United Nations Population Fund

a report on

The GBV Assessment

in Conflict Affected Governorates in Iraq

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Foreword

Iraq is facing the humanitarian crises and forced displacement since 2013, with over 250,000 Syrian refugees and about 3.4 million Iraqis internally displaced. The Iraq crisis is characterized by extreme violence including, Gender-based Violence (GBV). Women and girls are more at risk and have been the most affected by GBV.

GBV impairs the lives of too many refugees and Iraqi IDPs and presents a major obstacle to many women and girls achieving their full potential. In the recent Iraq complex crisis, GBV has been cited by experts, humanitarian actors and development practitioners as a major impediment to justice, peace and to end poverty.

An effective prevention and response to GBV require a multi-sectoral approach and ensuring protection and safety for women and girls fleeing their places is critical for Iraq. The issues raised in the report are useful to all partners working towards upholding protection of women and ensuring quality services are accessible to women and girls who need them. It is our hope that the issues raised in the report will help to improve the availability, accessibility and quality of a multi-sectoral response to GBV (covering healthcare, legal assistance, psychosocial support, safety and security) in Iraq delivered by government entities, international and national NGOs as well as to strengthen the design of GBV prevention and mitigation interventions. Most importantly, the results presented in the report will support IDP and refugee communities in developing a dialogue forum with service providers on accountability and efficient service delivery.

UNFPA, together with all other UN agencies, will continue to engage closely with government agencies, civil society organisations and other service providers, including the refugees and IDPs themselves, to ensure safety, protection and dignity of women and girls are the priority for Iraq humanitarian response.

Ramanathan Balakrishnan
UNFPA Country Representative, Iraq

LIST OF ABBREVIATIONS

CMR – Clinical Management of Rape
CRSV – Conflict Related Sexual Violence
DOH – Directorate of Health
DV – Domestic Violence
FGD – Focus Group Discussion
FPU – Family Protection Unit
GBV – Gender Based Violence
GBV IMS – Gender Based Violence Information Management System
GDC VAW – General Directorate for Combating Violence against Women
IDP – Internally Displaced Person
IOM – International Organization for Migration
IPV – Intimate Partner Violence
KII – Key Informant Interview
KR-I – Kurdistan Region – Iraq
MOH – Ministry of Health
MOI – Ministry of Interior
MOLSA – Ministry of Labor and Social Affairs
NFI – Non-Food Item
NGO – Non-Governmental Organization
NRC – Norwegian Refugee Council
PDS – Public Distribution System
PHC – Primary Health Care
SOP – Standard Operating Procedures
SV – Sexual Violence
UN – United Nations
UNDP – United Nations Development Program
UNFPA – United Nations Population Fund
WCC – Women Community Centers
WG – Working Group
WHO – World Health Organization

REPORT ORGANIZATION

The organization of the Assessment Report is presented below.

The Report starts with the Executive Summary that presents information about organization of the Assessment and brief account of the findings. First section of the Report, titled Background to the Assessment features the description of goals, objectives, scope of the study, limitation of the study and its methodology. The Report's second section, Background to humanitarian crisis in Iraq, offers the overview of the armed conflict and humanitarian crisis in Iraq. The section contains information on the main characteristics of GBV in Iraq and the way it was affected by armed conflict and forced displacement. The third section of the Report, titled Main Findings, presents the account of the key findings revealed by the Assessment. The section consists of four sub-sections. Each sub-section presents a response to the four (4) research questions. Each sub-section starts with specific research question, then presents the Assessment findings relevant to that particular question. The report's final section, titled Recommendations, features recommendations to address the gaps and challenges identified in the course of the Assessment.

The Report includes one Addendum, which presents the connections between the risk of GBV and residence type used by IDPs/refugees (information derived from the focus group discussions and key informant interviews).

EXECUTIVE SUMMARY

The Assessment of gender-based violence (GBV) in eight conflict affected governorates of Iraq was commissioned in 2016 by UNFPA on behalf of the GBV Sub-Cluster (under the Protection Cluster of the UN humanitarian response in Iraq). The Assessment research started in April 2016 and covered a desk research as well as a 10 day data collection mission to Iraq's Kurdistan Region.

The goal of the Assessment was to establish factors limiting the access of internally displaced persons (IDPs) and refugees (focusing on women and girls) to services available for GBV survivors in eight conflict affected governorates of Iraq (Baghdad, Diyala, Kirkuk, Najaf, Kerbala, Erbil, Dohuk and Sulaymaniyah) and identify the gaps in service provision.

Data collection for the study included focus group discussions (FGD), key informant interviews (KII) and group interviews with beneficiaries and service providers from key sectors (health, law enforcement, judiciary and psychosocial support).

The results of the current Assessment are envisioned to a) improve the quality of a multi-sectoral response to GBV (covering healthcare, legal assistance, psychosocial support, safety and security) in Iraq delivered by government entities, international and national NGOs; b) improve the design of GBV prevention and mitigation interventions, and c) support IDP and refugee communities in developing a dialogue forum with service providers on accountability and efficient service delivery.

The Assessment revealed several common characteristics in GBV trends across all selected governorates. Significantly, the findings of the Assessment (based on FGDs and KIIs) support the data provided by GBV Information Management System (GBVIMS)[1]. GBV is pervasive in IDP and refugee communities across all governorates and disproportionately affects women and girls. Violence directed at women and girls within family is normalized and legitimized by survivors, perpetrators and communities through reference to cultural and religious norms. Husbands were most commonly named as perpetrators. Mother-in-laws and father-in-laws were also frequently brought up in FGDs as common GBV perpetrators.

The Assessment found that GBV survivors are most open to talk about psychological violence and seeking psychosocial help. Disclosure of sexual violence (most stigmatized form of GBV) is rare and can have very serious, at times tragic, repercussions for survivors (including honor-killing of a sexual violence survivor by her by family members). GBV Sub-Cluster partners and the Ministry of Health prepared a protocol for the Clinical Management of Rape (CMR), an important guidance for mainstreaming sexual violence response in public healthcare services across the country. Yezidi women who survived a conflict related sexual violence (CRSV) at the hands of ISIS are often open to seeking help, because they prefer to seek the support of religious leaders of their community. CRSV survivors have special needs and require a special set of services with strong focus on psychological rehabilitation. To address this crucial need, UNFPA supported Directorate of Health (DOH) in establishing and strengthening a Center that delivers confidential services for survivors of sexual violence.

The Assessment found that public services available for GBV survivors often remain underutilized by IDP and refugee women and girls. According to data from FGDs and KIIs, the majority of IDP/refugee women and girls suffering from violence do not disclose it. When it comes to seeking protection from domestic violence specifically, survivors tend to go to their own family members. Going through family and community-based mediation, protection and conflict resolution mechanisms is by far the most common pathway selected by IDP/refugee women and girls. The Assessment identified family and community based pathways are used by GBV survivors. It is important to understand unique family structures and cultural norms of various ethno-religious communities and engage family and tribal mechanisms as allies in enhancing women's access to services.

Women Community Centers ("safe spaces[2]" or other NGO/INGO run community spaces) with psychosocial support and referrals to healthcare are identified as the second most common pathway for GBV survivors. Compared to other pathways, women and girls rarely chose to go to police to seek justice and protection from GBV. The Assessment data suggests that the decision to stay away from police is linked to pervasive mistrust towards police among IDP and refugee communities. Psychological support is the service sought by the majority of IDP/refugee women visiting "safe spaces". However, women prefer to accept psychological support when it comes in combination with services that benefit their children or families. Accepting support that benefits them individually is often regarded as incompatible with women's cultural role as a care-giver[3]. Service providers found that combining psychological support with vocational/

1. The information management system is used to collect, store and analyse data on reported cases of GBV. GBVIMS was originally launched globally in 2006 by UNOCHA, UNHCR and IRC. GBVIMS Steering Committee currently includes UNFPA, UNICEF, UNHCR, IRC and IMC.
2. Centers where IDP/refugee women and girls can engage in vocational training, educational and recreational activities. The Centers also provide entry points for GBV survivors.
3. In their book Honor-Based Violence: Experiences and Counter Strategies in Iraqi Kurdistan and the UK Kurdish Diaspora (Routledge, 2016), N. Begikhani and A. Gill describe how the concept of "honor" in relation to women in some Kurdish communities in Iraq is opposed to practices involving self-gratification. Honor-Based Violence: Experiences and Counter Strategies in Iraqi Kurdistan and the UK Kurdish Diaspora, pp 11-10.

recreational activities, or children related activities makes it easier for the beneficiaries to accept and remove the possible stigma.

Examination of the pathways selected by IDP and refugee women suffering from GBV demonstrated that public services available for GBV survivors remain largely underutilized. GBV survivors cannot access services because of cultural, social, and organizational barriers. The factors vary for different governorates. The Assessment found that religious or cultural restrictions on women's mobility in public space, cultural (specifically linguistic) and physical isolation, erosion of social networks and shortage of personal time limit IDP women's chance to seek help. The Assessment identified several gaps in organization of coordinated GBV response among the key sectors (healthcare, law enforcement, judiciary, and psychosocial help). The study also revealed a number of good practices and facilitating factors generated by good policies and quality service delivery.

Each governorate presents a unique environment for GBV response due to larger structural factors: population composition (demographic, tribal, sectarian), displacement trends, prevailing shelter arrangements for IDPs and refugees, security situation, urban-rural balance and economic environment. The Assessment developed profiles for each of eight conflict affected governorates and highlighted structural challenges and facilitating factors that impact access to services in each governorate. Finally, the Assessment examined legislative barriers to service access.

The Assessment found that the GBV Sub-Cluster maintained a good level of coordination on the central, regional and governorate level. In a constantly changing complex humanitarian context, the Sub-Cluster was able to develop a coherent vision, goals and objectives that reflect priorities of GBV response in Iraq's humanitarian crisis. At the same time, the process of decentralizing coordination is unfolding successfully: GBV Sub-Cluster members are currently working to set up working group (WG) for all governorates. In addition, there is a discussion of camp-level WGs. The GBV Sub-Cluster maintained regular communication routine and organized sound coordination and information sharing system. The rollout and use of the GBVIMS system for data collection, sharing and analysis are one of the tasks successfully accomplished by Sub-Cluster members. Other good practices include: development and sharing of referral pathways, use of guidance notes to streamline GBV indicators for the reporting and the joint maintenance of service mapping by GBV Sub-Cluster members. Standard Operating Procedures (SOPs) for GBV response are currently under review and the CMR protocol will shortly be introduced into the hospital operations, not only in Kurdistan Region of Iraq (KR-I), but across the whole country.

The Assessment found several areas in need of improvement. Not all Sub-Cluster members regularly report on their activities. There are some delays in updating service mappings. The coordination between GBV Sub-Cluster and Child Protection Sub-Cluster in attending to the needs of adolescent girls and boys needs to be strengthened. The development of the Adolescent Girls Tool Kit is an example of a good practice in joining the efforts of two Sub-Clusters.

(c) UNFPA 2016

(c) UNFPA 2016

Background to the Assessment

The Assessment of GBV in eight conflict affected governorates of Iraq was commissioned in 2016 by the GBV Sub-Cluster (under the Protection Cluster of the UN humanitarian response in Iraq) chaired by UNFPA. The Assessment started in April 2016 and covered a desk research as well as a 10-day data collection mission to Iraq's Kurdistan Region.

The Assessment addresses one of the major gaps in humanitarian response to GBV in Iraq: the limited knowledge is one of the major challenges faced by GBV service providers, and limited access to available services in camp and non-camp environments. Closer examination of these challenges through situational analysis is essential to support and better inform the design of prevention and response interventions, develop data-driven solutions for the problems encountered by service providers in Iraq's diverse socio-economic, political and cultural contexts.

Goal of the Assessment: The goal of the Assessment was to identify the gaps in GBV service provision and factors limiting the access of refugees and IDPs (women, girls, men and boys) to available services.

The Assessment used the following definition of Gender Based Violence: "Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private."[4]

Objectives set by the Assessment: The following objectives were identified and achieved by the Assessment:

1. The Assessment collected information about the common patterns and trends of sexual and other forms of gender based violence experienced by IDP/refugee communities and the pathways selected by GBV survivors seeking help.

2. The Assessment examined policies and legislation within the health, psychosocial, security, human rights and justice sectors that respond to sexual and other forms of GBV during and after the conflict.

3. The Assessment collected information on the attitudes of the affected communities towards the GBV survivors and practices, community based mechanisms of protection and response, as well as risk factors.

4. The Assessment examined current coordination arrangements of GBV Sub-Cluster in relevant governorates, and identified gaps as well as positive results.

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private". GBVIASC guidelines 2015

Challenges faced by GBV service providers

lack of knowledge

limiting access to available services in camp and non-camp environments

The results of the current study are envisioned to a) improve the quality of a multi-sectoral response to GBV (covering healthcare, legal assistance, psychosocial help, safety and security) in Iraq delivered by government entities, international and national non-governmental organizations (NGOs); b) improve the design of GBV prevention and mitigation interventions and c) support IDP and refugee communities in developing a dialogue forum with service providers on accountability and efficient service delivery.

Geographical scope of the Assessment: The Assessment covered eight governorates of Iraq with sizeable refugee/IDP population (Erbil, Dohuk, Sulaymaniyah, Kirkuk, Baghdad, Diyala, Najaf and Kerbala). The areas accessible for

4. UN IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings (2015), p. 12, http://gbvguidelines.org/wp-content/uploads/09/2015/TAG-health2015_26_08-.pdf (last accessed on 2016/04/01)

field missions were visited for data collection in camp and non-camp settings. Respondents in the areas, that are not currently accessible, were reached through Skype or phone interviews.

Research scope: The data collection included 11 FGDs with over 130 participants (IDPs and refugee women and girls) in camps and non-camp venues and 34 in depth semi-structured KIIs (some in person, some by Skype), including some group interviews. In total, the data collection process included overall 45 data collection events in 10 days covering about 200 people. Among those interviewed were service providers and key-decision makers from the ministries (Ministry of Health, Ministry of Labor and Social Affairs, General Directorate for Combating Violence against Women (GDCVAW) in KR-I), police, judiciary, healthcare facilities, camp management, NGOs and INGOs.

Limitations of the Assessment: Heightened security risks outside the Kurdistan region would require the allocation of considerable resources and time into arranging the international consultant's visit. Thus, KIIs and FGDs with the service providers in the governorates outside Kurdistan region were conducted via phone and Skype.

Methodology of the Assessment: The Assessment used the following four research questions in order to structure the data collection process;

1. What are the most prevalent (commonly reported) patterns and trends of GBV experienced by IDP/refugee communities in the conflict-affected areas?

2. What are the pathways selected by the survivors of GBV?

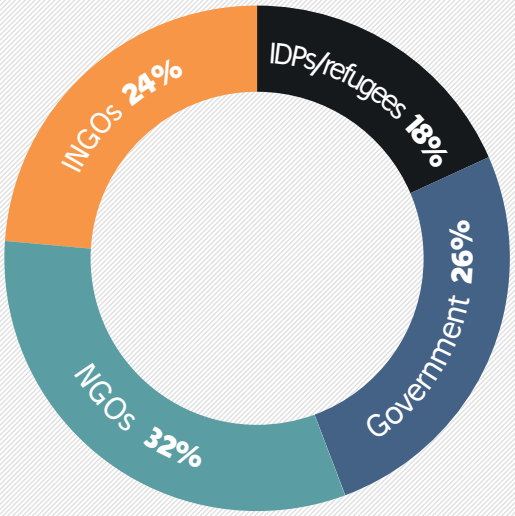
3. What are the barriers (attitudinal, institutional, legislative, financial and logistical) impeding GBV survivors from accessing services? What are the facilitating factors?

4. What are the primary gaps in coordinated multi-agency prevention, mitigation and response to GBV in selected areas?

Sample: The Assessment covered state service providers, international and local NGOs working in eight selected governorates. Data was also collected from IDPs and refugees in camp and non-camp settings in three governorates in the Kurdistan region (Erbil, Dohuk and Sulaymaniyah). Focus groups included IDP and refugee women and girls (separately), with age range of +19 and 18-9, respectively.

The Assessment used the following data collection methods: data was collected through KIIs (semi-structured in-depth interviews), group interviews (semi-structured) and FGDs (evaluative/descriptive type). The Table below presents information regarding the data collection.

Chart 2.
Data collection by respondent affiliation



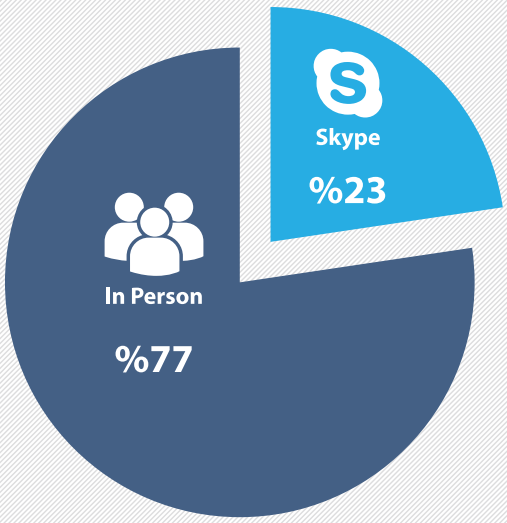
11
Focus groups

130
participants

34
interview

10
Days

Chart 3.
Type of communication



Data collection method	Respondents (organizations, agencies, ministries)	Type of site	Governorate
Key Informant Interviews (KIIs)	Ministry of Health, Ministry of Labor and Social Affairs, Ministry of Interior, General Directorate on Combatting Violence against Women, UNFPA, UNHCR, UNDP, UNICEF, OCHA, local NGOs, INGOs, camp management, community volunteers	Camp and non-camp, mainly offices. Some Women Community Centers (WCCs).	Erbil, Dahuk, Sulaymaniyah –face to face in-depth semi-structured interviews.
Group Interviews (GIs)	GBV Sub-Cluster/ Working Group members, social workers inin camp, community volunteers iin camp, service providers working in camp and non-camp settings.	Camp and Non-camp settings.	Key informants working in Baghdad, Diyala, Kirkuk, Najaf and Kerbala – semi-structured, in-depth interviews conducted through Skype and phone.
Focus Group Discussions (FGDs)	IDPs and refugees, women and girls.	Camps and non-camp settings (Women Community Centers, safe spaces, listening centers, NGO offices).	Erbil, Dohuk and Sulaymaniyah – in person. Baghdad, Diyala, Kirkuk, Najaf and Kerbala – group interviews conducted through Skype.
Focus Group Discussions (FGDs)	IDPs and refugees, women and girls.	Camps and non-camp settings (Women Community Centers, safe spaces, listening centers, NGO offices).	Erbil, Dohuk and Sulaymaniyah.

Data analysis: The data collected from various sources was separated and analyzed in accordance with four research questions. The analysis focused on recurring themes in the interviews and FGDs, identified repeating concerns and explored differences in explanatory frameworks used by various actors. The research used data triangulation to confirm and complement the findings identified through KII and FGDs. The study's theoretical framework relied on the recommendations presented in IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings (2015), the RHRC Consortium Gender-based Violence Tools Manual for Assessment and Program Design, Monitoring & Evaluation in conflict-affected settings (2004) and the WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies (2007). The Assessment used elements of organizational theories and network analysis to analyze the coordination among state and non-state institutions delivering healthcare assistance, protection and other types of help to GBV survivors.

The Assessment embraced a dual nature of "access" to services. On one hand, access to service is envisioned not only to assist and protect, but to empower GBV survivors. Gaining access opens opportunities for GBV survivors to make their own choices and determine their priority needs. On the other hand, in any social environment, but even more so in a society affected by displacement, armed conflict and poverty, "access" is a matter of power.[5] The ability to grant or restrict access gives institutions and actors a great deal of power over those who need and seek services. Thus, the issue of access has a potential to empower disenfranchised groups (for example, IDP/refugee women and girls) and generate conditions for power abuse and corruption. The survivor centered approach (placing the needs and decisions of GBV survivors at the center of the response efforts), used by the Assessment, allows no ambiguity regarding our priorities: needs and choices of GBV survivors are more valuable than making the work of institutions comfortable, efficient in terms of management and compliant to the existing rules if such rules isolate, marginalize or discriminate against women and girls.

5. Kimberly Howe, Elizabeth Stites, Danya Chudakoff, Breaking the Hourglass: Partnerships in Remote Management Settings – The Case of Syria and Iraqi Kurdistan, Feinstein International Center, Tufts University, 2015, p 24

Background to humanitarian crisis in Iraq

Conflict and displacement: Iraq's long and tumultuous history of political unrest and forced population movement generated waves of displacement and created a layered structure of displaced population groups in many communities. Host communities as well as IDPs and refugees across the country suffered from dramatic socio-economic challenges, disruption of support networks, demographic shifts and political tensions. Deterioration in the living standards of host communities all over Iraq constitutes one of the most devastating outcomes of the recent escalation of violence[6]. Armed conflict, stalled socio-economic development, destruction of hundreds of communities across the country, degradation of public infrastructure provided a context for the forced displacement of millions of Iraqis and thousands of Syrian refugees, thus generating a complex emergency situation and humanitarian crisis.

In addition, Iraq's economy currently faces increased risks due to its dependence on volatile oil market. The national government and the government of KR-I struggle to maintain economic stability, continue structural reforms, reduce the effect of budget deficit on an overwhelmed public service systems and rebuild crumbling or destroyed infrastructure[7].

Iraq's humanitarian crisis currently impacts almost one-third of the population. Sectarian violence caused the displacement of 1.1 million Iraqis in 2006 - 2007. Since the start of the most recent forced mass displacements in January of 2014[8] until 28 April 2016, 3,333,384 individuals (555,564 families) were internally displaced. The largest numbers of IDPs originated from Anbar, Ninewa and Salah al-Din governorates. Iraqis left their homes escaping military operations, devastation of homes and infrastructure, hunger and human rights violations and extensive abuse (specifically prevailing in the territories controlled by Islamic State of Iraq and Levant, also known as, ISIS[9]). Iraq also hosts 0.25 million Syrian refugees.

Among the governorates selected for the current Assessment, Baghdad hosts the largest share of IDPs (17%, the second largest in the country) while the governorates of Najaf and Kerbala provide home for the smallest share of displaced population[10](2% of the total identified IDP population) . Three governorates of the Kurdistan region (Erbil, Dohuk and Suleymaniyah) also host the vast majority of 250,000 Syrian refugees in Iraq[11]. Most governorates covered by the assessment were hit by every wave of displacement, which means facing challenges presented by different stages of the humanitarian crisis and catering to the immediate needs of groups recently displaced while also assisting those who arrived earlier.

Living conditions and scarce resources: IDPs currently reside in 3,805 locations across Iraq. According to International Organization for Migration (IOM)'s Displacement Tracking Matrix, seven governorates host 83% of the total identified IDP population[12]. The majority of IDPs (70%) reside in private dwellings (rented housing, host families and, rarely, hotels), 17% are in critical shelters (unfinished buildings, religious buildings, informal settlements and, rarely, schools), while only 11% live in camps, mainly concentrated in KR-I[13].

In the third year of the crisis, IDP and refugee families are running out of resources. Even prior to the recent mass displacement, Iraq had a serious problem of depleting and inadequate housing stock (shortage of 1.5 million units in 2009)[14]. With the in-flow of IDPs, the housing crisis reached an unprecedented severity and rent prices in many locations soared, depleting the meager resources of families. Eighty-five percent (85%) of all IDP families are currently in debt, and assessments of camps across the country demonstrate that 30 - 65% of families did not earn any income in the previous month and 20% of school age children in some locations are not attending classes.

Humanitarian aid: UN and 180 humanitarian partners regularly provide aid to more than 2 million Iraqis and 0.25 million refugees. Severely limited funding and the process of donor withdrawal pushes the international and local organizations towards scaling back on operations and goals. The crisis is further exacerbated by the fact that around 3 million people in need of urgent humanitarian assistance, including IDP and host communities, are currently residing in the areas with limited or no access due to military operations, ISIS control

6. 2016 Iraq Humanitarian response plan, Dec 2015, https://www.humanitarianresponse.info/en/operations/iraq (last accessed on May 2, 2016)
7. World Bank: Iraq overview, http://www.worldbank.org/en/country/iraq/overview (last accessed on April 22, 2016)
8. The displacement came as a result of fighting between the extremist organization Islamic State of Iraq and Levant (ISIS) and Iraq's national armed forces, Kurdish armed forces, various militia groups and US-led international coalition (through air strikes).
9. "Gross, systematic and widespread abuse" of human rights committed by ISIS in Iraq and Syria is well documented and was a subject of UN Security Council's Resolution 2170, in 2014. For further details, please, see http://www.un.org/press/en/2014/sc11520.doc.htm (last accessed on May 2, 2016)
10. Syria Regional Refugee Response Inter-agency Information Sharing Portal,
11. IOM Displacement Tracking Matrix(DTM) Round 44, April 28, 2016, http://www.uniraq.org/index.php?option=com_k2&view=itemlist&layout=category&task=category&id=161&Itemid=626&lang=en (last accessed on May 3, 2016)
http://data.unhcr.org/syrianrefugees/country.php?id=103 (last accessed on May 10, 2016)

or devastation of infrastructure[17].

GBV in Iraq: In the context of armed violence, surging poverty, human rights abuse and disruption of traditional social networks and protection mechanisms, women and girls become specifically vulnerable to GBV[18]. GBV is the manifestation of a hierarchical system of gendered domination and exploitation. GBV in the context of the current humanitarian crisis in Iraq unfolds within already existing patriarchal social structures and practices[19]: "honor killings", child marriage, bridal exchange[20], restrictions on women's mobility in the public space, two different forms of temporary marriage (among Muslim Shia population) and the low indicators of women's labor participation and secondary school enrollment in certain areas of the country [21].

At the same time, it is important to mention Iraq's proud tradition of struggle for women's rights. Social movements for women's rights were organized by Iraqi intellectuals as early as 1920s, with first Iraqi women's magazine Layla launched in 1923. Iraqi League for the Defense of Women's Rights was founded in 1952 by Naziha al-Dulaimi. In 1959-62, Dulaimi served as country's minister of municipalities (first female minister of state in the entire Arab world)[22].

Indicators of the prevalence of GBV for Iraq can be found in Iraq's Family and Health Survey, conducted by WHO and national Ministry of Health, which demonstrates that 21% of Iraqi women (ages of 15-49) reported physical violence perpetrated by husband while the 33% revealed being subjected to "emotional violence". The South/Central part of the country exhibited considerably higher prevalence rate of both physical and emotional violence, compared to the Kurdistan Region[23]. It is important to note that Iraq's indicator on violence against women in 2006-7 were not higher than those recorded by the World Health Organization for high income countries (23.2%)[24]. However, controlling behavior, including a strict control over women's mobility outside of home, was reported by a staggering 83% of women[25]. Iraq Women Integrated Social and Health Survey (I-WISH) revealed that 36% of married women were exposed to at least one form of violence by their husbands[26] and 46% of girls (10 - 14 years old) were exposed to violence perpetrated by a family member at least once during a month before the survey.

Armed conflict and forced displacement submerge IDPs into the continuum of structural, group-based and interpersonal violence, even legitimate violence as a common way of conflict resolution, and disrupt existing networks of social protection and support. Despite the lack of statistical data on the current rate of prevalence or incidence of GBV among IDPs and refugees on a country-wide or governorate level, qualitative research indicates sharp increase in GBV in Iraq[27].

12. IOM Displacement Tracking Matrix(DTM) Round 44, April 28, 2016, http: //www.uniraq.org/index.php?option=com_k2&view=itemlist&layout=category&task=category&id=161&Itemid=626&lang=en (last accessed on May 3, 2016)
13. IOM Displacement Tracking Matrix(DTM) Round 44, April 28, 2016, http://www.uniraq.org/index.php?option=com_k2&view=itemlist&layout=category&task=category&id=161&Itemid=626&lang=en (last accessed on May 3, 2016)
14. Ina Rehema Jahn In collaboration with Peter van der Auweraert and Igor Cvetkovski, A Preliminary Assessment of Housing, Land and Property Right Issues Caused by the Current Displacement Crisis in Iraq, 2015 https://www.iom.int/sites/default/files/our_work/DOE/LPR/A-Preliminary-Assessment-of-Housing-Land-and-Property-Right-Issues-Caused-by-the-Current-Displacement-Crisis-in-Iraq.pdf (last accessed on May 15, 2016)
15. UN-HABITAT predicted the shortage of housing units to reach 2 million in 2016
16. Kimberly Howe, Elizabeth Stites, Danya Chudakoff, Breaking the Hourglass: Partnerships in Remote Management Settings – The Case of Syria and Iraqi Kurdistan, Feinstein International Center, Tufts University, 2015, p. 7
17. OCHA, Iraq: Humanitarian snapshot, April 2016, http://reliefweb.int/report/iraq/iraq-humanitarian-snapshot-10-april-2016-enarku (last accessed on May 2, 2016)

"Gender-Based Violence (GBV) was recognized as a key protection issue by all humanitarian actors in Iraq both for Syrian crisis and IDP Humanitarian crisis"[28].

The observation is in line with the pool of global data on the connection between GBV, forced displacement and armed conflict. Protracted humanitarian crisis in Iraq dramatically increases the exposure of women and girls (and to a lesser extent men and boys) to GBV, including conflict related sexual violence[29]. Due to their subordinated position and limited resources within already existing structures of patriarchal domination, women and girls in the humanitarian crisis become specifically vulnerable to various forms of GBV during the displacement process, in the course of armed conflict, at the hands of local militias, ISIS[30] or local law enforcement, as well as power-holders in families and communities in camp and non-camp settings. In the fourth year of the crisis, the depletion of resources available to IDPs leads to the proliferation of negative coping practices, frequently based on sexual and physical exploitation of women (forced prostitution, trafficking, restrictive control and forced labor).

18. Adopted in 1993, the UN Declaration on the Elimination of Violence against Women offered the first official definition of the term "Gender-based Violence": "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life.", Article 1.

19. Begikhani, N. and Gill, A. Honor-Based Violence: Experiences and Counter Strategies in Iraqi Kurdistan and the UK Kurdish Diaspora), Routledge, 2016, pp 1-8

20. "In a typical exchange marriage, a family chooses a bride for their son, and the bride's parents, if they have sons, request that the groom's family provide a bride for one of their children", Iraq-Kurdistan: Exchange-Arranged Marriages, WUNRN, 2007, www.wunrn.com (last accessed 6/22/2016)

21. For more detailed information, please, see Addendum I, Eight Conflict-Affected Governorates: Profiles.

22. Women's movement in Iraq faces setbacks, Al Monitor, 03.2014, http://www.al-monitor.com/pulse/originals/2014/03/iraq-women-rights-setbacks.html (last accessed on June 22, 2016). See also, Layla, Issue 6, April 1925, www.wdl.org/en/item/2866 (last accessed on June 22, 2016)

23. Iraq Family Health Survey, 2006/7, p 3

24. http://www.who.int/reproductivehealth/publications/violence/VAW_Prevelance.jpeg 25. IRS, Working Together to Address Violence against Women and Girls in Iraqi Kurdistan, p 7, http://www.rescue.org/sites/default/files/resource-file/IRC%20Addressing%20Violence%20Against%20Women%20in%20Kurdistan%205-12.pdf (last accessed on May 2, 2016)

26. No conclusion regarding the rise in prevalence rate can be drawn here, since 2006-7 and 2012 surveys used different methodology. However, prevalence rate indicators for both categories of respondents are high. For more information on I-WISH findings, please, see Iraq Women Integrated Social and Health Survey (I-WISH), 2012, pp. 46-50

27. Ibid, see also http://reliefweb.int/report/iraq/iraq-gbv-sub-cluster-strategy-2016 and Protection Needs Overview, Iraq, 2015.

28. Terms of Reference for the GBV Assessment in Eight Conflict Affected Governorates in Iraq, UNFPA Iraq

29. According to the definition provided in March 2015 report of UN Secretary General "conflict-related sexual violence…refers to rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization and other forms of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is linked, directly or indirectly (temporally, geographically or causally) to a conflict.", http://www.un.org/sexualviolenceinconflict/ (last accessed on April 28, 2016)

30. As stated in the Iraq GBV Sub cluster Strategy for 2016 "those living in areas under ISIL control are at risk of rights violations, abduction, sexual slavery, rape, torture and abuse", http://reliefweb.int/report/iraq/iraq-gbv-sub-cluster-strategy-2016 (last accessed on April 30, 2016)

Main findings

This section includes four sub-sections presenting the assessment outcomes in connection with four research questions.

3.1 GBV among IDPs: main trends and patterns

The sub-section answers the following research question: What are the most common patterns and trends of GBV experienced by communities in the conflict-affected areas? In relation to the research question, the Assessment generated the following findings:

• **Most commonly reported type of GBV** in IDP and refugee communities, based on FGDs, is psychological violence (mentioned in all FGDs), followed by physical violence (mentioned in all but one FGD). The stigma of discussing psychological abuse also seemed to be the weakest. FGD participants were most open to discuss psychological abuse, relating stories of threats, intimidation or blaming directed at women and girls by family members. In Baghdad, Diyala and Kirkuk, according to service providers, sexual harassment is most common.

• **Psychological and physical violence were mostly described by respondents as perpetrated by survivors' family members.** Violence inflicted outside of the family was very rarely mentioned and examples were related to abuse by ISIS.

• GBV happening inside families is often **normalized and legitimized** by all sides: perpetrator(s), survivors, witnesses and community at large.

• **Sexual violence and exploitation by ISIS** were frequently mentioned in FGDs in Dohuk governorate and in some FGDs in Erbil and Sulaymaniyah. ISIS systematically subjected women (for example, women from Sunni communities) to forced marriages to its fighters and other forms of CRSV. Yezidi women reported enduring sexual, physical and psychological violence. Yezidi women differed from other FGD participants in that they were more open in mentioning sexual and physical violence committed by ISIS against themselves or their relatives. According to KIIs, support to GBV survivors (subjected to abuse by ISIS fighters) from Yezidi religious leader played a major role, elevating social status of the survivors in Yezidi communities. Other religious leaders have not rendered similar public support to ISIS survivors. As emphasized by a number of key informants (providers of psychosocial support, government representatives in the health sector and camp management staff), ISIS survivors require a separate package of services with a very strong element of psychological rehabilitation and culturally sensitive service delivery practices. To address this crucial need, UNFPA supported DOH in establishing and strengthening a specialized Center in Dohuk governorate. The Center provides comprehensive services for survivors of sexual violence. The Center delivers services to Yezidi women, who suffered from violence inflicted by ISIS, and does it in a confidential and culturally sensitive way.

• "Husband" was invoked as t**he most common GBV perpetrator category** in all FGDs and KIIs. In KIIs, service providers revealed that they most often received complaints of domestic violence with husbands being the perpetrators in most cases. The finding supports the data provided by GBVIMS. It is important to note a shared belief among FGDs participants that violence by a husband inflicts most harm on a woman ("is the most important"[31] in affecting daily life of IDP/refugee women).

• IDP and refugee women also frequently mentioned **the father and mother in-law** as common perpetrators of physical (beating) and psychological (insults, threats of divorce, intimidation) violence. There is a gap in the current arrangement of data collection form in GBVIMS. The option does not allow respondents to select "mother-in-law" or "father-in-law" as a separate category of violence perpetrator[32]. It is important to include the option in order to receive data on that specific type of perpetrator and design targeted interventions.

• According to the majority of service providers, as is the case in other parts of the world, **sexual violence (specifically, sexual assault and rape) is significantly underreported** in IDP and refugee communities due to stigma, fear and loss of social capital. When it comes to sexual violence, cultural norms prescribe silence and secrecy. For unmarried women and girls, the loss of virginity as a result of rape presents a very serious threat to life and well-being due to spread of honor killings. It also severely diminishes girl's social status and

29. According to the definition provided in March 2015 report of UN Secretary General "conflict-related sexual violence…refers to rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization and other forms of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is linked, directly or indirectly (temporally, geographically or causally) to a conflict.", http://www.un.org/sexualviolenceinconflict/ (last accessed on April 28, 2016)

30. As stated in the Iraq GBV Sub cluster Strategy for 2016 "those living in areas under ISIL control are at risk of rights violations, abduction, sexual slavery, rape, torture and abuse", http://reliefweb.int/report/iraq/iraq-gbv-sub-cluster-strategy-2016 (last accessed on April 30, 2016)

31. The wording was used by FGD participants.

32. The finding came up in the course of a very productive KII with GBV IMS Coordinator, UNFPA, Iraq

undermines marriage prospects. The FGDs also suggested that revealing abuse to local authorities is viewed by some IDPs as damaging to the reputation of the community or ethnic group.

• Another type of GBV frequently mentioned in the course of FGDs was the **deprivation of resources.** The stories described how husbands or in-laws punished women by restricting or banning them from accessing food, non-food items (NFI) or cash. Oftentimes, the distribution of food or NFI is organized based on public distribution system (PDS) cards[33]. The husband or family elders keep the PDS cards of all family members and receive the resources on behalf of everyone in the family. Deprivation of resources, according to KIIs, is used as a "punishment" and the means of pressuring women to obey violence perpetrator(s).

A story told by a key informant (service provider):
"Many men in this IDP community have two or even three wives. They will go and get married and then tell the authorities that they have already arrived with two families. Then, they would get two tents, each for one wife and kids. A man would keep PDS cards for both families. He uses the cards to collect all resources distributed among the IDPs, on behalf of two families. If one of the wives starts complaining about anything, he simply stops giving her food, or blankets or other items she and kids need."

• **Harmful traditional practices,** such as honor-killings, forced bridal exchange and early marriage, often come in combination and, according to service providers, are **exacerbated by conflict** related threat of sexual violence, poverty and general lack of security.

• The KIIs with local service providers highlighted **important difference between some local and international actors' perception of early marriage and way to address it**. While INGOs routinely define early marriage as a harmful traditional practice and place it under the umbrella of GBV[34], the perception among some representatives of local NGOs have a different angle[35]. Some view child marriage as a protective strategy, taken by families to enhance the security of young girls and expand their survival resources. **They do not condone the strategy,** but are concerned about the efficiency of alternative protective solutions. "We do not like it (child marriage – A. V.), it inflicts trauma on girls, but what alternative social protection mechanisms do we offer? I constantly ask myself, what we offer?" narrated by a local service provider working at camp. In situations that involve child marriage among IDP/refugee communities, raising awareness about the harm caused by child marriage is very important and is currently conducted by several INGOs and local NGOs. Designing and promoting culturally sensitive life strategies for IDP girls and families is an essential part of awareness raising. It is a complex task that requires deliberation and open discussion.

3.2 Pathways selected by GBV survivors

The sub-section answers the following research question: What are the pathways selected by the survivors of GBV? The Assessment findings in details are presented below.

FGDs and KIIs with service providers demonstrated that **majority of IDP and refugee women and girls do not report GBV or seek help outside of family**. The situation is similar in camp and non-camp settings.

• The relation to violence perpetrator(s) does not play a significant role in women's decisions to seek help. **Women do not report violence by family members, because they are ashamed, scared of repercussions or are concerned with protecting husbands or family members.** GBV survivors are often afraid that if they report GBV by a family member, they will lose access to resources or will be kept away from their children[36]. When violence is perpetrated by someone outside their families, IDP and refugee women would rarely reveal it. They are **predominantly scared of stigma and shame tied to the status of GBV survivor**. In the case of sexual assault, the fear of honor killing is a major factor.

• Yezidi women mainly select the **pathway of seeking help from religious authorities,** but also often **approach NGOs**

33. PDS cards are part of the Public Distribution System (PDS) introduced in Iraq in 1999, PDS is a nation-wide safety net, operating through ration cards, main vehicle for distribution of food and NFIs. For more information on PDS, please, see Considering the Future of The Iraqi Public Distribution System, World Bank, Middle Est and North Africa region, 2005

34. As does the Domestic Violence Law in KR-I

35. Since the Assessment did not use quantitative methods, we cannot provide any numerical estimates of the share of local NGO workers who share this opinion. We are highlighting a repeated concerns expressed by several key informants from various governorates.

36. According to key informants, the latter is not required by Iraqi law in case of divorce, but is a deeply rooted cultural norm (specifically among rural Muslim population).

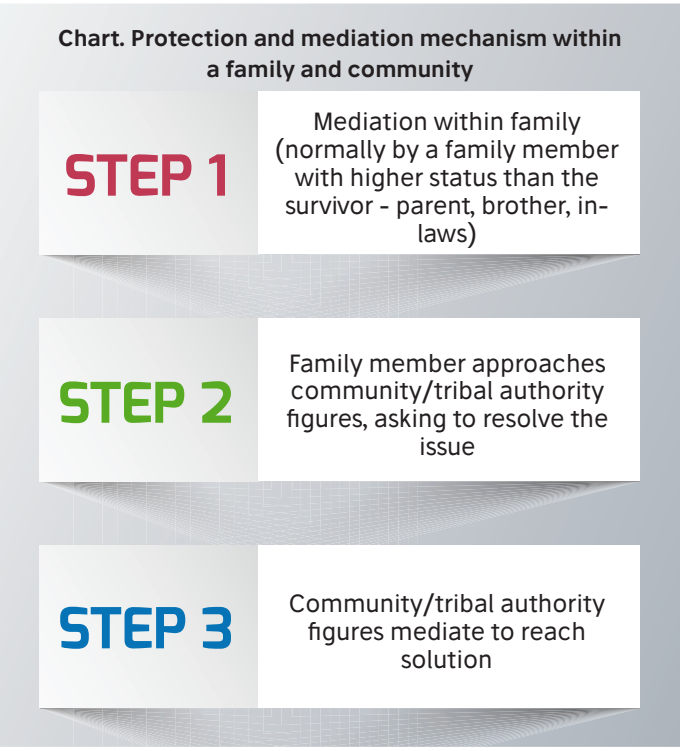
and public facilities.

• Regardless of locations, the most common path selected by FGDs participants was to seek protection through family[37] or tribal mechanisms. **In cases of domestic violence,** women expressed that seeking protection within the extended family, normally, comes as a first step. If family mediation does not solve the issue, the community elders or tribal leaders can be approached (the latter option was specifically suggested by the IDPs from Ninewa governorate and may differ for various cultural groups). However, it is not a woman herself, who approaches the authority in the community. The mediation will be conducted by power figures within her family.

• In cases of sexual violence (which is very rarely revealed), as stated by key informants[38], once again, **families tend to seek resolution,** if possible, by marrying the survivor to violence perpetrator.

• Specific ethnic and religious communities among Iraq's IDP and refugee population have unique **family structures** and cultural norms regulating interactions inside a family[39]. The structures and norms inform the protection and resolution mechanisms families use to address GBV.

Chart. Protection and mediation mechanism within a family and community



In the course of FGDs in two different camps, the IDPs were asked to analyze a hypothetical situation: A young woman, residing on camp, is regularly subjected to physical violence by her husband. He beats her and threatens to take away food and blankets. Where will she go for help? Majority of participants suggested that young woman will seek help inside her family. The next question was: Will she go to her parents? Responses highlighted important differences between two IDP communities. Those in camp in Dohuk immediately rejected the option of seeking help from parental family. "She is now with her husband's family, parents will not help her" – was a common conclusion. The advice of the group was to seek help from the mother-in-law or sister-in-law. The recommendation matched one of the stories told in the same FGD: a woman told that the wife of her husband's elder brother was instrumental in stopping abuse.

On the contrary, the participants in camp-based FGD in Sulaymaniyah advised that GBV survivor should seek help from her parental family, particularly her father or brother(s). As noted by one participant: "They will go and have a talk with her husband's father. It may help" (this quote is not exactly matching with the previous sentence, and seems incoherent)

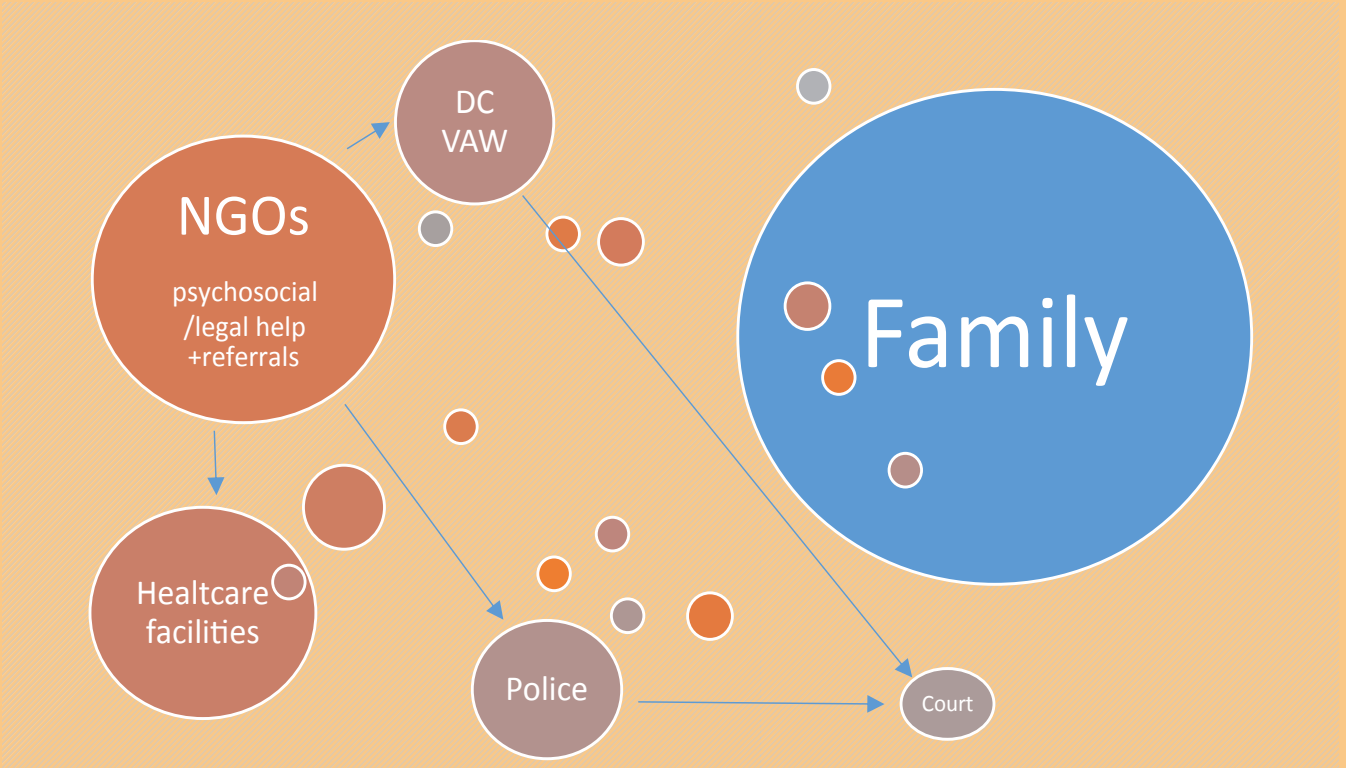
Below diagram indicates where GBV survivors go for help.

37. The finding matches the outcomes of Iraq Woman Integrated Social and Health Survey (I-WISH) indicating that 89.3% of respondents believed that in case of violence against women, women should approach family for protection. Iraq Woman Integrated Social and Health Survey (I-WISH), 2012, p. 25

38. FGD participants did not discuss sexual violence because the issue is strongly stigmatized. We would like to emphasize that local service providers repeatedly stressed that cases of sexual violence are very rarely reported.

39. Understanding of tribal mechanisms of conflict resolution is also important. However, service providers need to keep in mind that the preservation of social cohesion, existing order and peace, rather than women's safety, is often a priority for tribal mechanisms.

Where do GBV survivors go for help?[40]



(The size of the ball designates how often IDP and refugee women select a particular option). For the absolute majority, the path starts and ends inside the family. Sometimes community elders, tribal authorities can be engaged by families to resolve the problem. Solid arrows show paths outside families that are taken by a small number of GBV survivors.

• The second path, considerably less frequently taken, is to approach camp-based safe spaces/women's centers or NGO offices in non-camp settings. NGOs provide psychosocial support and referral to other facilities. It normally stops right there with a small number of survivors accessing healthcare services and even smaller number daring to go to the police. The majority chooses not to use other services[41]. The staff of the centers regularly engages in mediation in cases of domestic violence. Key informants reported that mediation is often efficient.

• **Psychological support** is the service most commonly sought by GBV survivors. This finding is supported by GBVIMS data. Psychological violence is the least stigmatized form of GBV and seeking help to address this is least likely to cause a negative reaction in families or communities.

• According to service providers in camp and non-camp settings, **legal support is often offered together with psychosocial support,** but rarely requested. In the words of a key informant, "people do not appreciate the importance of legal help, because they are not willing to take the case all the way to the court"[42]. According to the absolute majority of opinions voiced in FGDs, people commonly believe it shameful to reveal GBV outside of family circle.

• The Assessment found that in cases of physical violence by a family member, IDP and refugee women commonly tend-

40. The chart mainly covers domestic violence, although some key informants mentioned that family mechanisms are predominantly used for cases of sexual violence, because sexual violence is strongly stigmatized and is considered detrimental for family reputation. Honor-killings were invoked as one tragic effect of family interference in sexual violence cases. Arranged marriage with violence perpetrator was another outcome generated by family mediation.

41. The reasons will be discussed in the next sub-section dedicated to the examination of the barriers, preventing GBV survivors from accessing services.

42. KII, Sulaymaniyah, April 2016

ed not to seek medical help. As described by one FGD participant, "I just wait and the pain fades". Respondents did not mention long term consequences of physical violence. The decision reflects a general attitude towards using healthcare services. For a large share of women in IDP and refugee communities visiting a doctor requires considerable effort. Woman has to a) ask a permission from husband/parents; b) find someone to accompany her (often violence perpetrator or people close to him/her); c) make time for a visit between home chores; and d) find money; e) travel sometimes long distance (security concern and a hidden cost, very relevant for IDPs in sparsely populated, rural areas). Subsequently, healthcare facility visit is often not on the list of women's priorities. The attitude is dangerous for GBV survivors' immediate well-being as well as their long-term health.

• Police protection is the least common service required by GBV survivors and the least common path in all governorates selected for the Assessment. The Assessment found that accessing police is strongly discouraged by families, NGO workers and police officers, including at times, the representatives of GDCVAW (in KR-I). FGDs also demonstrated that the mistrust and fear of police and camp security service are very common among IDPs[43]. FGD participants mentioned the arrest (of violence perpetrator), victim-blaming and police brutality among the reasons they mistrust the police force[44]. When the perpetrator is a family member, IDP women are very concerned that a) the arrest is inevitable and they will lose protection and access to resources, b) family and community (and sometimes police officers) will blame and punish them for involving police in "private affairs", and c) police involvement will not be confidential and will cause the embarrassment for family.

• Refugees were also very much against complaining to the police or uniformed personnel. They were less scared of police brutality but more scared of being sent back home.

• The Assessment found that many IDP women were reluctant to ask or accept psychological help when it was not combined with other services or resources for other family members. "The best help you can give me is to help my children" is a common response given by IDP women to service providers. Many women are culturally expected to put family needs first. Service providers related that the most efficient way to encourage IDP and refugee women to seek help (psychological or health related) is to integrate it into a family assistance package. "We provide books and toys for kids, women come and we get to talk, then some open up about psychological abuse," told a key informant in Erbil. Service providers emphasized that sessions offering vocational recreational activities and stress management help women to talk about their problems and build self-esteem of GBV survivors.

3.3 Barriers encountered by IDPs and refugees in accessing services for GBV survivors and challenges faced by service providers

The sub-section answers the following research question: What are the barriers impeding GBV survivors' access to services and what are the facilitating factors?

First, we will present the Assessment findings regarding the barriers arising from the community attitudes, cultural factors and gaps in organization of services. Then, we will outline larger structural factors (security, economic hardships, damaged infrastructure, logistical barriers and legal gaps) and legislative barriers impeding IDPs accessing to services in the selected governorates.

3.3.1 Cultural and social barriers

Cultural barriers for women's mobility in the public space: Restrictive religious/cultural norms limit women's mobility in public space and generate a male-dominated working environment in public offices, thus stopping women from seeking help from there. Restrictions to women's mobility in public spaces were regularly mentioned by service providers and other informants. It is a major factor present in most governorates. Cultural norms in Erbil and Sulaymaniyah (and to some extent in Dohuk, Kirkuk and certain areas of Baghdad) that are accommodating women's presence in the public space and working environment present a facilitating factor for the access to services and livelihood opportunities.

3.3.2 Lack of Personal time

• **Lack of personal time:** The vast majority of FGD participants in camps explained that they simply do not have time to access services. "I attend to kids in my tent, I am busy all day and do not have time to go to the doctor," explained a participant from Dohuk, who earlier complained about being stressed due to "tensions in the family". Lack of time was repeatedly brought up by IDP and refugee women and connected to hardships of homemaking in the camp environment.

3.3.3 Language Barrier

• **Language barriers** limit all interactions, including the ac-

43. The finding matches women's attitude towards reporting GBV to law enforcement, registered by the Iraq Women Integrated Social and Health Survey. 51.4% of respondents did not report to the police fearing reputational damage, while 30.8% believed that police cannot help them. I-WISH, Summary Report, March 2012

44. The finding matches the conclusions of the report on violence again women in Iraq conflict prepared by Ceasefire. Please, see Miriam Puttick, No Place to Turn: Violence against Women in Iraq Conflict, Ceasefire Center for Civilian Rights and Minority Rights International, February 2015, pp 22-30

cess to services for GBV survivors. This factor is very relevant for Syrian refugees and all IDPs with poor or no knowledge of the Kurdish language in all three governorates in KR-I.
• In some camps in KR-I, up to 30% of IDPs reported **restrictions in going outside the camp area.**

3.3.4 Low awareness on available services

• **Low awareness on services available in camp site** (health services specifically) was detected among some participants of the FGD in Sulaymaniyah.

3.3.5 Erosion of Social Network

• Social networks are important for receiving information about services or getting support in seeking help. Data from camp-based FGDs revealed that IDP/refugee women suffered from the **erosion of social networks,** more than men. Men can gather in public spaces, but it is not an option for many IDP/refugee women. Service providers working in camp sites noted that many women and girls are banned by husbands/parents even from going to "safe spaces". In many camps, living arrangements did not allow women to have a private space in their shelters, where they could meet friends. "How can I have any guest over, when there is one room for men and women in my tent?" – asked a participant from Sulaymaniyah. "Most women are not here ("safe space" iin camp – A. V.), they never come here, they are not stepping outside of their tents", the opinion came from FGDs participant in Dohuk and was supported by many in the group.

3.3.6 Community attitude

• **Community attitudes to women who reveal GBV** are harsh. IDP and refugee communities strongly disapprove of women and girls who complain about GBV outside the family. "Our community does not have violence, no one should bring the police here" said an FGD participant in Erbil. The sentiment was supported by numerous participants. Community and family attitudes a) normalize domestic violence; b) consistently engage in victim-blaming and c) strongly connect all attempts to seek help outside the family circle to the concept of "shame". Stigmatization and threats are also among the tactics used to stop GBV survivors from complaining to "outside" actors. Service providers often expressed that they regularly face situations when suggesting measures to protect GBV survivors (like, going to the police) may lead to isolation or punishment of the survivors. The only pathway recognized for women and girls by such attitudes leads to family or community-based conflict resolution mechanisms.

3.3.7 Inter-community and/or sectarian tension

• **Inter-community and/or sectarian/ethnic tensions** are a major factor in Baghdad, Kirkuk and Diyala governorates. The tensions increase restrictions on women's mobility in the public space, thus making it harder for them to access services.

Good practice.
Two camp-based service providers in KR-I and a service providing NGO in Baghdad work with tribal authorities to secure support for assisting GBV survivors and facilitate the attitudinal change towards women's right to be protected from domestic abuse.
Starting a conversation with tribal leaders about domestic violence is a hard and sensitive task. Social workers described that first meeting generated anger and frustration among many male participants. However, as the conversation continued, the parties found some common ground. "It is a difficult conversation, you have to accept that there will be frustration and you will only achieve minor progress, if any. Now we have reached the level of trust where we can often rely on their support in stopping domestic violence. I am a member of this community, it helps. Men here decide everything. We need to learn to talk to men. We do not talk to men nearly as much as we should" – told one key informant, based in camp.

• Another negative impact of inter community (sectarian or ethnic) tensions is the reluctance of GBV survivors to rely on the assistance provided by staff that belongs to other religious or ethnic group. The factor is strong in Baghdad and Kirkuk, but also was reported by respondents from Dohuk.

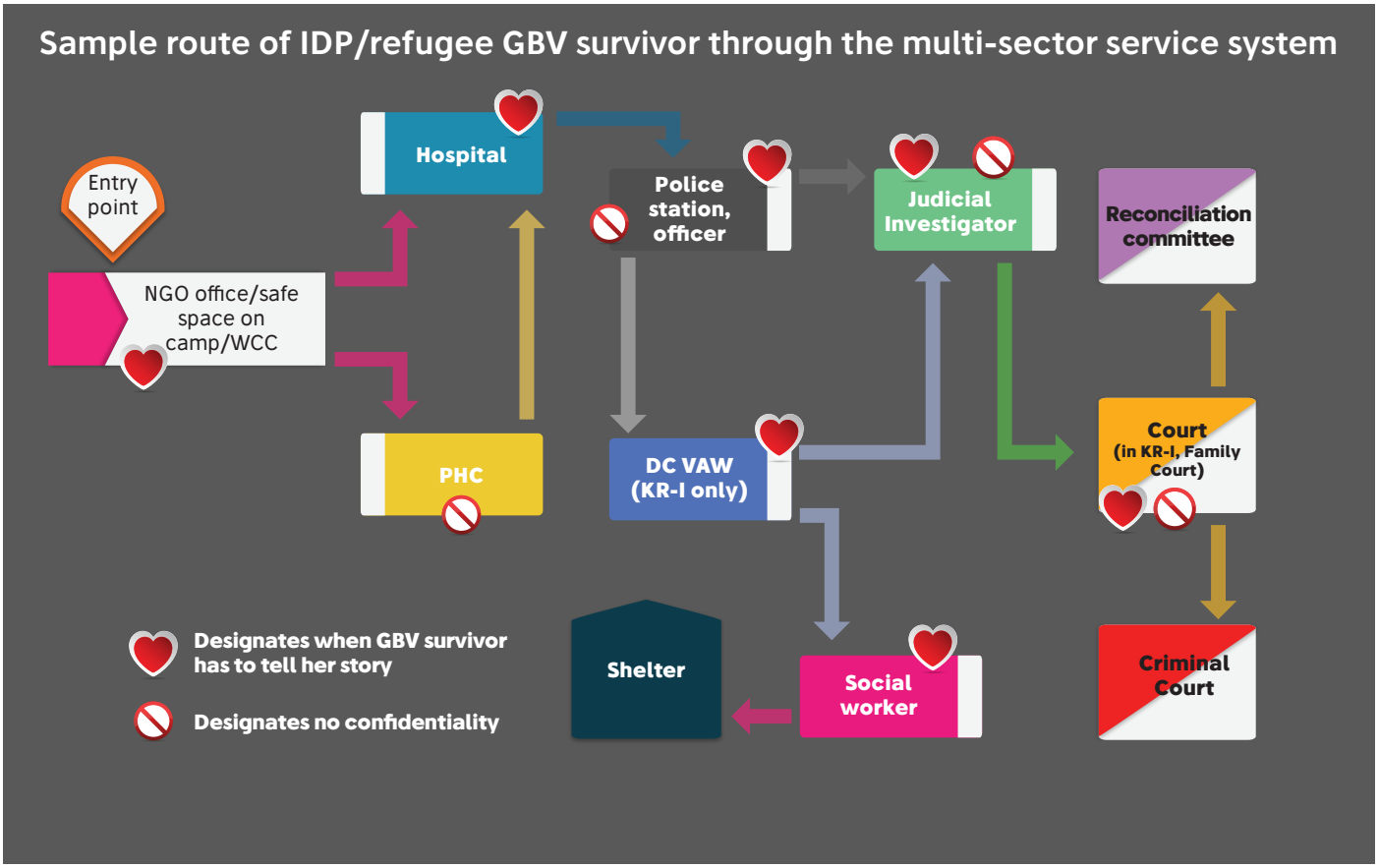
3.3.8 Gaps in organization of services for GBV survivors

The Assessment identified several gaps in service provision and coordination among key sectors tasked with delivering services to GBV survivors: healthcare, police, GDCVAW (in KR-I only), judiciary and social protection. The gaps result in generating additional barriers that stop GBV survivors among IDP/refuges to seek and receive assistance.

Below is the model of current services available for a GBV survivor as described by the key informants representing the health sector, GDCVAW and the social workers (NGOs). We would like to stress that the key informants were specifically asked to describe **routine daily operations.** Thus the model reflects daily practices of the service providers working with GBV survivors. As noted by respondents in FGDs and KIIs, the majority of IDP/refugee women and girls suffering from GBV does not make it to even the most common entry point (NGOs). The share of those making it to healthcare facilities is even smaller[45] and the share of those reaching the police or GDCVAW is very small.

GBV survivors in camp and non-camp settings enter the system predominantly through NGO offices/"safe spaces"/"listening centers"/Women's Community Centers, where they receive psychosocial support, get referrals

45. Healthcare provider in one of the KII stated that in her 8 years of practice, she had one patient who revealed exposure to sexual violence.



and, sometimes, receive free legal help. GBV Sub-Cluster partners achieved considerable improvement in developing and introducing referral pathways and mapping various areas for services available to GBV survivors. At the same time, as evident from the model, a route that GBV survivor has to navigate within the multi-sector system is long and convoluted. IDP/refugee women would have to risk their own safety, find time and navigate through bureaucratic system (for some in a language they do not speak/speak well) to progress down this route successfully.

• **A barrier in accessing services for GBV survivors among IDP/refugees** is the absence of a single hubs/one stop centers where a GBV survivor could get psychosocial support, legal help, healthcare assistance (at least on the basic level), timely forensic examination (if requested) and safe and confidential referral to law enforcement.

• There is a **gap in coordination** (referral and information sharing) between the health sector and law enforcement. Medical professionals often try to avoid reporting possible GBV cases. The vast majority of healthcare staff interviewed believed that they have to report GBV to the police and feared the retaliation from the perpetrator and/or survivor's family. According to healthcare staff, patients also routinely avoid acknowledging any GBV related problems.

• There is **no legislation specifically geared towards protecting service providers** from retaliation by families of GBV survivors. Healthcare staff (especially in primary health care (PHC) closely tied to local communities) and some social workers stressed that they wish there were mechanisms protecting them from retaliation by families of GBV survivors or angry community members.

Two perspectives.

Key informant from health sector:
"Mandatory reporting puts doctors in danger and patients do not want it. That is why it does not work."

Key informant from law enforcement sector:
"Nurses keep complaining that reporting forms are too long to fill. Well, they can't even fill those correctly, they need to be trained"

• There is a **gap in communication** between the sectors and beneficiaries. Some healthcare staff and all law enforcement sector representatives stated that reporting the details of the injuries does not mean automatically opening the case. However, the pervasive opinion among the IDP/refugee women is that it starts the investigation of GBV by police. They are not aware of the alternative solution (talking to social workers and getting free psychosocial support without

opening legal case/police investigation) offered to GBV survivors in GDCVAW and Family Protection Units. Several healthcare sector key informants had the same opinion. This lack of clarity contributes to more general problem of IDPs mistrusting police.

"When she comes here, she needs to know, she needs to understand: she does not have to file a claim! It is her choice, there is a second path for her here." – key informant (in KR-I), speaking about the GBV survivors accessing GDCVAW offices.

• Service providers in healthcare facilities and police[46] need stronger awareness of specific steps-by-step procedures in addressing GBV cases. Respective SOPs for healthcare and police need to be **synchronized**.

• The adoption of the CMR protocol is an important step in ensuring adequate response to GBV in healthcare facilities. In addition, there is a need to expand training of healthcare staff (in primary and secondary healthcare facilities) about non-judgmental and comprehensive treatment of **GBV cases not covered by CMR.** Healthcare professionals also lack training on **testifying in court** on GBV cases[47].

• **Barrier: failure to provide confidentiality:** Rooms in PHC, hospitals and police stations often do not allow a confidential disclosure of GBV. Disclosing GBV in front of family members or strangers is embarrassing and dangerous for survivors. Confidentiality of the disclosure is breached at several points across the route going through multi-sector response system (please, see the sample model above).

• Severe **shortage of female police officers** is a problem for all governorates. Entering an office environment with exclusively male staff can be extremely uncomfortable for women and girls due to cultural restrictions on interactions with unrelated men, and could cause a very serious reputation damage and even result in physical punishment by families. Stories of GBV can involve details that women find impossible to reveal to male service providers.

• The practitioners in some government services (police, healthcare, court) were not aware of a **system for confidential information sharing among the sectors.** In a description of the real daily process of GBV survivors navigating the system, key informants indicated that survivors have to repeat their stories several times while going from one office to another (please see the model above). It is important to note that 15 partners (GBVIMS data gathering organisations) have signed the information sharing protocol. Local NGOs and international organization are following the confidentiality precautions. However, service providers in government services, interviewed in the course of the Assessment, were not aware of any procedures that would spare GBV survivors from repeating their statements.

• In KR-I, distribution of tasks between police and GDCVAW is unclear. Police officers are required to refer all cases to GDCVAW and the focal points were established in every police station to refer cases to GDCVAW. However, a common complaint from the key informants was that referrals were not done regularly. The reason given by informants is that the ordinary police officers are not aware that they have to refer such cases to GDCVAW. Some NGO workers stressed that police officers actively advise women against filing complaints, suggesting that women should solve the issues without the involvement of police.

Bureaucratic procedures are time-consuming. A police officer first takes the statement from the GBV survivor, however, the investigation process is conducted by judicial investigator[48]. Due to bureaucracy, the "claim" filed by GBV survivor can travel through the system for days before reaching the person tasked with investigating it.

It is important to note the role of judiciary investigators (lawyers working directly for investigative judges) in the criminal justice system in Iraq. Police compiles preliminary findings, but the actual investigation is a responsibility of the investigative judges and judicial investigators. "The Iraqi prosecutor is very much an administrative official whose job is to review the case file for completeness, and to provide recommendations to the judges as they try the case and deliberate their findings. The judges (first the investigative judge, then the trial judges) take center stage- literally- as they run the criminal investigation, issue arrest warrants, interview witnesses, determine appropriate charges, weigh the evidence, issue findings and pass sentences", Warnock, Dan, The Iraqi Criminal Justice System, An Introduction, - In: Denver Journal of International Law and Policy, 2010, pp. 3-4

46. Key informants told that police and GDCVAW currently do not have SOPs regulating the treatment of GBV cases. Given that police officers do not refer cases to GDCVAW regularly, the need for such SOPs becomes even more prominent.

47. The concern was raised in KII by a service provider in camp working with GBV survivors as well as by the law enforcement representative working with GBV cases.

48. IRC's report on obstacles faced by women and girl victims of violence in KR-I also found the process to lack efficiency and clear distribution of responsibilities. Please see Working Together to Address the Violence against Women and Girls in Iraqi Kurdistan, IRC, http://IRC%20Addressing%20Violence%20Against%20Women%20in%20Kurdistan%205-12.pdf (last accessed on May 5, 2016)

• For the coordination between **shelters and law enforcement, the lack of synchronized criteria** for accepting GBV survivors is a major issue. For example, in KR-I, there is a disagreement between the Ministry of Labor and Social Affairs (MOLSA, the agency running the shelters) and the Ministry of Interior (MOI) and the Ministry of Justice (agencies sending women and girls to stay in shelters). Key informants indicated that the lack of criteria results in the survivors with mental health issues sent to the shelters, while shelter charter explicitly prohibits that[49]. Law enforcement officers noted that there is no alternative safe location where they could take survivors. Shelter management also complained about not having separate quarters for teenage residents and adults. Non-citizens, specifically refugee women and girls, are normally not accepted by shelters.

• A separate and disturbing issue is an **accusation of prostitution.** Key informants from local NGOs revealed that sexual violence survivors are at times accused of prostitution by police, judges and shelter staff. The accusation is extremely damaging for survivors' social status. It also affects their chances to be accepted into shelters. Some key informants working with shelters expressed their concern about placing those who, they believed, were involved in prostitution, together with other GBV survivors, because it makes reintegration into community very hard for the latter[50].

• In KR-I, the presence of **GDCVAW is a facilitating factor** with a strong potential. For example, having social workers ready to help GBV survivors in GDCVAW offices (with confidentiality respected and separate rooms provided) is an important arrangement making survivors' route within the system faster, safer and more efficient. However, the Directorate is in a need of stronger financial and institutional support as well as capacity building (specifically, increasing the number of mobile teams and cars, strengthening the case management skills of social workers and specialized investigation techniques to address GBV cases for police officers)[51]. Sixteen Family Protection Units operating around the rest of the country carry function similar to GDCVAW and present a potential for multi-sectoral coordination[52].

3.4 Structural barriers for accessing GBV services in eight governorates

All violence, including GBV, unfolds in specific socio-economic, legal and cultural environment, and is shaped by such environment and impacts it in return. Governorates of Iraq present a diverse spectrum of economic, social, political and cultural conditions. History of ethnic and sectarian tensions, oppression by the central power, security risks and the range of displacement-related challenges faced by the governorates differ considerably. The legislative environment for addressing GBV differs between the Kurdistan region and the rest of the country. Specific set of socio-political and economic conditions can also generate factors that enable or limit violence perpetrators and make it easier or harder for the survivor of GBV to access services and seek justice and help.

3.4.1 Security, political and economic barriers

• **Security barrier:** Security threats related to on-going fighting, the legacy of ISIS presence (mines or booby-traps in buildings), kidnappings, assassinations and terrorist attacks continue making the access to services very hard for GBV survivors in Baghdad, Diyala and Kirkuk. Subsequently, stability and low security threats in three KR-I governorates constitute a **facilitating factor** for the service delivery to GBV survivors.

• **Constant population movement** (including **secondary displacement**) due to poverty, security threats or intimidation by armed groups or local governments makes it very difficult for service providers to reach out to IDPs, maintain contact, provide follow-up services or collect information. The challenge is relevant to some extent for all governorates, however, Baghdad (certain districts), Diyala, Kirkuk and some areas in the KR-I are specifically affected by this problem. The stable presence of IDPs in camps and non-camp setting across the three governorates of KR-I constitutes a **facilitating factor** for service delivery to GBV survivors.

• **Barriers in logistics, infrastructure and the shortage of service providers:** Infrastructure damage to public buildings (healthcare facilities, schools, local administrative offices) and the shortage of healthcare staff, especially female medical staff, present major challenges for delivering services to GBV survivors in many locations (for example, Diyala, Kerbala, Najaf and Kirkuk among the selected governorates).

• **Limited presence of NGOs and/or low level of coverage by GBV-related humanitarian activities:** The factor is often in itself an outcome of the security situation and challenges in accessing certain areas. It adds to already damaging conditions of limited mobility, destroyed infrastructure and absence of services within reach (Kirkuk, Diyala, Najaf and some districts of Baghdad governorate). The comparison of coverage numbers in Najaf and Kerbala demonstrate that Najaf lacks in GBV services provided to IDPs. The reasons for

49. Please see Article 5 of Shelter by-law instructions (based on English translation)

50. Reintegration into the community was also brought up by the MOLSA as a serious issue affecting girls who are rejected by their families. The issue, its consequences and possible solutions require further investigation.

51. Requests were made by GDCVAW in the course of KIIs

52. The network of sixteen Family Protection Units across the country encountered challenges in building coordination with other sectors, as reported in 2015 Trafficking in Persons Report, http://m.state.gov/md243458.html (last accessed on 06/23/2016)

this situation require further investigation.

• **Budget cuts** in KR-I undermining public service provision result in partial shutdown of facilities delivering services (healthcare facilities, safety services (shelter), for example) and strikes by public servants. Recently, the fees were introduced for some previously free healthcare services. Even a small fee becomes a burden for IDPs, due to scarce financial resources they have. All these factors are damaging for public service delivery in all governorates of the KR-I (Erbil, Dohuk and Sulaymaniyah).

• **Multiple and competing sources of authority and mechanisms of law enforcement generate the environment** where the rule of law is highly dependent on personal status. The power of armed groups to inflict sexual or physical abuse is unrestricted and domestic violence issues get subsumed in the general reign of violent practices by all actors. The factor is relevant for governorates (Baghdad, Najaf, Kirkuk, Kerbala, Diyala) with parallel law enforcement or armed protection forces (like militias, local armed groups, factions involved in sectarian fighting). It was reported in KIIs that NGO representatives in Baghdad at times are simply not allowed by fighting factions to access locations. Stable, government-led law enforcement and the government body specifically tasked with addressing GBV (GDCVAW) in KR-I governorates and Family Protection Units in other parts of Iraq present a **very important facilitating factor** in delivering protection and justice to GBV survivors in IDP and refugee communities.

• **Delivering services in hard to access areas** is challenging for service providers working in Diyala, Kirkuk and some parts of Baghdad, Anbar, Salahadin and Dohuk governorates. The Assessment identified several **good practices** used by service providers in such situations. Some key informants described the use of mobile teams with staff trained to give basic medical assistance and emergency psychosocial support to women and girls, conduct safety audits of site, where necessary, and distribute dignity kits. Mobile teams are ready to take GBV survivors outside of the area if referral is needed. Another method of delivering help was to use volunteers from the members of local communities. Members of local communities willing to serve as volunteers are being trained outside of hard to access areas. They come back to hard to access areas prepared to provide information and emergency psychosocial support to GBV survivors. Volunteers keep in touch with professional service providers via cell phone/email. Cell phones are used to monitor and supervise the operations. The third method used for delivering services in hard to access areas is for service providers to set up temporary offices (working once a week, for example) in damaged local facilities. Local population then was informed about the working hours and services available for them in temporary offices. Finally, some organizations partner with local grass-roots groups and community-based structures (for example, local community-based women's groups) or with government structures (such as the offices of the MOLSA) to deliver emergency services in hard to reach areas.

• **Depletion of IDPs resources (often due to unemployment and soaring rent prices)** forces IDP families to change homes and move farther away from areas with available public services, thus rendering the access more difficult both logistically and financially (remote or deserted locations). Unemployment is a major factor limiting the opportunities of IDPs across all governorates. Soaring rent prices push IDPs out of areas with well-developed infrastructure and public services. This factor is relevant for the governorates with relatively high cost of living (for example, Erbil). Depletion of resources forces IDPs further into cheaper and more remote areas, which means further distance from public services in the governorates that are scarcely populated (Najaf, Kerbala) or predominantly rural (Diyala, Dohuk).

• **Challenges for service providers in accessing IDPs residing in various shelter arrangements:** In terms of shelter arrangements and its connection to the GBV prevention and response, central governorates present challenges for reaching out to IDPs in critical shelters and introducing preventive measures in generally unsafe living environment. The governorates of Baghdad, Diyala and Kirkuk as well as Erbil and Suleymaniyah in KR-I have a high share of IDPs living in host families or rented housing. Scattered across the governorates, IDPs in rented housing or host families are more difficult to reach compared to those in camps. Some NGOs use canvassing neighborhoods through door to door approach to reach out to IDP women and girls. NGO workers (all women) regularly visit local neighborhoods with high concentration of IDPs. They knock on doors and get acquainted with IDP women and girls, talking about vocational and recreational activities, health and social assistance offered by the organization they represent (all informants using this method represented local NGO). They build on family and neighborhood connections to further expand the outreach to the IDP communities. The approach is the only way to connect with dispersed population when IDP women's mobility in the public space is limited. However, the method is time consuming and requires considerable human resources.

• Finally, Dohuk has a very high concentration of IDPs and refugees living in camps (the highest in the nation). Reaching out to people with GBV-related information or distributing dignity kits is much easier in camp settings. IDP women and girls do not have to travel far to access safe space, healthcare facility or security. However, providing services to GBV

53. Social workers in "safe spaces"/WCC noted that for many women, even a visit to "safe space" is out of limits. Social workers described numerous situations when they personally talked to IDP men in order to convince them that "safe spaces" have good reputation and provide useful services for women and kids. Personally reaching out to men often generates a positive outcome.

survivors iin camp has its own challenges. In highly congested camp settings, **confidentiality is a major issue for GBV survivors in camp settings, because women's every move is scrutinized by family and community.** For example, visiting a security office in camp to complain about intimate partner violence (IPV) or domestic violence (DV) is a visible step that can cause severe repercussions for GBV survivors. "Safe spaces"/WCC in camp sites offer a safer entry point into the system of coordinated services for GBV survivors[53]. Social workers put a lot of effort in making the centers publicly accepted gathering areas for women and girls.

3.5 Legislative barriers

• The Iraqi Constitution (2005) provides a sound framework for gender equality. It guarantees equality to all and prohibits discrimination based on gender (Article 14), prohibits all forms of violence in private and public spaces (Article 29) and forbids forced labor, slavery, sex trade and trafficking (Article 37). **However, national legislation contains several gaps that create challenges for legal protection of GBV survivors**[54]. Personal Status Law (1959) is based on Sharia Law. It allows polygamy under certain conditions[55] and permits to marry at the age of 15 years old (subject to approval by a judge[56]). In order to get a divorce, women suffering from physical violence have to demonstrate that their injuries are incompatible with married life. Country's Law on Trafficking, adopted in 2012, imposes high fines on traffickers of women and children, although the law was criticized for not covering child prostitution.

• The Iraqi Penal Code (1969) considers **wife beating a private matter of disciplining** one's spouse (Article 41). The Code criminalizes rape (but not a marital rape), sexual assault, and abduction. However, unless the victim (or her guardian) files a complaint, the state is not responsible for taking action. The Code allows the investigation **to inquire into a victim's "sexual history"** and use it during deliberation. According to KIIs, "virginity tests" are assigned by some judges in order to clarify the "sexual history" of girls in cases of sexual assault. Such tests can have devastating consequences for victims' future and were reported to be used **to accuse assault victims of prostitution** and shield violence perpetrators. Iraq's Penal Code uses marriage as the means of reconciliation between the victim of rape (or abduction) and the perpetrator. Position secures the impunity of violence perpetrators and presents a serious obstacle for GBV survivors who seek justice.

• Iraq's Penal Code **minimizes penalty for "honor killing"** (Article 409) if a judge finds the motivation was victim's adultery. Accusations of adultery were used as motivation for killing hundreds of women with perpetrators receiving minimized sentences[57].

• In terms of addressing GBV, the legislation in KR-I has made some steps to go ahead of the federal legal base. Several key informants emphasized that it happened as a result of advocacy by women's rights organizations. In 2001, the parliament of Kurdistan suspended the article 41 of Iraq's Penal Code (protection of wife batterers)[58]. In 2002-4, the parliament of KR-I removed Penal Code provisions protecting the perpetrators of "honor killings". In 2008, KR-I adopted amendment making polygamy illegal unless authorized by a judge (agreement of the first wife, listed as one the conditions)[59].

• **The absence of federal law defining domestic violence** or violence against women, its forms and the state mechanisms responsible for addressing presents a serious challenge for service providers outside of KR-I. The legislative base in KR-I includes Domestic Violence Law which serves as a **facilitating factor** helping service providers in KR-I to draw on the power of legislation to support and protect GBV survivors[60]. However, as stressed by many key informants, implementation of the laws continues to fall prey to corruption, nepotism and interpretations informed by religious and tribal rules.

• There is a lack of clarity about the leading implementing agency for DV Law. As expressed by key informant from GD-CVAW, "As a normal practice, the final section of each law clearly states the implementing government agency. Unfortunately, DV Law does not provide the indication. It generates the confusion in terms of who is the leading agency

54. However, it is important to note that while being a signatory to Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Iraq introduced reservations regarding a number of articles prohibiting discrimination against women (2 (f and g), 9 and 16), due to its decision to stay within the limits of Sharia Law.

55. Iraq's Personal Status Law, Chapter 1, Article 3.4

56. Iraq's Personal Status Law, Chapter 1, Section 2, Article 4

57. Violence against Women in the Legal Framework, prepared by Rebaz Khursheed Mohammad, 2015, p. 39

58. Ibid., p 36 and KIIs

59. Violence against Women in the Legal Framework, prepared by Rebaz Khursheed Mohammad, 2015, p. 50. In reality, the stipulation requiring the agreement by first wife can expose her various forms of pressure, including violence. Another loophole in the law is that it allows men from KR-I to marry Arab IDPs outside of KR-I. (p 43)

60. We talk about the legislative barriers for service provision to GBV in a separate sub-section.

61. KII in Erbil, April 2016.

responsible for implementation"[61]. The lack of clarity results in a lack of leadership in implementing the law.

• The DV Law does not have a comprehensive explanation of the **duties of reconciliation committees.** The reconciliation committees are tasked with helping to stop GBV without further involvement of judiciary. Committees include representatives of GDCVAW, the High Council for Women's Affairs, religious figures, MOLSA and, sometimes, NGOs (only in Sulaymaniyah, according to KIIs). Currently, reconciliation committees do not have mechanisms for monitoring situation after the formal reconciliation was made.

• The custody of children after divorce presents a good example of **informal cultural rules prevailing over the formal legislative provisions.** Iraq's federal law grants a mother custody over children[62]. A father is required to pay for child support. However, numerous service providers reported that the threat of taking children away was often used by husbands to stop wives from seeking help and protection from DV. Cultural expectation strongly supports a father in taking custody of his children. Social pressure on women to give children away is very high. One of the key informants explained: "In our society, the legislation is more advanced compared to social norms".

3.4.3 National machinery for the advancement of women's rights

• On a level of **national machinery for combating GBV,** KR-I has an advantage (**facilitating factor**) over the rest of the country. On August 16, 2015, the national Ministry of Women's Affairs and the Ministry of Human Rights were eliminated by Prime Minister's decree as a part of large-scale effort to reduce the size of the government. At the moment, on the national level, there is no specialized government body exclusively dedicated to the development of policies and programs addressing women's issues. KR-I has both specialized government agency for the advancement of women (High Council for Women Affairs) and the special division within the MOI tasked with combating GBV (GDCVAW). GDCVAW has a strong potential to become a hub for GBV response in KR-I, one stop shop agency for providing coordinated multi-sectoral response. Family Protection Units in Central governorates present a mechanism with similar potential which should be developed and supported.

3.5 Gaps and positive practices in multi-agency coordination within the GBV Sub-Cluster

The sub-section answers the following research question: What are the primary gaps and positive practices in the current coordination arrangements of GBV Sub-Cluster?

In February, 2014, in accordance with the recommendation of the Humanitarian Country Team in Iraq, the Emergency Relief Coordinator activated the Cluster system. In Iraq, the National Protection Cluster covers whole of the country. KR-I Protection Working Group covers the Kurdistan region and the areas under the de-facto control of the KR-I government, while the South-Central Protection Working Group serves southern and central governorates. Since GBV is recognized as a key protection issue for IDP humanitarian response, the GBV Sub-Cluster is a part of Protection Custer. The GBV Sub-Cluster also follows the division of the area of coverage into KR-I (and some bordering areas) and South-Central governorates. In addition, in KR-I, there are GBV Working Groups (WG) at the governorate level. The Assessment examined coordination at the level of the GBV WG in Erbil, Dohuk and Sulaymaniyah and South-Central WG[63]. The GBV Sub-Cluster is chaired by UNFPA with NRC as Co-chair.
GBV Sub-Cluster members include UN agencies, local NGOs, international NGOs and line ministries of the federal government and the government of KR-I.

Assessment findings in relation to the research question are presented below.

• The GBV Sub-Cluster maintained a level of coordination at central, regional and governorate levels. In a constantly changing complex humanitarian context, the Sub-Cluster was able to develop a coherent vision, goals and objectives that reflect priorities of GBV response in Iraq's humanitarian crisis through the Regional Refugee & Resilience Plan/ Humanitarian Response Plan and its own GBV Strategy. At the same time, the process of decentralizing coordination is unfolding successfully: Working Groups are functioning at the governorate level in some governorates, the GBV Sub-Cluster members are currently working to set up WGs for all governorates. In addition, there is a discussion of camp level WGs.

• The GBV Sub-Cluster maintained regular communication routine and organized sound coordination and information sharing system. The rollout and use of GBVIMS system for data collection, sharing and analysis are one of the successful tasks accomplished by Sub-Cluster members.

• Other good practices include: the development and sharing of referral pathways, the use of guidance notes explaining how to streamline GBV indicators for the reporting on activities, joint maintenance of service mapping – an exercise, where Sub-Cluster members share information about relevant and available services for GBV survivors in geographical locations across their regions. SOPs for GBV response are currently under review and the CMR protocol currently being finalized, and will shortly be introduced into the hospitals operations not only in KR-I, but across the whole country.

62. Based on the information provided by key informants from judicial sector

63. Group interview was conducted by Skype with the members of the WG

• There is a need to update service mappings and referral pathways more frequently. Changes in the location of offices should be updated in time (on a monthly basis, for example as an option). In some areas, service providers move offices often due to security concerns or infrastructural damage. Across all governorates, projects open and close rather rapidly due to limited funding. Several key informants indicated that they took GBV survivors to specific locations, just to find that offices there were closed. Information on working days and hours is also very important to be included.

• Information on service providers should include the details about categories of beneficiaries they cover.

• In the governorates of Baghdad, Diyala and Kirkuk, according to key informants, organizations tend to report on activities more slowly due to volatile security situation. Working with computer-based format is not very convenient for people who travel a lot. A smartphone format would be much more user-friendly.

• Activity reports are not regularly submitted and are often incomplete. That creates a shortage of information on who is doing what and generates overlaps.

• Resource sharing between smaller and more populous WGs needs to be more intensive. Smaller teams have a hard time developing resources and could save time and efforts by adapting rather than creating from the scratch.

• Many WG members across governorates requested more training on GBVIMS, tool development and usage, and servicer mapping development (what kind of information about services should be included in the map). Some partners had problems with using all the options offered by GBVIMS. Possibly, it affects the level of reporting.

• Referral pathways need a follow-up mechanism. GBV Sub-Cluster members expressed that they refer survivors based on referral pathways, however later it became really difficult to follow-up on further development of the case. Organizations follow different protocols on case management and confidentiality of information. Inability to do the follow-ups affects the quality of service and undermines the trust service providers are trying to build with GBV survivors.

• Government representation in Sub-Cluster (WG of certain governorates) is an area in need of improvement. Frequent changes in focal points make communication with the government sporadic.

• Coordination between the Child Protection (CP) Sub-Cluster and GBV Sub-Cluster needs some improvement. Apparently gaps in coordination in the past limited the scope of services for some categories of beneficiaries. Adolescent girls suffering from GBV, for example, were a category at the border of responsibilities and area of expertise of each Sub-Cluster. Several key informants emphasized the need for cross-training and joint development of tools between CP and GBV. Some important steps in that direction were being made in spring of 2016, while the Assessment was conducted. The development of the Curriculum for Adolescent Girls is an example of a good practice in joining the efforts of two sub-clusters.

RECOMMENDATIONS

Recommendations are designed to address the most essential of numerous barriers identified in the course of the Assessment. Recommendations are meant for GBV Sub-Cluster members and cover key sectors responsible for coordinated GBV response.
To enhance the pool of information on trends and patterns of GBV among IDP/refugee communities, GBV Sub-Cluster members in all governorates should:

• Improve the quality and regularity of reporting on main GBV related indicators, pathways selected by GBV survivors, services requested and rejected. It can be done through additional training on the use of GBVIMS, since some partners found the format complicated. Smartphone friendly reporting format would make the data input easier and the process much faster. It was specifically requested by service providers working close to high-risk environment in central governorates.

• Change GBVIMS input format to add a separate perpetrator categories for in-laws. The need was determined based on repeated pattern in KR-I governorates.

• Data disaggregated by governorates is currently not produced by GBVIMS due to failure of many partners to input data in the system. There is a need for further training to explain the importance of having information disaggregated by governorates. Governorate-based data can help humanitarian actors in designing more nuanced needs assessments and in developing custom-made interventions.

To capitalize on Assessment findings about pathways commonly used and mostly avoided by GBV survivors, GBV Sub-Cluster members in all governorates should:

• Strengthen cultural sensitivity of GBV prevention, mitigation and response and recognize the impact of culturally diverse norms on the needs and choices of GBV survivors. The recommendation is specifically important for the governorates with diverse IDP population and significant refugee population (all three of selected governorates in KR-I, Baghdad and Diyala). The organizations working with IDPs/refugees should:

a. Increase participation of the members of ethnic and religious groups in prevention and mitigation work in respective IDP/refugee communities;

b. Enhance cultural sensitivity training to all staff members serving IDP/refugee communities; The training should include information on how to analyze family structures, community or tribal power hierarchies and identify the figures of authority in those structures;

c. Constantly maintain two-way communication with beneficiaries;

• Develop a strategy for further engaging family and community based mechanisms of protection and mediation to address GBV and CRSV. Determine the most efficient family and community mechanisms for protection of GBV survivors and conflict mediation. Develop training and information materials for target categories (older women, young men, tribal leaders).

Overcome cultural barriers by:

• Strengthening the engagement of IDP/refugee men in preventing and addressing GBV (DV, specifically). Given that women overwhelmingly prefer family as a first source of protection and resolution of GBV, engaging the power of men in IDP families to prevent and respond to GBV is a promising approach. Prominent role of men in IDP communities and families and strong family ties means “men as caring and responsible relatives”, which can provide an efficient cultural framework for male engagement in combating DV. For advocacy purposes, it is important to disaggregate male population into groups based on their roles and responsibilities towards women within the extended family networks (brothers, maternal/paternal uncles[64], fathers and fathers-in-law) to support women and girls.

• Empowered bystander methodology by Jakson Katz and other methods from his Mentors in Violence Prevention[65] approach can be modified to address specific groups of men through men-to-men advocacy/education format. For example, educational and advocacy campaigns should use male role models (athletes, religious and community leaders) to engage and impact male population to combat violence against women.

In addition to strong existing effort to prevent Child Marriage, address the practice through economic empowerment:

• Increase advocacy efforts to help the government and humanitarian actors in supplementing awareness raising with economic empowerment measures. Providing economic and social incentives directly to girls (or families of girls who attend school) should help families to alleviate economic hardships and forge strong connection between girls’ opportunitiesand improvement in families’ well-being.

• Use female role-models to illustrate the connection between well-being of young woman/girl and prosperity of her family.

• Discussion of sustainable and culturally sensitive

64. Maternal and paternal uncles carry different functions and responsibilities in relation to their nieces and nephews depending on a cultural group. The differences should be examined and taken into consideration in working with these groups.
65. www.jacksonkatz.com

alternatives to perceived "protective" function of child marriage should involve international and local actors. Conduct a seminar on "Child marriage: culturally sensitive and sustainable prevention strategies" to provide an open forum for generating new ideas and removing "conversation stoppers".

Make access to services easier and safer for GBV survivors through further strengthening coordinated response system by:

• Strengthening remote management modality to reach beneficiaries in the hard to access areas (specifically relevant for South and Central governorates), through building the capacity of mobile teams, training local volunteers, opening temporary offices and setting up partnerships with local community-based structures, pre-conflict networks, grassroots groups and activists.

• Strengthening connections with the networks of community volunteers, neighborhood groups and the centers of Shia learning (specifically, in Najaf and Kerbala governorates) to raise awareness and remove cultural barriers in accessing services for beneficiaries in governorates, where women's mobility in public spaces is restricted.

• Increasing the number of entry points through training service providers in remote locations and adding mobile teams. In KR-I, GDCVAW specifically needs support in increasing the number and expanding the training for its mobile teams.

• Together with MOH, MOI and Ministry of Justice, address the problem of repeated statements survivors have to give while navigating the system. Explore the possibility of computerized on-line storage of the data with confidential password-protected access available for a restricted number of actors. Also, address the failure to provide confidentiality in PHCs, police stations, GDCVAW offices and courts.

• Further strengthen training of healthcare providers on CMR and the treatment of GBV cases not covered by CMR. Also, expand the training of healthcare providers on testifying in court about GBV cases.

• Develop and conduct joint trust building training with local law enforcement and IDP community in order to overcome the mistrust of police.

• Support MOH and MOI in disseminating a clear information regarding the reporting of GBV. Healthcare providers and law enforcement officers should be trained to provide GBV survivors with clear, unequivocal and consistent explanation (in a standard written form, if needed) about the options available for GBV survivors, specifically, explain the difference between reporting to police and opening a legal case.

• Support MOH and MOI in synchronizing SOPs on GBV response for first-line responders in two sectors. SOPs should be incorporated into the internal guidelines and procedures of respective institutions.

• Current referral pathways between healthcare, law enforcement and judiciary sectors are sometimes long, convoluted, unsafe, traumatizing and lacking in confidentiality. All actors should put joint efforts into increasing the number of shortcuts in the network of coordinated GBV response. The most efficient way to provide these shortcuts is through the creation of one stop shop "hubs", where bundles of services are offered to GBV survivors. Currently, in KR-I, GDCVAW is in the best position to create a network of such "hubs" – bringing together protection, psychosocial help, case management, access to justice and strengthened link to healthcare facilities. In the rest of the country, Family Protection Units can carry similar function. However "hubs" need stronger mandate, capacity building, administrative and financial resources. Health sector can also provide such opportunity for "hubs" placed on the hospital level, with GBV incorporated into reproductive health, training of hospital-based police officers and placing psychosocial help in the hospital venues.

To expand the opportunities for survivors' access to services through increased coordination within GBV Sub-Cluster, the members should

• Continue increasing the quality of information shared through referral pathways charts/lists, service mappings (with updates reflected on a monthly basis).

• Develop a mechanism for follow-up on GBV cases referred from one GBV Sub-Cluster member to another and synchronize information sharing protocols of member organizations.

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ADDENDUM I

FGDs and KIIs revealed that shelter arrangements carry specific set of GBV risks for IDP women and girls. The results are displayed in the Table below[66].

Table 2. Type of residence and risk of GBV

The table allows to determine the main areas of concern and helps to determine preventive measures needed to decrease the risk of GBV for IDP women and girls. Depending on the prevalence of certain shelter arrangement in specific governorates, service providers working on GBV prevention face unique challenges in each of the selected governorates.

		Type of residency	CAMP
	Lack of privacy inside the residence venue (conducive to IPV or domestic violence)		XXX
	Lack of public lighting (exposes residents to physical /sexual attacks)		XX
	Tents, buildings , bathrooms/ latrines lacking proper doors, or locks, latrines unsegregated[67] (exposes residents to intrusion, physical/psychological/sexual violence)		XXX
	Eviction (exposes residents to intimidation, physical, sexual violence, sexual harassment)		X
	Relations of dependency outside of family: landlord, illegal employer, sponsor (intimidation, physical, sexual violence, sexual harassment)		X
	Poor / no access to public services, (facilitates the impunity of violence perpetrators prevents GBV survivors from receiving help)		XXX
	Lack of protection i. e. no camp policing, being far from the police precinct, no police patrols (exposes IDPs to GBV in private and public spaces)		XX

IDPs residing in critical shelters (unfinished buildings, religious buildings, illegal settlements) are specifically hard to access with services for GBV survivors. In addition, IDPs in critical shelters often are subject to evictions and lack basic facilities (water, electricity, latrines) which makes them particularly vulnerable to a heightened risk of GBV. IDPs in critical shelters are present in high numbers in the following governorates: Najaf (the highest share of IDPs living in religious buildings), Kerbala (high share of IDPs in various critical shelters), Kirkuk (high number

66. The information presented in the Table derives from FGDs, KII with service providers (working in all selected governorates) and camp management (IDP/refugee camps in Dahuk, Erbil and Sulaymaniyyah)

XXX represent high risk, XX – moderate risk, and X – low risk

CRITICAL SHELTER	RENTED HOUSING	HOST FAMILY	INFORMAL SETTLEMENTS
XXX	XXX	XX	XXX
XXX	XX	X	XXX
XXX	X	-	XXX
XXX	XX	-	X
XX	XXX	-	XXX
XXX	XX	XXX	XXX
XXX	XX	XX	XXX

of IDPs with unidentified residency type, over 8000 living in informal settlements and over 27,000 in unfinished buildings), Dohuk (over 68,000 IDPs residing in unfinished buildings and over 17,000 in informal settlements) and Baghdad (over 19,000 in informal settlements and almost 11,000 in unfinished buildings).[68]

67. According to the study of GBV risks for the residents of critical shelters, 64% of latrines in such shelters lacked locks or were unsegregated. GBV risks amongst IDPs Living in Critical Shelters and Camps, International Organization for Migration (IOM), September 2015

68. Table 4.1, Number of IDPs by shelter category, May 2016, IOM Displacement Tracking Matrix(DTM) Round 44, April 28, 2016, http://www.uniraq.org/index.php?option=com_k2&view=itemlist&layout=category&task=category&id=161&Itemid=626&lang=en (last accessed on May 20, 2016)


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United Nations Population Fund

Contacts

UNFPA Iraq: Main Office: UN Compound- Baghdad/Iraq.
Regional Office: UN Compound- Erbil, Kurdistan Region/ Iraq.

Website: http://iraq.unfpa.org/
Facebook: https://www.facebook.com/UNFPAIraq/
Twitter: https://twitter.com/UNFPAIraq