Emergency Mobile Teams: Gender-Based Violence (GBV)\textsuperscript{1}

Why is mobile response needed in Iraq? The humanitarian situation in Iraq continues to worsen due to the escalation of fighting and intensification of military campaigns. GBV, in particular sexual violence, is widespread and one of the largest crises emanating from the current conflict. Recent developments underscore the criticality for improving GBV response services and contingency planning for current and likely future large scale displacement in Anbar, Salah al Din, Kirkuk, Erbil, Dahuk and Nineveh.\textsuperscript{2} Given resource constraints and humanitarian access challenges in some areas, mobile teams are essential to immediately reach populations and provide lifesaving emergency GBV response during transit and after displacement.

When should a GBV emergency mobile team deploy? Mobile teams deploy immediately after displacement occurs, availing services before a static service can set up and/or if a static response is not possible due to security, operating context, etc. When a static response is functional, mobile teams move out and expand coverage. The number of mobile teams needed depends on displacement density and population per site. Waiting for or seeking population-based data on the magnitude of GBV should not be a priority in an emergency due to safety and ethical challenges in collecting such data. We must assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take action, regardless of the presence or absence of concrete ‘evidence’.\textsuperscript{3}

What do GBV emergency mobile teams provide? GBV mobile teams provide immediate lifesaving services to newly displaced women and girls. GBV services to be prioritized during acute stages include: essential health, case management and psychosocial support (PSS) services, safety options, GBV risk mitigation, coordination and advocacy. These are adapted to the context based on the availability of services, needs of women and girls, and risks and patterns of violence, as determined from rapid assessments. In some cases, a GBV intervention may not actually be a stand-alone program but instead may integrate essential services into existing programming including health, protection, and child protection (CP).\textsuperscript{4}

Who comprises a GBV mobile team? It is recommended that mobile teams consist of a team leader, two case workers, two community mobilisers, and a driver.

| Team leader | o Oversee case management and provision of PSS at safe spaces  
o Lead mobile team, including day-to-day management  
o Strengthen GBV coordination, referrals and capacity to provide timely care to GBV survivors and determine if GBV or CP will be primary service provider for child survivors  
o Develop emergency GBV protocols and referral pathways with CP, protection, health and other service providers and community structures  
o Share information regularly with local coordination mechanisms, including GBV working group |
|---|---|
| Case worker | o Conduct emergency GBV case management (if deemed safe)  
o Facilitate age-appropriate group PSS sessions for women and girls  
o Hold regular information sessions for women and girls in safe spaces  
o Facilitate safe and confidential referrals to other service providers  
o Train community focal points on GBV core concepts and safe referrals |

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\textsuperscript{1} This guidance note is adapted from International Rescue Committee (IRC) “Increasing Access, Increasing Healing: Mobile Approach to GBV Service Provision and Community Mobilisation in Lebanon” (2016).  
\textsuperscript{2} Est. population in Mosul is 1,859,000; it is assumed that 76% of the population will be women and children, who will be facing specific needs and vulnerabilities while fleeing the military operations and trying to reach safety (Protection Cluster Response Plan, 2016)  
\textsuperscript{3} IASC, 2015. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action.  
How do the mobile teams intervene? Once locations are identified, GBV mobile teams will do the following in the first three months of intervention:

Assessments & planning:

- Support the Protection Cluster with the Rapid Protection Assessment (RPA) to identify immediate risks faced by women and girls. Prior to deployment, trainings should be provided to ensure assessments do not place women and girls at risk.
- Conduct emergency GBV assessments (including focus groups, individual interviews, and GBV safety audits) to identify immediate needs, concerns and risks for women and girls.
- Conduct initial rapid service mapping immediately upon arrival to location to identify other service providers in area (especially health, mental health, security and CP).
- Develop emergency referral pathways based on available services.
- Assess needs for material support – specifically dignity kits, hygiene items, clothing, etc. – for women and girls.
- Develop response plans for a determined amount of time based on needs identified through assessments.

Provision of GBV case management services and psychosocial support (PSS) within safe spaces:

- Once deployed, identify a safe, accessible and confidential area in collaboration with women and girls to set up a temporary safe space staffed with GBV case workers where they can provide PSS, individual case management and information.
- Hold initial FGDs to provide information on services and general introduction and agree on activities, days and times for sessions with women and girls.
- Provide GBV case management and individual PSS, including care for child survivors (if GBV service provider has capacity), by case workers at the safe spaces if a confidential space is available.
- In recognition of the barriers of direct help-seeking among GBV survivors due to fear, stigma, and a lack of information, provide both basic and more tailored PSS at the safe spaces:
  - Basic PSS, skills-building activities and information sessions should be available to all women and girls.
  - In addition, case workers should run age-appropriate group support sessions for vulnerable women and girls. These structured sessions are designed to be short-term, quick-impact interventions to build coping and resilience among women and girls and support social networks.
- Provide material support to individual survivors according to their needs (e.g., clothing, pads).
- If Rapid Response Mechanism (RRM) distribution occurs, support the distribution partner’s dignity kit distribution with key messages. If no RRM occurs, consider procuring and distributing dignity kits.

Development of referral pathways:

- Continually update initial rapid service mapping with key services, in particular health, mental health and CP. As emergency becomes protracted, add other sectoral services, e.g., legal and economic.

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3 The RPA is a set of tools of the Iraq Protection Cluster to provide data about the protection environment at the initial and fluid stages of a crisis to inform action. If the Protection Cluster conducts a RPA, GBV mobile teams should use findings to inform which type of follow-up GBV assessment may be needed. If no RPA occurs, then various GBV-specific rapid assessments may be necessary to inform the response.

Assess, Plan and Implement. Key actions should include:

- Listen to the survivor, use healing statements and key messages ["it is not your fault," "you are not alone," validate feelings]
- Provide accurate information on available services and develop immediate action plan with the survivor to meet urgent needs
- Implement the plan and ALWAYS offer accompaniment.

Community outreach:

- Disseminate key messages and IEC materials on protection of women and girls: prevention of family separation, including UASC support services; GBV; mine/IED risk; service providers and helplines.
- Conduct information sessions with women and girls to disseminate information about available services, including GBV response services.
- Conduct outreach visits including house-to-house, community discussions, etc., to provide information, inform women and girls about activities and invite participation.
- Identify referral or information needs among displaced women and girls.
- Conduct trainings for community focal points – psychological first aid (PFA), GBV core concepts, and safety audits.

Safety audits and community safety planning:

- Regularly conduct safety audits to assess emerging risks. Advocate with other service providers to remove or mitigate identified risks.
- Based on the findings, carry out community safety planning to respond to threats to the safety and security of women and girls. It should involve various groups, including adolescent girls, adult women and men, in identifying risks and putting in place simple measures to protect women and girls.

Minimum standards for intervention: Safe Spaces

The establishment of safe spaces must be done in collaboration with women and girls to ensure it is located in an area that feels confidential and safe, where activities can be conducted comfortably and one that they can access safely. Safe spaces should include at a minimum:

- 1-2 rooms for activities and room for case management and focused PSS activities (ideally there will be a separate room case management)
Case management room is co-located to the activity room so that it can be accessed without notice.

- Simple furniture available (e.g., tables, chairs, mats, etc.).
- Private (i.e., no one can overhear discussions from outside the room or can view what is happening).
- In safe locations and away from armed actors.

### What resources are needed for the mobile teams?

<table>
<thead>
<tr>
<th>First 72 hours response</th>
<th>72 hours – 3 months (additional)</th>
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</thead>
<tbody>
<tr>
<td>Vehicle</td>
<td>Lockable cabinet(s)</td>
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<tr>
<td>Printed IEC materials with key messages</td>
<td>IEC materials, including posters, charts, and visual aids for any information sessions</td>
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<tr>
<td>Tents (2) + chairs, table</td>
<td>Chairs and a table each for private room and activity room</td>
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<tr>
<td>Stationary and supplies</td>
<td>Supplies for activities based on requests from women and girls (recreational/skill building)</td>
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<tr>
<td>Materials for PSS and recreational kits</td>
<td>Toys and books for children.</td>
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<tr>
<td>Trained staff</td>
<td>Trained staff, outreach teams and community volunteers</td>
</tr>
<tr>
<td>Hotline number to receive referrals (on GBV risks in area) and case management.</td>
<td>Additional space/building for activities if space permits and WASH facilities</td>
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### Data security:

If a location is deemed too insecure or if security of staff, data or survivors is uncertain, no hard copies of GBV consent or intake forms should be transported with mobile teams. In situations considered too risky or insecure, for GBVIMS data, consent should be obtained verbally for case management, referrals and to record data using GBVIMS. GBV case workers/response officers should then complete the intake form once they return to their office in a safe and secure location where data security can be maintained. Survivor codes should be allocated during case management sessions and used later to input key data points during acute phase. All hard copies should be stored in a lockable filing cabinet, accessible only to responsible individuals specified by the case manager, and soft copies should be password-protected. Rooms containing paper and electronic information should be locked securely when the staff leave the room.

### Preparedness:

Due to the sensitive nature of GBV emergency responses, emergency GBV teams require at a minimum training on:

1. GBV core concepts
2. Basic PSS and/or PFA
3. GBV case management (comprehensive and emergency) and crisis counseling
4. Caring for child survivors

### Joint Emergency Deployment with Child Protection & Health Responses:

GBV mobile responses are most effective when deployed alongside health and/or CP responses to ensure comprehensive needs are met. GBV mobile teams should understand how mobile response is implemented and what services are offered by CP and Health. GBV, CP and Health actors in an area should come together and determine how best to integrate based on vehicle space, contact time in community, security protocols, and structures used to deliver services (tents, open air, buildings, etc.). It is recommended that GBV and CP teams travel in convoy with MMU/MMT. For the safety and community acceptance of GBV teams, the joint response should be seen as a health response to avoid stigmatizing GBV services. Other joint activities can include:

- Joint outreach and RH/GBV or RH/GBV/CP messages – used as entry point to GBV services
- Joint service mapping and referral network
- GBV case worker within health team