitte Laboukly and Shantony Moli illustrate the importance of a gendered approach to community-based disaster risk reduction in the South-West Pacific. Nicola Jones, Workneh Yadete and Kate Pincock draw on research in Ethiopia to explore the gender- and age-specific vulnerabilities of adolescents. The edition ends with an article by Julie Rialet-Cislaghi on how humanitarian responses can better address child marriage.

As always, we welcome any comments or feedback, which can be sent to **hpn@odi.org.uk** or to the **HPN Coordinator, 203 Blackfriars Road, London SE1 8NJ**.


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Making humanitarian action work for women and girls

Saving lives and saved lives: why women matter in humanitarian crises

Jacqueline Paul

We know that humanitarian crises are times of turmoil when structures, systems and socio-cultural norms can be transformed for the benefit of all persons: for equity, equality of rights and justice. Feminists working in humanitarian settings continue to be told that gender can only be considered following the immediate response because the first focus must be on saving lives. The unstated assumption is that gender is irrelevant to the lives of people affected by crises – and that attending to gender will come at the cost of saving lives. Yet the impacts of 'shocks' are not gender neutral. An analysis of data from 188 countries, for the period 1989 to 2011, reveals that conflicts, natural disasters and crop failures reduce the life expectancy of women significantly more than men. Moreover, this mortality impact increases with the level of discrimination against women. The analysis indicated that improvements in women's status in society have the potential to mitigate the excess mortality of women when such shocks strike.[1] So, on average, pre-existing gender inequalities render women more vulnerable than men to the fatal impact of crop failures, sudden-onset natural disasters and conflict that have a systematic effect on the gender gap in life expectancy. And, as women's socio-economic status increases, the adverse impact of 'shocks' on women relative to men – death – is reduced and eventually disappears.

This is one example of the relevance of gender to each stage of the humanitarian programme cycle – from emergency preparedness to analysis, planning, deployment and support of personnel, delivery of assistance and relief operations, leadership of humanitarian clusters, monitoring, evaluation and learning. In this cycle, women matter – as humanitarian response actors and as persons impacted by humanitarian crises.

Women as humanitarian actors

Sometimes, still, rapid assessment teams and initial humanitarian response teams are composed of only or mostly men. Sometimes, still, a response to a protracted crisis can be a masculine one. Yet we know that women humanitarian actors are needed. Women are needed so that all persons affected by a crisis can be seen, met, heard and engaged with, and have their needs fairly addressed. This is particularly important for recognising and responding to the diversity of women and girls, as distinct from categorising them as, for example, single heads of households.

> Humanitarian worker (Syria): *From the beginning you need to have access to women. You need to tell the men that we need to talk to women. If there's only men from your side, and only men from their side, when the men ask to meet with women they will not be allowed.*

> Humanitarian worker (Afghanistan): *In areas where we operate, you need women to talk to women. Whether this is good or bad, this is the local culture and we have to do this if we want women to have their voices heard, women need to talk to women. How can you design and implement a project for women, without asking women what they need?*

> Humanitarian worker (several countries): *If, in 'normal times', a woman needs permission to leave her house, at a time of emergency is she going to leave her house to speak to humanitarian responders or wait until someone knocks on her door or gives her permission to leave? If there is a lack of understanding of context – of gender norms – is this woman going to be seen, let alone, heard?*

Women's presence and capabilities are needed to, at a minimum, minimise risks of causing harm to persons already affected by crises. This may be women being present at distribution points to ensure safe access to food and non-food items or women being available to provide services to women violence survivors. Or it could be that the presence of women allows other women to call attention to an intervention that can hurt them. For example, in a livelihood initiative the health of women was being harmed as they sat for long hours in damp, dark rooms weaving carpets, preceded and followed by unpaid domestic work. As a national humanitarian worker stressed: 'You need women staff to talk to women' and we 'need to ask women what they need'.

In addition to identifying the barriers to equitable and safe participation in humanitarian action and opportunities for transformative changes, women who are part of a humanitarian

1 The analysis was conducted by Lorenzo Motta, with contributions from Chifundo Ntupanyama, drawing from several data sources. Anyone interested in the details of the analysis and further information on the data sources can contact Lorenzo Motta (lorenzo.motta@wfp.org).

response are role models for women (and men) constrained by restrictive gender roles. One such role model – and leader – is the former head of the World Food Programme (WFP) Damascus Field Office, who managed a team of ten women and men assisting 220,000 food-insecure households, while also being the sole parent of three children.

> Humanitarian worker (Syria): *Being a woman head of field office is such a powerful position. She is a decision-maker, saying to people yes or no. It has an impact on the society around her.*

Alongside role-modelling and reaching women, we have learned and seen repeated the need for diversity among women workers. This supports localised responses that are amenable to the engagement of women and local women's rights organisations, as well as professional development opportunities for national women employees. And for this to be possible – for diverse women to be part of localised humanitarian responses – employers need to evolve. The evolution is for organisations that have supportive systems, practices and cultures that make it possible for women to choose to contribute their knowledge and skills for equitable and empowering action. This means decent employment contracts, flexible working arrangements, adequate deployment lead times, respect, safety and security measures (like flak jackets that fit and transportation) and infrastructure (such as separate toilets and places for showering and sleeping safely). Too many women are, however, still finding themselves choosing between career and care, and being concerned about their physical integrity.

> Humanitarian worker: *I have chosen a different path to become a national officer. When I compare myself with other women colleagues in the office, those who have chosen to have a so-called normal life in this context – getting married, having children – they had to compromise with their career. In our office, I was the only woman national professional officer in the whole country office until a few months ago [when another woman was recruited to a professional post]. The rest of the women in our office are assistants, with very few associate level, junior level. And the reason for that is that they find it very difficult to have both a career and fulfil the role of a woman in this culture. I choose to work on my career instead of focusing on other areas. The expectations of a 'good woman' is that she will not travel alone or frequently. However, this is an essential part of a humanitarian worker's job, but an inaccessible privilege for many married women. You have to think about whether you want to build your career or remain an assistant. Many women have to choose either to work on their careers or their personal lives.*

If a woman chooses a career, there is a chance she will be confronted by an unstated assumption that she is more of a 'hassle' than a male peer because she may have caring responsibilities. And she will need to prove her worth.

> Humanitarian worker (Syria): *You feel [as a woman] you have to do more, to prove yourself. I missed many meetings at the school. I came back home tired. I spent more time – 2, 3 hours extra – in the office. When I come back home I am under pressure to respond to messages on my mobile.*

With empowering employers, feminist humanitarian workers – women and men – are attuned to gender roles, relations and responsibilities. As such, gender and age analyses are considered routine and essential to inform humanitarian work. There is also the notion that such analyses can be done prior to a crisis occurring, such as for Venezuela or in anticipation of a climate change-induced event, like crop failure. Tied to participatory responses and gender-responsive monitoring, such attention is linked to seeing and seeking to understand the individual, without problematising or essentialising women – seeing women as not solely victims, nurturers or peacemakers. Masculinities and masculine identities, and their role in humanitarian contexts, are also explored and addressed.

Working with women affected by humanitarian crises

Women humanitarian workers are vital for effective and empowering humanitarian action. Another essential element is working with women (and girls) who are part of the 'affected population'. This means that we see and respond to diversity, make sure we're inclusive and ensure that participation underpins our communication, consultations, cooperation and collaboration.

> Humanitarian worker (Afghanistan): *As an Afghan woman, it is important to me to know who designs the actions and how (and if) the actions speak to me. Acknowledging the fact that Afghan women, like women worldwide, have their own definitions and visions of empowerment, an action that is from (not for) Afghan women, representing (or focusing on) women's diverse voices, experiences, visions, interests and needs in their own historical, cultural, and socio-religious contexts, is not only transformative, but also an empowering strategy that fits into a framework for understanding Afghan feminism as indigenous and decolonial.*

What is being argued and advocated for is seeing and valuing women in an active way – taking actions that remove the obstacles to women sharing their knowledge, skills, ideas and leadership to protect lives, reinforce resilience and create the communities they want. This includes dealing with power in its many manifestations.

> Humanitarian worker (Syria): *If they [women] are willing to change, we need to help them change. If they are willing to be part of our response, our committee, we need to help them.*

> Humanitarian worker (Afghanistan): *A major problem in Afghanistan is that women are invisible. They have their reproductive role, but they are not decision-makers. Whatever is being done for women, is not something they necessarily need. Our humanitarian responses need to be linked to resilience, development initiatives. If we really want our assistance to change lives, we need to help women gain some power so that they can talk about their needs and they can be part of the solution, rather than always being behind the scene and invisible.*

From this perspective, the opinions and experiences of women and girls, equitably with those of men and boys, determine whether a humanitarian response meets the needs of the 'affected population' – if the persons who need food, water, shelter, clothing and health services get them, and they are (physically and emotionally) safe.

Humanitarian action can do more than meet basic needs. Humanitarian action can be feminist when – as one humanitarian worker describes – it is 'a response that takes women's historical, social, economic and political positionality, significance and resistance – as well as their different visions, interests and needs at its core. It [feminist humanitarian action] should also appeal to and inform their [women's] social, cultural, religious and communal identities and values'. In this framework, core components of feminist humanitarian action include direct provision of information to women, in forms that they can safely receive and readily understand (so not mediated by, for example, a male relative or community elder); protection from exploitation and abuse; awareness-raising, learning, education and training, from 'basic' competencies of signing one's name and numeracy to livelihoods and leadership abilities; access to resources, including money and property; the provision of services, including sexual and reproductive health services; investment in women's social capital; and attending to reproductive roles, including recognition and redistribution of the unpaid care and domestic work largely done by women (and girls).

One example of feminist humanitarian action is the training offered to women in Syria. Following displacement to Damascus, and with no formal education but with resistance from her relatives, Jalilah completed a sewing machine maintenance course. From this, she learned for herself, and demonstrated to others, that she is a capable person. Jalilah also developed a strong appreciation for education and supports her children's education – particularly her daughters – including paying school fees.

> Jalilah (Damascus): *I'm learning. I'm a woman. I can do what men do … I'm trying to improve myself … Women were ignored before. But now we're leading by example. And we must be followed. A woman can do all the jobs a man can do.*

A fellow trainee, Lina, had also been displaced to Damascus with her four children and husband. The displacement came with the opportunity to leave the domestic space unaccompanied for the first time in her life. Despite opposition from relatives – her father disapproved of women working outside the home – Lina completed the sewing machine maintenance course and got a job with a tailor. Her financial independence gave her pride in being able to provide for her family, a desire for further learning and a 'wish that all the women in the Arab world only depend on themselves – learn, get jobs and be independent'. The sense of personal empowerment can be transmitted. As one woman in Syria remarked: 'I want [my daughters] to believe in themselves. Once you believe in yourself you will step wherever you want. If you present yourself as strong, you will be taken as being strong'.

The self-efficacy and empowering changes reported by women in Syria are seen elsewhere. For example, one young woman who completed a training programme that prepares female youth – returnees and those residing in neighbourhoods with high rates of violence – for employment in the hospitality industry in San Salvador reflected that 'I feel better prepared. That I can make decisions about my life. That I decide what is best for my life'. In Afghanistan, women acquired skills in carpet weaving, sewing, knitting, basic mechanics, cell phone repairs and vegetable production that they have used to generate income for themselves and their households, including to send girls to school.

By working with women from the outset, it is possible to design and deliver humanitarian responses that directly address both their immediate needs and their longer-term interests. And, as noted by another humanitarian worker, in doing so 'we don't need to be confrontational. She'll get afraid. Make the action practical – for her life, to benefit herself, her children, her household. She shouldn't have to fight everyone in her community to be able to participate so that she can have more income, more food'. Breaking the isolation of women and supporting the creation or strengthening of social networks and coalitions are part of this process. And in doing so, the existing roles and workloads of women – at different stages in the 'life cycle' – need to be recognised and addressed.

Meeting needs and embracing uncertainty for equality

Working in the 'humanitarian sector', we are seeking to meet the specific immediate needs of women, men, girls and boys in an 'affected population', as well as supporting the attainment of their longer-term goals. We are also attempting to embrace the instability that comes with a crisis because of the potential for transformational change: for re/establishing institutions and norms grounded in gender justice. In seeking equity and equality of rights, gender is an integral part of the humanitarian programme cycle, rather than a box to be checked. Women are not external to the masculine norm, remaining an 'other' subject to special provisions. Rather, the emphasis is on empowerment over disempowerment, where each person is seen as an actor, not a passive recipient. In so doing, we remain resolute in the

knowledge that effective humanitarian action – action that saves lives and changes lives for equity and equality – is feminist.

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Feminist practice: local women's rights organisations set out new ways of working in humanitarian settings

Jean Kemitare, Juliet Were and Jennate Eoomkham

Local women's rights organisations (WROs) have been working to prevent and respond to violence against women and girls (VAWG) in humanitarian contexts for decades. While they have long been recognised as change-makers and leaders, they still face well-documented obstacles in delivering aid to women and girls in development and emergency settings. These obstacles include a lack of sustainable funding, limited operational capacity, unequal partnerships with international agencies and barriers to accessing direct funds from donor governments or pooled funding streams.[1] These challenges hold the global community back from prioritising partnerships with and leadership by WROs.[2]

To push forward, feminist activists and regional civil society networks have come together to strengthen locally led responses to VAWG, prevent sexual exploitation and abuse and promote the learning, leadership and resourcing of local WROs. These are hefty goals, particularly when local WROs and the voices of women leaders are currently so under-valued.[3] Formal disaster management and emergency response efforts frequently overlook or ignore grassroots social networks, including those addressing violence against women and girls. According to data from the UN Office for the Coordination of Humanitarian Affairs (OCHA) Financial Tracking Service, in 2016 just 2% of international humanitarian response went to local and national responders directly, and the majority of that went to local and national governments; only 0.3% was passed directly to local and national NGOs.

Without internationally funded and recognised programming, local civil society and women leaders are often left out of the humanitarian decision-making process, which prioritises international agencies and organisations based in the Global North. For too long, actors within the humanitarian system have sought to maintain it as it was created, rather than undertaking meaningful reforms so that the system works for all. We know from experience that this status quo has a direct, negative impact on the lives of women and girls.

WROs and local VAWG actors are on the ground and often ready to respond before international humanitarian actors mobilise resources and deploy; they can access remote communities cut off to international actors due to insecurity; and they have deep knowledge of their communities and networks due to a history of working alongside them, and often have already established trust. As a result, they can be well-placed to support survivors of VAWG and, through their links to community members and networks, to ensure access to information about available services. This also makes them a direct entry point and critical partner in the prevention of and response to sexual exploitation and abuse by humanitarian actors – abuse that is possible due to the dramatic power imbalances between international actors and the communities they serve.

The humanitarian system needs to fundamentally transform itself if we are to meaningfully influence the experience of women and girls affected by crisis. Partners in one initiative with this aim, Building Local, Thinking Global,[4] came together in January 2018 to co-design our work to strengthen VAWG response in emergencies, and to define ways of working that stem from feminist thought and practice. At that first meeting, representatives of civil society networks focused on VAWG outlined a vision for humanitarian action that listens to and values the expertise of local actors, that is underpinned by a strong base of activism and that is accountable to women and girls. We also identified priorities for skill-building for member organisations, all of which are civil society actors working on

1 IRIN, 'Local Aid Agencies Still Waiting for Bigger Share of the Funding Cake', 27 March 2017 (www.thenewhumanitarian.org/analysis/2017/03/27/local-aid-agencies-still-waiting-bigger-share-funding-cake)

2 Victoria Metcalfe-Hough and Lydia Poole with Sarah Bailey and Julie Belanger, *Grand Bargain Annual Independent Report 2018* (London: ODI, 2018) (www.agendaforhumanity.org/sites/default/files/resources/2018/Jun/Grand%20Bargain%20annual%20independent%20report%202018_full.pdf)

3 IRC, *Are We There Yet? Progress and Challenges in Ensuring Life-saving Services and Reducing Risks to Violence for Women and Girls* (London: IRC, 2015) (www.rescue.org/sites/default/files/document/664/ircarewethereyetwebfinalukspell.pdf)

4 The coalition of networks and organisations leading this initiative includes Akina Mama wa Africa, the GBV Prevention Network, Gender Equality Network, Isis-Women's International Cross-Cultural Exchange, El-Karama and the Strategic Initiative for Women in the Horn of Africa. The International Rescue Committee is a convener and partner. Building Local, Thinking Global is funded by the generous support of the Bureau of Population, Refugees and Migration of the US State Department.

Amneh Helweh of El-Karama, one of the organisations leading the Building Local, Thinking Global initiative with the IRC.

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VAWG. We envisioned a world in which the role of international non-governmental organisations is dramatically changed, and patriarchal power and inequality are ended. 'Nothing for us, without us', was our rallying cry.

Later, in January 2019, we came together again with a wider circle of activists to help build a three-year initiative called Listen Up.[5] Our goal this time focused on amplifying the voice of women in the prevention of and response to sexual exploitation and abuse in humanitarian settings. Again, we grounded our work in shared feminist principles, expanding on those set out the previous year. 'We believe,' we wrote, 'that through feminist analysis, feminist leadership, and feminist activism, we can spark transformational change that is sustainable beyond the lifecycle of one emergency or one project.' With this in mind, we set out new 'rules of engagement' for shifting power and resources to regional civil society networks working on VAWG and local WROs leading prevention and response efforts. They are:

- First and always do no harm, put women and girls, and the needs and wishes of survivors, at the centre.
- Hold ourselves accountable, to each other and to the women and girls we work with and for, to contribute collectively to the change we seek.
- Listen to women and girls, amplifying their voices by stepping up for them when they need support, and stepping back to make space for them to speak for themselves.
- Be transparent and open in our communications and decision-making, ensuring that decision-making does not fall into the patriarchy, hierarchy or bureaucracy that contributes to the failures of the system as it currently stands.
- Acknowledge power differentials and work to shift power and resources to local women and girls' organisations.
- Take an intersectional approach, which centres women in all their diversity, creates more spaces that are accessible to women and girls and widens spheres of influence.

These commitments complemented those of shared ownership and sustainability, solidarity, influence and curiosity that already underpinned the work of Building Local, Thinking Global. Here, we would like to reflect on how some of these feminist principles translate into practice.

Solidarity. We believe we are stronger as a collective, and that we can and should consistently learn from each other, capturing best practice from the feminist movement and other social change movements to improve and evolve our work. We support each other, and we stand aligned with the women and girls we serve. This echoes African 'Ubuntuism', which emphasises the bond that connects us. We find strength in our coming together, and in our joint work for radical, visionary change. This has long been our experience as leaders and members of civil society networks working to end VAWG. We came together, recognising that in this way we multiply learning, opportunities and impact.

We've seen that exponential effect. Women's rights organisations engaging with initiatives like Building Local, Thinking Global say that they are successfully leveraging connections and learning to access new partnerships and resources from other international agencies. Over several years, Building Local, Thinking Global has supported and resourced a cohort of locally and regionally based experts in VAWG so they can provide training and technical guidance to peers at the field level. Our solidarity across organisations and contexts is allowing us to reduce reliance on international organisations

5 Listen Up is also funded by the generous support of the Bureau of Population, Refugees and Migration of the US State Department.

for technical support, and instead to situate that leadership across women's rights networks and organisations.

Similarly, through Listen Up, women rights activists are working in solidarity to end sexual exploitation and abuse and sexual harassment in humanitarian settings. We are leveraging activists' extensive expertise in transforming patriarchal systems in the Global South, and co-creating new approaches. We experience this as a new way of working on the prevention of sexual exploitation and abuse and sexual harassment – one that is driven by local women's movements.

Intersectionality. Interlocking systems of oppression mean that women and girls experience violence and discrimination differently based on their race, class, nationality, disability, sexual orientation and gender identity. An intersectional approach requires that action to achieve social justice is informed by an understanding of the multiple experiences of inequality experienced by women and girls, rather than prioritising the experiences or needs of one group of women over another. We have seen this lens applied in the work of our partners as they adapt services to ensure accessibility for women and girls with disabilities, or tailor programming for adolescent girls. As feminist activists, we are also driven to ensure services for women and girls with diverse sexual orientation and gender identities, and to do so safely, despite legal frameworks and cultural contexts that fail to protect them. Through Building Local, Thinking Global in 2019, our cohort of experts and local leaders will come together to examine inclusivity in our work with women and girls in all of their diversity. This is also an act of solidarity.

Influence. As women's rights activists, we are constantly seeking to change beliefs, attitudes and behaviours in order to create a more gender-equitable world. We face the same challenges within the humanitarian system. By including influence as one of our feminist principles, we demand that women and girls powerfully participate in decisions on humanitarian funding, strategies and policies, and that the voices of women and girls are heard in all spaces – from settlements to the halls of government. We promote, for example, refugee women taking on leadership roles within refugee coordination mechanisms, and WROs claiming more than a tokenistic presence in inter-agency spaces, panels and events. In February 2019, the potential of feminist organising and influence was on display at the African Union, when members of the 'Gender is My Agenda Campaign' – including Building Local, Thinking Global partners Akina Mama wa Africa, Women's International Cross-Cultural Exchange and the Strategic Initiative for Women in the Horn of Africa – articulated the urgency of addressing the challenges of women and girl refugees on the African continent.

Listen Up has provided an important avenue for influence by WROs. Our co-created theory of change emphasises the following high-level outcome: that humanitarians use power positively, and respect and value women and girls. We include in the requirements for this outcome a recognition by humanitarian staff of their own power and privilege. To this end, we are adapting the proven *Get Moving!* curriculum developed by Raising Voices for use within humanitarian organisations.[6] These tools, grounded in feminist analysis, will support humanitarian actors in collectively reflecting on their own personal attitudes and behaviour, rigorously analysing the causes of sexual exploitation, abuse and harassment in local humanitarian response and agreeing together on priority actions to ensure that women and girls access aid equitably and safely. The combination of personal and professional reflection, analysis and commitment continues to inspire and sustain collective action.

Transparency. We are open in our communication and decision-making as we strive for equality in design, planning, access to information and power. These are key to project success, but also foster positive working relationships, trust and participatory and open discussion. Members of the Building Local, Thinking Global initiative believe that welcoming disagreement, alternative ideas and new voices was positive and drove us towards improved results. Transparency has also increased confidence in decisions, ultimately reducing friction because partners communicated under a set of clear expectations. This is rare in humanitarian partnerships, which too often involve Global North organisations determining the goals and workplans for joint efforts that are then handed to Global South actors to execute. Instead, the project's international organisation partner, the IRC, has prioritised listening to feedback, adjusting as needed and putting in place mechanisms to check in regularly with local partners. This has been possible thanks to investment in relationship-building as a coalition of activists. We consider all members as equal owners, with voice and a role to play in determining our direction and priorities.

Effective response to VAWG in emergencies will require a more radical shift and application of feminist principles across humanitarian work. The obstacles mentioned at the top of this article – lack of sustainable, direct funding; limited operational capacity; unequal partnerships – will not be removed without a new understanding of the relationship between international agencies and local actors, particularly WROs.

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6 See http://raisingvoices.org/innovation/creating-methodologies/get-moving/

Leveraging global and grassroots expertise to improve access to sexual and reproductive health services in humanitarian emergencies

Marcy Hersh and Diana Abou Abbas

Over the past decade, there has been growing agreement among international, national and local humanitarian actors that much more must be done to ensure access to essential sexual and reproductive health (SRH) services in emergency responses. There are currently 32 million girls and women of reproductive age affected by humanitarian emergencies,[1] who face increased risks of multiple forms of gender-based violence (GBV), unintended pregnancy, maternal morbidity and mortality, sexually transmitted infections (STIs) including HIV, and unsafe abortion. Research from multiple humanitarian settings shows that up to 40% of women experiencing forced displacement want to avoid becoming pregnant in the next two years.[2] Taken together, these realities have pushed advocates and policy-makers to champion SRH services as a priority in humanitarian action.

To help drive progress, organisations at all levels are documenting solutions and developing guidance for improving access to SRH services in humanitarian emergencies. At the international level, the humanitarian community has developed and vetted standards and guidelines for the provision of SRH services in the *Inter-Agency Service Field Manual for Reproductive Health Services in Humanitarian Emergencies* (IAFM).[3] At the same time, many local and national first responders – including women-focused CSOs, health providers and community-based clinics in protracted crisis settings – have worked for years to provide safe and inclusive access to SRH services. In many contexts, these grassroots organisations have built unparalleled trust and understanding with local communities, enabling them to deliver SRH services effectively.

Mainstreaming and applying international and local expertise on SRH remains a challenge, and a 2014 assessment found that SRH services were still unavailable at the onset of many humanitarian responses.[4] Within many international organisations, leadership and relevant field-based teams are not sufficiently knowledgeable on the IAFM, and more training is needed to build capacity in this area. At the same time, the expertise of local and national responders is still largely overlooked – a missed opportunity to invest in effective grassroots solutions.

Addressing these problems requires supporting and building expertise on SRH at the global and grassroots levels. To that end, this article highlights key opportunities for supporting both global and grassroots expertise to drive more concrete action on SRH in emergencies – and outlines what still needs to be done to create real change.

Utilising global guidance on providing SRH services at the onset of emergencies

Respected global guidance on providing SRH services in emergencies exists in the IAFM – and, when fully funded and implemented, can be lifesaving for girls and women in humanitarian settings. The IAFM offers authoritative guidance on how to provide reproductive health services at every stage of a humanitarian emergency, including in the critical first 48 hours. The guidance was released in 1999 as a tool to help humanitarian practitioners plan, implement and evaluate SRH services, in refugee situations specifically. In 2010, the Inter-Agency Working Group on Reproductive Health in Emergencies (IAWG) – a broad-based coalition that works to expand and strengthen access to SRH services in crises – published a new edition to encompass the SRH needs of people affected by all forms of humanitarian emergencies.

Since 2010, evaluations of the IAFM have found that, despite increased funding, awareness and ability to deliver SRH services in humanitarian settings, significant gaps remain. In particular, practitioners have explicitly requested more guidance and assistance in providing adolescent SRH services, comprehensive contraceptive methods, abortion care, emergency obstetric and newborn care and addressing sexual violence.[5]

In response, IAWG led a collaborative two-year revision process that used this feedback to inform the 2018 revision of the IAFM. In addition to sharing documented evidence and best practices for the challenges mentioned above, the 2018 IAFM also updated the Minimal Initial Service Package (MISP) – a list of crucial actions to respond to reproductive health needs at the early stages of a humanitarian emergency. These include:

- **Enhancing leadership:** guidance for the health sector/cluster to identify an organisation to lead implemen-

1 OCHA, *Global Humanitarian Overview 2017* (http://docs.unocha.org/sites/dms/Documents/GHO_2017.pdf)

2 T. McGinn et al., 'Family Planning in Conflict: Results of Cross-sectional Baseline Surveys in Three African Countries', *Conflict and Health*, 5:11, 2017 (www.conflictandhealth.com/content/5/1/11)

3 See http://iawg.net/iafm/

4 Inter-Agency Working Group on Reproductive Health in Crisis, *Taking Stock of Reproductive Health in Humanitarian Settings: Key Findings from the IAWG on Reproductive Health in Crises' 2012–2014 Global Evaluation*, 2014 (http://iawg.net/wp-content/uploads/2016/08/IAWG-GE-Summary_English.pdf)

5 Ibid.

tation of the MISP, and what their responsibilities will entail to ensure successful MISP implementation. This includes hosting regular meetings to coordinate activities, reporting back to relevant clusters, mapping existing services and ensuring community awareness of SRH services.

- **Addressing sexual violence:** best practices for preventing sexual violence and responding to the needs of survivors, including ensuring preventative measures are in place to protect affected populations, making clinical care and referral services available and creating safe spaces in health facilities to support survivors.
- **Preventing transmission and reducing morbidity and mortality due to HIV and other STIs:** establishing safe blood transfusion, access to condoms, provision of anti-retrovirals and other treatments and ensuring that STI diagnosis and treatment services are available in health facilities.
- **Preventing excess and maternal and newborn morbidity and mortality:** ensuring access to clean and safe delivery spaces, obstetric care services and newborn health services and supplies; establishing round-the-clock referral systems from community clinics to health centres and hospitals; ensuring that post-abortion care is available; and ensuring access to clean delivery supplies when access to a health facility is not possible.
- **Preventing unintended pregnancy:** ensuring the availability of a range of contraceptive methods at primary health facilities; improving access to comprehensive SRH information; and promoting community awareness of the availability of contraceptives.
- **Planning for comprehensive SRH services:** services are integrated into primary healthcare.
- **Providing safe abortion care:** the updated MISP also emphasises the need for safe abortion care in health centres and hospitals, provided to the fullest extent allowable under the law of the country where the MISP is being implemented.

However, the IAFM and MISP are ultimately just words on paper – and challenges related to funding, staff capacity and community engagement still impede real action. For example, while humanitarian funding for SRH activities generally increased between 2009 and 2013, it was still only 43% of what was requested.[6] Additionally, there is an urgent need to build institutional capacity within international, national and local organisations to better understand and implement the IAFM and MISP when it matters most. This includes capacity strengthening around commodity management to prevent stock-outs of essential SRH supplies during crises and ensure a smooth transition from the MISP to comprehensive SRH services in the recovery phase. Finally, much more must be done to provide technical assistance to national and community-based organisations on the MISP, to ensure SRH services are appropriate to local contexts and can be sustained after international actors leave.

Evidence shows that, when the IAFM and MISP are effectively implemented and backed by good funding, skilled staff and meaningful community engagement, the effects can be life-saving. The following case study from the International Rescue Committee (IRC)'s work to utilise the MISP in Cox's Bazar, Bangladesh, is one example.

MISP implementation in Cox's Bazar, Bangladesh

Nearly 700,000 Rohingya refugees have fled to Cox's Bazar in Bangladesh – adding to the 300,000 already living in the area, having fled previous waves of violence in Myanmar. Girls and women have been exposed to extremely high levels of violence, sexual assault and rape, and have very limited, if any, access to health services – both before and after displacement. Experienced emergency responders were urgently needed, particularly in GBV and SRH, as well as effective coordination and collaboration among different actors on the ground.

The IRC's SRH emergency coordinator was deployed to Cox's Bazar to ensure the availability of contraception, screening and treatment for STIs, clinical care for sexual assault survivors, safe delivery and emergency obstetric care – essential components of the MISP. The IRC also partnered with and provided technical support for RTMI, a local NGO, to set up comprehensive women's centres to provide a package of essential services. With these comprehensive centres in place, the IRC and RTMI ensured girls' and women's access to lifesaving protection and SRH services, while responding to the needs of GBV survivors in a safe, dignified and confidential manner.

In the space of just two months, 421 contraceptive methods were distributed and 427 clients received psychosocial counselling. The IRC and its partners have since moved beyond implementing the MISP to providing comprehensive SRH services, including basic emergency and neonatal care, post-abortion care and menstrual regulation. Through this work, the IRC has demonstrated that providing SRH services is feasible, even in the most complex environments, especially through collaborations with local experts like RTMI.

Supporting grassroots expertise to ensure sustainable SRH services

As the IRC case demonstrates, grassroots organisations have an essential role to play in expanding access to SRH services in emergencies and in their aftermath. To maximise impact, strengthening and investing in the existing expertise of grassroots organisations must begin before emergencies strike.

This is particularly true in places where humanitarian emergencies have been frequent or cyclical. For example, countries like Uganda, Lebanon, Jordan, Serbia and Colombia have

6 Ibid.

Marsa Sexual Health Center provides safe, confidential and non-discriminatory access to sexual and reproductive health services, including HIV testing, to anyone who walks through their door.

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hosted refugees and internally displaced people affected by more than one crisis; others, like Haiti, the Philippines and Tonga, have experienced cyclical natural disasters. Enhancing preparedness and resilience is critical to ensuring that communities are equipped to respond to these crises and recover more quickly.

When it comes to SRH, this means ensuring services are integrated in primary healthcare systems and national plans for risk reduction and emergency response.[7] This requires continuous training and supervision of healthcare providers to make sure that they have the skills, supplies and resources they need to deliver safe, inclusive and non-discriminatory access to SRH services, including to girls and women in disaster-prone areas. When emergencies strike, recruiting skilled and trained SRH providers is challenging, so investing in local capacity strengthening before emergencies occur can help mitigate this.

Integrating SRH in preparedness and resilience efforts also requires identifying and investing in local and national women-focused organisations that are already providing SRH services. However, there's still a long way to go. Globally, only 3% of humanitarian aid was directed to local and national organisations in 2017 – and even less to those focused on girls and women – a massive missed opportunity to build capacity among local actors who know the context and entry points to deliver SRH services most effectively.[8] Identifying and investing in these organisations as part of broader preparedness activities can help ensure they have the resources they need to extend their services to crisis-affected populations quickly. In Lebanon, organisations like Marsa Sexual Health Center fill crucial gaps in government health provision by providing free and low-cost sexual health services and information inclusive of LGBTQIA+ communities, sex workers, undocumented migrants and Palestinian refugees.

Marsa Sexual Health Center in Lebanon

A Beirut-based non-profit organisation, Marsa provides essential sexual health services and information to a rapidly growing client load. Programmes emphasise respect, privacy and confidentiality. Marsa's safe and inclusive approach to providing SRH services means it is well-placed to extend SRH services to other marginalised communities, including girls and women, young people and Syrian and Palestinian refugees, who also often face stigma and discrimination. Through their work, the team at Marsa have demonstrated the wide reach and impact a local organisation can have. It has provided voluntary counselling and rapid HIV testing to more than 12,500 clients and subsidised medical consultations for another 4,195 clients, and psychosocial counselling and alternative therapies for 2,000 clients.

7 Sneha Barot, 'In a State of Crisis: Meeting the Sexual and Reproductive Health Needs of Women in Humanitarian Situations', *Guttmacher Policy Review*, 20, 2017 (www.guttmacher.org/gpr/2017/02/state-crisis-meeting-sexual-and-reproductive-health-needs-women-humanitarian-situations)

8 Development Initiatives, *Global Humanitarian Assistance Report 2018*, 2018 (http://devinit.org/wp-content/uploads/2018/06/GHA-Report-2018.pdf)

Even with their considerable reach, the team at Marsa know that one Beirut-based health clinic cannot accommodate the SRH needs of all who seek these services in Lebanon, including the over one million registered Syrian refugees in the country. A situational analysis conducted by the Center found that many medical and nursing staff in Lebanon still lack knowledge on SRH, and the skills to provide these services in a stigma-free environment – which is particularly important for LGBTQIA+ and refugee populations, who are already highly stigmatised.

To that end, the team have worked to share their expertise in providing safe, inclusive and non-discriminatory SRH services with other health providers. The Center began offering vocational training for family medicine and dermatology residents around SRH, training 50 so far. To address the lack of information on sexual heath in medical and nursing schools' curricula, Marsa also launched a project called Inc!te in three Lebanese universities, which aims to positively change the attitudes of healthcare providers towards sexuality and sexual practices.

Marsa plans to provide training for other centres in the region on its activities. It is also hoping to produce a best practice manual for SRH in complex environments in the Middle East and North Africa. However, limited donor funding for SRH activities makes it difficult to bring this work to scale, and poor access to flexible and long-term funding opportunities for local organisations working on SRH stifles Marsa's ability to plan for the future.

Promoting learning and evidence-building around SRH takes time, particularly when working in contexts like Lebanon, where sex and sexuality are taboo. To support local and national organisations to scale up direct services to refugees, contribute to scientific evidence, and build a basis for advocacy, more flexible and sustainable funding is critically needed.

Conclusion

If one thing is clear, though, it is that enhancing access to SRH services in humanitarian settings requires leveraging and supporting the expertise of humanitarian actors at all levels. At the local and national levels, this includes supporting local women-focused CSOs, health providers and broader national health systems to deliver comprehensive SRH services before, during and after emergencies. At the global level, this means ensuring that international humanitarian organisations and UN agencies have the knowledge, resources and funding to fully implement actions outlined in the IAFM and MISP, without delay or interruption.

Between local, national and global actors, we have the critical guidance and knowledge we need to increase access to sexual and reproductive health services in humanitarian emergencies. It's time to put money, resources and concerted action behind that expertise.

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Saving lives and empowering women: delivering contraceptive services in disaster response in Vanuatu

Jane Newnham

Sexual and reproductive health is recognised as a global health, sustainable development and human rights priority.[1] During a disaster, women and girls' essential reproductive health needs, including access to contraception, are often forgotten, leaving them vulnerable to unplanned pregnancies and associated maternal morbidity and mortality through complications of pregnancy and unsafe abortion.

Food, water and shelter are often seen as the most important elements of humanitarian aid, but essential lifesaving sexual and reproductive health services are also a core component of any humanitarian response. Globally, one in four women experience an unmet need for modern contraceptives. In emergencies this figure increases as clinics are damaged and destroyed, health workers leave the area and populations become displaced. For women and marginalised groups, emergencies are particularly dangerous. The basic protective structures normally in place around women – such as the family unit or family home – are disrupted, and police resources are diverted to the disaster response. The cumulative effect is an increase in unintended pregnancies, maternal mortality and morbidity, sexually transmitted infections, HIV and sexual and gender-based violence.

In Vanuatu, as part of a localised emergency response, nurses and midwives offered contraceptive options to women and girls in remote areas affected by a catastrophic volcanic disaster. The number of women who accepted the contraceptive services and their stories demonstrate how making contraceptives available during an emergency can empower women and transform lives, particularly in a context like

1 M. Temmerman et al., 'Sexual and Reproductive Health and Rights: A Global Development, Health, and Human Rights Priority', *The Lancet*, 348:9941, 2014

2 The 2013 Vanuatu DHS (https://vnso.gov.vu/index.php/component/advlisting/?view=download&fileId=2967)

Senior Midwife Leias from the Vanuatu Family Health Association conducts a sexual and reproductive health awareness session for community members of Lovutialau.

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Vanuatu, where the use of contraception is low and large families are the norm. A woman, on average, will have 4.2 children during her life.[2] Almost half of Vanuatu women (48%) have experienced non-partner physical or sexual violence or both since turning 15, substantially higher than the global average.[3] Stories from women in Vanuatu highlight the common practice of reproductive coercion, with male partners influencing and limiting women's contraceptive choices.

The Mt Monaro eruption

Vanuatu comprises 80 islands in the South Pacific, with a population of around 280,000. Located on the Pacific Ring of Fire, it has nine active volcanos. It is also regularly affected by cyclones, earthquakes, tsunamis and floods, making it one of the most disaster-prone countries in the world.[4] Disasters pose a particular risk to women, with women and children 14 times more likely to die than men.[5]

On 26 September 2017, Mt Monaro Volcano on the Island of Ambae began to erupt, spewing ash, volcanic rocks and acid rain over the island. The government declared a state of emergency and ordered an unprecedented evacuation of the entire population. Over 10,000 people were moved to surrounding islands, including around 2,500 women of reproductive age and pregnant women. Six weeks later the government ordered people to return to their homes, but the situation remained unstable. Volcanic ash and acid rain had contaminated water sources, ruined crops and made large areas of the island uninhabitable. Residents also returned to reduced health services as many health workers had elected not to go back. Meanwhile, the volcano remained extremely active and volatile. The entire population faced an uncertain future.

The VFHA response

The Vanuatu Family Health Association (VFHA), an International Planned Parenthood Federation (IPPF) Member Association and a key provider of sexual and reproductive health and rights (SRHR) services in Vanuatu in stable times, responded to the call for assistance from the government. With funding from the Australian government, VFHA launched a Minimum Initial Service Package (MISP)[6] response that prioritised the provision of SRHR, including contraception.

3 Global statistics on violence against women show that, on average, 35% have experienced physical and/or sexual violence by someone who is an intimate partner or sexual violence by someone who is not a partner.

4 The World Risk Index 2018 (https://reliefweb.int/sites/reliefweb.int/files/resources/WorldRiskReport-2018.pdf)

5 Gender and Disasters (www.undp.org/content/dam/undp/library/crisis%20prevention/disaster/7Disaster%20Risk%20Reduction%20-%20Gender.pdf)

6 The MISP is a series of essential lifesaving reproductive health services to be delivered at the onset of an emergency response (http://iawg.net/areas-of-focus/misp/)

VFHA worked in collaboration with the Ministry of Health and provincial health workers, the National Health Cluster, community leaders and volunteers. This was a locally led response to provide essential SRH services targeting women in the affected area. Female service providers were at the centre of the response.

In order to reach the affected population on Ambae, VFHA teams had to transport medical supplies and aid in small boats, which then had to be offloaded on rocky beaches. Medical teams hiked through steep bush terrain on tracks circling the volcano to reach remote villages, carrying their equipment and supplies with them. There were two outreach teams, each comprising medical and non-medical staff. The teams were led by Leias, a senior VFHA midwife. In total, they visited 23 villages over a three-week period.

Leias started each clinic by conducting awareness sessions with affected communities on the importance of reproductive health in women's lives. This was an opportunity to address common myths and misconceptions surrounding family planning, increasing acceptance and uptake of services. Sessions covered topics such as preventing STIs and HIV, teenage and unintended pregnancies, unsafe abortion and information about modern methods of contraception. Men and women participated in awareness sessions separately – as is culturally appropriate in Vanuatu. As reproductive coercion is common, increasing knowledge and acceptance of contraception among men in these remote communities is particularly important to counter opposition to women accessing SRH services.

Once the awareness sessions were complete, nurses and midwives provided SRH consultations and contraceptive counselling to all clients seeking SRHR services. Esther, 31, is one of the 42 women who received a contraceptive implant from the VFHA team. Esther (not her real name) is a single mother with eight children, one of whom has cerebral palsy, and it was extremely difficult for her to evacuate the island with so many children. The disaster made her realise the importance of contraceptives and spacing her children – and the difference this would make in her own life. She decided to get a contraceptive implant provided free of charge through the humanitarian response. The nurses in the VFHA mobile clinic travelled to her village, helping her to overcome the enormous barriers she faced in accessing contraceptives due to her remote location. Esther's story highlights that women in humanitarian settings both want and need contraceptives, even those who have never used them before. Without VFHA bringing the services to Esther and providing counselling to support her choice, she would have remained one of the many women around the world with unmet contraceptive needs. Leaving no one behind means making the effort to reach these small communities, no matter how remote.

Vanuatu is a small country with a small population, so focusing on numbers alone can underplay the impact of the response. Of the 10,000 people affected on Ambae Island, 834 accessed the SRHR services provided through VFHA, of whom 177 received contraceptives. For many women, this was their first time accessing modern contraceptive methods. Forty-two women chose long-acting contraceptive implants. The success of the response was centred on the localised approach implemented by VFHA, involving local expert female service providers who were able to take SRHR services to women in remote villages facing significant barriers to accessing contraceptive services. Effective quality services and counselling delivered in a culturally appropriate and contextually responsive way is essential to enabling access to contraception for women. When there is trust and confidence in the provider and service delivery model, women will choose to use contraceptives, even for the first time, and even during a humanitarian response.

Contraceptives are in demand by women in times of disaster. They are also an essential component in fully meeting the needs of women and girls in emergencies. The Sustainable Development Goals (SDGs) cannot be met without increasing access to modern methods of contraception. There is an urgent need for governments, decision-makers and influencers to acknowledge access to contraception as a human right, both in stable contexts and in disaster settings.

Postscript

Sadly for the people of Ambae, Mt Monaro volcano became increasingly unstable in the weeks and months that followed the response. The entire population, including Esther and her eight children, were evacuated for a second time in April 2018 to nearby islands, where they remain a year later. VFHA continues to provide SRHR services targeting women and girls in this protracted crisis setting.

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Overcoming myths and misperceptions: expanding access to safe abortion services in humanitarian settings

Tamara Fetters, Bill Powell, Sayed Rubayet and Dr. Shamila Nahar

Today, there are over 68.5 million people living in humanitarian settings. This is the largest displacement crisis the world has seen in decades – and it's getting worse. The number of people displaced due to natural disasters, civil unrest, conflict and human rights abuses is increasing at an alarming rate. So too is the length of time a person spends in displacement, which is now almost 17 years on average. The impact of living in a humanitarian setting is devastating, but for women the hardships are even more life-altering. Many women and girls face increased risks of exploitation, sexual violence and transactional sex, and all have to overcome often seemingly insurmountable obstacles when trying to access sexual and reproductive health (SRH) care at a time when managing their reproductive lives is crucial.

Ipas, an international reproductive health and rights organisation, works globally to reduce the number of maternal deaths due to unsafe abortion by ensuring that all women and girls have access to safe and legal abortion, including those living in humanitarian settings. In partnership with the government of Bangladesh and other international organisations, Ipas is working with healthcare providers to offer comprehensive SRH services, including safe abortion and postabortion care (PAC), to Rohingya refugee women and girls.

Delivering sexual and reproductive health services in the Rohingya crisis

In August 2017, hundreds of thousands of Rohingya fled to neighbouring Bangladesh to escape violence and persecution by the Myanmar army. By the end of the year, over 655,000 had found shelter in Cox's Bazar, increasing the number of Rohingya refugees already settled in Bangladesh to over 900,000.

Kutupalong camp in Cox's Bazar is now the largest and most densely populated in the world. Over half of the refugees there are women and girls, many of whom have suffered rape or other forms of sexual violence at the hands of the Myanmar army. Although there are no precise statistics on the number of rape-related pregnancies, the information that is available highlights the importance of providing abortion services –or menstrual regulation (MR) as it is known in Bangladesh – and PAC services in the refugee camps as a basic health service and a human right.

Since 1979, MR in early pregnancy has been practical and a legal part of the nation's family planning programme, helping to reduce maternal mortality in this large and diverse country. MR is decentralised to even the most remote areas of the country, provided by female welfare volunteers using manual vacuum aspiration (MVA) or a combination of mifepristone and misoprostol to regulate the menstrual cycle when menstruation is absent for a short time.

This national MR programme was rapidly and naturally established for Rohingya refugees. This crisis marks the first known open introduction of safe abortion care in a humanitarian setting during an acute emergency. Although many in the field saw it as a 'non-essential service' or as 'too complicated', Ipas's experience working in the camps in Bangladesh, the increasing demand for SRH services plus the experience of thousands of women able to decide when and where to have their next birth, proves those beliefs to be unfounded.

Ipas's work with Rohingya refugees

'It was obvious to me this crisis was overwhelming' says Dr. Sayed Rubayet, country director for Ipas Bangladesh. 'The Rohingya women and girls suffered sexual torture and humiliation, they needed reproductive health care services that could help alleviate some of their pain'. In September 2017, under Dr. Rubayet's leadership, Ipas began working in the Rohingya refugee camps with the goal of improving the availability and accessibility of comprehensive SRH services, including MR, PAC and a broader range of contraceptive methods, including long-acting and reversible contraceptive (LARC) methods.

Ipas trained health workers in the camps and, in some cases, embedded a skilled clinician to provide MR services and conduct on-the-job training at selected government and NGO facilities in Cox's Bazar. 'We started our work initially at eight facilities', says Dr. Shamila Nahar, a physician and advisor who manages Ipas's health provider training in Cox's Bazar. 'We arranged and conducted training on MR with medication or MVA in collaboration with partners and the government of Bangladesh for doctors, nurses, family welfare visitors and paramedics at Cox's Bazar district hospital.' After getting government approval, Ipas trained clinicians to insert IUDs and contraceptive implants.

Just one and a half years after the influx in 2017, SRH services have been established at 36 facilities and 250 healthcare providers have been trained in comprehensive abortion care provision, including postabortion contraceptive services. Nearly 9,000 Rohingya women have received MR, PAC and family planning services.

Ipas will continue to work with local, national and international organisations in Cox's Bazar, focusing on increasing health workers' knowledge of and commitment to MR, PAC and family planning. Strategies for sharing accurate and complete SRH

Rohingya refugee women play *Kele-Kele shiki* with community health workers.

information within the refugee community will continue to be employed.

Early in 2018, Ipas partnered with IDEO.org, an organisation using human-centred design to develop creative solutions to complex social challenges. A team of designers, staff and researchers from Ipas conducted design research, iterating and testing ideas and assumptions, in camps in Cox's Bazar. After interviewing over 150 women and men about their cultural and religious beliefs and SRH knowledge and decision-making, the team came away with many of their expectations challenged, as well as new insights about how to better reach Rohingya women with SRH information.

It was clear that accurate knowledge about MR and LARC was absent. Men and women were operating in separate spheres, with little overlap. Despite men being the main decision-makers on whether to use family planning, they had unreliable health information. Only women were receiving SRH information, but they were unable to act on it on their own. 'Most of us are forced by our husbands to become pregnant' said one 25-year-old woman. 'Whatever our husbands say, we have to do.' The religious beliefs of the Rohingya were also initially perceived to be a barrier to the adoption of family planning but, ultimately, Imams were flexible and willing to change their originally tentative views in light of the conditions the refugees found themselves in. One Imam, when speaking to the team about reproductive health services and MR, said: 'Life is hard here. It goes against the Quran, but now we are in a troubled condition, so you should go to the hospital and take the advice of the doctor'.

The team saw an opportunity and began to prototype a board game about contraception, *Kele-Kele shiki* – Rohingya for 'learning through playing'. The aim is to reach women and men separately with information about – and gain men's acceptance of – family planning and the availability of MR, by involving Imams, local administrative leaders known as Mahjis, doctors and community health workers as trained facilitators. Players are given decision cards to facilitate a discussion between husbands and wives about desired family sizes in their homes. Finally, women are consulted by community health workers about the results of their discussions, and given more detailed information on contraceptive methods and MR using a flip chart developed to answer questions identified during the human-centred design process.

Although Ipas will move forward with its work in the refugee camps, the need for SRH services goes beyond the Rohingya crisis: all women and girls deserve access to safe reproductive health services, including safe abortion and family planning. As such, Ipas is also working to build capacity in the humanitarian sector so that organisations working in fragile and crisis settings can more rapidly respond to the SRH needs of displaced women

and girls. 'I think Ipas's work with Rohingya refugees can be a model for other countries, governments, donors and aid groups. Through our work in the refugee camps, we know it is possible to offer reproductive health services, including menstrual regulation, quickly and safely in humanitarian settings', says Rubayet. 'We need to show everyone that women and girls need safe reproductive health services. We need to dismantle the myth that abortion services cannot be offered in crisis settings'.

Myths, misinformation and stigma: abortion in humanitarian settings

At the onset of any crisis, humanitarian organisations prioritise shelter, food and water but, historically, not all organisations have prioritised the need for reproductive health services, particularly safe abortion. Indeed, many humanitarian practitioners and leaders in the field have said that it is impossible to provide safe abortion care in humanitarian settings. In 2016, researchers from Columbia University, Therese McGinn and Sara Casey, surveyed practitioners from humanitarian organisations to determine why safe abortion services were not provided to refugee women.[1] Their findings highlighted four myths that continue to impede the provision of abortion services in humanitarian settings.

- Myth one: there is no need.
- Myth two: abortion is illegal.
- Myth three: donors don't fund it.
- Myth four: abortion is too complicated to provide in crises.

These myths are perpetuated by misinformation, stigma and a lack of commitment to the basic human rights of women. Additionally, the restrictive legal and policy environment around abortion in many countries, including the United States, makes it easier to ignore the need for it. These myths need dismantling so that women can access reproductive health services, including safe abortion, in emergency settings.

Debunking myth one: there is no need

Unsafe abortion occurs in every country, regardless of the legal or social context, because women everywhere experience unwanted and unintended pregnancies and many are determined to end them. Although there is little to no research on the topic, the need for safe abortion services likely increases in humanitarian settings.

Debunking myth two: abortion is illegal

Ninety-three per cent of the world's population lives in a country where safe abortion is permitted under one or more circumstances. Only three countries ban abortion entirely: El Salvador, Nicaragua and Malta. Many international and regional agreements support the imperative to provide safe abortion in crisis settings. International agreements such as the Geneva Convention, UN Security Resolutions 2106 and 2122 and the Maputo Protocol support access to safe abortion care for survivors of rape, regardless of national law. That is not to say that navigating the legal landscape is easy. For example, although Médecins Sans Frontières (MSF) took a policy decision to provide safe abortion in 2004, it has taken time for the organisation to fully act on the policy.[2]

Debunking myth three: donors don't fund it.

The US government, a major humanitarian donor, doesn't fund abortion care under the Helms Amendment, and foreign organisations that receive USAID funding are prevented from offering advice, referring clients for abortion services or advocating for abortion law reform irrespective of funding source. However, many other bilateral and foundation donors do fund safe abortion care.

Under its Feminist International Assistance Policy,Canada has allocated CA$650 million for the sexual and reproductive health and rights (SRHR) of women and girls. The policy promotes a comprehensive package of SRH services including safe abortion care, comprehensive sexuality education, gender-based violence interventions and services to meet the needs of women and girls in humanitarian crises.

Debunking myth four: abortion is too complicated

The perception that abortion is too complicated for humanitarian actors to provide is simply wrong. With proper training, early abortion is among the safest and simplest medical procedures. Manual vacuum aspiration and medication abortion, abortion methods recommended by the World Health Organization (WHO), can be safely and effectively performed in the first trimester by primary care providers, and in the case of medication abortion by women themselves. Neither method requires electricity, running water or sophisticated equipment.

Moreover, most of the equipment, medications and infection-prevention procedures needed for safe abortions are the same as those needed for basic emergency obstetric care and other gynaecology services. The procedure is very similar to PAC, used for treating complications arising from unsafe abortion or to manage miscarriages, and any organisation supporting primary healthcare in humanitarian settings could provide safe abortion services with little additional input.

That doesn't mean that there aren't unique challenges to providing safe abortion care in humanitarian settings. Abortion stigma exists at all levels within humanitarian aid organisations, from top leaders to frontline health workers. There is also a severe lack of trained healthcare providers, as

1 T. McGinn and S. E. Casey, 'Why Don't Humanitarian Organizations Provide Safe Abortion Services?', *Conflict and Health*, 10(8), 2016 (https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-016-0075-8)

2 C. Schulte-Hillen and J.-F. Saint-Saveur, 'Why Médecins Sans Frontières (MSF) Provides Safe Abortion Care and What that Involves', *Conflict and Health*, 10(19), 2016

many countries still needlessly exclude abortion care from the scope of practice of primary and mid-level providers, such as nurses and midwives. There is a false belief that established safe abortion training models aren't feasible during an acute crisis, but models can and have now been adapted to be nimbler; Ipas's work training health providers in the Rohingya camps shows that providing safe abortion services during an acute emergency can be done.

'We have struck down many barriers by offering women access to safe abortion services during this crisis. I have seen how women have reacted and what it meant to them', says Nahar. 'But there is more work to be done and we need to see more humanitarian organisations delivering reproductive health services to refugee women, it is their human right'.

The way forward

While there is a dearth of evidence on SRHR, and especially abortion, in humanitarian settings to guide programming and service implementation, we know safe abortion care reduces unsafe abortions and ultimately saves lives – in any context. Unfortunately, we also know that sexual violence against women in humanitarian settings is not only a risk during flight, but continues during protracted emergencies, when women are supposed to be safe from coercion and assault.

The Inter-Agency Working Group (IAWG) on Reproductive Health in Crises is a coalition of governmental, non-governmental and donor organisations and United Nations agencies working to expand and strengthen comprehensive SRH services for people living in crisis settings.[3] The IAWG advocates that 'safe abortion services must be accessible, adequate, and available at any time during displacement, of good quality, without discrimination, violence or coercion' and that 'health care providers in crises should be trained to provide high-quality, rights-based safe abortion services'. One area of focus for IAWG is ensuring that women and girls have access to safe abortion care during all phases of a crisis, or as early as possible during an emergency. The Minimum Initial Service Package (MISP) for reproductive health, developed by IAWG, outlines a set of priority activities that should be implemented in every humanitarian crisis. The activities in the MISP form part of a comprehensive reproductive health package – including safe abortion and PAC – that should be implemented and sustained throughout protracted emergencies.

Ipas's work in the Rohingya camps has the support of the Bangladeshi government and many aid agencies, and we know it is possible to offer reproductive health services, including menstrual regulation, quickly. Let this be a model and a call to action for other countries, governments, donors and aid groups: it is vital that humanitarian NGOs normalise and integrate abortion into maternal healthcare and commit to ensuring that all women have access to high-quality and non-discriminatory health services. The availability of safe abortion in conflict-affected settings is not only a matter of urgency – it is also a moral imperative. Women's rights – including access to comprehensive reproductive health – are human rights.

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3 See http://iawg.net/

Music heals: a brief background of Healing in Harmony

Darcy Ataman, Shannon Johnson, Justin Cikuru and Jaime Cundy

Make Music Matter believes that music can play an integral role in the healing of individuals and communities in a concrete and measurable way.[1] Together with our partners at Panzi Hospital and Foundation in Bukavu in the Democratic Republic of Congo (DRC), and with the support of Elhra's Humanitarian Innovation Fund, we have been able to transform this belief into innovation through the Healing in Harmony programme. At its core, Healing in Harmony develops the potential for transformative change in traumatised people and their communities. While our primary focus is on survivors of sexual violence, we have also successfully applied the model in the case of abandoned children, adolescents of child-headed households, former child combatants and other vulnerable individuals.

1 See https://makemusicmatter.org/

How it works

Healing in Harmony uses music therapy to help survivors of trauma. Over a four-month period, working in tandem with a locally trained therapist and music producer, participants begin to heal by writing, recording and producing songs about their emotions and experiences. Psychosocial group counselling incorporated in the recording sessions uses various methods adapted from the cognitive behavioural approach to provide participants with tools to overcome PTSD, anxiety and depression. As they talk through their experiences, participants are encouraged to write down their stories. When a narrative emerges, the producer begins composing an instrumental accompaniment that eventually results in a song performed individually or in groups. The articulation of participants'

The Singing Women of Panzi Hospital, Healing in Harmony music therapy programme.

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traumatic events through song enables a more specific, detailed and therefore effective treatment pathway to be established and utilised.

The emotional state of each participant is closely monitored and individual counselling is provided when required. The environment created is one of joy and healing, focusing on turning negative thought patterns into positive and more adaptive ones through cognitive restructuring. Participants emerge as confident artists and advocates, publicly disseminating their music through local radio and television broadcasts, social media, community concerts and CD distribution. Internationally, artists and their songs are promoted on major digital streaming services and in stores via our record label on Warner Music Canada (A4A Records).

Preliminary research by the International Centre for Advanced Research and Training (ICART) has shown that Healing in Harmony has a positive impact on participants' mental health, with reductions in the prevalence of PTSD, anxiety and depression. The data suggests that these benefits are substantially maintained up to six months after completion of the programme, though there is some evidence that participants continue to experience conflict-related trauma. Further benefits include:

- Giving participants a new and more effective channel to express their feelings, experiences and needs.
- Facilitating improved communication and contact with caregivers.
- Strengthening solidarity among survivors through participation in musical groups, forming peer-to-peer support mechanisms and eventually promoting the emergence of group leaders.
- Opening up channels of communication to facilitate the reconstruction of families and reintegration into communities.
- Combating stigma and helping to reduce feelings of isolation.
- Creating powerful messages for positive change in the form of tangible and professionally produced music that can also be a beacon for others in need of help.
- Supporting partners, including therapists, music producers, researchers and humanitarian professionals, through an innovative community of practice.

Scaling up

Demand for the programme has been remarkable given the stigma usually associated with participation in psychotherapy programmes, particularly around sexual violence. There has been a three-fold increase in those wishing to participate since the programme began in

2015.[2] Based on this evident demand the programme has been scaled up, and is now working in a hospital in Mulamba, a rural area one and a half hours from Bukavu. Standard Operating Procedures (SOPs) and an easy-to-use manual were developed based on experience in Bukavu and Mulamba to enable other organisations to 'franchise' the Healing in Harmony model. In partnership with World Vision DRC the first affiliate site, at Beni, was launched in September 2018, though insecurity and the presence of Ebola made this challenging. In March 2019 another affiliate site was launched in Conakry in Guinea, this time in partnership with the Mukwege Foundation. There are also plans to launch sites in Uganda and South Africa in July 2019 with more potential DRC sites in August 2019.

Recognising the cultural context

Throughout the scaling process and adaptation of the model, it has been important to identify and articulate the cultural nuances in each area, in particular by drawing on local expertise. Without this local touchstone it would have been easy to miss material cultural differences between the various sites. For example, from a local perspective Bukavu is considered a very metropolitan area, where multiple cultures co-exist and people are more exposed to the modern world. Residents also face more standard life pressures, such as having to find the money for store-bought food, rent and school fees. The issues surrounding an individual or community's trauma are diverse as people tend to migrate to Bukavu as refugees from different areas, and a variety of reasons might have caused the trauma. In contrast, rural areas in DRC such as Mulamba and Beni are active conflict zones, where various rebel groups are a direct source of stress and resulting trauma. People in these areas are trying to protect themselves physically, while growing food and gathering water to sustain themselves and their families.

There are also material differences in the cultural view of the family. For example, communities in rural DRC are heavily patriarchal; women are viewed more as servants than equals and are expected to care for the family. They are rarely afforded the luxury of medicine or medical intervention to treat illnesses, which can make their trauma more pronounced and endemic. The ways in which a community manages trauma can also differ between a relatively safe area such as Bukavu and areas of conflict, where recently deceased bodies are routinely left in the open for everyone to see and homes are regularly burned down in violent attacks.

Articulating these subtle but profound differences is critical to the successful adoption of the Healing in Harmony model as it expands into different contexts and works with different partners. The model needs to be flexible, robust and dynamic enough to respond to different problems in different communities driving the trauma the programme is designed to heal. The key to this challenge is to fully understand the issues that the environment presents, and to let groups themselves present the problems at hand. From there, techniques within the Healing in Harmony framework can be adjusted. We are not aiming to dictate to a community specifically what it needs to be healed from, but rather to create an environment and space where the community can inform us of their needs.

A concrete example of how we are addressing this challenge relates to the music and songs people create. These stem from participants' emotions, which are usually conveyed in their mother tongue. This is a critically important note as mental formation is predicated on culturally based values. As such, cultural values that are integrated into the creative process and the songs that are subsequently produced are a main tenet of Healing in Harmony. The programme and model are as malleable as music itself.

Looking ahead

One risk is that quality control will suffer as the model expands and the number of partners and range of cultural and political contexts increases. The vulnerable populations Healing in Harmony aims to help deserve the highest quality programme with the highest ethical standards. To mitigate this risk, we provided further detail in the codification of our model after receiving critical community feedback and the successful replication of the model in our first scaling site. An example of this can be found at our site in Beni with World Vision DRC, where we subsequently focused on combining groups of women from forced prostitution and male former combatants in order to create empathy among them and coherence within the community they reside in. Because of this community feedback, each site becomes more precise and therefore more effective in the trauma we are trying to heal. This subsequent step in our codification process has resulted in a step-by-step guide for replication within our Standard Operating Procedures, as well as clearly outlining essential standards. For example, for affiliates to receive official certification as Healing in Harmony practitioners, they must demonstrate that they have the policies and procedures in place to ensure the ethical protection of the vulnerable groups they are working with. They must also apply for re-certification annually following an evaluation/audit of the programme by Make Music Matter. In return, they have permission to use the model and brand and have access to the manual and its various modules, training and oversight, post-production and dissemination services and the Healing in Harmony community of practice.

There is a constant need for analysis by Make Music Matter to judge the proper rate of growth so that organisational capacity and bandwidth are sufficient to ensure that a high-quality service is provided to our artists. While to date we have not had a single instance where lack of musical ability or lack of desire to participate musically negatively affected the roll-out of the model, we must guard against thinking that there

2 Frances Hill, 'Local Songs with a Global Voice: Resilience through Music Therapy in Eastern Congo', Elhra blog (www.elrha.org/project-blog/local-songs-with-a-global-voice/)

are no barriers to participation. Africa in general is a very musical culture, but we do not yet have substantive feedback in operating contexts such as the Middle East, where artistic participation may not be viewed as culturally acceptable or inclusive, particularly for females.

Finally, Make Music Matter must itself be wary as an organisation as Healing in Harmony grows. In the early stages, the organisation comprised passionate innovators, mostly from the music industry, who over time closed the gap between music creation, psychosocial care and formalised research. As we continue to build our organisational capacity to maintain more Healing in Harmony sites, we must not lose the entrepreneurial spirit and innovative vigour that gave birth to the programme in the first place. Conversely, as the Healing in Harmony model spreads, it must remain bespoke in order to be as effective as possible for the local context it is operating in and the population it is serving. If we grow too fast and present a homogenised version of Healing in Harmony, we run the danger of hollowing out our core and imploding.

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Advancing access to education for girls and women in humanitarian emergencies: critical insights into community engagement in Afghanistan

Emilie Rees Smith, Emma Symonds and Lauryn Oates

Over the last 15 years, girls have gone from being forbidden from enrolling in school to representing 39% of learners in Afghanistan's basic education system.[1] However, significant challenges in girls' education remain: an estimated 3.7 million children are out of school – 60% of whom are girls. Only 37% of female youth and 19% of adult women are literate, compared to 66% of male youth and 49% of adult men.[2] A range of factors keep girls out of school, including lack of government schools in rural areas, low levels of trained female teachers, the poor quality of teaching and the school environment and targeted attacks by insurgents on girls' schools. Traditional gender norms confine girls to the domestic sphere and preparation for marriage: early marriage rates in Afghanistan are among the highest in the world, with over a third of girls married before the age of 18.[3]

This article is framed by perspectives from the UN Girls' Education Initiative (UNGEI)'s experience as global convener on girls' education and as co-convener of the Inter-Agency Network for Education in Emergencies (INEE) Gender Task Team. It draws on insights from the Steps Towards Afghan Girls' Education Success (STAGES) project, part of the DFID Girls' Education Challenge, led by the Aga Khan Foundation (AKF). STAGES works at grassroots level in remote and insecure locations across Afghanistan to increase access to and quality of education for girls, and to improve community and parental attitudes. Since 2013, the project has enrolled 40,795 girls and 18,038 boys in various levels of education. This article discusses emerging good practice and lessons from the first phase, and how these have shaped the project's next phase (STAGES II) and includes independent reflections by Canadian Women for Women in Afghanistan (CW4WAfghan).

STAGES' experience of community-based education and community engagement

STAGES is implemented in close collaboration with the community and local government authorities. The project provides the teacher and classroom materials, teacher training and mentoring and supports community engagement; the community contributes classroom space and volunteer time. Results have shown increased enrolment, attendance and transition to secondary school as well as improved levels of reading fluency and numeracy over the course of the project, and higher levels compared with counterparts in government schools. This is particularly the case for marginalised girls, including girls with disabilities, those engaged in labour and girls who do not initially speak the language of instruction. STAGES I was designed to progress the same group of students from grade one to graduation, but this excluded those who missed out on initial class registration. Learning from this, STAGES II is piloting multi-grade classrooms, where new students are enrolled in grade one each year, and multiple grades are taught simultaneously.

Through the project's community-based education (CBE) and engagement of community members, girls can continue their education even in insecure areas. CBE classes remain open on the basis of community acceptance, and with the support of local teachers and community members who can leverage relationships with local decision-makers. Non-governmental actors are able to enter areas controlled by armed opposition groups, where government actors are not present, and

1 Note that figures for the number of girls in school in Afghanistan vary considerably according to the data source.

2 United States Agency for International Development (USAID) and European Commission, *Afghanistan Gender Country Profile – Final Report: Short Version*, 21 September 2016, p. 9

3 UNICEF, *State of the World's Children* (New York: UNICEF, 2017)

Student at Fatema Tul Zahra Girls School in Kabul.

when NGO staff members are unable to access communities community members can keep classes going. Although classes can be suspended due to fighting, learning outcomes in areas that are insecure or under the control of armed groups are not necessarily lower than those of students in communities under government control.

School Management Shuras (SMSs) are a key part of STAGES' community engagement approach. SMSs comprise community members who provide daily oversight of the school, mobilise community resources and advocate for education. Members are trained on their roles and responsibilities and on topics such as gender and community mobilisation. Where communities become inaccessible to project staff due to insecurity, SMSs can step in to ensure that schools continue to operate. SMSs help ensure that schools are safe and respectful learning spaces, and are proving successful in bringing back girls who have dropped out and improving girls' attendance. They have helped learners and their parents manage household needs and educational activities, in one case listing household chores together with the parents and setting a schedule for them, and have intervened when domestic labour appears to be negatively affecting school attendance.

Female shura members are an important resource for girls, who feel more comfortable talking to them about issues at home or in class, or on matters of hygiene. However, many communities still believe that it is not appropriate for women to participate in an SMS, and STAGES has found it extremely difficult to engage female SMS members. Participation in SMSs is usually dictated by gender rather than by individual skill sets or capacity, with male members in decision-making roles, while female members fulfil socially prescribed roles such as cleaning classrooms or cooking for the men. STAGES II is experimenting with different strategies to address this, including developing a job description for SMS members outlining roles for men and women and specifically removing responsibility for cooking and cleaning from women, and hiring more female community mobilisers to work with hiring and training female shura members.

STAGES also works with the broader community, elders and religious leaders to promote girls' education. In community meetings, men and women identify the challenges to girls' education and jointly develop solutions relevant to their context. Project staff run awareness-raising campaigns, host radio programmes and organise mobile theatre productions. These activities have contributed to strong positive shifts in community attitudes towards girls' education, especially among men and boys. The project has also seen increased local ownership, with community members providing significant levels of in-kind contributions.

The most effective messages tend to highlight the link between girls' education and the wellbeing of the entire community. Dedicated female teachers show that teaching is a respectable

profession for women, and female SMS members demonstrate that women in positions of authority are capable, competent and responsible, working on behalf of and for their communities. Gradually communities become accustomed to seeing women in new roles, while girls have role models who broaden their horizons on what's possible in the future.

Building sustainable systems for girls in partnership with government

Through projects such as STAGES, NGOs play a critical role in maintaining a lifeline to education during emergencies. CBE is often the only chance an Afghan girl will get to go to school, especially during emergencies. However, externally funded NGO-run programmes are not sustainable without government engagement. A key component of STAGES is therefore working towards the transition of girls to government schools. Since girls who move to government schools are more likely to be from wealthier households, STAGES provides targeted support to girls in the final year before they transition to government schools, with particular attention to girls at risk of dropping out for financial reasons.

STAGES also works to ensure the systematic engagement and coordination of community and local education officials in the delivery of CBE. STAGES II includes regular training workshops, joint monitoring visits and meetings with Community Development Councils (CDCs) and provincial and district education officials. The project also engages with the Ministry of Education at the national level, and is initiating sustainability and handover planning much earlier than in the first stage. Government officials are directly involved in programme delivery, including co-developing tools and processes and participating in project committees and working groups. Collaboration between the government and NGOs features in the National Education Strategic Plan, and the recently launched Girls' Education Policy – the first of its kind in Afghanistan – underscores the role of CBE in bringing out-of-school girls into the system. The policy also supports the establishment of SMSs and the importance of women's role within them. This new institutional framework presents an opportunity to cement changes brought about by community-based efforts such as STAGES through greater investment and systematic uptake nationwide.

Conclusions

Efforts to improve the quality of teaching and the school environment alongside community engagement strategies are proving effective, both in addressing more immediate access challenges for girls in particular, and influencing attitudes and behaviours relating to gender equality. Establishing a two-way relationship between the school and the community is contributing to increased levels of girls' enrolment and attendance among STAGES target communities across Afghanistan. The STAGES experience underscores the importance of meaningfully engaging local and national education officials at all stages of implementation, and providing support for the careful formulation and execution of transition plans from CBE to government schooling.

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Further details on practical approaches to gender-responsive education in emergencies, including community participation and engagement, are available through the recently launched INEE *Guidance Note on Gender*. This provides key information and resources on providing, managing and supporting education services as part of emergency preparedness, response or recovery programmes.

Addressing the systematic barriers facing women and girls in the aid system in Somalia

Degan Ali and Deqa Saleh

In the twenty-first century more than ever before, we're seeing positive global initiatives to tackle gender inequality, gender-based violence and other gender-related issues. However, we're also getting more reports of abuses and inequalities affecting women and girls, including in the aid sector. When I decided to move back to Somalia in the early 1990s my goal was not only to help Somalis deal with the effects of the civil war, but also to help women and girls take on more leadership and decision-making roles. I founded the grassroots organisation Adeso (African Development Solutions), then called Horn Relief, in order to meet this objective.

Adeso worked with traditional leaders and elders, as well as existing women's community groups and individual women who wanted to come together in their communities. We designed programmes that specifically included women, for example in non-formal education for pastoral youth, environmental programmes and peace-building initiatives, as well as leadership and governance. Women usually know their communities better than men: who's the most vulnerable, and what the needs are. We felt that their inclusion in decision-making and leadership roles would help create more resilient and sustainable communities, not least because, as a result of

Bocame local council.

© Suban Mohamed

the conflict, women were becoming breadwinners and taking on more of a decision-making role in their households.

Programming and implementation

For Adeso's first large-scale cash project, in 2003, our donor required that we ensure that all the beneficiaries were women. Cash assistance was new and controversial: donors were risk-averse, and even the most progressive were looking for ways to reduce the risks of misuse or misappropriation, and felt that targeting women ensured that the money would be spent productively. Although we felt very uncomfortable with this demand we complied with it, and prioritised women-headed households and structurally vulnerable groups. For married couples, we registered the woman and ensured she received the transfer. After two cash projects it was clear that this was disrupting societal norms and causing tensions between men and women. One day, while undertaking registration in a community, a man stood up and challenged us, saying: 'Do you think that I am capable of buying Qat while my children starve? What kind of man do you think I am?'. This was a pivotal moment for me in understanding two things: one, that doing gender work cannot be at the expense of dehumanising men; and second, that we should never have an outsider, whether a donor or international humanitarian actor, drive the design of aid programmes.

From this point on we explicitly stopped saying to communities that all beneficiaries had to be women. Instead, we made sure that our cash programmes used vulnerability-based targeting, and that we tried to engage and consult women (as well as youth and minorities) in the mobilisation and registration process. Women were deliberately involved in community decision-making structures, such as village committees, and we held private meetings with women to develop and review registration lists. For women to fully participate we recognised that we needed to create a safe and private space for them to speak directly to project staff, without creating conflict in households and communities. This led to a natural process where 50–70% of direct beneficiaries were women. We strongly believe that this is one of the key factors that contributed to a truly inclusive and effective targeting methodology called Inclusive Community Based Targeting (ICBT). The key features of ICBT are community mobilisation, setting up village committees, developing targeting criteria, beneficiary identification (by the committee), verification (by the agency), registration and distribution or implementation.

Adeso trained a large number of INGOs and UN agencies throughout Africa on this approach. It was a shock to learn that what we assumed to be standard was actually extremely uncommon, with traditional community engagement processes led by male staff who engaged with traditional male leadership structures, marginalising women and minority groups in the process. Adeso documented the ICBT approach and developed a training manual for Adeso staff. In 2012, we developed this into a training methodology, with funding from USAID and the European Commission, for local and international NGOs and UN agencies throughout Africa.

In our advocacy work we promoted women's participation in political processes. Adeso helped women to organise and develop advocacy skills to promote women's participation in political processes. We also advocated for 30% of members of parliament and representatives at the municipality level to be women. This led to the establishment of local councils in Puntland State. The movement that originated from Puntland spread to the Federal Government and other states throughout

the country. Adeso's successful organising and training of women's groups also ensured that women were effectively represented in municipal structures that UN agencies were working to develop. While the process of developing these structures was flawed in our opinion (they adopted a top-down approach and the process was dominated by men and elders), we tried to correct this by encouraging women at the grassroots to put pressure on men to ensure that they had a space in these municipal structures. This eventually led to 17.8% of women being selected in 10 municipalities throughout Puntland..

Staffing

How inclusive of women was Adeso? How could we ensure that women could compete against more qualified and educated men for employment? Adeso decided to create internship positions in all its offices, almost all of which were allocated to local women from the communities we were working in. Where we could, we also introduced affirmative action in employment, even if on paper a woman was slightly less qualified than a man. In this way, female project beneficiaries became colleagues, who went on to work for UN agencies and INGOs. Many of these women occupied traditionally male-dominated positions, such as project management and finance. We headhunted female interns and staff, as well as reaching out to community leaders, especially female and youth leaders, to attract women interested in working with us.

Operations

We also sought to include women in the Adeso supply chain. For men in the organisation in control of operations and procurement processes, it was initially extremely difficult to recognise that it was their responsibility to seek out women in the market who could meet our requirements as suppliers and service providers, and support them in effectively responding to tenders and competing against much more experienced men. We had to identify business women who could secure capital, and then train them on our requirements and tendering processes. We began in one location and one procurement, for fuel for our vehicles. The woman we identified quickly learned the business and later became a successful supplier for Adeso, and one of the biggest traders in the district.

So what?

First and foremost, Adeso understood the context and knew how to effectively navigate the cultural norms and values of Somali society. We were locally established and driven, not by external influences, but by the desire to ensure culturally and religiously appropriate systemic change. This intimate understanding allowed us to navigate through difficult cultural terrain that international actors would have found very difficult to understand, let alone successfully manoeuvre through. We also realised that, to achieve our objective of fully integrating women into our work, we could not limit ourselves to project and beneficiary level. We needed to have the courage to confront our own organisational culture and barriers to procurement and recruitment.

We didn't always succeed, and we weren't always able to introduce these attitudes and ways of working consistently throughout the organisation. We were most successful where we had champions who genuinely had ownership of gender inclusion and were able to consistently lead and challenge the local team and our senior leadership. At times this led to tensions within the organisation as many of the men in the senior leadership team did not want to work in such radically different ways, even though some had been trained on gender issues. It is essential to include this in the recruitment process before potential staff are hired and, even more importantly, that an organisation effectively institutionalises this way of working into every facet, and ensures that new staff at all levels are properly inducted and trained in understanding the organisational culture and in working in this new way.

In our work over the years, we believe the strategies we have used have enabled us to address some of the systematic barriers faced by women and girls in the aid system. In order for this to work you need to involve all stakeholders, men and women, so that everyone is working in a collective effort towards a common goal and do not feel excluded from the process. You also have to have an intimate understanding of the context and be willing to go beyond programming and implementation as a humanitarian actor when promoting gender equality.

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The role of gendered norms in driving suicidal behaviour in Vietnam: why are girls more vulnerable?

Fiona Samuels and Taveeshi Gupta

Drawing on primary qualitative data collection in 2017 and a review of secondary sources,[1] this article explores patterns of suicide among children and adolescents in Vietnam, with a particular focus on the role of gendered norms in driving suicidal behaviour.[2] Several factors intertwine to make some people more vulnerable than others, ranging from individual histories of psychopathology and cultural and social background to crisis-related factors, including the type and magnitude of the event, the threat to life and the extent of losses. In post-disaster contexts people may face insecurities and uncertainties arising from, for instance, unemployment and limited support structures.[3] In countries undergoing large-scale economic change such as Vietnam, pressure is increasing on individuals and families as norms and expectations change, giving rise to mental and psychosocial distress.[4] Vietnam's conflict history is still present in the minds of many of its people, and the country is highly exposed to natural hazards such as droughts, earthquakes, floods, forest fires, landslides, sea water intrusion, typhoons and volcanic eruptions.[5] Against this background, and in light of evidence that suicide rates among children and young people in Vietnam may be rising,[6] it is crucial to understand how the current context places children and adolescents at risk.

Individual risk factors

In our sample, females were perceived as being at higher risk of suicide. Reasons put forward largely by boys for why girls are more likely to attempt or commit suicide include their greater susceptibility to emotions and living in remote areas, isolated from support structures: 'There are more girls among those who commit suicide and do harm to their bodies like chopping their hands or confining themselves, as girls are more sensitive to their emotional issues. Their hearts are easy to be hurt, meanwhile boys are more steadfast and calmer when encountering a problem'. Gendered norms were mentioned as a strong driver for suicide, particularly for people in rural areas. Girls in one focus group discussion in Dien Bien Phu felt that norms around son preference in rural areas may put girls at higher risk of suicide: 'In the commune, girls face more difficulties, because in ethnic [minority] groups, people often value men over women … some parents are not knowledgeable, so they often prefer having sons. They may treat daughters a bit differently'. Similarly, interviews with females found that, in rural areas in particular, norms persisted around what a girl 'should' do. One girl was told that she was better suited to be a flight attendant rather than a police officer like she wanted because she had a 'beautiful body'. Attitudes such as these all contribute to creating contexts where girls may feel isolated and unheard, and consequently experience emotional difficulties that are potential risk factors for suicide.

Gendered norms were also found to be a risk factor for suicide among boys and men who felt unable to live up to expected masculine attributes and behaviours, including an inability to maintain the household, leading to negative emotions and sometimes suicide attempts; one 17-year-old male said that 'Most men are under pressure from the responsibility to feed their wives and children, while in fact some are incapable of doing that'.

Household and relational factors

Relational factors influencing suicide ideation and attempted suicide among the study respondents included problems at home (being scolded by parents, lack of communication with parents, parents not having enough time to talk to their children, parents disagreeing with the choice of marriage partner, conflict between parents, a violent father, financial pressure and parental addiction); problems at school, including bullying, teasing, getting low marks and self-isolation; and failure in romantic relationships, such as being abandoned/discarded, usually by a boyfriend. All of these factors were said to lead to young people feeling sad, upset and frustrated, which in turn led them to attempt suicide and sometimes even succeed in taking their own lives.

Gendered norms related to early and forced marriage of girls, which are closely related to pressure to drop out of school, were frequently cited as a reason behind suicide attempts by young women. One respondent noted that there is fear of 'being kidnapped' into marriage in their area, and recounted

1 For further details of the full study see www.odi.org/projects/2852-mental-health-study-children-and-young-people-vietnam

2 Vietnam's reported suicide rate was 7.3 per 100,000 people in 2016, up from 6.7 in 2000. This data is, however, unreliable, and real rates could be higher. See WHO, *Global Health Estimates 2016: Deaths by Cause, Age, Sex, by Country and by Region, 2000–2016* (Geneva: World Health Organization, 2016) (www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html); R. Blum et al., 'Youth at Risk: Suicidal Thoughts and Attempts in Vietnam, China, and Taiwan', *Journal of Adolescent Health* 50(3), 2012

3 C. A. Alfonso 'PTSD and Suicide After Natural Disasters', *Psychiatric Times*, April 2018 (www.psychiatrictimes.com/ptsd/ptsd-and-suicide-after-natural-disasters)

4 A. Gabriele, 'Social Services Policies in a Developing Market Economy Oriented Towards Socialism: The Case of Health System Reforms in Viet Nam', Review of *International Political Economy*, 13, 2006; A. Hansen, 'The Best of Both Worlds? The Power and Pitfalls of Vietnam's Development Model', in *Emerging Economies and Challenges to Sustainability* (Abingdon: Routledge, 2014)

5 Global Facility for Disaster Reduction and Recovery, 'Vietnam' (www.gfdrr.org/en/vietnam)

6 Ministry of Health, *Survey Assessment of Vietnamese Youth Round 2*, 2010

School children in Dien Bien Province, Vietnam.

how a 16-year-old girl who had been kidnapped had committed suicide because she was so unhappy in her new marital home. Instances of bullying and teasing in school were also linked with suicide ideation, particularly for boys; one explained that 'Back then, I was often made fun of by a classmate. I'm very sensitive, so being made fun of by other people affects my feelings the most … they all liked to bully me and so I had suicidal thoughts'.

Access to the internet can be both a suicide risk and a protective factor. Study respondents spoke about the internet as addictive, leading to anti-social behaviour such as stealing and affecting mental health and psychosocial wellbeing, particularly for boys. Limited leisure opportunities for children and young people often led them to spend a lot of time on the internet, which was also seen as being dangerous and a risk factor for suicide, particularly by girls. Many children mentioned romantic relationships as being risk factors for suicide: 'Many cases of suicide are due to emotional issues from intimate relationships'. Suicide triggers could include unrequited love, parents discovering, disapproving of or forbidding the relationship and, for girls in particular, feelings of jealousy.

Community factors

Study respondents suggested that socio-economic difficulties could be related to suicide. One adolescent male in An Giang stated: 'The majority of those who commit suicide and use substances are from poor families'. Living in rural areas also emerged as a risk factor. Entrenched and discriminatory gendered norms frequently associated with ethnic minority status were most often cited as the reason why living in rural areas may be a risk factor. Indeed, key informant perceptions indicate a belief that Hmong people are more prone to suicide than other ethnic groups, further fuelling negative stereotyping and marginalisation.[7] Our findings indicated that not only are Hmong people perceived as being 'haughty and proud', but their limited awareness was considered a driver of suicide.

> *Not all the ethnic minority groups are the same. It occurs only with the Hmong people … Hmong people have a bad custom of eating la ngon to kill themselves … The reason relates to the superiority complex of Hmong people. When a child has an urgent matter with classmates or disagrees with their parents, he or she is easy to commit suicide.*

Institutional factors

Services for mental and psychosocial health, including suicide prevention and treatment, are limited in Vietnam. What services do exist focus largely on severe mental health problems, but given that suicide results from factors which are often not related to severe mental health problems such services are largely inadequate. Even where services exist, people may be reluctant to access them for a range of reasons, including stigma, lack of awareness and lack of affordability. Even if they do access them, service quality is extremely variable and may not be age- and gender-sensitive, all of which can result in limited uptake.[8]

Conclusions

At the individual level, the findings of this research show that young people, particularly girls, are more likely to face mental health and psychosocial difficulties. Hence, understanding the particularities of this population group as well as their needs and priorities in relation to suicide ideation and attempts is important to effectively direct resources towards those most in need, and to ensure, not only that services are gender-sensitive, but also that they address the specific needs of children and young people.

7 Hmong are the majority ethnic group in Dien Bien rural areas. Hmong people account for less than 10% of Vietnam's population, and like other ethnic minorities in Vietnam (e.g. Tay, the Thai, the Khmer), are poorer, less likely to be employed, have poorer-quality education and are more likely to be married early than other ethnic minority groups (e.g. Kinh).

8 M. Do et al., 'Perceptions of Mental Illness and Related Stigma Among Vietnamese Populations: Findings from a Mixed Method Study', *Journal of Immigrant and Minority Health* 16(6), 2014

Both the family/household and the school setting either create an enabling/protective environment for suicide ideation and attempts, or can potentially be a risk factor for, or fuel, suicide ideation and attempts. Supportive family members, especially parents, can protect children facing stress and pressure, and can also be important carers for other household members facing psychosocial distress. Interventions at family level could include parenting and communication skills, and learning to recognise triggers and symptoms of mental distress.

At community level, the challenges of poverty and rural life are often compounded by gendered norms around early marriage, accepted masculine behaviours and stereotypes around ethnic identities, all of which can fuel suicide ideation and attempts. Greater awareness is needed of the links between discriminatory gendered norms – child marriage pressures, expectations around appropriate masculine behaviours – and the mental ill-health and social isolation that many girls and boys often feel in such situations. This awareness-raising could be done at various levels, starting at the commune level by providing communities with more information about symptoms, manifestations and available services.

At the institutional level, Vietnam has some experience of using a community mental health model, which appears to have been relatively successful. It would be useful to revisit and potentially expand this model, including providing mental health literacy training and programming to community health workers, for instance in counselling and referrals and in the identification and prevention of potential suicide cases. Improved coordination between child protection workers, medical workers, school staff and women's and youth unions at commune level would be vital for this to be effective.

Given that schools are an existing platform to work with children and adolescents, it is critical to promote the role of the Ministry of Education as a champion for supporting child and adolescent mental health and psychosocial wellbeing. This could be done through teaching children skills to deal with emotional and psychological difficulties and relieving study pressure, often a cause of mental health distress, by evaluating the volume of knowledge children are expected to learn.

While the internet can be a driver of psychosocial distress, it can also be protective: school children engaged with it to learn, to help them deal with feelings of sadness or anger, to watch videos and to connect with friends. Facebook was frequently mentioned – possibly more by girls among the study respondents – as a vehicle through which to express feelings. Exploring and harnessing the potentially protective role of new technologies could be an important step in addressing issues around suicide ideation and attempts, alongside other strategies focusing on improving the broader mental health and psychosocial wellbeing of children and adolescents in Vietnam.

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Disaster, response and relationships: a gendered approach to localising disaster risk reduction in the Pacific

Subhashni Raj, Brigitte Laboukly and Shantony Moli

Cyclones, floods, droughts and earthquakes in the Pacific are increasing in both intensity and frequency, with devastating impacts, especially for women and girls. Global evidence indicates that women are generally at higher risk of being affected by disasters and have different levels of resilience and capacity to recover.[1] This is particularly true in Pacific countries, where women experience significant gender inequality, evidenced by their lower socio-economic status compared to men, lower access to paid employment, lower access to information and early warnings, less control of and access to economic resources and high levels of sexual and gender-based violence.[2] Moreover, the skills of Pacific women are often under-utilised in disaster preparedness, response and recovery, even though women and girls are often first responders in crises and, when given the opportunity, have the capacity to lead in disaster preparation and response and resilience-building. This article illustrates the importance of using a gendered approach to community-based disaster risk reduction, and highlights the challenges of localising such efforts in the South Pacific.

The Women's Peace & Humanitarian Fund: galvanising gender-responsive humanitarian action

Despite recognition of the critical role women and girls play in humanitarian response and peace-building, very little funding globally is being directed towards interventions focused on women and girls. According to OCHA's Financial Tracking System, only 1% of projects had an explicit goal of closing gender gaps by taking targeted action for women and girls. Similarly, the Organisation for Economic Cooperation and Development (OECD) reported that, between 2012 and 2013, only 1% of all funding to fragile states went to local women's groups or government ministries with a mandate for women.

1 E. Neumayer and T. Plümper, 'The Gendered Nature of Natural Disasters: The Impact of Catastrophic Events on the Gender Gap in Life Expectancy, 1981–2002', *Annals of the Association of American Geographers*, 2007, 97(3)

2 R. Lane and R. McNaught, 'Building Gendered Approaches to Adaptation in the Pacific', *Gender & Development*, 2009, 17(1)

The Women's Peace & Humanitarian Fund (WPHF) was established in 2016 in response to these global disparities in funding. WPHF aims to galvanise action globally to mobilise resources for women's participation, leadership and empowerment in the humanitarian, peace and security sphere. The Fund is a global partnership of donors, conflict-affected states, United Nations entities and civil society. Overseen by a Board made up of representatives of these stakeholders, the Fund provides funding to local women's groups and ministries globally. UN Women provides secretariat support and coordination to implement the decisions of the Funding Board.

The first round of WPHF proposals in the South Pacific was solicited between 2017 and 2018. With a total allocation of $2 million in the Pacific, seven full projects and one pilot were selected from among the submissions. The eight projects span five Pacific Island countries, with three projects in Fiji, two in the Solomon Islands and one each in Palau, Samoa and Vanuatu. The implementation timeframe for each full project ranges from 18 to 24 months. This article examines one of the WPHF grantee projects, the Localization Project in Vanuatu, to draw out lessons for gender-responsive disaster risk reduction and response.

Context

Vanuatu, an island nation west of Fiji, consists of about 80 islands comprising a total land area of 12,281 square kilometres. Its population is around 289,000, with a roughly even gender split. Vanuatu is highly prone to disasters given its geographical location. It is ranked first out of 172 countries in terms of disaster risk, and sits on the 'Ring of Fire', a seismically active zone bordering the Pacific basin.[3] Countries in this zone are more likely to be exposed to natural hazards like earthquakes, volcanic eruptions and tsunamis because of seismic activity. Vanuatu also faces significant threats from climate change, which is increasing the frequency and magnitude of disasters.

In relation to the socio-economic context, women and girls in Vanuatu (and across the Pacific) experience persistent gender inequality. Gender disparities are illustrated by the low number of seats held by women in parliament: currently zero, and only five women have been elected to parliament since independence in 1980.[4] Less than 1% of the total government budget was allocated to women's ministries and departments.[5] Sixty percent of ni-Vanuatu women have experienced partner violence and 49% of women affected had left their homes temporarily several times, though lack of income limits their choices following acts of violence.[6] Low rates of political participation and funding contribute to gender-blind political structures and processes, especially in traditionally patriarchal societies such as Vanuatu.

The Localization Project

The Localization Project, jointly implemented by Save the Children and CARE Vanuatu, sought to increase the involvement of local civil society organisations (CSOs) in leading work on gender and protection responses in emergencies. The project, which ran for 17 months from August 2017, was based on the premise that, by localising the functions of the Gender and Protection Cluster in Vanuatu, women and girls' participation in disaster response would be increased. The project trained female members of Community Disaster and Climate Change Committees (CDCCCs) and Provincial Disaster Committees (PDCs) on disaster preparedness, response and relief. Implementing partners also trained girls aged 12–17 participating in School Disaster Committees (SDCs) on child-led disaster risk reduction, enabling them to engage with PDCs. This work was carried out in two provinces, Tafea and Sanma. Knowledge-sharing events were organised with the Protection Clusters in Fiji, the Solomon Islands and Papua New Guinea.

What did the project achieve?

The project trained 85 women and girls, 40 men and boys and had 88,944 indirect beneficiaries. But the project also had a deeper impact. Prior to the project, women and girls in Tafea and Sanma had limited capacity to participate in disaster preparedness and response, were unaware of the concepts of gender and protection, the work of the Gender and Protection Cluster was not well understood and integrating a gender lens into post-disaster assessments was not common practice at the national, provincial or community level.

Pre- and post-training evaluations suggest that the project has increased participants' knowledge about gender and protection in emergencies, and their capacity to participate in preparedness activities. According to the Gender Equality Project Manager at CARE Vanuatu: 'One of the most visible impacts was seeing the light bulbs turn on for community members when we unpacked gender and protection and ran them through the simulations. The dawning of the realization that different members of the community have differentiated needs, and that we need to think about these differentiated needs for disaster planning'. Training and community development work has increased capacity among women and girls from Sanma and Tafea provinces, provincial government and national CSOs, and given them the confidence and skills to participate in emergency preparedness and response efforts. All members of participating CDCCCs, PDCs and national CSOs

3 K. Radtke et al., *World Risk Report*, Bündnis Entwicklung Hilft and Ruhr University Bochum – Institute for International Law of Peace and Armed Conflict (IFHV), 2018

4 UNDP, *Pacific Women in Politics*, 2019 (www.pacwip.org/country-profiles/vanuatu/)

5 SPC, *National Minimum Development Indicators – Gender Indicators*, 2016 (www.spc.int/nmdi/gender)

6 Vanuatu Women's Centre, *Vanuatu Women's Centre and Vanuatu National Statistics Office, Vanuatu National Survey on Women Lives and Family Relationships*, 2011

developed an increased ability to integrate a gender lens into post-disaster assessments and subsequent analysis.

A key lesson from the community-embedded work was the need to engage men in the training to ensure that women's involvement in disaster management would be championed: although the focus of the project was empowering women, it was clear that men, as advocates of women's participation, would be critical. The project also contributed to increased knowledge about the role of the Gender and Protection Cluster, and how it fits within the national humanitarian system, and increased ownership of the Cluster among local CSOs, as well as their willingness to engage as part of the Cluster.

Taken together, the Localization Project contributed to disaster risk reduction on three levels: at the community level, by training and empowering women and girls; at the provincial level, through training and capacity development; and at the national level, through engagement of local CSOs and government ministries. However, while the project was well-received and contributed to national, provincial and community priorities, it also faced numerous challenges. One key challenge was a series of disasters over the course of the project, which required implementing partners to refocus on preparedness and engagement in the national emergency response. Two months into the project, a volcano on Ambae Island erupted. Continued eruptions and high levels of volcanic activity led the government to declare a state of emergency, first in September–December 2017 and then from April to November 2018. During this period, the government ordered the full and mandatory evacuation of the population of the island. Both implementing partners, the four CSOs that were part of the project's mentoring programme and members of the Gender and Protection Cluster were all involved in the relocation process. Another eruption in December 2018, this time on Ambrym Island, triggered an earthquake that required response efforts. Vanuatu was also affected by cyclones and a tsunami over the implementation period.

Although unintentional, the project was well-timed to meet the needs of people affected by the developing humanitarian crisis. The four CSOs that underwent mentoring were able to put their new skills and knowledge to the test in the field almost immediately. Project implementers also noted stronger relationships between national government and CSO partners. One government official said that 'The Localization Project has facilitated stronger collaboration between government and cluster members and strengthened existing relationships. I believe through this fostering of strong relationships the project has allowed for longer-term programming in the Ambae response that the government would not have been able to shoulder alone'. Being able to support government efforts during the response also increased the visibility of the Gender and Protection Cluster, and gender and protection issues nationally. The sentiment of the government official captures the critical nature of localising funding in high risk disaster regions and the need for funding to capacitate women and girls to strengthen disaster management and response operations.

Collaboration in action – Save and CARE project coordinators working together to implement community disaster management training.

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It is clear from the Vanuatu experience that WPHF funding has enabled multiplier effects that should help galvanise attention towards women's participation in disaster risk reduction and response. The funds have contributed to relationship-building and facilitating an active response, while also developing internal capacity to respond to disasters among women and girls, and with male advocates. While the Localization Project has come to an end, its impacts will continue to shape the disaster risk landscape in Vanuatu. There is strong evidence that, with more funding for women and girls' participation in disaster management and resilience, larger gains are possible.

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Raising the visibility of IDPs: a case study of gender- and age-specific vulnerabilities among Ethiopian IDP adolescents

Nicola Jones, Workneh Yadete and Kate Pincock

Over 1.39 million people were displaced in Ethiopia in 2018 – more than anywhere else globally during the same period.[1] Many were displaced along the Oromia and Somali regional border, where tensions over the allocation of pasture and water resources are thought to have contributed to a sudden escalation of ethnic violence in late 2017 and over the first half of 2018. Since the violence began, however, there has been major political transformation in the country, spearheaded by new Prime Minister Abiy Ahmed. A new regional president has been appointed in Somali region, and a Ministry of Peace has been established in part to raise the visibility of the problems facing internally displaced people (IDPs), including the need for humanitarian assistance and the heightened risk of sexual and gender-based violence.[2]

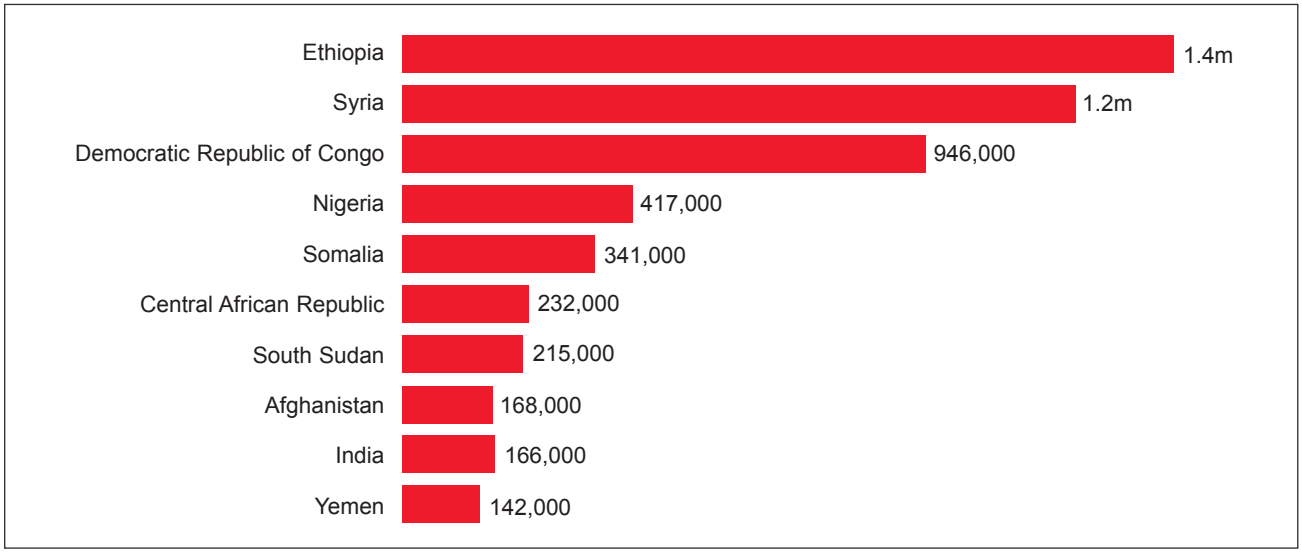
This article draws on findings from Gender and Adolescence: Global Evidence (GAGE)[3] longitudinal research study in Ethiopia to explore the gender- and age-specific vulnerabilities adolescents affected by internal displacement experience, and to identify entry-points for strengthening programming, monitoring and evaluation. The research draws on qualitative research with young people and their families displaced from Somali region in the last quarter of 2017, and now living in East Hararghe Zone in Oromia region.

Adolescent-specific vulnerabilities

Globally, it is estimated that half of those displaced by conflict are under 18 years of age.[4] Much of the literature stereotypes youth, with young women framed as 'at risk' and young men 'a risk to others' in ways that have problematic implications for programming with young IDPs.[5] Our findings highlighted that there were highly varied experiences among adolescent girls and boys, with young people both as targets and perpetrators of violence during the initial displacement, and involved in different ways in the armed defence of their communities.

During the initial violence in Somali region, adolescent boys reported facing serious physical threats. As one 17-year-old boy from Community I in East Haraghe noted: 'There was ethnic conflict between Oromo and Somali. We were displaced because we are Oromo. They took all the property we had. We faced serious physical attack, many were killed'. An 18-year-old girl displaced from the same community highlighted that adolescent boys were often specifically targeted: 'They kept younger and stronger boys together. They took ten of them out. They took them to an open latrine pit. They forced them to walk through it one by one. When they refused to do so, they threw them into it with their face down and killed them one by one'.

Figure 1: Number of new IDPs per country in 2018



Source: Internal Displacement Monitoring Centre, 2018.

1 See www.internal-displacement.org/countries/ethiopia

2 As of January 2019, 3.19 million people were internally displaced in Ethiopia, with 30% in acute need. Most of IDPs and returnees are in Oromia (47%), Somali (32%) and Southern Nations, Nationalities and People's (SNNP) (13%) regions (according to the OCHA Ethiopia Humanitarian Needs Overview 2019).

3 For details see www.gage.odi.org

4 E. Ferris and R. Winthrop, *Education and Displacement: Assessing Conditions for Refugees and Internally Displaced People Affected by Conflict* (Washington DC: Brookings Institute, 2011)

5 R. Evans, C. Lo Forte and E. McAslan Fraser, *UNHCR's Engagement with Displaced Youth: A Global Review* (Geneva: UNHCR Policy Development and Evaluation Service, 2013)

Adolescent IDPs in Batu, East Shewa, Ethiopia.

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A 13-year-old boy emphasised that the violence often involved peer-to-peer attacks: 'I was so shocked when I observed that the adolescent boys from one ethnic group attacked their peers from another ethnic group. They attacked them with stones … These adolescents were beaten brutally'.

Violence has also directly impacted adolescents in the host community. Organised groups of adolescent boys and young men, locally called '*qeerroos*', were reported to be playing a central role in protecting the community in the absence of broader state-provided security. As a female local government leader noted: 'Young individuals are trying to protect the community going to the border, though they do not have guns. They put their life at risk of death to protect the community. You do not get the kebele [community] administrator or youth in the community … The government brings the military to the border, but they have not stopped the fight'.

While violence was a central theme in adolescents' and caregivers' accounts of their experiences during displacement, limited access to livelihoods, social protection and education were also repeatedly underscored as major challenges. This resonates with UNHCR's findings on its engagement with displaced youth, where many described their lives as in a 'state of limbo'.[6] A year on from their displacement, adolescents in affected communities in East Hararghe complained that they were still in temporary shelter and had been given very limited support. As one 13-year-old boy noted: 'We still live in the shelter. Many of the displaced people also live in [a] similar way. This is because of shortage of money to construct the houses. The government gives us only food grain but not money'. Older adolescent boys participating in a focus group discussion highlighted similar concerns.

Some have been compelled to engage in paid work within the host community, often on exploitative terms. One 16-year-old boy noted that 'Adolescents in the host communities are working on their own farmlands, while we are becoming their servants just for the sake of earning some money. Most of us don't have our farmland, even if we have a farmland, we don't have oxen to plough the lands. That is why we become paid labourers and servants of better-off people. We have little opportunity to work and improve our livelihoods'. For some, meeting economic needs was coming at the cost of school attendance. While school can help to promote young people's psychosocial wellbeing, leading to improved resilience and post-conflict stabilisation and recovery[7] and UNHCR's Guiding Principles on Internal Displacement[8] underscore that national authorities have a responsibility to ensure free compulsory primary education is

6 Evans et al., *UNHCR's Engagement with Displaced Youth*

7 Ferris, E. and Winthrop, R. *Education and Displacement: Assessing Conditions for Refugees and Internally Displaced Persons Affected by Conflict*, 2010 (https://unesdoc.unesco.org/ark:/48223/pf0000190715)

8 OCHA, *Guiding Principles on Internal Displacement* (New York: United Nations: 2001)

available to internally displaced children, a number of respondents in our research highlighted that there was inadequate support to make schooling a reality for the most vulnerable. One 17-year-old boy explained: 'We sacrifice our schooling for income-generating work'. Another noted: 'I dropped out from grade 8 due to the violence in Somali region. After I came back here [Community I], I restarted my education but I dropped out again due to lack of support from government'.

Gender-specific vulnerabilities

Evidence suggests that displaced women and girls may be further marginalised as a result of pre-existing gendered inequalities, including heightened risk of gender-based violence.[9] A number of factors contribute to these risks, including human rights violations during displacement, minority status, lack of access to water, food or fuel, lack of social support and extreme poverty.[10] Our findings suggest that sexual violence against young women and girls was widespread during displacement. As an NGO key informant from Community I in East Hararghe emphasised: 'We did an assessment among the displaced that live in [neighbouring districts]. We observed a lot of abuses there against females who have been raped by many males … A girl who was 11 years old raped by many males, after the rape they cut her breast and sex organ with a sharp object. She has been getting treatment at the hospital'. In a similar vein, a social worker from the same community noted that, in some cases, girls and women had been subject to sexual torture: '[They] committed a very huge crime on our girls and women in the region. After having sex many times they inserted battery to her genital organ. There are females whose breast was cut. I have seen many women whose breasts were cut'.

Participants in a community mapping exercise highlighted the heightened risks that adolescent married girls faced: 'There was an Oromo girl who was married to a Somali man. She was pregnant. He removed the child and burned it and sent her away. He did this because she was going to take the child back with her'. Girls involved in domestic work and without family members to help them escape were especially vulnerable.[11] A 16-year-old girl from Community I explained: 'While I was working in their house, the lady of the house came to kill me. Then I hid myself and left the house. Even I didn't take my materials when I left. I asked her for my salary but she refused me. Then I closed her door from the outside because she prepared a knife to stab me'. Similarly, a 15-year-old girl recalled her experience as follows: 'I left because of the war. I heard that she called her daughter and discussed to harm. They slaughtered people in front of me. For example, if you have "sayiba" [house maid] you tell each other to slaughter her'.

9 C. Cazabat, *Sex Matters: A Gender Perspective on Internal Displacement* (Geneva: IDMC, 2019)

10 R. Asgary, E. Emery and M. Wong, 'Systematic Review of Prevention and Management Strategies for the Consequences of Gender-based Violence in Refugee Settings', *International Health*, 5, 2

11 See also Asgary, Emery and Wong, 'Systematic Review'

Implications for programming

Overall, our findings from Ethiopia point to a number of priority actions for programming to better support adolescent IDPs and address their gender- and age-specific vulnerabilities.

First, it is critical for the international community to advocate for and monitor the extent to which IDPs are provided with adequate support, including social assistance to cover food, shelter, access to healthcare and education-related costs for IDPs in camps as well as in host communities. This is especially important given that, unlike refugee populations, for whom there are clear mandates and lines of accountability, in the case of IDPs a 'cluster approach' has been implemented in which various humanitarian actors, including the UN, governments, ICRC and NGOs come together to address gaps rather than to deliver a coherent and comprehensive action plan.

Second, this same cluster of humanitarian agencies needs to ensure that the specific age- and gender-related needs of adolescent IDPs, including those identified in the UNHCR Guiding Principles on Internal Displacement,[12] are adequately addressed. This includes support for adolescents to return to education, given that schooling can help to promote young people's psychosocial wellbeing, contributing to improved resilience and post-conflict stabilisation and recovery. For older, out-of-school adolescents, providing credit services and business skills training can also be critical in promoting economic independence for young people from IDP communities, and mitigating their vulnerability to exploitative labour practices.

Third, given widespread experiences of violence it is also vital to ensure that survivors of physical and sexual violence have access to adolescent-sensitive healthcare, and where possible counselling to overcome the trauma. In so doing, however, it is essential to move beyond reductive framings of gender (e.g. females as 'victims' and males as 'perpetrators' of violence), and to provide responses that are context-sensitive. It is also important that programme interventions include an awareness-raising component in order to help address issues of exclusion and stigma towards IDPs in host communities. Such efforts could be pursued under the umbrella of broader efforts to advocate for the establishment of a Truth and Reconciliation Commission to help deal with the trauma and loss suffered by IDPs and over time to promote social cohesion. In such a process it will be critical to ensure that adolescent girls' and boys' voices and perspectives are also reflected, rather than subsumed under those of adults, so as to better tailor programming and services to young people's diverse needs.

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12 OCHA, *Guiding Principles on Internal Displacement*

Child marriage: a major obstacle to building adolescent girls' resilience

Julie Rialet-Cislaghi

After fleeing her home in Syria and moving around different locations in Lebanon, Haya's parents forced her to marry when she was 15 years old. The same happened to 14-year-old Salma in Pakistan, after her family lost their home due to floods. In the Democratic Republic of Congo (DRC), Olive was kidnapped by a member of an armed group on her way home from the market. Her kidnapper forced her to marry him. The world is full of stories like these, with 12 million girls married every year before they turn 18. Nine of the 10 countries with the highest rates of child marriage are considered fragile or extremely fragile. All over the world, child marriage has long-term consequences for girls and their families. Health issues linked to early and frequent pregnancies, high risks of domestic violence, inter-generational cycles of poverty and limited opportunities to build their agency are some of the consequences faced by child brides. Girls living in humanitarian settings often face a greater range of vulnerabilities, which requires adapting approaches to prevent and respond to child marriage in these contexts.

A practice rooted in stable contexts, and worsened in humanitarian settings

A few years ago, the issue of child marriage in humanitarian settings was highlighted by a UNICEF study warning that the proportion of Syrian refugee girls married before 18 in Jordan had almost tripled, from 12% in 2011 to about 32% in 2014. Similar trends have been observed in Lebanon, where 41% of young displaced Syrian women were married as children, and among conflict-affected and internally displaced populations in Yemen, Chad, Iraq, South Sudan, Northern Cameroon, Nigeria and elsewhere. Local and international humanitarian actors have reported cases of child marriage following earthquakes, floods and droughts in Bangladesh, Indonesia, Pakistan, Nepal and Mozambique.[1] Most locations affected by humanitarian crises lack recent data to measure the scale of the issue.

In both stable and crisis contexts, child marriage is rooted in gender inequality and sustained by cultural and social norms, poverty and lack of opportunities. Girls are married off primarily because they tend to be considered less valuable than boys, and are seen as needing protection – either for their own safety or to prevent sexual relationships and pregnancy outside of marriage, which can be perceived as a threat to girls' and their family's reputation. For many families facing poverty, violence and lack of opportunity, marrying their daughters may seem like the only option, reducing mouths to feed, providing extra income in the form of a bride price or protecting girls from sexual violence.[2] We still need to better understand both the risks and the protective factors across geographical and cultural contexts, and across different types and stages of humanitarian crises. However, child marriage is often practised in communities before a crisis, so evidence from development contexts could help in finding solutions in humanitarian settings.

A cross-cutting issue requires a comprehensive and collaborative approach

To prevent child marriage and support girls who are already married, we need a combination of measures and action across areas traditionally associated with child protection, gender-based violence, education and health and livelihoods, among others. We need locally led long-term initiatives that are supported nationally and internationally, and that help adolescent girls to build the skills and confidence they need to exercise their rights and make decisions on issues that affect them.

These initiatives should provide health, education and vocational services for youth and young women, and remove any practical, social and financial barriers to accessing them. They should engage with families and community members that have a major influence on the life of girls, raising awareness of the harmful consequences of child marriage, exploring values, traditions and gender norms that sustain the practice and helping them envision alternative roles for girls. A comprehensive approach to ending child marriage should also

Box 1: Key resources

Girls Not Brides, *A Theory of Change on Child Marriage*, 2014 (www.girlsnotbrides.org/theory-change-child-marriage-girls-brides/)

ICRW and Girls Not Brides, *Solutions to Ending Child Marriage: What the Evidence Shows*, 2011 (www.icrw.org/wp-content/uploads/2016/10/Solutions-to-End-Child-Marriage.pdf

Save the Children, *Toward an End to Child Marriage: Lessons from Research and Practice in Development and Humanitarian Sectors* (https://resourcecentre.savethechildren.net/node/13485/pdf/child_marriage_report_june2018.pdf)

Population Council, *The Global State of Evidence on Interventions to Prevent Child Marriage*, 2018 (www.popcouncil.org/uploads/resources/2017PGY_GIRLCenterResearchBrief_01.pdf)

1 Girls Not Brides, *Child Marriage in Humanitarian Settings*, 2018 (www.girlsnotbrides.org/resource-centre/child-marriage-in-humanitarian-crises/)

2 Ibid.

Girls taking part in a workshop on child marriage run by Girls Not Brides member SOFERES pose for photos with posters they have made.

include a strong legal and policy framework to protect girls' and women's rights, and increase educational, economic and social opportunities to accelerate and sustain change.

Addressing child marriage in humanitarian settings: action by local, national and international organisations

Work to end child marriage in a humanitarian setting can come up against a specific set of challenges. Conflict can create new causes of child marriage, for example when girls are abducted and forced to marry armed combatants. The capacity of a national government to provide basic services and implement laws and policies might be considerably limited, and the short funding cycles typical in humanitarian settings are an obstacle to the sustained action needed to address the root causes of child marriage. Security concerns are an obvious challenge for practitioners delivering programmes on the ground, and a combination of gender norms, increased insecurity and mistrust of communities and service providers can mean that adolescent girls, especially those who are already married, are often even harder to reach.[3]

Local organisations are finding ways to implement initiatives, most of the time with very limited resources. In DRC and Malawi, local organisations are raising awareness of the issue of child marriage and providing vocational training for girls. Solidarity of Refugee Women for the Social Welfare (SOFERES), a grassroots organisation created by women refugees, works to increase access to reproductive health information and services, and provides vocational training in the Dzaleka camp in Malawi, where many girls are forced to marry at 13 or 14 years of age. Refugees are not allowed to work in Malawi, but they can start businesses inside the camp. Volunteers from SOFERES teach hairdressing and tailoring skills to out-of-school girls, so that they can earn an independent living, and weekend workshops cover child marriage, HIV/AIDS and gender-based violence (GBV): 'We teach girls about their rights and work with them and their families to keep them in school', they explained.

In DRC, the Association pour le Développement des Initiatives Paysannes (ASSODIP) worked with a local committee for rights and development to help Olive escape her forced marriage and enrol in a sewing training programme. Olive told the organisation that her new skills meant she could reintegrate into her community, and was able to earn money to provide for her children and pay for their education. ASSODIP also works at the community level to ensure that girls can safely express their newly acquired skills. 'We try to adopt a holistic approach because girls who were abducted not only have to deal with the trauma of being captive, but also face a lot of stigma when they come back to their community', explained the head of the organisation. 'Communities are the best placed to understand

3 Women's Refugee Commission, *A Girl No More: The Changing Norms of Child Marriage in Conflict*, 2016 (www.womensrefugeecommission.org/girls/resources/1311-girl-no-more)

the issues that they face. So we help set up community-based committees including influential women, community leaders etc., and work with them to raise awareness about child marriage and other forms of abuse, and to address issues of stigma so that girls can come back to a safer environment.'

Building on community-based capacities and networks is a common approach across a number of regions. National organisations such as Cooperation for Peace and Development in Afghanistan and Naba'a in Lebanon work with community-based groups to encourage secondary education for girls, and train parents to raise awareness among their peers of child marriage and related issues. They support the community with participatory assessments to plan for interventions themselves, or promote inter-gender and inter-generational dialogue and debate to address the root causes of child marriage. These discussions are particularly important as humanitarian crises can offer an opportunity to change the way things are normally done: a crisis disrupts everyday life, including spaces, movements, roles and potentially power dynamics, and so can create conditions to challenge the status quo.[4]

Community-based and national organisations use a range of strategies to provide comprehensive prevention and response to child marriage. For example, Lebanese Democratic Women's Gathering (RDFL) works at the community level to raise awareness of child marriage. However, the message can easily be weakened if national laws continue to support the practice, so RDFL also runs national campaigns to advocate for a minimum legal age of marriage at 18 and promote women's rights in Lebanon. In Afghanistan, Humanitarian Assistance for the Women and Children of Afghanistan (HAWCA) and Women for Afghan Women offer safe accommodation, legal aid and medical and psychological support in mobile clinics in IDP camps or at stationary centres, as well as educational opportunities for married and out-of-school girls.[5]

International organisations also have an important role to play in advancing efforts to tackle child marriage in humanitarian settings. The International Rescue Committee (IRC), the Population Council and the Women's Refugee Commission (WRC) have used innovative approaches to identify and reach out to girls at risk in humanitarian settings. In Lebanon, IRC used the results of a study on child marriage in the Bekaa region to design a package of life-skills sessions tailored to the specific needs of married girls and consider external factors such as allowing young mothers to fully engage in activities by providing volunteer-led childcare. Many of these girls reported feeling stronger and more self-confident, and able to make important decisions in their life.

Investing in local capacities and building effective partnerships across sectors to reach scale

In the past few decades, the international humanitarian community has made great progress towards better consideration of the specific vulnerabilities of women and girls. Yet child marriage is still not adequately addressed in humanitarian response. Local civil society and a number of international organisations use targeted approaches to support girls at risk of child marriage and married girls, but these efforts remain sparse and are mostly not evaluated.[6]

Child marriage is recognised as an important issue by child protection and GBV professionals. Further collaboration between these two sectors could help prevent adolescent girls, especially married girls, getting lost among services dedicated to children and women that may not meet their needs, though practitioners can lack the space for peer-to-peer learning on child marriage through sub-cluster coordination platforms. Many other humanitarian sectors have a role to play in addressing child marriage. Girls with secondary or higher education are three times less likely to marry by 18 as those with no education,[7] so education initiatives are an important part of a prevention and response strategy. In humanitarian settings, families have repeatedly turned to child marriage to cope with extreme poverty, or in an attempt to protect girls from violence, so food security and livelihood initiatives can ensure that families' basic needs are met and they have the resources to care for their daughters. Camp management can improve girls' safety by addressing the risks of violence they can face in detention centres and at water points and latrines, and on their way to health and other service locations. Few protection, education, health and food security initiatives have the prevention of, and response to, child marriage as an objective, but integrating indicators that track the impact of these interventions on child marriage can be a simple way of assessing what is helping to address child marriage in humanitarian contexts.[8]

We know much more about the drivers of child marriage across the world than we did a decade ago, and sharing learning across development and humanitarian sectors is key

4 ODI and CARE, *Disaster and Violence against Women and Girls: Can Disasters Shake Social Norms and Power Relations?*, 2016 (www.odi.org/publications/10644-disasters-and-violence-against-women-and-girls-can-disasters-shake-social-norms-and-power-relations)

5 Ibid. See also ICRW and Girls Not Brides, *Solutions to Ending Child Marriage*, 2016. Department for International Development, briefing paper, *Violence against Women and Girls in Humanitarian Emergencies*, CHASE Briefing Paper, October 2013 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271932/VAWG-humanitarian-emergencies.pdf)

6 Save the Children and Human Rights Centre, *Toward an End to Child Marriage: Lessons from Research and Practice in Development and Humanitarian Sectors*, 2018 (https://resourcecentre.savethechildren.net/library/toward-end-child-marriage-lessons-research-and-practice-development-and-humanitarian-sectors)

7 United Nations Population Fund, *Marrying Too Young: End Child Marriage*, 2012 (www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf)

8 Girls Not Brides and ICRAW, Sector Briefs, 2016 (www.girlsnotbrides.org/resource-centre/child-marriage-brief-role-of-sectors/)

to making progress. Development can help prevent families turning to child marriage when a crisis strikes; humanitarian actors can use this learning and adapt strategies based on their expertise and knowledge of constraints specific to humanitarian contexts. They can pilot and evaluate these strategies to build evidence of what works in addressing child marriage in humanitarian contexts. Organisations including the International Rescue Committee, CARE International, Plan International, Save the Children, UNICEF, UNFPA and the Women's Refugee Commission, to name just a few, are moving in that direction. However, while change is supported by national and international efforts, it ultimately needs to happen locally. Greater and longer-term support to local actor is key to promoting reconstruction and ensuring that change is sustainable, as testimonies from groups including the Association de Lutte contre les Violences faites aux Femmes (ALVF) in northern Cameroon, Aide Rapide aux victimes des Catastrophes (ARVC) in South Kivu and Action for Women and Children Concern (AWCC) in Somalia attest. Of course, local civil society organisations and international actors cannot do all the work, and in many humanitarian contexts the national government has a major role to play in ensuring that efforts are sustainable and can happen at scale.

Conclusion

In the past decade, although an estimated 25 million child marriages were prevented,[9] rates continue to increase across many humanitarian contexts. As long as girls are married, exposed to violence within their home, trapped in poverty and denied their rights to health and education, other efforts to meet their needs and help them become strong women within their communities will be held back. Learning from the child marriage movement offers a strong evidence base for humanitarian actors to build upon, and adapt solutions to emergencies and protracted crisis contexts. Greater collaboration across humanitarian clusters and sectors will provide the comprehensive approach needed to prevent and respond to child marriage, bridge the gap between humanitarian and development initiatives and contribute to the resilience of at-risk adolescent girls.

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9 UNICEF, *Child Marriage: Latest Trends and Future Prospects*, 2018 (https://data.unicef.org/resources/child-marriage-latest-trends-and-future-prospects/)

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