MULTI-COUNTRY REAL TIME EVALUATION OF UNICEF GENDER-BASED VIOLENCE IN EMERGENCIES PROGRAMMES

SOUTH SUDAN COUNTRY REPORT

CHILD PROTECTION SECTION
PROGRAMME DIVISION
July 2016
MULTI-COUNTRY REAL TIME EVALUATION OF UNICEF GENDER-BASED VIOLENCE IN EMERGENCIES PROGRAMME

SOUTH SUDAN COUNTRY REPORT
United Nations Children’s Fund  
3 United Nations Plaza  
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July 2016  

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This report for South Sudan is one of seven country evaluations which form part of the Multi-Country Real Time Evaluation of UNICEF Gender-based Violence in Emergencies Programmes global evaluation. The South Sudan country report was prepared by Vine Management Consulting Ltd, an independent company recruited by the Child Protection Section of Programme Division to conduct this evaluation. A five-person internal UNICEF Evaluation Management Group was responsible for the management of this evaluation including inputs to quality assurance.

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For further information, please contact:

United Nations Children’s Fund  
Three United Nations Plaza  
New York, New York 10017  
evalhelp@unicef.org
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The Evaluation Management Group, whose responsibilities have included supervising and guiding the evaluation team in each step of the process; reviewing, commenting and approving the evaluation deliverables; approving the final report and supporting dissemination and management response process, is comprised of Mendy Marsh, GBViE Specialist, CPS, Krishna Belbase, Senior Evaluation Specialist, Evaluation Office, Jennifer Keane, CP Specialist on Knowledge, Planning and Evidence, and Laili Irani, Senior Adviser, Gender & Evaluation, Gender Section and Sophie Read-Hamilton, GBViE Consultant with the CPS.
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<td>CRSV</td>
<td>Conflict-related Sexual Violence</td>
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<td>DDR</td>
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<td>GoSS</td>
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<td>GPAA</td>
<td>Greater Pibor Administrative Area</td>
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<td>HCT</td>
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<td>HRBP</td>
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<td>ICF</td>
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<td>IEC</td>
<td>Information, Education &amp; Communication</td>
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<td>IGP</td>
<td>Inspector General of Police</td>
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<tr>
<td>INGO</td>
<td>International Non-Government Organization</td>
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<tr>
<td>IP</td>
<td>Implementing Partner</td>
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<td>IPV</td>
<td>Intimate Partner Violence</td>
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<td>IMC</td>
<td>International Medical Corps</td>
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<td>IRC</td>
<td>International Refugee Committee</td>
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<tr>
<td>JTWG</td>
<td>Joint Technical Working Group</td>
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<td>NGO</td>
<td>Non-Government Organization</td>
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<tr>
<td>MARA</td>
<td>Monitoring, Analysis and Reporting Arrangements</td>
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<td>MoGCSW</td>
<td>Ministry of Gender, Children and Social Welfare</td>
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<tr>
<td>MRM</td>
<td>Monitoring and Reporting Mechanism for grave violations against children</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
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<td>PBEA</td>
<td>Peacebuilding, Education and Advocacy</td>
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<td>PoC</td>
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<td>PSEA</td>
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<td>PSS</td>
<td>Psycho-social Support</td>
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<td>RC/HC</td>
<td>Resident Coordinator/Humanitarian Coordinator</td>
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<td>RTE</td>
<td>Real Time Evaluation</td>
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<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
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<td>SEA</td>
<td>Sexual Exploitation and Abuse</td>
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<td>SOP</td>
<td>Standard Operating Procedures</td>
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<td>SPU</td>
<td>Special Police Unit</td>
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<td>SRDA</td>
<td>Sudd Relief and Development Agency</td>
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<td>SSCO</td>
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<td>SSDP</td>
<td>South Sudan Development Plan</td>
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<td>ToC</td>
<td>Theory of Change</td>
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<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNMISS</td>
<td>United Nations Mission in South Sudan</td>
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<tr>
<td>USAID/BPRM</td>
<td>United States Agency for International Development/Bureau for Population, Refugees &amp; Migration</td>
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<tr>
<td>WOCO</td>
<td>Widows, Orphans and Children’s Organization</td>
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EXECUTIVE SUMMARY

The Child Protection Section of UNICEF’s Programme Division, New York, is undertaking a multi-country real time evaluation of UNICEF’s Gender-based Violence in Emergencies (GBViE) programming with the overall purpose of strengthening UNICEF’s current and future GBViE programming based on real time learning. The core of the evaluation is seven RTEs which are being conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic and a brief study of the GBViE programme the Democratic Republic of Congo conducted by telephone.

This report presents the findings, conclusions and recommendations of the mission conducted in South Sudan, March 7-18, 2016.

CONTEXT

After decades of conflict that effectively halted its development, South Sudan signed a peace agreement with Sudan in 2005, formally gaining independence in 2011. Development efforts have been severely compromised by myriad social, political and economic challenges—most notably since December 2013, when a power struggle erupted between President Kiir and his ex-deputy Riek Machar. Subsequent fighting between rebels and government forces resulted in the loss of thousands of lives and massive displacement. Despite the fact that an Agreement on the Resolution of the Conflict in the Republic of South Sudan was signed in August 2015 and both sides have recently taken steps to implement the agreement, violence continues between armed actors in hotspots across South Sudan. In addition to the conflict, communities are struggling with inter-communal violence (on-going for generations), including as a result of cattle raiding. GBV is a widespread concern. In late-2014, the Special Representative to the Secretary General (SRSG) on Sexual Violence in Conflict stated the situation for women and girls is the worst she has seen in her thirty-year career in health and women’s rights. Further to that, UNICEF’s 2015 Situation Assessment of Children and Women in South Sudan suggests that the problem is worsening, rather than improving. In this context of increased need, donor fatigue and diversion of resources to other humanitarian crises has resulted in a decrease in funding in 2016, which is expected to continue.

CONCLUSIONS:

Successes

1. UNICEF’s GBV-specific programming in South Sudan is informed by regular assessments and monitoring to enhance the ability of programmes to meet the needs of beneficiaries. A focus on prevention, risk mitigation and response has been prioritized in line with a South Sudan Country Office (SSCO) GBV strategic plan relevant to the needs of South Sudan and in line with the GBV Subcluster (SC) strategy. UNICEF’s focus is also highly consistent with global good practice for addressing GBV in emergencies as well as core UNICEF strategies and UNICEF’s draft GBViE Programme Resource Pack. (Relevance)

2. UNICEF’s WASH-GBV project not only represents a model for good practice in integrated programming, it is a strategic approach to generating funds for GBV programming insofar as donors report enthusiasm for supporting integrated initiatives. The WASH-GBV initiative facilitated strong relationships between the WASH and GBV teams because of the need to plan and write joint donor proposals, and has also raised the profile of the value of integrated approaches within the UNICEF SSCO. (Relevance)

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1 This represents a brief overview of key findings and conclusions. Points are discussed more fully in the relevant sections of the report. The “Successes” and “Gaps and challenges” conclusions follow a general order in alignment with the findings.
3. **UNICEF has developed a number of contextually responsive and innovative approaches** that not only contribute to overall effectiveness of its GBV interventions in South Sudan, but also represent models for good practice that could be replicated globally. These include participatory approaches in designing and implementing its GBV strategy, graduated capacity building of local implementing partners through a tiered model of support, systems building through training and support to police and social workers, monitoring and evaluation mechanisms and community-based prevention work. (Effectiveness and Sustainability/Connectedness)

4. **UNICEF employs flexible strategies to improve coverage** in the highly challenging environment of South Sudan, including the tiered capacity building approach of local partners and mobile Clinical Management of Rape [CMR] training teams. (Coverage)

5. **UNICEF has a good relationship with the Government of South Sudan (GoSS) and a history of working successfully on legal and policy reform (e.g. the Child Act of 2008) that positions the office well for scaling up efforts to support the government to develop a legal and policy framework for GBV which is aligned with international good practice, as well as to support the government to endorse and implement the Standard Operating Procedures (SOPs) for GBV.** (Relevance and Sustainability/Connectedness)

6. **UNICEF has the largest UN programme focusing on GBV and is a leader in standard-setting initiatives that provide critical guidance and serve to establish a performance baseline in South Sudan, such as supporting the development of the CMR training and developing Women and Girls Friendly Space (WGFS) Guidelines.** (Coordination)

7. Given UNICEF’s significant contributions to GBV work in South Sudan, **UNICEF’s leadership role in coordination activities has been critical.** UNICEF participates in many coordination fora at the national level that ensure its support to a variety of GBV-related initiatives. UNICEF’s leadership in coordination at the state level in Upper Nile has resulted in effective and efficient response to GBV needs in Malakal, most recently illustrated in the rapid re-establishment of GBV-related services following fighting and looting in the Protection of Civilian (PoC) site that resulted in the destruction of a third of the PoC and the displacement of an estimated 30,000 IDPs. (Coordination)

8. **UNICEF also has a leading role in coordinating Protection from Sexual Exploitation and Abuse (PSEA) response in the Malakal POC, where UNICEF has facilitated training and has conducted community awareness-raising through its GBV programmes on access to services for complainants.**

9. **UNICEF has been able to achieve its GBV successes because of its investment in GBV staffing, including one P4 position.** The current GBV staffing levels (3 internationals staff and 1 national staff) are the very minimum necessary to implement its GBV programme in South Sudan given the huge scope of the problem; the low level of government capacity and relatively few international non-governmental organisations (INGO) working on GBV in South Sudan; and the nature of GBV prevention and response programming in South Sudan, which is particularly human resource intensive given the great need for capacity building/ongoing mentoring of national partners. (Efficiency)

10. **Support from the GBVIE Specialist at UNICEF headquarters has also been a contributor to the South Sudan CO’s successes in GBV programming.** The GBV team in South Sudan has received multiple support missions; fundraising support; technical review of key documents and resources (e.g. the capacity-building strategy); bi-weekly consultations linked to the Communities Care programme implementation, etc.

11. **UNICEF is a highly valued GBV partner in South Sudan** among the international and national community alike because of their technical competence and their participatory and partnership approaches. (Efficiency)
Gaps/Challenges

12. Due to an array of contextual challenges such as lack of infrastructure, limited functioning of government, few implementing partners, the need to prioritize care for sexual violence in the emergency response, etc., there are significant gaps in some programme areas, while others which are addressed are very limited in scale and geographic coverage.

- UNICEF’s support to a multi-sectoral approach does not yet include strategies for legal justice work, which is a service area of very limited capacity across all of South Sudan.
- UNICEF’s support to systems building of police and social workers has been limited to two sites.
- UNICEF (and other GBV actors) have not yet supported programming to address intimate partner violence (IPV) and child marriage, both of which are significant concerns in South Sudan.

13. Again due to contextual challenges and prioritization of sexual violence response, specialized GBV prevention work on GBV in South Sudan has been limited, with most prevention work focusing on community messaging. Importantly, however, UNICEF’s Communities Care social norms GBV prevention and response programme is currently being piloted in South Sudan (and Somalia) in two “green states”—meaning stable humanitarian sites. Several implementing partners (IPs) have recently been encouraged by UNICEF to adapt some aspects of Communities Care for use in their community outreach, but this is not yet being done in a standardised way. UNICEF has also drafted a terms of reference for support to standardize the community engagement to ensure good practice.

14. Targeted integrated risk reduction programming across UNICEF sections has been undertaken most comprehensively in the WASH-GBV project, with some other notable strategies for integration in the global Peacebuilding, Education and Advocacy (PBEA) programme and in proposals linked to DDR and justice for children. Other UNICEF sections have not evidently integrated GBV risk mitigation measures as recommended in the revised 2015 IASC GBV Guidelines (though they may be undertaking some risk mitigation work but not capturing it in any reporting). As well, GBV has not been integrated into two UNICEF structures that have the greatest monitoring reach in South Sudan: the Rapid Response Mechanism (RRM) and the state-level CP staff. This represents a significant missed opportunity for improving GBV-related protections for girls and women.

15. Although adolescent girls are a group which is at very high risk of GBV in general and particularly in South Sudan, GBV programming (both specialized and integrated) has not adequately focused on the needs of adolescent girls, including in WFS and Demobilization, Disarmament, and Rehabilitation (DDR) initiatives. CMR trainings currently include only basic information about caring for child and adolescent survivors.

16. WGFS are not functioning optimally to meet the needs of participants, particularly their livelihoods needs. Reportedly due largely to the need to generate income, women and girls are regularly leaving the POCs to collect firewood to sell, which puts them at risk of sexual violence. Challenges in mobilizing the United Nations Mission in South Sudan (UNMISS) patrols to accompany the women when they leave the sites is a major contributor to this situation. There is no programming for alternative fuel.

17. Different and non-comparable assessment tools used by IPs and other protection partners contribute to challenges in collating data on the nature and scope of GBV, including for key guidance.

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2 Many of these gaps and challenges are not specific to the SSCO, but are inherent challenges in working on GBV generally, and in working on GBV in the extremely complex environment of South Sudan.

3 The Rapid Response Mechanism has reportedly come to an end since the evaluation; however, the finding remains in order to highlight the value of integrating GBV monitoring in this mechanism if/when it is reinstated.
documents such as the Humanitarian Needs Overview. In addition, measuring and reporting on programme results remains a significant challenge in terms of the GBV team’s ability to illustrate the importance, value and impact of their work. This is a problem inherent to GBV programming, which the GBV team is trying to address in some measure by standardizing indicators for partners’ reporting, but which requires more attention and support from the GBV AoR community at the global level. (Effectiveness-Data)

18. Although there is a recognition in the SSCO of the value of linking emergency GBV work to the development agenda, there is to-date no clear plan for establishing and maintaining this link. A more explicitly articulated emergency/development strategy will allow UNICEF’s GBV programmes to continue to meet emergency needs as they arise, but to also accelerate programming approaches (e.g. legal reform and building multi-sectoral systems) critical to advancing the sustained safety of girls and women. (Sustainability/Connectedness)

19. There have been challenges in GBV Subcluster coordination at the national level which can be linked in part to the absence of clear terms and responsibilities of key GBV actors.

20. UNICEF leadership of the Monitoring and Reporting Mechanism (MRM) for grave violations against children has resulted in the development of monitoring systems to capture data on conflict-related sexual violence against children. UNICEF has also provided support to the Monitoring, Analysis, Reporting and Accountability (MARA) mechanism by contributing extensively to a draft information sharing protocol on the MARA as well as an annex in the GBVIMS ISP dedicated to when/how GBVIMS data can feed into MARA. However, UNICEF has not yet linked its leadership of the MRM to support the MARA mechanism. Nor has UNICEF exploited its relationship with UNMISS through the MRM to conduct advocacy around accountability for POC firewood patrols. (Coordination)

21. Limited support for the GBV programme has been provided from the Regional Office as, until recently, there has been no Gender or GBV Advisor who could provide technical assistance or support to the CO to mobilise additional resources for GBV. This led to missed opportunities for sharing good practice. (Coordination)

22. The funding to overall programming in South Sudan, and particularly protection programming, is declining, while needs are increasing. The SSCO’s reliance on one major donor for the majority of its GBV programme makes the GBV programme highly vulnerable. Although joint partnerships are often a useful way to generate donor support, particularly for large-scale programming, to date UNICEF has not engaged in any joint partnerships for GBV programming. (Efficiency)

23. While some efforts have been made to improve Protection from Sexual Exploitation and Abuse (PSEA) in the UNICEF SSCO and among IPs and the community in the Malakal POC, understanding by staff interviewed in Juba about mechanisms for support to complainants through GBV referrals appears limited. The reporting channels are not well-defined for the SSCO and it is not clear how survivor response to PSEA can and should be linked to GBV service delivery.

RECOMMENDATIONS

RECOMMENDATION 1. Build on the SSCO’s existing GBV specialized programming approaches in order to improve prevention and response programming across the emergency to development continuum.

a. In the short term, with a focus on emergency response in order to improve effectiveness and quality of existing programming:

i. Lead rollout of the new WGFS Guidelines and use the rollout as an entry point for monitoring effectiveness of WFS to meet needs of participants, especially adolescent girls and survivors of IPV. Where expertise and resources permit and in line with the new Guidelines, identify and implement feasible livelihoods (e.g. soap-making) and basic skills development in WGFS
to reduce women’s and adolescent girls’ protection risks linked to income generation, particularly in relation to firewood collection.

ii. Undertake an assessment to determine the value of reintroducing fuel-efficient stove strategies in the PoCs, while also joining with other protection partners (e.g. UNFPA and UNHCR) to conduct advocacy with UNMISS to meet their responsibilities in leading firewood patrols outside the PoCs.

iii. Strengthen integration of specialized approaches to caring for child and adolescent survivors in case management and CMR training and make sure that drugs are procured for child dosages as per guidance in the UNICEF/IRC Inter-agency GBViE Case Management Guidance and Toolkit (to be released before end of 2016).

iv. Develop and implement a strategy for rolling out select components (e.g. the social norms prevention component, and, in some contexts, the community-based care component) of the Communities Care programme in emergency-affected locations through an adapted approach relevant to the specific settings.

b. In the longer-term, with an eye to developing a more comprehensive approach to GBV in relatively stable areas of South Sudan:
   i. Using UNICEF’s leverage with the GoSS, and in collaboration with the GBV SC, vitalize the approval process for the national Standard Operating Procedures (SOPs) and roll them out at state level, using the rollout as an opportunity to identify additional geographic areas for priority support.
   ii. Take police training to scale by introducing GBV into the national police college training curriculum.
   iii. Capitalize on strong relationships with the GoSS to support legal reform and bring it in line with international good practice, particularly in relation to a law against IPV. Support the implementation of GBV elements of the Child Act of 2008.
   iv. Undertake an assessment (building existing research) followed by a preliminary test project on child marriage to identify key drivers as well as safe and ethical approaches to address the issue and feasibility of scaling up prevention initiatives across South Sudan. Consider a joint project to address child marriage with UNFPA and other partners, taking advantage of and learning from UNFPA and UNICEF’s global partnership on this issue.

Lead responsibility: CP GBV Team
When: 2016-2017

Recommendation 2: Strengthen integration of GBViE across all UNICEF sectors in line with the 2015 IASC GBViE Guidelines recommendations, with the objective of each sector proactively leading integration in all phases of the programme cycle.

a. Use the rollout of the 2015 IASC GBV Guidelines in South Sudan during 2016 as a catalyst for all UNICEF sections to adopt relevant recommendations from the Guidelines on systematic integration of GBV prevention and risk mitigation strategies in their humanitarian response, with indicators to be monitored regularly in the Results Assessment Module (RAM).

b. Ensure Chiefs of Section identify a focal point to work with a dedicated (short-term) GBV specialist to support this systematic integration across programmes.

c. Maximise existing entry points for each sector to strengthen GBV risk mitigation, e.g. scaling up integrated elements of the WASH-GBV joint project across all UNICEF-supported WASH interventions; ensuring successes from the PBEA project are carried forward into the regular education programme and that additional strategies (e.g. lifeskills) are introduced into Education programming to address the protection needs of adolescent girls; supporting implementation of the GBV elements in the
RECOMMENDATION 3. Ensure ongoing UNICEF commitment to GBV and adequate levels of dedicated staffing for the GBV team in order to facilitate prevention, risk mitigation, response and coordination that is in line with global UNICEF mandates and guidance.

a. Ensure that the current level of staffing, including one P4 and two P3s (one specifically focused on capacity building of local partners, including capacity in adapting Communities Care work in emergency affected locations), is retained.

b. Introduce a dedicated (short-term) GBV specialist to the team to work with section focal points to facilitate integration of GBV across UNICEF sectors as per the revised 2015 IASC GBV Guidelines.

c. Clarify UNICEF corporate commitments on GBV within the CO to all staff, and the respective areas of focus of the GBV and Violence Against Children (VAC) approaches. Through the leadership of the CP team at UNICEF HQ, work with them to finalize and distribute an internal briefing paper as part of the clarification process for circulation around all staff in the CO, as well as an external advocacy note clarifying UNICEF’s areas of focus and commitment to addressing GBV in South Sudan.

d. Explicitly link GBViE programming to longer-term development programming within country programme documents and in the SSCO GBV Strategy for 2017. Highlight specific preparedness activities for GBV which the SSCO will undertake for ongoing and future emergencies.

f. Establish a dedicated GBV position at the East and Southern Africa Regional Office to provide technical support to SSCO GBV programming and support in mobilising additional funding, as well as conducting advocacy at the regional level and facilitating regional coordination of GBV partners.

g. Ensure UNICEF leadership at the country and regional level prioritise the identification of funds to support immediate and long-term GBV programming.

Lead responsibility: CO Senior Management, Chief of CP, CP Team, Regional CP Advisor, Regional Deputy Director, Regional Gender Advisor

When: On-going

RECOMMENDATION 4. Strengthen the evidence base to improve understanding of need as well as to demonstrate programme effectiveness. Collate and disseminate the evidence of need as well as good programme practice nationally, regionally and globally.

a. Work with UNICEF GBV partners to standardize assessment tools and data collection measures in order to consolidate monitoring data and strengthen shared knowledge of the nature and scope of the problem of GBV in South Sudan as well as effective interventions. Support the GBV SC to also undertake this work as a core function.
Work with UNICEF GBV partners and the GBV SC to develop a few key messages (that include South Sudan and global data on GBV) to increase all GBV partners’ ability to speak with one voice around key issues of concern and have the messages clearly heard by national and international actors.

Build on the UNICEF 2015 *Situational Assessment of Children, Adolescents and Women* with more targeted analysis on GBV issues, particularly intimate partner violence and child marriage, with an eye to identifying factors linked to an enabling environment to address these issues, so to determine the most feasible entry points for programming.

Leverage UNICEF’s leadership of the MRM and its support to the MARA to develop linkages among the MRM, MARA and UNMISS in documenting, reporting and conducting advocacy on conflict-related sexual violence (CRSV) through an Information Sharing Protocol (ISP) that includes MARA, MRM, and UNMISS. Also ensure MRM training includes capacity-building on providing basic psychological first aid (PFA) for survivors.

In coordination with RO and HQ, dedicate staff time to document innovative and best practice programmes, such as the tiered approach to capacity building, and disseminate these regionally and with other COs and with the Child Protection Section in New York. Consider bringing in a consultant to support this documentation.

Continue standard setting through publication in professional journals of the monitoring and evaluation outcomes prioritized in the UNICEF SSCO 2016 GBV Strategy, such as results from the Communities Care programme and the integrated WASH-GBV project.

**Lead responsibility:** GBViE Specialist, RO Gender Advisor

**When:** Immediately and ongoing

**RECOMMENDATION 5.** Scale up leadership on PSEA and strengthen understanding in the CO on appropriate responses and processes.

Through support from a short-term PSEA specialist training consultant who is under the supervision of senior management, and in collaboration with the UNICEF CO PSEA focal points, finalize training materials on PSEA. Engage the GBV team to include information about safe and ethical referral pathways in the training. Roll out to all staff and IPs, with more specialized training for the PSEA focal points and for GBV IPs on receiving reports and providing referrals.

Advocate with the HC/RC to revive the PSEA In-country Focal Point Network.

Complete guidance note for the HCT related to PSEA responsibilities.

**Lead responsibility:** Deputy Representative, Human Resources Chief

**When:** Immediately
1 INTRODUCTION

1.1 UNICEF’s Approach to GBViE
UNICEF defines Gender-based Violence (GBV) as 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. This definition draws on UNICEF’s core mission to protect the health and well-being of children and women and its mandate to support states and other duty bearers, civil society and communities to prevent all forms of violence against children and women in emergencies, including GBV, and to ensure availability of appropriate systems and services for children and women survivors.

UNICEF is committed to providing comprehensive and coordinated programming across sectors to address the rights and needs of girls and women at risk of GBV holistically, leveraging UNICEF’s leadership and programming across humanitarian response, especially in Child Protection (CP), Education, Health, HIV/AIDS, Nutrition and WASH sectors. In addition to a programme response, UNICEF is global co-lead of the GBV Area of Responsibility (AoR), part of the Global Protection Cluster, with associated responsibilities for coordination and as a provider of last resort.

The Theory of Change (ToC) for UNICEF GBViE programming (see below) has been developed by the evaluation team and the Child Protection Section (CPS) Gender-based Violence in Emergencies (GBViE) Specialist based on the Resource Pack and other UNICEF GBViE guidance and strategies. The ToC was used to inform the evaluation approach and tools and is discussed during country evaluations with CO colleagues. As relevant the ToC will be updated to reflect evaluation findings.

1.2 Impact of Armed Conflict and Natural Disasters on GBV
GBV occurs in all societies in the world. However, conflict situations and disasters typically intensify many forms of GBV with which children and women live, even in times of peace and stability. Tensions at household level can increase intimate partner violence (IPV) and other forms of domestic violence (DV) specifically aimed at females and affecting all children. The pervasive impunity which characterizes conflict settings can exacerbate sexual violence, including its use as a weapon of war. Poverty, displacement and increased dependency resulting from crises may increase the risk for women and girls of being forced or coerced to engage in sex in return for safe passage, food, shelter or other resources. Insufficient security in camps and informal settlements increases the risk of sexual and physical assault, as well as trafficking.

The consequences of exposure to violence are as extensive as the scope of violence itself, in terms of the myriad acute and chronic health problems that accompany many types of GBV, and because victimization

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4 UNICEF programmes to address GBViE generally focus on the rights and needs of women and girls given their high vulnerability to violence rooted in systemic gender-based inequality in all societies and the importance of developing targeted programming to address violence against them. While prioritizing the protection of women and girls within UNICEF’s GBViE programmes, UNICEF’s CP programmes may target specific protection-related rights and needs of boy survivors and those at risk, promoting their access to care and support.


PROBLEM: GBV is exacerbated in an emergency environment (women and girls are more vulnerable to GBV in an emergency)

DRIVERS: Conflict drives violence against women and girls; social systems break down; existing power imbalances increase vulnerability and lack of information for women and girls; adequate care and support is limited.

SUPER IMPACT: Women and girls are able to access their rights and live with equal value and dignity to men.

IMPACT: Improve the safety and wellbeing of women and girls in emergencies.

THE LIKELIHOOD OF GBV OCCURRING IS REDUCED

Ongoing response and recovery: Sector programmes mitigate risk and build resilience to GBV; women and girls are meaningfully engaged in humanitarian programming; violations of IHL are identified and actions taken to address them.

Immediate: Humanitarian actors recognize the urgency of addressing GBV; GBV risks, vulnerabilities and threats are identified and action taken to address them; resources and services are available to meet women and girls’ specific safety, dignity and protection needs.

SURVIVORS BENEFIT FROM APPROPRIATE CARE

Ongoing response and recovery: Women and girls are safely accessing appropriate and coordinated response services; referral systems in place for all GBV survivors; coverage and quality of services strengthened; actions taken to improve access to services.

Immediate: Life-saving services are put in place (health, psychosocial, safety) and communities are informed about them.

CONDITIONS THAT FOSTER GBV ARE TRANSFORMED

Ongoing response and recovery that starts through the Law and policy that promote women and girls’ rights are implemented; relevant social norms that promote equality, safety and dignity begin to take hold; communities are taking action to prevent violence against women and girls; women are empowered.

OUTCOMES

MITIGATE RISKS

- Advocate for prioritisation of GBV
- Implement and monitor essential actions outlined in the IASC GBV Guidelines across clusters/sectors

BUILD RESILIENCE

- Community safety assessments
- Distribute dignity kits
- Establish safe spaces
- Integrate GBV into DRR efforts

PROMOTE ACCOUNTABILITY

- Monitor CRSV
- Engage and advocate with duty bearers to comply with IHL
- Advocate for PSEA

PROVIDE QUALITY SERVICES TO SURVIVORS

- Make health, psychosocial and safety services available
- Identify and addressing barriers to accessing services
- Strengthen quality of available services
- Publicize information about availability and benefits of survival
- Establish/strengthen referral systems, including for victims of PSEA

LAY THE FOUNDATION FOR LONG-TERM CHANGE

- Economic and social empowerment interventions for women and girls
- Programming to shift harmful social norms
- Support legal and policy reform and build capacity of government to implement and enforce them

STRATEGIC INTERVENTIONS

- Leverage resources and supplies (procuring PEP kits, dignity kits, donor support)
- Develop capacity
- Provide TA across sectors and clusters
- Promote GBV Guidelines and uphold standards across all sectors
- Facilitate knowledge generation and exchange
- Coordinate humanitarian actors (at national and sub-national level)
- Advocate across humanitarian system (to ensure prioritization of and action around GBV prevention and response)

- Take on responsibilities when government cannot
- Advocate for and monitor compliance with international laws and norms
- Advocacy and technical support for enactment and enforcement of appropriate laws, policies, and protocols
- Leverage connections
- Fund services and programmes
- Develop capacity

- Promote accountability for PSEA
- Fund programmes/partners
- Develop capacity
- Providing TA to enhance programme quality
- Promote GBV Guidelines and uphold standards across all sectors
- Facilitate knowledge and learning exchange

This facilitates strategic interventions in the following areas.

Support STATE and other duty-bearers to uphold responsibilities to address GBV.

Support CIVIL SOCIETY to address GBV.
can increase risk of future ill-health for survivors. In humanitarian settings, where community support systems and formal health and psychosocial services are often severely compromised, the results can be even more profound than in peacetime. The extent and impact of GBV not only affects survivors, it also limits the ability of entire societies to heal from conflict. Violence may affect child survival and development, raising infant mortality rates, lowering birth weights and affecting school participation. GBV can limit women’s access to reproductive health services including family planning, leading to unwanted pregnancies and unsafe abortions, and increasing women’s risk of contracting sexually transmitted diseases. At the same time that GBV increases costs to public health and social welfare systems, it decreases women’s and children’s voices, agency and ability to participate in social and economic recovery.

While the primary responsibility to ensure people are protected from violence rests with the State, humanitarian actors play an important role in supporting measures to prevent and respond to GBV. According to the *IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action, 2015,* (‘2015 IASC GBV Guidelines’) “All humanitarian actors must be aware of the risk of GBV and—acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their areas of operation” (p 14). This responsibility is supported by a framework that encompasses international and national law, UN Security Council Resolutions, Humanitarian Principles and Humanitarian Standards and Guidelines.

1.3 Background to the GBViE Evaluation
In the past decade, UNICEF has been at the forefront of efforts to prevent and respond to GBV in emergencies, both globally and at country level. UNICEF HQ is committed to supporting Regional and Country Offices (ROs/COs) to continue to deliver on UNICEF’s mandate to protect children and women from GBV, and ensure the well-being of all children, through consistent and effective GBV prevention and response in emergencies. The Child Protection in Emergencies Team (CPiE), is currently developing a range of resources for COs to use for designing, monitoring and evaluating stand-alone GBV programmes and improved integration of GBV prevention and response across all sectors of UNICEF’s humanitarian response, in line with the Core Commitments for Children (CCCs) and other humanitarian standards. This includes the development of the new UNICEF GBViE Programme Resource Pack (‘Resource Pack’).

To facilitate continuous learning and improvement within UNICEF’s ongoing GBV response in emergency-affected countries and to inform the development of the Resource Pack, the CPiE Team of the CP5, in collaboration with ROs and COs, is undertaking this multi-country evaluation of UNICEF’s GBViE programming. The evaluation is being conducted between November 2015 and July 2016.

2 EVALUATION SCOPE AND METHODOLOGY
2.1 Purpose and Objectives
The overall purpose of the multi-country GBViE evaluation is to strengthen UNICEF’s current and future GBViE programming based on real time learning.

The objectives are to:
1. Assess GBViE programming in UNICEF country programmes using standard criteria for evaluating humanitarian action to generate learning that informs future UNICEF GBViE programming.
3. Develop a real-time GBViE programming evaluation methodology that can be used by UNICEF and other GBViE actors.

4. Develop recommendations to help UNICEF operationalise its organizational commitments to GBViE at HQ, regional and country levels.

During the country missions, the evaluation team focused primarily on objective 1 (above), but has also addressed objective 2, especially through the short case studies and the longer comparative Intervention Specific component of the evaluation. Objective 3 was addressed through the inception phase when the evaluation tools were developed, and was also a particular focus of the first two missions (to Pakistan and Lebanon), after which some tools were revised. But through each of the country missions the team has been aware of minor revisions which were required in the evaluation tools in the light of the particular context. The final version of the tools is included in the final overall evaluation report as well as in the Resource Pack (see below). Objective 4 has been addressed in the country reports with recommendations developed for the specific countries visited. The recommendations in the final evaluation report focus on agency-wide and some regional level recommendations.

This evaluation assesses UNICEF’s programming response to GBV in seven current emergencies against standard criteria for evaluating humanitarian action, namely: relevance, effectiveness, connectedness/sustainability, coordination, coverage and efficiency. Evaluation questions to be addressed under each of these criteria are included in Annex 1.

For this RTE, guidance on good programming practice from two documents is being used as the benchmarks on which UNICEF GBViE programmes should be modelled, representing current thinking on best practice for GBViE programming for specialised and integrated programming respectively:

(i) The GBViE Programme Resource Pack (the ‘Resource Pack’) currently being developed by the Child Protection Section of Programme Division, (CPS) provides detailed guidance for conducting assessments and designing and implementing specialised GBV programmes relevant to UNICEF’s operations. The Resource Pack (due to be finalized in 2016) includes information and resources for implementing a minimum package of essential services for GBV protection and response in the aftermath of an emergency or population displacement. It also contains guidance for expanded programming to strengthen structures, systems and services and institutionalize prevention, protection and response to GBV during ongoing response and throughout recovery.

(ii) The recently launched IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action, 2015, (‘2015 IASC GBV Guidelines’) provides detailed guidance and good practice

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8 This component will provide a comparative study across several of the evaluation mission countries, in more depth than the short case studies, of three types of intervention: child marriage, safe spaces and capacity strengthening activities and strategies which will inform the Resource Pack and provide examples of good practice for these GBV interventions.

9 To clarify programming terms being used in the evaluation as well as the nature of GBViE programmes to be evaluated:

‘GBV specific programmes’ are understood to be:

(a) Multi-sectoral response and referral services for survivors focusing on health care; security (including safe spaces) and psychosocial support (including within schools);

(b) Dignity kits (distributed by Child Protection (CP) and Water, Sanitation and Hygiene (WASH) teams or just CP teams), economic strengthening for adolescent girls, community based protection activities;

(c) Prevention programming including work on social norms, economic and social empowerment of women and girls, legal and policy reforms.

‘Integrated’ programming refers to the mainstreaming of GBV prevention and risk mitigation approaches/activities across other sectors.

2.2 Evaluation Focus and Scope
The evaluation includes data gathering at global, regional and country levels. The core of the evaluation is seven real time evaluations (RTEs) which are being conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic, with missions lasting one to two weeks each and one brief country assessment conducted remotely for the Democratic Republic of Congo. The primary focus of the evaluation is on learning:

- To promote learning in each of the RTE COs on how existing programmes can be enhanced in the light of good and emergent practice as captured in the 2015 IASC GBV Guidelines and in the Resource Pack; and,
- To promote learning at HQ and ROs through the CO reports and the final evaluation, as well as short case studies of good practice and a detailed comparative review of three GBViE specific interventions across three to four of the mission countries which will inform the development of the GBViE Resource Pack.

To provide an overall picture of UNICEF’s GBViE programming, a mapping exercise is being conducted by electronic survey of 39 UNICEF COs which are reporting against corporate targeted priorities within the Gender Action Plan (GAP).

Implementing Partners
Any evaluation of UNICEF programming means, de facto, an evaluation of the programming of their implementing partners (IPs). The country missions will clarify UNICEF’s role vis-à-vis their IPs and how these roles may differ in different contexts and in different types of emergencies. This will include clarification of the nature of support UNICEF staff are offering their partners, (national and international); and how UNICEF staff are overseeing partnerships and ensuring programme quality.

GBV Sub-clusters
The evaluation will not include an assessment of the global GBV Area of Responsibility (AoR), or of country level GBV sub-clusters (or other GBV coordination mechanisms) per se, as it is focused on the GBV programming function of UNICEF. It will, however, consider the extent/nature of UNICEF’s programming contribution in realizing sub-cluster strategy/plans for addressing identified gaps/priorities, and will address how the agency has added value to the whole GBV response (including leadership and advocacy activities) within the CO and across the response as a whole.

GBV and Sexual Exploitation and Abuse (SEA)
The evaluation ToR doesn’t specifically include SEA within the scope of this evaluation. However, in the light of the recent report on the UN response to allegations of SEA in CAR, several donor interviewees have indicated that UNICEF, in common with all UN agencies, needs to have clear policies and guidelines in place to implement the UN Secretary-General’s October 2003 bulletin: Special Measures for Protection

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10 The length of each mission is dependent on the extent of the GBV programme and access to programme areas.
11 An evaluation of the coordination function was not included in the ToR. Additionally, the UNICEF, via the Cluster Management Unit of UNICEF EMOPS and UNFPA HQ are undertaking a Review of the GBV AoR leadership function.
from Sexual Exploitation and Sexual Abuse. The evaluation scope therefore includes questions on the existence of protection from SEA (PSEA) policies and action plans, and familiarity with them by CO staff, and whether alleged victims of SEA are referred to for care and support services.

**Audience**

The primary audience for the overall evaluation findings and collated good practice is the CPS, (who commissioned the evaluation and will use the findings to inform future priorities as well as the GBViE Resource Pack). Findings will also be used by GBV specialists, CP specialists and Gender Advisors in Regional and Country Offices (CO) who are implementing, managing and providing support to GBV programmes. The secondary audience includes other sectors and UNICEF senior management at headquarters (HQ), Regional Offices (RO) and COs.

Given the paucity of evaluations on GBViE programming, it is hoped that the final evaluation report will also be of interest and use to non-UNICEF actors implementing and/or resourcing GBViE programmes.

**2.3 Methodology**

The evaluation is based on collection and analysis of primary and secondary data. Data collection includes document review (at global level and for each mission country); key informant interviews (KIIs) with stakeholders at global, regional and country levels; focus group discussions (FGDs) with programme beneficiaries in country; and field observation by the evaluation team. As a learning tool for country office personnel, staff are being asked to assess their programming against good practice checklists based on the 2015 IASC GBV Guidelines and the Resource Pack that were distributed prior to and during the field trips. National consultants are recruited to support the evaluations in each country to ensure that approaches and tools used are culturally sensitive and appropriate, and to support the team with language translation.

The evaluation team are visiting a selection of projects in each mission country to make field observations, interview IP staff and conduct FGDs with different groups of beneficiaries. Criteria have been developed for the selection of projects to be visited, but, in practice, final decisions have been taken by the CO evaluation focal point and CP Chief in advance of the evaluation team mission in light of accessibility, willingness of IPs to host visits and arrange FGDs, those projects with the most learning potential, and safety of beneficiaries, in-country staff and partners and the evaluation team.

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13 ST/SGB/2003/13, 9 October 2003
14 UNICEF and all other protection actors are obliged to mainstream prevention of GBV within all programmes. Along with mainstreaming GBV prevention, UNICEF also delivers targeted programming where possible to address identified risk factors for GBV. All of these efforts will contribute to protection against SEA.
15 SEA committed by UN/UNICEF staff or related personnel against any persons of concern is based on abuse of power and—in the case of women and girls, who are the primary victims of SEA—gender inequality and gender discrimination. The SG’s Bulletin requires that all humanitarian personnel ensure action is taken to prevent SEA in their areas of operation, and report it when they observe any risks or abusive behaviour. PSEA should link with GBV programming to ensure survivors’ rights are respected and to improve victim assistance and the development of community-based complaints mechanisms. SEA agency focal points should link with GBV actors to develop referral systems that support survivor-centered care. While CP and GBV staff in UNICEF country programmes should know and promote the key principles and standards of conduct outlined in the Secretary-General’s Bulletin, the accountability for PSEA lies with senior management (Country Representatives) and human resources (Heads of Human Resource Departments). The IASC GBV Guidelines fully support the mandate of the SG’s Bulletin and provide several recommendations within each sector guidance chapter on programming that mitigates SEA, including incorporating PSEA strategies into agency policies and community outreach.
16 Including both self-reported data by mission CO staff and data gathered by the evaluation team.
Tools developed by the evaluation team guide country mission preparation and data collection and analysis. These tools were reviewed the Evaluation Management and Reference Groups and were tested and refined during the first two missions. The final versions of the evaluation tools will be included in the Resource Pack to support future GBViE evaluations.

In line with RTE methodology, a workshop is held at the end of each country mission to share and validate the initial findings and reflect, with CO colleagues, about how the findings can be used to enhance GBViE programming in that setting.

A country mission report, based on the workshop presentation and discussion is drafted by the evaluation team, and reviewed by the COs and the Evaluation Management Group. The findings section of the country mission reports addresses the evaluation questions relating to each of the evaluation criteria. The country reports will inform the final, overall evaluation report.

2.4 Evaluation Management
The evaluation has been commissioned by the Child Protection Section (CPS) of UNICEF Programme Division, who also selected the case study countries and has closely overseen the process throughout.

A five-person UNICEF EMG was formed with responsibility for ‘daily management of the evaluation’ including supervision of the evaluation team, review of all products (Inception Report, tools, workplan, country and final reports, coordinate with the Evaluation Reference Group (ERG) and disseminate the final evaluation findings).

The Evaluation Reference Group (ERG) is composed of internal and external experts who provide quality oversight to the evaluation. Responsibilities include reviewing and commenting on the Inception Report, two early country reports and the draft final report, and sharing the final report with partners and networks. The ERG includes the following individuals: Mary Ellsberg, Director, Global Women’s Institute at George Washington University; Mazeda Hossain, Social Epidemiologist, London School of Hygiene and Tropical Medicine (LSHTM); Jina Krause-Vilman, Senior Area Practice Lead, Refugees, Gender and Livelihoods, Near East Foundation; Diana Jimena Arango, Senior GBV and Development Specialist, World Bank; Verena Phipps, Social Development Specialist, World Bank; Maha Muna, Regional Gender Advisor, UNICEF CEE-CIS; Michael Copland, Regional Child Protection Advisor, UNICEF ESARO; Laurent Chapuis, Regional Child Protection Advisor, UNICEF MENARO; and Kate Alley, Emergency Specialist: Assessment, Planning, Monitoring and Evaluation, Humanitarian Policy Section, UNICEF EMOPS.

3 SOUTH SUDAN MISSION OVERVIEW

3.1 Mission Overview
The country mission to South Sudan was conducted from March 7-18, 2016 by two consultants from the evaluation team. Interviews and focus group discussions were undertaken in Juba town and in Protection of Civilian (PoC) sites in Juba and Malakal. On the final day of the mission, a debriefing workshop was attended by ten UNICEF staff members, including the Chiefs of Child Protection and WASH, as well as representatives from CP, WASH, Education, Health & PM&E sections.

17 EMG Terms of Reference.
3.1.1 Data Collection
A country document review was compiled by the evaluation team before the mission to provide background for the evaluation team on the South Sudan and CO contexts as well as the humanitarian response and the current GBViE programme. During the mission additional programme documentation was received from the country office (CO) that has been used to inform this report.18

Good practice self-assessment checklists for integrating GBV were completed by all UNICEF programme sections: 12 checklists were completed by CP; 5 by Education; 4 by Health; 5 by Nutrition; and 4 by WASH. Three UNICEF GBV specialists completed the GBV-specific self-assessment.

A total of 77 interviews (45 female, 32 male) were conducted with UNICEF staff and partners in government, UN agencies, INGOs, civil society organisations (CSOs)/Implementing Partners (IPs). Four FGDs were conducted in Juba (beneficiaries of Confident Children out of Conflict [CCC] programmes) and Malakal (clients of International Medical Corp’s [IMC] Women Friendly Space [WFS]) with women, adolescent girls and adolescent boys.19

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF staff</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Government</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>UN Agencies</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Donors</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>INGO/CSO/Academic/Other</td>
<td>23</td>
<td>14</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total KII</strong></td>
<td></td>
<td></td>
<td>77</td>
</tr>
<tr>
<td>FGD-adult female only</td>
<td>38</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>FGD – adolescent (15-24) and adult female*</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FGD – adolescent male (15-24)</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total FGD and KII</strong></td>
<td>45</td>
<td>32</td>
<td>77</td>
</tr>
<tr>
<td>* Note, that female adolescents and adults were combined in one focus group</td>
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3.1.2 Limitations
A key limitation of this mission was that only one field site was visited outside of Juba. The team discussed and agreed on the proposed itinerary with the GBViE specialist focal point in South Sudan, and were guided in the choice of projects and partners to visit within the two weeks allotted for the research using a real time approach. Because travel within South Sudan can be very challenging, and because of the high number of partners available for interviews in Juba, it was agreed only one field site outside the capital would be included. However, visits to three field sites in or near Juba were conducted by the team.

3.2 Country Overview
3.2.1 Country Context
After decades of conflict that effectively halted its development, South Sudan signed a peace agreement with Sudan in 2005, formally gaining independence in 2011 following a referendum that passed with 98.8% of the vote. In the wake of the peace agreement, South Sudan had to begin the process of building its governance and social services “from scratch.”20 Development efforts have been severely

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18 See Annex 4 for bibliography.
19 The focus groups were organized by UNICEF’s GBV IPs, and the profile of FGD participants reflects their beneficiary groups.
compromised by myriad social, political and economic challenges—most notably since December 2013, when a power struggle erupted between President Kiir and his ex-deputy Riek Machar. Subsequent fighting between rebels and government forces resulted in the loss of thousands of lives.\textsuperscript{21} Despite the fact that an Agreement on the Resolution of the Conflict in the Republic of South Sudan was signed in August 2015 and both sides have recently taken steps to implement the agreement, including Machar’s return to Juba in late April 2016, violence continues between armed actors in hotspots across South Sudan. In addition to the conflict, communities are struggling with inter-communal violence (on-going for generations), including as a result of cattle raiding.

It is estimated that over 2.3 million people have been forced to flee their homes since the onset of the 2013 crisis, including 1.66 million internally displaced people (with 53.4 per cent estimated to be children) and nearly 644,900 refugees in neighbouring countries. Some 185,000 internally displaced people (IDPs) have sought refuge in UN Protection of Civilians (PoC) sites, while around 90 per cent of IDPs are on the run or sheltering outside PoC sites. South Sudan also hosts refugees from Sudan, the Democratic Republic of the Congo (DRC), Ethiopia and the Central African Republic (CAR). It is expected that the number of refugees in South Sudan will rise to 304,072 by the end of 2016. With nearly 90 per cent of refugees living in camps in Upper Nile and Unity States where the conflict has been particularly intense, tensions over scarce resources have increased between refugees and host communities.\textsuperscript{22}

Infrastructure losses are extensive, affecting the availability of all services throughout South Sudan. For example, an estimated one in every three schools in South Sudan has been destroyed, damaged, occupied or closed. As of September 2015, some 55 per cent of the health facilities in Unity State, Upper Nile State and Jonglei were no longer functioning. The rising cost of living and impact of the conflict have undermined people’s ability to access safe water, including due to the destruction of water points.\textsuperscript{23}

In addition to the political crisis, South Sudan has suffered a severe economic crisis that has elevated humanitarian needs. The price of staple foods, such as sorghum, maize and beans, are up 150\% compared to pre-crisis. Since December 2013, an additional one million South Sudanese are living below the poverty line.\textsuperscript{24} At the same time that the Government’s ability to support and build social services is starkly compromised as nearly all public money is being diverted to the military, the high inflation in South Sudan has created a new set of challenges for humanitarian actors, whose operating costs are both high and volatile.\textsuperscript{25}

Despite being one of the largest humanitarian operations globally, persistent insecurity, extremely limited infrastructure across a vast geographical area, nascent government and civil society capacity, and a harsh physical environment contribute to South Sudan’s ranking as one of the most under-developed countries in the world. For the last two years South Sudan has had the highest score in the world on the Fragile States Index.

\textsuperscript{21} The International Crisis Group estimated that between 50,000 to 100,000 people across South Sudan had been killed in the period December 2013 to November 2014 This number increased as fighting continued in 2015. In Leer, Mayendit and Koch counties of Unity State alone, an estimated 1,000 civilians were killed, 1,300 women and girls were raped and 1,600 women and children were abducted from April to September 2015. Mortality has been exacerbated by acute malnutrition and disease, including an unprecedented malaria outbreak and a cholera outbreak in 2015 for the second year in a row. (Humanitarian Response Plan, 2016)
\textsuperscript{22} Excerpted from Humanitarian Response Plan, 2016.
\textsuperscript{23} Ibid.
\textsuperscript{24} Ibid.
\textsuperscript{25} USAID WASH/GBV Donor Report, 2015.
Against this backdrop of ongoing instability, new federalization arrangements proposed last year by the government call for a shift from 10 states to 28. Already adopted by local government in some parts of the country and ignored in others, such a redrawing may not only result in further political instability, but may also have significant impact for humanitarian actors in engaging with the government on policy and programming, particularly as new government roles, responsibilities and relationships evolve to accommodate these shifts.  

3.2.2 GBV Context

Numerous assessments, human rights reports, and other data sources paint a very grim picture of the scope of GBV in South Sudan, which UNICEF has characterized as “a daily reality for girls and women.” Even before the 2013 crisis, GBV was a widespread concern. War-related rape and abduction were reportedly committed with impunity by the Sudan People’s Liberation Army (SPLA), Sudan Armed Forces, and militia groups during Sudan’s civil war, according to a 2005 assessment. In 2009 UN Women released a report on the incidence and prevalence of violence against women in several areas of South Sudan, which found that of respondents, “70% reported to have known someone who experienced GBV; 49% experienced themselves one form of GBV in the last year.” Child marriage, bride price and wife inheritance were identified as common forms of GBV as well as risk factors for future GBV, including IPV, which is rife in South Sudan. According to research undertaken in 2010, 1 out of 5 women in South Sudan are affected by GBV and 79% of both male and female respondents find it justifiable for men to beat their wives or partners under some circumstances. Nearly half (45%) of girls in South Sudan marry before the age of 18. “Booking” (or negotiating a bride price) can begin when a girl is as young as five years old, with the marriage potentially initiated immediately following the girls’ first menstrual cycle.

Amid long-standing factors such as poverty, impunity and widespread gender inequality, the current conflict and displacement has further heightened women’s and girls’ vulnerability to violence and exacerbated protection risks. According to UN Mission in South Sudan (UNMISS), all parties to the recent conflict have committed acts of rape and other forms of sexual violence against women and girls of different ethnic groups and foreign nationalities. Even in close proximity to the PoC sites, women have been killed or attacked when collecting firewood and food. Rape and other forms of sexual violence constituted 25% of cases recorded through the Gender-Based Violence Information Management System (GBVIMS) in 2015. Of the reported incidents to GBVIMS partners in the same period, 97% of the survivors were female. Some reports conclude that there are reasonable grounds to believe the scale and nature of sexual violence as a result of the 2013 crisis could constitute crimes against humanity in terms of

26 Apart from the duplication of effort involved for humanitarian agencies in liaising with 28 rather than 10 provincial governments, there are insufficient human or financial resources to staff and run this many provincial governments making the likelihood of resources being available for government provided services even lower than it is now.
28 “Because men are really sitting on our heads and pressing us down: A Preliminary Assessment of GBV in Rumbek, Aweils, and Rashad County” (USAID, 2005).
30 2010 South Sudan Household Survey (SHHS).
31 Ibid.
34 Japan Proposal, also see Violence Begets Violence, Justice Africa, May 2016.
systematic sexual violence by both government and opposition forces since the resurgent fighting.37

Living conditions inside the PoCs and at other IDP sites can further increase exposure to GBV risks for women and girls. Many sites are over-crowded, lack sufficient lighting and, in some cases, multiple families are sleeping in the same communal shelter. IDP FGD women participants confirmed that whole families sleeping in tents are more of a safety concern that safety outside the home in the IDP camps themselves (in which there are community patrols at night). In their view: “Parents, adolescent children and small children cannot all sleep together, so often men leave and live with relatives in Juba and women are left in the camp with the children”.38 Some water and sanitation facilities do not meet basic standards for mitigating GBV risk: many are not sex-segregated, constructed with inadequate materials, and/or lack locks or other mechanisms to ensure privacy and safety. Early in the crisis, women and girls in all locations repeatedly cited latrines and bathing facilities as some of the highest risk areas for sexual violence and harassment, particularly at night.39 There are also reports in the PoCs of domestic abuse increasing due to substance abuse, especially alcohol.40 Child marriage may also be on the rise as a means of poverty alleviation.41 Sexual exploitation is an ongoing threat due to social and economic vulnerability.

In late-2014, the Special Representative to the Secretary General (SRSG) on Sexual Violence in Conflict stated the situation for women and girls in South Sudan is the worst she has seen in her thirty-year career in health and women’s rights.42 UNICEF’s 2015 Situation Assessment of Children and Women in South Sudan suggests that the problem is worsening, rather than improving.

South Sudan has few systems in place to protect women and girls from GBV and to respond to the needs of survivors. Overall, only a small percentage of the total population has access to even the most basic GBV services, such as clinical management of rape and psychosocial support. Legal services are “all but non-existent”43 and the lack of a functioning justice system further contributes to the culture of tolerance and impunity for GBV.44 While Special Protection Units (SPUs) have been established in 14 police stations throughout the country to provide police services to women, children and vulnerable groups, their levels of capacity vary greatly from one location to another.45 Standard Operating Procedures (SOPs) for addressing various forms of GBV were developed several years ago but have yet to be endorsed by the government, further undermining care and support for survivors.46

Although legislation and policies are generally weak related to GBV (for example, there is no law on IPV), there are some areas of promise. For example, government and opposition forces each issued communiques in 2015 committing them to undertaking measures to prevent conflict-related sexual violence. A National Gender Policy was adopted in 2013 and the government ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) in September 2014. The South

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38 FGD participants, Juba.
40 Japan Final Proposal.
42 UNICEF GBV Briefing Note, December 2015.
Sudan Child Act of 2008 protects girls from child marriage and other forms of GBV and South Sudan’s Penal Code (2008) designates rape and other forms of sexual violence (outside of marriage) as a crime. Even so, the Penal Code predates independence and is not valued or recognized by all South Sudanese, and the conflict has further stalled the implementation of protective laws and policies. There is deep and widespread impunity for all forms of GBV. The result is that women and girls continue to face grave violations of fundamental rights and remain under-represented in most spheres of influence.

3.2.3 Humanitarian Response

3.2.3.1 General Overview of Humanitarian Response Mechanisms

The conflict that erupted in December 2013 shifted aid attention from development back to emergency. The humanitarian community in South Sudan has grown considerably since that time, with approximately 200 organizations operating emergency programmes across the country, including more than 90 international non-governmental organizations (INGOs), more than 80 national NGOs (NGOs), 9 UN offices, agencies, funds and programmes, relevant authorities, and community- and faith-based organizations. Of these, 114 partners have projects in the 2016 Humanitarian Response Plan (see Humanitarian Snapshot, below).

Coordination is provided through the Cluster System, which was introduced to South Sudan in mid-2010. The Inter-Cluster Working Group (ICWG), which comprises UN and NGO cluster leads, advises the Humanitarian Country Team (HCT) on operational priorities, concerns and gaps in humanitarian operations and formulates cluster strategy and response plans. The clusters coordinate their response at central and state levels. State level coordinators are expected to ensure that technical information from the field is shared in a timely and efficient manner. UNICEF leads the nutrition and WASH clusters, the child protection sub-cluster and vaccination, communication and social mobilization within the health cluster, and co-leads the education cluster at national level.

The UN also has a peacekeeping mission in South Sudan. The United Nations Mission in South Sudan (UNMISS) was established on 8 July 2011 by UN Security Council Resolution 1996 to ‘consolidate peace and security and to help establish conditions for development’ in South Sudan. Coordination structures between UNMISS and humanitarian actors are intentionally separate. Within UNMISS, the main coordination structure is the PoC Working Group (PCWG), which brings together those sections of the mission working on PoC. Chaired by the Deputy Special Representative to the Secretary General (DSRSG)/Political, participants include the DSRSG/Resident Coordinator/Humanitarian Coordinator (RC/HC), the UNMISS Force Commander and UN agencies. It meets monthly, at HQ and state levels.47

With the conclusion of the Agreement on the Resolution of the Conflict in August 2015, there are new opportunities to strengthen efforts towards peace and development. Among other opportunities, the Agreement provides for the Transitional Government of National Unity to establish a new national development framework during the transitional period until 2018. The Peace Agreement of August 2015 and recent promising overtures by political leaders may offer an opportunity to refocus (to an extent) on

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47 The search for common ground: Civil–military coordination and the protection of civilians in South Sudan, Wendy Fenton and Sean Loughna, December 2013.
development concerns, but ongoing vulnerability to conflict requires that both humanitarian and development approaches are maintained because of the levels of need.\textsuperscript{48}

The South Sudan Development Plan (SSDP) originally launched after independence in 2011 for a period of two years was extended until mid-2016 as the momentum for development weakened, first by the fiscal crisis in 2012 and then by the conflict from 2013 onwards. Until a new development framework is in place, and in order for the UNCT to better align the policy and programmatic work to the current context, the UN Country Team has decided to launch an Interim Cooperation Framework (ICF) as its overarching Strategic Plan covering the period 2016 and 2017. The ICF will replace the current UNDAF on an interim basis until a new UNDAF can be developed, based on a new national framework. Crucially, the UNCT will assist the Transitional Government of National Unity in formulating this new national development framework that would have the Sustainable Development Goals (SDGs) mainstreamed in it.\textsuperscript{49} Women and girls are specifically features in one of the five strategic outcomes of the ICF, which are: (1) More resilient communities; (2) Strengthened social services for the most vulnerable; (3) Strengthened peace and governance; (4) Invigorated local economy; and (5) Improved status of women and youth.

\textsuperscript{48} UNICEF’s Draft Country Programme Document notes: “A key lesson from the country’s first United Nations Development Assistance Framework (UNDAF), 2011–2016, is the need to maintain core development programming, even during acute humanitarian crises, to prevent further erosion of the already limited capacity to deliver public services. As important is investing in capacities of subnational governments and communities to promote service continuity during crises and ensuring that conflict-sensitivity and peacebuilding are mainstreamed in all interventions.” P 4, March 2016.

3.2.3.2 General Overview of Humanitarian Response Mechanisms Related to GBV

A national GBV Working Group was established in 2007 by UNIFEM, but it did not meet regularly. In July 2008, based on consensus of coordination partners (and following the arrival of a UNFPA Junior Professional Office [JPO] GBV Specialist to Juba), UNFPA assumed leadership of the working group. A formal TOR was developed for the working group in 2008, and meetings were held once a month. In 2010 when the cluster system was initiated, the GBV Subcluster (SC) was formally introduced under the Protection Cluster (PC). At the national level it is currently led by UNFPA with IMC as the co-lead. At the sub-national level UNFPA supports coordination in three states: with Intersos in Jonglei; with the International Refugee Committee (IRC) in Unity; and with IMC in Lakes. UNICEF leads in Upper Nile.

In immediate response to the December 2013 crisis, humanitarian actors established GBV services and coordination mechanisms in five PoCs sites (Bentiu, Bor, Malakal, UN House (Juba), and Tomping) as well as some non-PoC settlements in Awerial, Nimule and Juba.\(^{50}\) According to data from the GBV SC, thirty international and national partners are now working across the country, each providing “at least one type of GBV prevention and response.”\(^{51}\) The majority focus on the provision of safe spaces, Clinical Management of Rape (CMR) and psychosocial assistance for survivors and those at risk, as well as awareness raising and support to community-based protection mechanisms. The GBV SC’s 2016 annual workplan identifies the SC’s key outcome objectives as: 1) Increased availability and improved quality of timely, safe, and high-quality child and gender-sensitive prevention and response services to survivors of GBV; and 2) Improved coordination among GBV partners, across other humanitarian clusters and with UNMISS.

(Map excerpted from GBV SC Gender-based Violence Factsheet, Nov 2015. There may have since been changes, but no other updated map is available.)

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\(^{50}\) GBV Subcluster Strategy, July 2014.

\(^{51}\) GBV Subcluster Gender-based Violence Factsheet, Nov 2015. Note that updated data on subcluster partners is not available on the OCHA website, www.humanitarianresponse.info
Other national GBV-related mechanisms and initiatives include:

- **Gender Based Violence Information Management System (GBVIMS) Task Force** – The GBVIMS was put in place in 2014. Currently eleven partners across 5 states in South Sudan track the delivery of their services with the GBVIMS. UNICEF joined the Task Force in February 2016.

- **CMR Task Force of the Reproductive Health Working Group within the Health Cluster**: Led by UNFPA, the TF aims to provide coordinated technical guidance for the development of a strategy and plan for the systematic integration and implementation of gender and GBV response in the health sector, particularly in terms of technical guidance on CMR and the finalization of a national CMR protocol. UNICEF is an active partner.

- **Joint Technical Working Group on Conflict-Related Sexual Violence (JTWG)**: After signing a high-level joint communiqué on CRSV, the President designated a Minister in the Office of the President to be in charge of a JTWG on Sexual Violence, which includes line Ministries as well as UNICEF, UNMISS, UN Women, UNDP, and UNFPA. This is seen by some partners as a “real commitment from the GoSS” to engage more actively in GBV prevention and response.

- **Monitoring, Analysis, and Reporting Arrangements on Conflict-related Sexual Violence (MARA) Working Group and Joint Consultation Forum**: Established in late 2014, the MARA WG is co-chaired by UNMISS and UNFPA and is only open to UN agencies. The MARA is organized around 5 pillars: (i) Prevention and Early Warning/Early Action (EWEA); (ii) Engaging with parties to conflict; (iii) Support with referral of cases; (iv) Mainstreaming GBV into mission training; (v) Supporting government with capacity building. In Dec 2015 an agreement was signed between MARA and GBVIMS Task Force to share select data. Two hundred cases of CRSV were verified in 2015. The Joint Consultation Forum is a linked mechanism that is open to the government and NGOs. It will be integrated into the GBV SC, with the first meeting in spring 2016.

- **Monitoring and Reporting Mechanism (MRM) for Grave Violations against Children Task Force**: UNICEF co-leads the MRM Task Force with UNMISS, increasing the capacity of partners to record and verify reports through the training of 194 partner staff. Grave violations include killing and maiming, recruitment and use of children, sexual violence against children and attacks on schools and hospitals. MRM data feeds into the MARA.

### 3.3 UNICEF GBV Programme

Shortly after UNICEF SSCO’s first GBV Specialist arrived in September 2013 to support GBV programming in the context of UNICEF’s development plan, the crisis struck. UNICEF’s programme shifted its focus to emergency response, and the P4 specialist position based in Juba was supplemented in 2014 with another international specialist recruited to oversee GBV response in Malakal and the wider Upper Nile State (a

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52 KII.

53 According to the MRM data, more killings, maimings and abductions of children were recorded in the first half of 2015 than in all of 2014, as a result of the upsurge of violence in Unity and Upper Nile states. (UNICEF Country Office Annual Report, 2015)

54 This was the first UNICEF staff position for GBV; an Norwegian Refugee Council (NRC) GBV surge position was in place from 2011-2013.
UNICEF’s GBV work in South Sudan covers prevention, risk mitigation and response. UNICEF is also engaged in coordination, standard-setting and advocacy related to GBV, as described throughout this report.

### 3.3.1 GBViE-Specific Programmes

At the time of the evaluation UNICEF was working with 11 partners in Central and Western Equatoria, Jonglei, Warrap, Unity and Upper Nile States, as illustrated below.

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55 At the time of the evaluation, the GBV Specialist based in Juba had recently finished her post and her replacement had not yet arrived. The CC consultant completed her contract in 2015.
Highlights of UNICEF’s GBV specific programming include:

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<tr>
<td><strong>1.</strong> <strong>Women Friendly Spaces (WFS)</strong></td>
<td>UNICEF supports 8 WFS in 6 locations (Malakal, Wau Shiluk, Pochalla, Akobo, Mandeng and Jikmír) for PSS and referrals. These centres serve as a safe space for women and girls to engage in group PSS and other activities, including group discussions on health, GBV and other issues; literacy classes; and craft-making. The WFS also serve as an entry point for referrals to other GBV services.</td>
<td><strong>2.</strong> <strong>Interim care centre for children</strong></td>
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<td>UNICEF works with Confident Children out of Conflict (CCC) to support an interim care centre for vulnerable children (including GBV survivors) that offers GBV case management, group PSS and individual counselling in Juba.</td>
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<td><strong>3.</strong> <strong>Mobile team for CMR training</strong></td>
<td>UNICEF works with the International Medical Corps (IMC) to deliver CMR training in Western and Central Equatoria, Unity, and Upper Nile and with IRC in Rumbek.</td>
<td><strong>4.</strong> <strong>Capacity Building for local NGOs</strong></td>
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<td>In 2015 UNICEF designed and rolled out a capacity-building approach to working with 7 local NGO partners with the aim of supporting them to variously:</td>
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<tr>
<td>• Provide services to survivors (e.g. medical, PSS, case management)</td>
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<td>• Build referral systems</td>
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<td>• Undertake social mobilization (i.e. awareness raising)</td>
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<td>• Implement women friendly spaces</td>
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<td>• Conduct safety audits and support risk mitigation through other sectors’ interventions</td>
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<td>• Undertake assessments</td>
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<td><strong>5.</strong> <strong>Police and social worker capacity building, including SPU</strong></td>
<td>In collaboration with IsraAid, UNICEF is supporting a joint police/social worker programme in Central Equatoria State, which has recently been expanded to Western Equatoria. The objectives are to:</td>
<td><strong>6.</strong> <strong>Resource/Supply mobilization</strong></td>
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<td>• Strengthen capacity of police and social workers working with vulnerable groups including GBV survivors;</td>
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<td>UNICEF procured and supported distribution of dignity kits in Upper Nile and Jonglei, as well as sourcing CMR supplies for the Malakal PoC.</td>
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<td>• Strengthen coordination mechanisms among service providers;</td>
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<td>• Build bridges between coordinated services and to encourage help-seeking and access to services for survivors.</td>
<td><strong>7.</strong> <strong>Prevention programming</strong></td>
<td>The “Communities Care” (CC) programme is a UNICEF-wide flagship pilot initiative being rolled out and evaluated in South Sudan and Somalia. It aims to create safer communities for women and girls by transforming social norms that promote sexual violence into norms that promote dignity, equality and non-violence, as well as improve quality of response to survivors. The programme offers an Introductory training for the community, then the community select 25 people for committees that engage in 15 weeks of discussions, twice per week, on subjects such as human rights, human dignity, fairness, power, violence, etc. Times for group to meet are identified by the group themselves. The programme also has a community-based care component. Introduced as a pilot in two relatively stable sites in South Sudan, UNICEF is now encouraging partners to identify select elements of CC that can be applied in emergency-affected locations, including in Yambio (Catholic Medical Mission Board-CMMB), Bor (Sudd Relief and Development Agency--SRDA), Yei State (African Humanitarian Action-AHA), and Malakal (IMC).</td>
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<td><strong>8.</strong> <strong>Coordination</strong></td>
<td>UNICEF leads coordination in Upper Nile, and at the national level is an active participant in the GBV SC, the RH Working Group (including the CMR task force), the MARA Task Force and JTWG. UNICEF has recently joined the GBVIMS Task Force.</td>
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<td><strong>9.</strong> <strong>Standard-setting</strong></td>
<td>UNICEF is supporting the development of guidelines for WGFS that will, at minimum, address a) the purpose of WGFS, b) step-by-step guidance for establishing a new WGFS, c) suggested activities to take place within WGFS, and d) monitoring and evaluation (M&amp;E) tools to systematically receive feedback from WGFS participants. UNICEF is also supporting the development of a national CMR protocol and standardized CMR training curriculum through</td>
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56 Note that the Communities Care project was not included in the real time evaluation because 1) it is a development project; and 2) it is being independently evaluated. That there are few references to Communities Care in the findings is not a negative reflection of the value of the project.
10. Advocacy

UNICEF has engaged in extensive advocacy with the former Inspector General of Police (IGP) and others related to the Form 8 in order to ensure and raise awareness that it is not necessary for survivors to pay the police for the form prior to receiving health care.

### 3.3.2 Integrated GBVIE Programming

The UNICEF GBV team will facilitate the roll-out of the revised IASC GBV Guidelines in the second half of 2016. Current areas of integration are highlighted below.

#### 3.3.2.1 WASH

The SSCO is implementing a three-year (2014-2017), US$23.9 million WASH-GBV project ($13.9 million in the first year, and $10 million added for 2015-2017) funded by USAID to provide adequate and gender sensitive WASH facilities and services to empower women and mitigate against GBV in Upper Nile, Unity, Lakes, Central Equatoria, Eastern Equatoria, Western Equatoria, and Jonglei states. The programme is a collaboration between WASH and Child Protection Sections aimed at ensuring the needs of women and girls are addressed in WASH project planning, implementation and monitoring. The UNICEF GBV team has already supported the WASH section to systematise GBV risk mitigation into their work plan, as well as in developing monitoring tools (such as the “latrine minimum checklist”) and programme cooperation agreements (PCAs). A key element of the WASH-GBV collaboration is monitoring, evaluation, and documentation of processes in order to help collate learning which will support similar risk mitigation efforts in other country contexts.

A Monitoring and Evaluation consultant has been recruited to the WASH team to track sex-disaggregated data which has supported gender-sensitive decision making.

#### 3.3.2.2 Education

UNICEF SSCO Peacebuilding, Education and Advocacy (PBEA) Programme within the Education section worked with UNICEF GBV partners to integrate gender equality and GBV messages in its curriculum development. The social and citizenship development domain of the PBEA life skills programme has one element on GBV and one on gender awareness and responsiveness. Capacity building for PBEA partners to roll out the curriculum includes conflict sensitivity, which involves understanding the potential impact of the PBEA programme on women’s safety – and to understand partners have been introduced to issues of GBV and how to mitigate risks through the ‘Do No Harm’ approach to programme implementation.

Another part of PBEA programme is a digital and audio discussion groups for pastoralists, including audio/digital sets given out with flash drives to communities of women and men who can discuss further the topics which have been raised in linked radio broadcasts. The radio programmes address family issues (including polygamy and IPV), women’s empowerment, and sending girls to school.

#### 3.3.2.3 CP

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57 The Form 8 is a form that survivors receive from police, which typically needs to be filled out by a health care provider before proceeding with police and judicial response. It used to be required that the survivors would have to report to police and get a Form 8 before receiving health care, which discouraged help seeking for those survivors who did not wish to report to police. Even for those who did wish to report to police, they had to pay for the Form 8, which also discouraged reporting.

58 UNICEF’s 2016 GBV Strategy.

59 UNICEF COAR 2015.
Currently there is limited integration of specific GBV-related activities into the CP programme. However, there are plans to integrate GBV programming into two pending initiatives. The first is a Demobilization, Disarmament and Reintegration (DDR) programme, and the second relates to justice for children.

**DDR.** At the impetus of DANIDA (donor), the UNICEF CP section is currently working together with its GBV colleagues to integrate GBV elements into UNICEF’s DDR programme being undertaken in the Greater Pibor Administration Area (GPAA). Following discussions with DANIDA, FAO and IRC in the first quarter of 2016, UNICEF and IRC have identified areas where gender and GBV considerations could be more systematically integrated into the release and reintegration work in GPAA. It is envisioned that the UNICEF/IRC collaboration will consist of three main pillars: 1) integration of GBV risk mitigation measures into all elements of UNICEF’s multi-sectoral programme; 2) ongoing monitoring of women and girls’ sense of safety and overall satisfaction with the programming and 3) establishment of GBV response services in GPAA. Capacity building of implementing partners, service providers, local organisations, and community members will be a cross-cutting element of all three pillars. UNICEF and IRC will also establish qualitative monitoring and feedback mechanisms (listening groups, safety audits, client satisfaction surveys) that can be handed over to the service providers and community members involved, once the project finishes. IRC plans to create a mobile support team, based in Juba and comprised of the relevant skillsets necessary to support all elements of this project.\(^{60}\) If funding is approved, the revised project with GBV elements is due to start in Oct 2016.

**Justice for Children.** The Justice for Children project is primarily development focused. There is potential for integration of GBV in the finalization and institutionalization of the Police Training Curriculum linked to the Justice for Children project. If the Peace Agreement is successfully implemented, there will be an integrated (government and opposition) police force which will need training on protection issues as a priority.

### 3.3.3 Programme Funding for UNICEF SSCO GBViE Programmes

The total available funds to UNICEF’s GBV Programming as of December 2015 was 2,493,000USD.

<table>
<thead>
<tr>
<th>Donor</th>
<th>Purpose</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID</td>
<td>WASH/GBV</td>
<td>@2,000,000</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Communities Care</td>
<td>@118,000</td>
</tr>
<tr>
<td>Norway</td>
<td>GBV Prevention and Response including Communities Care and work with police and other service providers</td>
<td>@375,000</td>
</tr>
</tbody>
</table>

### 4 EVALUATION FINDINGS

The section on evaluation findings addresses the evaluation questions related to the respective evaluation criteria in the ToR and Inception Report.

#### 4.1 Relevance

Alignment of UNICEF programming with assessed needs of beneficiaries (which may change over time), good GBViE programme practice and relevant UNICEF strategies and policies.

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\(^{60}\) Summary of Gender/GBV Enhancements to DDR Programme, Feb 2016.
4.1.1 Alignment with Assessed Needs of Beneficiaries

In the earliest stages of scaling up emergency GBV response after the 2013 crisis, basic GBV-related protection and service delivery gaps were so huge in South Sudan that the programme strategies were not determined as much by detailed GBV-specific situational assessments, but by the availability of partners, and in some instances (e.g. in Malakal with IMC), their availability to work in areas where few to no service providers were currently operating.

Even so, partners conduct assessment prior to implementing their programming. Periodic assessments\textsuperscript{61} and regular monitoring, particularly through safety audits, are also a core component of UNICEF’s GBV-specific programmes that serve beneficiary groups. One UNICEF partner related how they undertake safety audits on a weekly basis, during which they engage in site observation as well as direct dialogue with community members, and community mapping activities every month, where a map is used for FGD participants to identify where they feel safe and unsafe. These safety audits have been used to inform programme development. It was the safety audits conducted in the Malakal PoC, for example, that highlighted the significant concern women had about safety related to WASH facilities, eventually leading to UNICEF’s flagship WASH-GBV project, described further below. In another example, UNICEF supported IsraAid to undertake a pilot in 2015 to understand in which areas of Juba most sexual violence cases were being referred; IsraAid’s capacity-building project for police and social workers was then started in the area with the highest number of reported cases. Moreover, the UNICEF GBV team, along with its partners in the GBV SC, have drawn from numerous human rights reports and other up-to-date data (e.g. through the GBVIMS) to inform advocacy and draft proposals.

In other UNICEF sections GBV issues have emerged incidentally during assessments and as a part of programme planning. For example, dialogues with pilot communities were undertaken to inform the curriculum to be designed under UNICEF’s PBEA project. During the dialogues, it was reported that in pastoralist communities, cattle raiding in order to generate dowries often resulted in violence against women and girls. The PBEA curriculum was revised in collaboration with UNICEF GBV specialists to address this issue.

In 2015, UNICEF undertook a comprehensive situational assessment of children, adolescents and women in South Sudan. Usually undertaken every 5 years, UNICEF’s previous situational analysis was conducted in 2007 (the eight-year gap being an illustration of the challenges of data collection in the current South Sudan context). The 2015 assessment synthesizes information from a range of sources that is complemented by interviews with key stakeholders. According to the report itself, there is an expectation that deeper analysis of key issues-- including causality and stakeholder analysis—can be performed in the near future. The report includes discussion of GBV, including CRSV and harmful practices such as child marriage. The Assessment is informing SSCO and interagency planning processes, such as the Interim Cooperation Framework.

Even so, data on how best to meet the rights and needs of women and girls is severely limited, both in

\textsuperscript{61} In Upper Nile State where UNICEF leads the GBV SC, UNICEF and partners conducted a rapid assessment of barriers to access GBV services in September 2015. The findings from the assessment will help GBV actors to address the barriers for survivors to access services. The UN GBV Sub-Cluster will also develop a work plan for 2016 to further strengthen coordination to mitigate risks of GBV and provide quality services to survivors of GBV [USAID WASH/GBV donor report 2015].
UNICEF’S programming and generally. Moving forward, and in order to improve UNICEF’s ability to respond to the assessed needs of beneficiaries, UNICEF’s 2016 GBV strategy has placed monitoring and evaluation as a core cross-cutting component to all its programming, not only through strategies for monitoring partners’ performance, but also through targeted evaluations such as this real-time evaluation, the evaluation of the Communities Care project, and an evaluation of the WASH-GBV project.

4.1.2 Alignment with relevant UNICEF Strategies and Guidance

4.1.2.1 Alignment with UNICEF GBViE Resource Pack

Areas of alignment. UNICEF is undertaking all the Minimum Actions the UNICEF GBViE Resource Pack suggests should be addressed in immediate crisis-response (see Table 1). One area for improvement is risk mitigation across clusters and sectors. Risk mitigation is being undertaken by the WASH section through a flagship WASH/GBV integrated project and by Education in PBEA community outreach, but has not been widely taken up in other sections. Rollout of the GBV Guidelines for improved integration across all UNICEF sections is a priority intervention for this year.

In the early stages of the crisis, UNICEF established a WGFS providing PSS in Upper Nile and have subsequently expanded to 8 WGFS located in Upper Nile (Malakal, Wau Shiluk, Mandeng and Jikmir) and Jonglei (Pochalla, Akobo) for PSS and referrals, with an estimated 1000 beneficiaries accessing services monthly. From the early days of the emergency, UNICEF participated in GBV coordination at the national level and led the subcluster in Upper Nile because the needs in that state were high and not being addressed by other partners. UNICEF set an important precedent by recruiting— for the first time within UNICEF and across the UN system in any humanitarian setting—a P3 international staff person to this sub-national GBV coordination mechanism.

UNICEF also procured dignity kits and minimum initial service package (MISP) supplies through their own supply lines, as well as in collaboration with UNFPA, in order to support survivor response. Since 2014, UNICEF has distributed a total of 12,146 Dignity kits to partners in Malakal, Pochalla, Akobo and Mandeng. In one instance, a GBV specialist personally transported MISP supplies from Malakal to Juba in order to facilitate UNICEF’s Rapid Response Mechanism (RRM) to provide CMR should a case be reported. (None have been reported to the RRM to date, as responding to GBV is not yet a specific RRM intervention, although RRM have received some support from UNICEF GBV colleagues in principles for responding to a survivor.) Recognizing the high level of need for CMR services, UNICEF has stepped in to provide support to IMC to deliver trainings for health care providers.

In terms of the expanded GBV prevention and response interventions included in the draft Resource Pack, the SSCO also illustrates strong alignment. UNICEF participates in all the GBV-related coordination mechanisms operating in South Sudan (described above). UNICEF continues to work directly with IMC to support capacity building of health providers in CMR and has developed a CMR and Psychological First Aid

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62 The MISP is a coordinated series of priority actions designed to prevent and manage the consequences of sexual violence against women and girls, prevent reproductive health-related morbidity and mortality, reduce HIV transmission and plan for comprehensive reproductive health services in the early phase of emergency situations (Women’s Refugee Commission, 2006, revised 2011).

63 Since March 2014, joint WFP-UNICEF RRM teams deployed on a regular basis to reach affected populations in hard-to-reach locations, assessing and responding to acute needs, and seeking to help re-establish presence by international and national NGO partners. As such, the Rapid Response Mechanism aims not only to provide for those hardest to reach, but also to expand access and coverage of humanitarian operations. (UNICEF, The WFP-UNICEF Rapid Response Mechanisms in South Sudan: One year on, results, challenges and way forward, 2015.)
UNICEF is also contributing to the development of a national protocol to support standardized good practice in the provision of CMR. Given the context-specific challenge of the limited presence of international actors in South Sudan, particularly in hard to reach areas, UNICEF designed and has introduced a capacity-building approach for CBOs (described further in section 4.4).

### Table 1

<table>
<thead>
<tr>
<th>Minimum actions during immediate response to a crisis</th>
<th>Expanded GBV prevention and response</th>
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</thead>
<tbody>
<tr>
<td>1. Effective coordination of humanitarian action to address GBV.</td>
<td>1. Effective coordination of GBV-related humanitarian and recovery action.</td>
</tr>
<tr>
<td>2. GBV risk mitigation across clusters and sectors in line with IASC Guidelines.</td>
<td>2. GBV risk mitigation across clusters and sectors in line with IASC Guidelines.</td>
</tr>
<tr>
<td>3. Age-appropriate clinical and crisis care for sexual assault.</td>
<td>3. Strengthening coordinated multi-sectoral care and support systems and services.</td>
</tr>
<tr>
<td>4. Safe spaces for women and girls.</td>
<td>4. Ongoing protection interventions to reduce vulnerability.</td>
</tr>
<tr>
<td>5. Dignity kits.</td>
<td>5. Primary prevention initiatives to empower girls and women, address harmful attitudes and social norms and legislative and policy interventions. This includes testing and scaling up prevention initiatives.</td>
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</table>

UNICEF is one of the few agencies doing innovative work to address the lack of capacity among the security sector to respond to cases of GBV, through its IsraAid project that involves training of police as well as social workers and other community focal points. In 2015, IsraAid trained 147 service providers, including 21 police personnel, 5 legal personnel and 121 social workers in Juba. In 2016, the project has expanded to Western Equatoria. UNICEF also supports one of the only shelters in South Sudan through its funding to Confident Children Out of Conflict, which runs an interim care centre based in Juba which serves vulnerable children, including child survivors of GBV. 122 children (77 girls and 45 boys) accessed the interim care centre in 2015.

UNICEF has started involving men in GBV activities as change agents in community outreach activities. In UNICEF’s GBV-WASH programme, UNICEF and partners intend to “engage men for community discussions to transform negative norms and uphold girls’ and women’s right and gender equality.” One strategy for this involves adapting some of the tools from the intensive Communities Care pilot project to smaller-scale social norms work in other areas in South Sudan affected by conflict.

Across all of these interventions, UNICEF has built on guiding principles outlined in the UNICEF GBViE Resource Pack, the 2015 IASC GBV Guidelines, and elsewhere that emphasize the importance of survivor-centred approaches, participation and partnership, and developing context-specific strategies for the delivery of programmes (described in greater detail under Effectiveness, below).

Notably, the self-assessments completed by UNICEF’s GBV specialists (see Table 2) reflect the observations by the evaluation team in terms of programme alignment. UNICEF scored itself highest in terms of implementation of safe space programming, NFI distribution, psychosocial response, security

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64 USAID Donor Report, 2015.
response and health services. The evaluation team would have scored UNICEF higher on the health response given UNICEF’s important work on the CMR protocol as well as CMR training and service delivery. The lower self-evaluation may be explained by the fact that a significant amount of the checklist focuses on national level policy work, which is only being undertaken by one member of the GBV team, so responses of other team members not engaged in policy reform may have pulled down averages. Another possible explanation for the low self-evaluation is that respondents may have been reflecting on the UNICEF South Sudan’s health section integration of GBV, which to date has been very limited.

**Areas for growth.** UNICEF GBV specialists scored themselves lower on justice, economic strengthening for adolescent girls, and integrating GBV into DDR processes. The evaluation team agrees with this self-assessment. The legal/justice element (e.g. ensuring survivors can pursue prosecution if they so choose) is currently not addressed, referred to by one interviewee as a “dead service.” This is largely due to contextual challenges: laws in South Sudan are weak and the customary system prevails. UNICEF attempted to engage with one legal NGO, but problems with the capacity of the partners resulted in the discontinuation of the project.68

**Table 2**

<table>
<thead>
<tr>
<th>GBV Specific Self Assessments</th>
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<tbody>
<tr>
<td>Integrating GBV into DDR Process</td>
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<tr>
<td>Economic Strengthening for Adolescent Girls</td>
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<tr>
<td>Safe Space Programming</td>
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<tr>
<td>NFI WASH and Dignity Kit</td>
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<tr>
<td>Justice</td>
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<tr>
<td>Safety Response</td>
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<tr>
<td>Psychosocial Response</td>
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<tr>
<td>Health Response</td>
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</table>

With regard to **economic strengthening for adolescent girls**, the evaluation team agrees with the self-assessment that this is an area of limited work. While there are some social activities in the WGFS (sewing, working with beads) that give participants the opportunity to produce items they can sell, these activities are not specifically oriented to adolescents. In Malakal, a UNICEF colleague suggested that most WGFS activities were targeted at adult women, and that “we have to figure out a way to include more adolescent girls.”

**In fact, the GBV team noted that attention to adolescent girls could be scaled up in several aspects on GBV programming.**69 A lack of focus on girls is also somewhat reflected in the CMR trainings: although the training does include some information on caring for child and adolescent survivors, the medical aspects of the training could be improved, i.e. with regard to medication and child dosages.

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68 Note that the Communities Care project, which was not evaluated during the RTE, has a legal/justice element.
69 Several interviewees within UNICEF felt that it was not only GBV programming that was missing adolescent girls, but also other sections. One KII characterized programming for adolescent girls “as one of the weakest areas.”
Another programmatic area where adolescent girls are potentially being missed is in UNICEF’s DDR programming. As mentioned above, UNICEF was urged by DANIDA to integrate GBV issues—and concerns of girls—into their DDR work in the GPAA. Of the 1,755 children from the Cobra Faction for which UNICEF had supported release, 5 were girls. For the next phase of the project, UNICEF will place a strong focus on the inclusion of vulnerable girls, particularly because it is common for girls who are used by armed forces to be excluded from formal release programmes. In addition to investing in basic community services, such as WASH and education, UNICEF also proposes to enhance the overall equity and inclusivity of the intervention by ensuring gender and GBV risk mitigation and response are holistically integrated into all elements of the project. Currently there are no focused GBV services in GPAA. As a result, the specifics of the referral pathway and SOPs will depend on the initial assessment/service mapping and what is determined by GBV technical experts to be feasible in the context. The services/referral system will, in turn, influence the design of the other activities in the project that relate to GBV awareness raising, prevention efforts, etc.

In a recent public speaking event for International Women’s Day, UNICEF’s Head of Office highlighted the critical importance of including females in DDR processes.

Another area for growth identified by the evaluation team is related to the fact that UNICEF’s GBV programming has not focused significant efforts to address forms of GBV other than sexual violence, despite clear concerns related to intimate partner violence (IPV) and widespread child marriage. This is understandable and in line with the emergency context where the sexual violence is a major concern. Some issues around IPV are included in the PBEA community outreach tools and in sensitization in WFS (and case managers may be responding to individual reports).

Even so, attention to IPV is currently very limited given the scope of the problem. In a Knowledge, Attitude and Practices (KAP) survey undertaken in 2014 to create a baseline for UNICEF’s PBEA project, researchers asked about the common causes of violence affecting participants in the last few months and in a survey of 5,000 people, “IPV came out highest of all types of violence, even higher than military attack.” During the real-time evaluation itself, a FGD participant in Malakal reported that:

“I witnessed someone being taken to the hospital this morning. She was beaten by her husband severely.... The situation we are in now is like an open space. You cannot give your husband your body and this causes fights—when there is no chance this can bring fighting. People have nowhere to go but if you refuse your husband he will beat you.”

Finally, while UNICEF has developed systems for site-specific referrals (there are referral pathways for each PoC), the national Standard Operating Procedures (SOPs) for GBV have not yet been adopted. Although national SOPs were developed before the crisis, their institutionalization was held up for several years due to a lag in government approval. They are currently in the last stages of being endorsed by the Council of Ministers, but there is no evidence of any time frame for approval, nor of concerted engagement with the government by the GBV community—including UNICEF—to hasten the process.

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70 Summary of Gender/GBV Enhancements to DDR Programme, Feb 2016.
71 Ibid.
72 In the UNICEF Head of Office’s statement, he recognized: “Whilst boys tend to be more commonly recruited, girls are often used by armed forces and groups in other ways – cooks, cleaners and sometimes as wives. They are often not formally released, so deliberate efforts are made to target a greater percentage of girls during the identification of other vulnerable children from the communities (in accordance with the one-plus-one modality required by the Paris Principles) as this is how many of these girls can access the services to which they are entitled.” (March 2016).
73 KII, UNICEF.
4.1.2.1 Alignment with UNICEF Corporate Commitments

From a corporate perspective, the South Sudan GBV programme is aligned with the UNICEF Strategic Plan, the Equity Approach, and the UNICEF Gender Action Plan (GAP). However, this alignment has not been made explicit in all country programme documents. While the SSCO’s 2016 GBV Strategic Plan specifically mentions the GAP, many UNICEF programme colleagues were not familiar with the GAP. Moreover, there is no mechanism for the CO to monitor the GAP, including no Gender Specialist/Advisor despite the SSCO meeting the criteria of having a budget over $20 million.

Perhaps even more importantly in terms of the office meeting its corporate commitments to GBV, several UNICEF colleagues shared the impression that regardless of the vital work being done by GBV colleagues, the profile of GBV in the CO is low. According to one KII, this is because food security has been the CO priority for a long term. According to others, it may be related to the SSCO’s lack of clarity on UNICEF’s role and niche in GBV. One KII felt that “most people within UNICEF don’t understand that UNICEF has any commitment to GBV—they see it as big problem in South Sudan so the UNICEF office here committed to working on it, but they don’t know about global mandates.”

Some UNICEF colleagues are struggling with how to distinguish between UNICEF efforts to address VAC and GBV, including where programming should overlap and where it should remain distinct. For one colleague, this struggle is captured in the assertion that he is “still to find a form of violence which is not gendered.” While another colleague felt that the distinction was clear in terms of research and practice that understands GBV work to be targeted to women and girls because of issues of discrimination of women and girls, she suggested that there needed to be more clarification from UNICEF HQ around the critical distinctions between addressing the drivers of VAC and those of GBV/VAWG, as well as areas of potential synergy in the two programming fields.

4.1.3 Risk Reduction Integration into UNICEF Sections

UNICEF sections’ self-assessment checklists (see Table 3) generally reflect the findings of the evaluation team: UNICEF’s mainstreaming work has been limited, with health and nutrition integration particularly weak. Education scored themselves relatively higher, primarily related to establishing a protective environment for girls in schools: “Identifying and pre-positioning age-, gender-, and culturally appropriate supplies for education that can mitigate risk of GBV” and “Advocating for the integration of GBV risk-reduction strategies into national and local laws and policies related to education, and allocate funding for sustainability” scored highest at 4 and 3.5. These elements of integration were not specifically mentioned to the evaluation team during KIIs and were not observed in project documents reviewed by the team. They represent good practice that should be captured in a standardized way.

In contrast to the evaluation team’s findings about limited integration of GBV into Child Protection, CP colleagues also scored themselves relatively higher. This appears related to generalized protection work with children, rather than a reflection of any specific project. The highest score was in Identifying the environmental factors that increase children’s and adolescents’ risk of violence and understanding the different risk factors faced by girls, boys and particularly at-risk groups of children, with an average score of 3.67 out of 5. However, this ability to identify GBV-related concerns of girls does not appear to be systematized in a way that can be regularly captured and measured; an example of this is that the CP staff

74 The GBV Strategic Plan highlights that, “As indicated in the Gender Action Plan (2014-2017), GBV mainstreaming is a global priority for UNICEF.”
75 One KII from the CP section suggested enthusiastically—and poetically—that the SSCO needed “to fit GBV in all corners of CP.”
at the state level do not have any specific responsibilities within their terms of reference (TOR) for monitoring and reporting on GBV to the CP/GBV team.

Table 3

![Average Self Assessment Chart]

WASH scored itself lower than might be expected given the flagship WASH-GBV project, which represents an important model for integration (see box below). This may be explained by the fact that many integrated elements of the project have not yet been fully implemented (in its first year the project focused more on scaling up WASH and GBV services and integrating GBV into WASH workplans, as described in the box below). A WASH M&E consultant was hired in fall 2015 to develop WASH-GBV assessment and monitoring tools, which were just being implemented across 21 sites during the time of the evaluation. WASH colleagues also scored themselves low on coordination—surprising given that a GBV specialist from UNICEF sits in the WASH coordination meetings. There is no obvious explanation for this discrepancy, except that some of those answering the survey work outside Juba and may not participate in national cluster coordination and therefore are not aware of this integration. In Malakal, the WASH cluster is not chaired by UNICEF, so that even when the GBV specialist sits in WASH meeting, there is only one UNICEF person who attends.

One area of potential integration that is not captured in the self-assessment checklists is UNICEF’s RRM. The RRM package combines provision of food with preventive and curative nutrition and health interventions, support to re-establish access to safe drinking water and hygiene, together with child protection services and opportunities for children to regain access to education.⁷⁶ Steps were taken to promote integration across these RRM activities, such as a minimum checklist for RRM staff general do’s and don’ts linked to engaging with survivors, and some informal pre-departure briefings for RRM staff. To date, however, the RRM does not include attention to GBV as one of its specific areas of response.

This year the UNICEF SSCO plans to roll out the revised IASC GBV Guidelines across all UNICEF-led sectors. The GBV team intends to provide technical support to all of the sections to ensure UNICEF South Sudan upholds its responsibilities in this area.

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The USAID supported **WASH and GBV integrated programme** is focused on three key strategies:

1) Ensure a gender and risk analysis is conducted to define gender roles and responsibilities, cultural norms and belief in project.

2) Strengthen the delivery of effective coordinated and integrated life-saving WASH and GBV interventions to people affected by the current crisis.

3) Support vulnerable populations to better cope with shocks by strengthening their coping mechanisms.

The WASH/GBV collaboration will happen throughout the project cycle as indicated in the WASH cluster minimum commitments and IASC GBV guidelines.

In the first quarter of the new project year, (September-December 2015), UNICEF and its partners provided 83,710 people with access to improved water supply, 14,942 beneficiaries benefited from improved sanitation facilities while 65,518 beneficiaries were reached with hygiene promotion. In the area of GBV, UNICEF and partners provided 3,826 women and adolescent girls with services (including group discussions on health, GBV and other issues; literacy classes; and craft-making) in 8 Women Friendly Spaces (WFS) in Malakal, Wau Shiluk, Bentiu, Pochalla, Akobo, Nasir and Juba. As noted above, the UNICEF GBV team supported the WASH section to systematise GBV risk mitigation into their work plan, monitoring tools (such as the “latrine minimum checklist”) and programme cooperation agreements (PCAs).

Moving forward, UNICEF will also support the WASH cluster to systematically mainstream GBV into their work plan and standards i.e. through its M&E tools, cluster standards of WASH services, i.e. Menstrual Hygiene Management, WASH facilities (latrines, bathing facilities) and evaluation. A key element of the WASH-GBV collaboration will be monitoring, evaluation, and documentation of processes in order to help support similar risk mitigation efforts in other country contexts. UNICEF is implementing this strategy in three different types of locations: a) PoC or other IDP settings where main focus is humanitarian response; b) transitional location where main focus is recovery; and c) long-term developmental areas that are not affected by this current conflict.

4.1.4 Theory of Change

The SSCO GBV team does not have an explicit theory of change for GBV programming. However—and after working for several years according to what one GBV colleague described as an “implicit strategy”—in late 2015 UNICEF developed a written strategy for 2016 with clear objectives informed by and relevant to the South Sudan context. The strategy reflects a tactical approach that clarifies UNICEF’s added value within the GBV community in South Sudan. Situated within the larger South Sudan GBV SC strategy, it is designed to redress gaps in the SC strategy (which is focused heavily on CMR) as well as build on the SSCO’s key strengths and lessons learned, particularly to the extent that it prioritizes capacity building and monitoring and evaluation as cross-cutting issues.

When comparing this strategy against UNICEF’s corporate TOC, there are many areas of overlap in terms of the commitment to providing quality services, reducing GBV through support to risk mitigation, and promoting community-based prevention. The one major area of UNICEF’s corporate TOC that is not evidenced in the SSCO strategy is related to supporting State and other duty bearers to uphold responsibilities to address GBV. Even if not explicitly articulated as a component of the strategy, work with State and duty bearers is being undertaken, for example, with training to police and the MOH, and support to the MoGCSW through training of social workers as part of the IsraAid project, as well as through regular consultation.

4.1.5 Adapting to Changing Needs

In general, it is extremely challenging to adapt to changing needs in South Sudan because this more often means having to mobilize support for a new crisis rather than being able to scale up interventions according to a linear progression towards post-emergency/development. UNICEF’s ability to preposition dignity kits and MISP supplies has facilitated rapid response to women and girls in crisis, evidenced by the evaluation team and described below (section 4.2.2) in the Malakal emergency response. Another example of UNICEF adapting its approach to meet beneficiary needs relates to UNICEF’s work on CMR. Much of UNICEF’s early work to address GBV focused on the provision of PSS through WFS and other entry points. UNFPA led with health services. However, when gaps in CMR became a barrier to undertaking awareness raising and PSS programming, UNICEF decided to scale up their focus on CMR.

UNICEF’s GBV strategy for 2016 also reflects UNICEF’s ability to adapt to changing needs insofar as it reflects an attempt to find a balance between ensuring increased access to services for women and girls, as well as improving quality of existing services. While in 2014 and 2015 UNICEF focused on scaling up both the number of implementing partners for GBV and the geographic coverage of interventions, in 2016 UNICEF’s core aim is to improve quality of services and monitoring and evaluation among existing partners in an effort to establish a stronger foundation for evidence-based programming. One exception to this

The 2016 UNICEF South Sudan GBV strategy includes three pillars – strengthening systems for quality GBV service provision; promoting community-based prevention of GBV; and integrating GBV risk mitigation into other sectors’ interventions. Capacity-building and M&E are cross-cutting elements of the strategy that reinforce the three pillars.
approach will be CMR because it remains a major gap across the country: UNICEF plans to continue to support a mobile CMR training team with the aim of expanding CMR services to new locations.

4.2 Effectiveness
The extent to which the programme/activity is achieving or is likely to achieve its stated purposes, on the basis of outputs delivered.

4.2.1 Improved Access to GBV Services for Care and Support to Survivors
UNICEF estimates that in 2015 82,188 beneficiaries have received GBV prevention & response services—with psychosocial support, case management, medical care and key information—through their programmes. This is a major achievement—and one that happened relatively rapidly—considering the dearth of services available to women and girls prior to UNICEF’s intervention (the evaluation team were told that in most of UNICEF’s operational areas there were almost no services prior to UNICEF presence). However, as is noted below, when measured against the scale of need the scope of services being supported by UNICEF (and other GBV actors in South Sudan) is still small.

4.2.1.1 Health Response: Clinical Management of Rape
One effective way in which UNICEF has tried to redress the lack of services is through a mobile CMR training team. This approach is useful because the team can be deployed to not only improve coverage in existing service delivery sites, but also open the door to undertaking programming in additional locations. In 2015, 144 service providers from more than 50 health facilities were trained on CMR in Wau (Western Bahr el Ghazal), Yei (Central Equatoria), Juba (Central Equatoria), Yambio (Western Equatoria) and Rumbek (Lakes). An additional 56 clinical health care providers across 18 health facilities (in addition to 62 non-clinical staff) have been trained so far in 2016 in Unity, Jonglei, Lakes and Upper Nile states.

In Lakes, 25 health workers from 16 health facilities in Lakes state were trained using IRC’s clinical care for sexual assault survivors (CCSAS). One crucial element of this training is the follow up supervision visits of the CMR team to support implementation of learning.

4.2.1.2 Police Response and Social Services
The IsraAid project—although as yet limited to two states—is also promising in terms of its strategy for improving access to services through joint training to police and social workers, as well as the development of a referral pathway in Juba that lists 24 focal points (including 2 attorney generals) designated to provide care and support to survivors. Even though the information available is on a small scale, the IsraAid approach of in-depth capacity building seems not only to be improving availability of referral services, but also likelihood of community members to seek support. At the end of the pilot period for the Juba project, 70% of community members reached through FGDs expressed a willingness to access services, whereas at the start of the project there was reportedly wide scale distrust of service providers. And while numbers of survivors accessing health care remain small, there is some evidence of increased reporting to police (e.g. from around 3 reports per month during the first months of the project, to 22 reports in the last recorded month of the project).

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77 GBV Briefing Note, 2016.
78 Ibid.
79 Ibid.
80 See IsraAid Summary Evaluation Report, Nov 2015. Because the baseline and the end line data collection measures were not standardized, it is hard to ascertain the exact degree to which perceptions about help-seeking improved. Even so, there appears to be a significant shift towards positive attitudes towards service providers.
4.2.1.3 Women and Girls Friendly Spaces
UNICEF is supporting 8 WGFS in two of the 10 states. While coverage is relatively small, the evaluation team received positive feedback from WGFS participants about the value of the spaces. Those who participate in the WGFS in Malakal say they have developed a sense of community and safety in sharing issues:

“In the centre, we are happy when we sit together like this because we share ideas...if you have something that is paining you, you can tell someone. And also we do receive some of the messages here in the centre that can make change...”

However, one area which FGD participants repeatedly raised as a major concern was the lack of income generating activities in the WGFS. The WGFS provide some opportunities for women and girls to earn a little money from making handicrafts (beadwork, embroidering sheets or basket making) which in Juba the INGOs take and sell in Juba hotels, returning the money to those who made the crafts. In Malakal women and girls also receive supplies for beadwork and embroidery, but there is no organized strategy for selling what is produced.\(^{81}\)

FGD participants from two IDP WGFS around Juba expressed frustration that there was not more support to livelihoods, saying they were struggling with an inability to pay school fees, to buy sufficient food to feed families and to pay for clinic services to give birth.\(^{82}\) In Malakal, the lack of income generating activities was linked by FGD participants to women going outside the camps to collect firewood to sell, which puts them at significant risk of rape (see 4.2.3 below). Participants further suggested that women who were the most vulnerable—such as single-headed households—might not ever attend a WGFS because the spaces did not support their economic needs and they therefore do not have the time to engage in the WGFS social activities. Thus the lack of livelihoods was linked by FGD participants to lack of access to WGFS for at-risk women and girls.

This may go some way to explaining why some women and girls in Malakal seem not to use the WGFS to report their GBV concerns. In their donor report related to the WASH-GBV project, UNICEF highlighted that in Upper Nile

“Most girls and women report their security concerns to community leaders and community watch group but not GBV actors or UNPOL. Detailed thorough analysis of why girls and women do not seek support from GBV actors or protection actors on safety issues needs to be conducted and linkages with community leaders/community watch groups and GBV service providers need to be strengthened for effective referral.”\(^{83}\)

Recognizing the preference for reporting to community structures, UNICEF and partners have begun training community leaders and watch groups in GBV basic concepts, referral pathways, and guiding principles in order to support access of survivors to services. And, in order to improve the effectiveness of WFS and ensure commonly agreed-upon standards, UNICEF has commissioned the development of

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81 While there is no market in Malakal at the moment, IMC periodically organises exhibition events inviting UN and NGO staff to visit the centers, see items produced by women and buy them. Minimal proceeds generated from these sales are shared among beneficiaries.

82 One group of IDPS had lost their cattle through raids and therefore their economic base which was why they came to Juba and remained as IDPs, not able to go home with no cattle to support them.

83 Key findings and recommendations from the barriers assessment conducted in Upper Nile and cited in the USAID WASH/GBV Donor Report, 2015.
WGFS guidelines for South Sudan. However, they were not finalized at the time of the evaluation and therefore could not be reviewed for inclusion of livelihoods and other quality of care components.

### 4.2.2 Timely Response

In 2014, UNICEF rapidly reoriented its programming from supporting the development of a newly independent South Sudan to providing essential services and supplies to Greater Upper Nile. In 2015, humanitarian needs increased both in scope and in scale, requiring UNICEF to move more supplies and provide more services than ever before. As mentioned previously, the GBV team shifted from one member to 5 within a year, and UNICEF’s work on GBV was scaled up from 2 states to 6, and from 2 implementing partners to 11. Programmatic approaches such as the mobile CMR team and the prepositioning of supplies facilitate the ability to respond quickly to new crises, despite the significant contextual challenges related to geographical access, security, etc.

A particularly strong example of timely response that the evaluation team had the opportunity to observe was in Malakal following the recent crisis. As a result of violence in the Malakal PoC on 17 and 18 February 2016, at least 25 people, including three aid workers, were killed, and more than 120 wounded. About 3,700 families’ shelters were destroyed or damaged during the fighting and fires, and about 26,000 of the IDPs fled inside the UNMISS base, while around 4,000 IDPs fled from the PoC to Malakal town, where they are staying in public buildings and abandoned houses. Two of three clinics providing CMR as well as three women’s centres were destroyed/looted. UNICEF ensured GBV services were restored within the same day of gaining access to the PoC and created a temporary referral pathway. An emergency work plan was developed to coordinate GBV response efforts (led by UNICEF in Upper Nile State).

![Malakal POC following the destruction of the fighting (black areas are burnt portions of the POC).](image)

Key activities included:

- Two emergency women’s centers re-established to provide CM/PSS & referrals for CMR
- CMR services incorporated into emergency health response and CMR supplies re-stocked
- National staff & volunteers mobilized to inform communities about new GBV services and locations, and information disseminated on local radio

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84 There is a precedent in UNICEF SSCO for livelihoods, from which lessons learned could be applied to income-generation in the WFS: vocational and livelihoods skills training is supported in education and DDR programming, and social protection is engaged in cash transfers.
• Interim referral pathway established & key messages on essential GBV services displayed and distributed
• Service providers sensitized on GBV referral pathway
• International GBV manager deployed by IMC to support GBV response
• Dignity kits and solar lamps mobilized with support from UNICEF, UNFPA, UNHCR, IMC and the national GBV SC
• IASC checklists shared with WASH, Protection & CCCM sectors to promote GBV risk mitigation and prevention

4.2.3 GBV Prevention

GBV prevention is one of the three pillars in UNICEF’s 2016 GBV Strategy. Communities Care is the main vehicle through which the strategy aims to support prevention, but UNICEF has also developed a plan—not yet implemented due to competing priorities and funding constraints—to undertake efforts to streamline community messaging in order to ensure ethical and effective approaches. While not explicitly identified as a prevention activity in UNICEF’s GBV Strategy (or elsewhere that the evaluation team could identify), UNICEF has in the past undertaken efforts to address concerns related to firewood collection, which the evaluation team found the need to revive, as described below.

4.2.3.1. Communities Care

UNICEF is currently supporting the Communities Care (CC) Programme to address negative social norms linked to GBV and gender inequality and transform them to norms that uphold girls and women’s rights, while also supporting improved response services for survivors. In 2015, the programme engaged 520 people (44 per cent female) in community discussions and in making commitments to address gender inequality.85 Outside of the CC Programme, the GBV team is supporting several of its IPs to incorporate select elements of the CC Programme into their community outreach—this is a new initiative for which information is not yet available.

4.2.3.2 Community Awareness-Raising

UNICEF has also supported its IPs in undertaking community awareness-raising related to GBV through the WGFS outreach activities as well as through other outreach activities conducted by the local NGOs UNICEF supports in its capacity-building work (see 4.4.1 below). Women IDPs in FGDs near Juba said they had “learned about GBV and gained a lot” from the awareness-raising in WGFS. They now knew not to send their children out alone but in groups; that if there are cases of GBV they should report them; and knew to get help from social workers and/or protection focal points in each community.87 They also said they understood “that we shouldn’t marry our daughters at 13 years old, and that our daughters should stay at school until they are 18!” They planned to take their knowledge back to their homes when they return. A group of young men FGD participants said that as a result of community-awareness raising they

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85 As noted previously, the evaluation team did not include the Communities Care project in the RTE because it is currently being evaluated separately.
86 SSCO RAM Template, 2016.
87 Each WFS appoints focal points – one from each tribal group if the WFS includes several tribes within its participants. Focal points are women community leaders who are trusted and who can raise awareness of the WFS and services which they offer and can be points of contact for those wishing to seek help within communities.
knew that “women need to go in groups to get grass for thatching, and some prostitution has reduced as a result of the awareness raising.”

To date, the community awareness raising messages have not been standardized across IPs, and in South Sudan generally. UNICEF intends to create guidance on community mobilization/awareness raising in order to ensure that basic messaging related to GBV is in line with good practice which will include, at minimum, 1) what is social mobilization/awareness raising in the context of GBV programming, 2) what are some demonstrated methodologies for mobilizing communities, 3) development of effective communication materials, 4) how to select effective communication channels/methods, 5) M&E tools for measuring the utilization and effectiveness of GBV-related social mobilization/awareness raising programming. The final document will be shared with UNICEF partners and with the broader GBV sub-cluster membership for endorsement and uptake. UNICEF has designed a proposal for this important work, but at the time of the evaluation it had not been approved by the SSCO for submission to donors.

4.2.3.3 Prevention of Violence linked to Firewood Collection

During the real time evaluation, the issue of rape during firewood collection outside the Malakal PoC was raised as an on-going problem, despite previous efforts by UNICEF and other protection partners to advocate with UNMISS for the deployment of firewood patrols. Even though UNICEF shared with UNMISS the specific times that women want to go out of the PoCs, the patrolling has been inconsistent and UNMISS is not covering all areas outside the PoCs. Reportedly there have been examples when firewood patrols have functioned more effectively, both in the Malakal POC and in the Bentiu PoC, when there was a strong UNMISS focal point to ensure regularity in patrolling.

While the burden of responsibility for firewood patrols rests with UNMISS (an important point of advocacy for UNICEF and other GBV partners), it is concerning that there are not alternative fuel solutions for the most vulnerable. Alternative fuel solutions have been explored, but a meaningful project has not been introduced for myriad reasons, including budget issues, sustainability, questions about utility of fuel efficient stoves, and whether or not alternative fuel solutions will meet women’s essential needs. In the absence of alternative fuel options, women continue to go out to collect firewood. And because these women are among the least likely to have the time to participate in the WGFS, they may not report an incident because they have not benefitted from the trust-building within the WGFS that can encourage help seeking.

In the words of one FGD from the Malakal WFS, “the issue of sexual violence is daily happening but most of the cases are when women go out, but when they return they don’t report cases…they are fearing of shame.” A KII agreed that “reporting is a big problem—they don’t feel free to report, and if they do, it’s after 72 hours.” In the Malakal PoC, IMC received 9 cases of sexual violence in 2014, and in 2015 there were 15 cases. According to the nurses receiving the cases, most reported being raped in Malakal town

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[88] These adolescents were not part of CCC awareness raising activities as they work with women and girls, but they had had some discussions on GBV.

[89] Because many women are selling the firewood they collect, rather than using it themselves, there’s concern that introducing alternative options a) may not address the problem and b) could actually have a negative effect on income generation. Any alternative fuel solution must be carefully considered and piloted to determine best strategies for meeting the needs of women and girls.

[90] KII. Notably, there are two other providers in addition to IMC offering CMR within the POC.
or along the river—and this happens when they go to look for firewood.\textsuperscript{91} This suggests an urgent need to re-examine the possibility of introducing alternative firewood schemes.

4.2.4 Risk Mitigation across UNICEF Sectors

As mentioned previously, and as acknowledged by SSCO, there is significant room for improvement in undertaking risk mitigation across UNICEF’s sections, which is being planned to link with the rollout of the 2015 IASC GBV Guidelines. To date, the most evident areas of effectiveness related to risk mitigation are in PBEA and WASH. For PBEA, programme monitoring has illustrated the value of the revised curriculum: an M&E specialist for PBEA collected stories from communities in Yambio indicating that the radio programmes are empowering the women and helping them to become ‘opinion leaders’ (a PBEA desired result). The women reported that they feel enabled to have conversations about challenging issues with the men and youths as a result of the audio/digital prompted discussion groups, and they are now voicing their opinions about not raiding cattle to gather dowries because it can lead to violence against women. These results are only happening in one small group of people, but indicate that the approach could be scaled up.\textsuperscript{92}

Even before the current WASH-GBV project, UNICEF GBV staff in Malakal was working with WASH sector partners. Strategies were developed collaboratively related to latrine structure and placement. WASH were encouraged to use different color sheeting for latrines for males and females along with illustrations and words for signage. Regular joint walk-arounds were conducted by GBV and WASH staff to ensure that latrines were being built according to specification, identify issues, and brainstorm solutions. FGDs were held with beneficiaries, in which women reported enhanced safety. Success factors related to this project were linked to the fact that GBV staff recognised the good work of WASH and focused their support on very practical suggestions, keeping the responsibility for the programme within WASH (rather than shifting it to the GBV team). The GBV team also focused on the fact that WASH were making their own programming better, never using ‘mainstreaming’ language, but talking about enhancing dignity, privacy and safety of WASH projects, and using language which was familiar to WASH cluster colleagues. The GBV team went to WASH cluster meetings and developed a practical tool together with WASH actors.\textsuperscript{93} This “fantastic work”\textsuperscript{94} in Malakal reportedly generated concrete results that trickled up to the national level because it illustrated how GBV mainstreaming helped WASH actors to achieve their own goals.

While the current WASH-GBV project has yet to generate results on effectiveness related to safety reduction, the evaluation team found that the project appears to be having a positive ripple effect within the SSCO related to a heightened awareness of GBV issues linked to WASH. In the words of one programme specialist:

“I think there are certain activities we are running that we didn’t think were linked to GBV but they are...like we are putting gender-segregated latrines in schools. We are making very clear to partners that whatever facilities go in school are segregated. I think my eyes have been opened a

\textsuperscript{91}UNPOL was also identified in Malakal as a weak partner, one that “has teeth but can’t bite.” Another significant gap is the absence of safe shelter; A KII in Malakal strongly pushed for the existence of a safe haven outside of the POC but in close proximity to UNMISS.
\textsuperscript{92}KII, UNICEF.
\textsuperscript{93}Lesson Learned GBV WASH in Malakal, April 2015.
\textsuperscript{94}KII.
According to an interviewee, this heightened awareness among colleagues outside of UNICEF’s GBV team is unusual, in part because UNICEF structures and processes do not generally facilitate cross-sectoral programming. The WASH and GBV colleagues reportedly worked well together because they planned and wrote joint donor proposals, but in the absence of GBV focal points or a designated staff person to facilitate this kind of mutuality, it is not likely to occur:

“UNICEF always talks about convergence in all CO, but to do this you have to spend time and sit together and plan together. UNICEF planning is done by section and donor proposals are done completely separately, which makes it difficult to integrate GBV after everything was planned and funds mobilised. In emergencies, there is pressure to write proposals in 3 hours sometimes, which makes it impossible to write joint, integrated programming proposals.”

4.2.5 Capturing and Using Programme Results

Monitoring and evaluation is a major component of the SSCO’s 2016 GBV strategy, which places high value on M&E in order to improve quality of services. There are a number of excellent and forward-looking strategies that the UNICEF GBV team is developing, even in the challenging context of South Sudan. For example, the GBV team is currently developing methods for trying to improve reporting of partners against indicators from the strategy document—and linking those indicators to donor reporting. The intention is to develop a master framework where partners have indicators they can select from—and identify additional indicators as necessary—that are consistent with both the strategic plan and donor indicators. According to the GBV strategy, partners will conduct their own internal monitoring (supported through capacity building, described in section 4.4) and report according to PCA requirements. Information reported will be subsequently verified through regular field monitoring visits, which will also provide an opportunity for field monitors to identify areas for additional technical support.

In addition to the monitoring of local implementing partners linked to capacity building, the GBV team has expended considerable time and effort in improving IPs’ abilities to capture and use programme results. As noted previously, tools have been developed with IMC and Nile Hope to obtain feedback from beneficiaries on interventions. More intensive support has been provided by UNICEF to IsraAid to develop an innovative suite of M&E tools and systems aimed at more effectively capturing results, analyzing programming, ensuring accuracy of reporting and the application of learning based on monitoring results to improved quality of interventions.

In one example of a very promising practice identified by the evaluation team, IsraAid’s staff and partners have been trained to use a “Monitoring and Evaluation Matrix.” The Matrix contains tools that can be used to evaluate the knowledge and practice of three target groups: 1) community members; 2) community-based focal points; and 3) service providers working with vulnerable communities, especially with GBV survivors. A list of the tools for service providers is below.

<table>
<thead>
<tr>
<th>Tool</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Checklist for Service Providers.</td>
<td>To verify whether the basic principles for service provision are respected, including ethics and skills (PFA and referrals).</td>
</tr>
</tbody>
</table>

95 KII, UNICEF (Education).
96 KII, UNICEF.
On a broader scale, UNICEF’s GBV strategy is supporting a variety of initiatives: this real time evaluation; an evaluation of the Communities Care programme; and an evaluation of the WASH-programme. The outcomes of these evaluations will be used to determine UNICEF’s GBV strategy for 2017 and contribute to the GBV knowledge base in South Sudan and at the global level. UNICEF is also part of the technical advisory group for the What Works study.97

Even with these important and innovative approaches to capturing and using data for improved programming, significant challenges measuring/reporting on specific GBV interventions remain. These challenges are certainly not exclusive to South Sudan—they are inherent in all GBV programming when attempting to quantify and assess performance. Underreporting by survivors (which appears to be very high in South Sudan) means that programmes with service delivery components cannot measure or report on their “success” based on increased numbers of survivors accessing care (and without a baseline, increases or decreases in survivor reports is hard to interpret). Even for programmes conducting awareness-raising or other non-service delivery activities there are challenges in the extent to which partners can both access and share GBV data that may emerge in their work. As a consequence, according to one interviewee, the GBV reporting of the UNICEF SSCO is linked primarily to activities and outputs rather than higher level outcomes.98 According to the GBV team, some colleagues (both internal to UNICEF and within the wider humanitarian community) perceive this level of reporting to be somewhat “fluffy”, signaling the importance of conducting on-going education about good practices in reporting on GBV programmes.

Another challenge identified by the evaluation team is that numerous field-based protection data collection systems are not fully aligned. This challenge, as with programme reporting described above, is not exclusive to UNICEF. However, it is a limitation in the GBV community in South Sudan to which UNICEF may be inadvertently contributing. One KII noted that humanitarian partners use different—and sometimes unaligned—assessment tools when investigating GBV issues, resulting in “an acute challenge

97 See: http://www.whatworks.co.za/about/what-works-components/what-works-vawg-in-conflict
98 One major exception to this is the Communities Care programme, which collects information on opinions of the community before, during and after the programme. However, as noted previously, Communities Care was not a part of this evaluation.
during the Humanitarian Needs Overview (HNO) process.” This was evidenced by the evaluation team in the Malakal PoC, where various protection actors were employing different tools and modalities for assessing and monitoring protection risk; in particular, community-based protection monitoring mechanisms developed by protection actors were distinct from community-based GBV monitoring systems developed by UNICEF IPs as a component of outreach of the WGFS. The protection monitors might receive reports on GBV but, according to one interviewee, it was conceivable the report might never reach the GBV team because of different processing paths, even though relationships and coordination were strong among humanitarian protection and GBV actors.

4.2.6 Leadership Contribution
According to several KIIIs, UNICEF leadership has a “willingness to say things which may not be popular but are critical to say.” For example, UNICEF has reportedly been consistently outspoken in the HCT about atrocities, including issues related to protection, CP, and GBV. While the team was visiting, the Head of Office presented at the Roundtable Discussion for International Women’s Day (March 11) speaking about UNICEF’S role in addressing GBV. This willingness to highlight protection abuses is highly valued by some donors and partners. UNICEF also co-leads the country task force on MRM.

4.2.6 Regional and HQ Support
Until recently there has been no GBV expert in the Regional Office (RO) providing technical support and helping mobilise additional funds for GBV. There is now a Gender Advisor in place who intends to provide support as possible to South Sudan, and is considering hiring a GBV specialist to her team. Given the high level of need in South Sudan, the evaluation team views this as a highly positive development. Coordination with the RO may also provide an opportunity to introduce strategies for cross-country learning of South Sudan partners as an added element of the capacity building approach.

The GBV team in South Sudan has also received significant and valuable support from UNICEF HQ, including multiple support missions; fundraising support; technical review of key documents and resources (e.g. the capacity-building strategy); bi-weekly consultations linked to the Communities Care programme implementation, etc.

4.3 Coverage
The extent of UNICEF’s programming reach (geographic and numerical) compared with the needs of those at risk of or affected by GBV as assessed by UNICEF and/or the GBV sector as a whole.

In 2015, UNICEF reached:
- 82,188 beneficiaries for GBV prevention and response based on a target of 80,000
- > 500 service providers, trained in survivor-centred GBV response, including police, government social workers, and community-based partners
- 144 individuals in more than 50 health facilities trained on CMR, based on an initial target of 20 health facilities
- 12,146 WAG received dignity kits
- Eight WGFS are operating in six locations and more than 1000 girls/women access the spaces monthly

99 Note this information was gleaned from discussion with the RO for ESARO.
• 51 people from NNGOs and government ministries trained on GBV basics

Given the scope of the problem of different forms of GBV and the attendant lack of baseline data, it is virtually impossible to compute coverage in South Sudan. What can be noted, however, is that UNICEF’s GBV coverage is based geographically where partners are available and interested to work as well as where there is an identified need (particularly in terms of mobile CMR training)—which is almost everywhere. In part UNICEF’s determination about where to programme is a reflection of the ubiquity of needs: “coverage is so scarce, you could set up a programme anywhere.” It is also related to lack of access to certain areas, issues of recurrent conflict, the lack of available partners, etc. While most of these issues are beyond UNICEF’s control, UNICEF is tackling the latter issue through its capacity building strategy for local partners. In one example of how the capacity building approach will expand coverage, 4 partners who had never before implemented GBV programming (WOCO, HRSS, MAYA and SRDA) were identified in 2015 through GBV Basics training and supported to “enter” the foundational level of capacity-building, coupled with a peer-to-peer support arrangement with a higher-capacity international NGO in the same location.

UNICEF’s CMR training teams—which are anticipated to expand reach nationally-- are also a tool to assist UNICEF to identify new locations for more comprehensive programming and expand strategically into underserved areas.

UNICEF’s integrated WASH-GBV project is another strategy for scaling up programming: donors are reportedly “keen” to support this type of collaboration as it is perceived as an efficient use of increasingly limited resources, particularly in the South Sudan environment where operating costs are very high and where funding may be decreasing. The WASH-GBV project is exceptional in its degree of integration in that it includes mainstreaming strategies as well as support to GBV-specialized programming. Integrated approaches are reportedly easier for some donors to fund because they can draw from a wider variety of financial resource allocations.

4.4 Sustainability / Connectedness
To what extent emergency response activities take into account and support a longer-term approach, including in connection with UNICEF’s regular development programming.

4.4.1 Building National Capacity and Ownership

Systems Building. UNICEF’s work with IsraAid on training police and social workers is an excellent example of an approach directed at building sustainable capacity of service delivery systems. In 2015 the IsraAid project trained 33 police in its first pilot in Juba. A year later, the commitment of trainees reportedly remains high: 18 police who were trained are still in post and liaising with the community. Out of 15 social workers trained in the joint police-social workers program, 11 are committed to the implementation of the programme and active after the training in the period from June to October. (Commitment is measured through the consistency of presence to both bi-monthly joint coordination meetings and bi-weekly community-based activities, including awareness-raising/outreach activities, preparatory meetings and FGD with communities.)

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100 KII, UNICEF.
The effectiveness of the IsraAid project has been recognized by the National Police Services and the Ministry of Gender, Children and Social Welfare (MoGCSW), who are interested in scaling it up. It is the basis for UNICEF’s current work with UNDP and other partners to develop a standardized GBV-related national training curriculum for the police, which will link to the trainings UNICEF is planning to support for the police school related to justice for children. And, as highlighted above, UNICEF was also reportedly instrumental in advocacy for drafting as well as in dissemination of a memo from the former Inspector General of Police (IGP) stating that the Form 8 was not necessary for a survivor to access health services.

**Sustained norms change.** Although not a target for the real time evaluation, the Communities Care programme approach was also flagged by several KIIIs as a potentially effective strategy for long-term social norms change in South Sudan, particularly because of its community-based approach, which was described by one donor as “a very relevant choice of programme approach by UNICEF.”

**Building capacity of national IPs.** Perhaps most notable in terms of strategies for sustainability is UNICEF’s commitment to building the capacity of NGO partners. According to one KII, “where UNICEF is directly supporting partners is where UNICEF is leading.” In 2015 UNICEF brought in a GBV specialist to promote capacity of CBOs. In part the impetus for the capacity building work was driven by the relative lack of international partners across South Sudan, but the significant commitment to “making small systems work” has resulted in the design and implementation of a model approach for support to local NGOs “which indicates a deep understanding of the context.”

UNICEF designed and implemented a “step model” for support to NGOs, illustrated below. The base of the pyramid represents the most introductory level interventions (requiring the least advanced skillset and fewest resources), while the tip of the pyramid represents the most complex interventions (requiring staff with high GBV capacity and more resources). The wide base of the pyramid also reflects the fact that the majority of GBV actors in South Sudan currently operate at the most basic level. However, partners at higher levels of the pyramid often implement some elements of programming at the lower levels, such as awareness raising.

Through capacity building such as on-site technical support, peer-to-peer learning and development of guidelines/minimum standards, UNICEF seeks to enable partners to “graduate” to implementing GBV interventions illustrated in the higher levels of the pyramid. Close monitoring and evaluation of projects is aimed at supporting quality implementation and shaping the technical support provided by UNICEF’s GBV team.

In the second half of 2015, UNICEF GBV staff conducted more than 20 field visits to provide direct mentoring and technical support to GBV partners. The on-the-ground presence and ongoing engagement with partners has been used as a complementary approach to reinforce the material covered in more traditional, classroom-style trainings. 51 participants (23 female and 28 male) completed the three-day “GBV Basics” foundational training, of which 33 came from national organizations, 11 from government ministries and 7 from international organizations. In total, 19 organizations (15 national and 4 international and all operating in emergency-affected areas) were represented along with 3 government

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**UNICEF’s “tiered capacity development is really good practice, technically and contextually appropriate...and it provides a potential opportunity to have a uniform tool for capacity building to be used outside UNICEF-specific partnerships.” -KII, Donor**

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102 KII, Donor.
ministries. Two peer-to-peer learning workshops were convened to allow partners to share experiences and best practices and to learn directly from one another. Average improvement from pre-test to post-test was 29.3%.  

According to one UNICEF colleague, following the more targeted and strategic capacity building, several national NGOs started getting funds from CHF and other donors, and have stronger teams and a much bigger geographic coverage. The evaluation team agrees with a donor interviewed during the RTE, who characterized this approach as “smart— tiered capacity development is really good practice, technically and contextually appropriate...and it provides a potential opportunity to have a uniform tool for capacity building to be used outside UNICEF-specific partnerships.”

**Relationship with government.** The UNICEF GBV team has a strong relationship with government partners, particularly with the Minister of Gender, Children and Social Welfare (MoGCSW). However, given the instability within government following from the 2013 crisis and frequent rotation of Ministers and government staff, investments in government capacity-building and/or legal reform have not been prioritized. One key area for growth in terms of sustainability the evaluation team noted is **opportunities to reengage more actively with government**, particularly around policy and legal frameworks to support prevention of and protection from GBV. There is legislation against sexual violence and child marriage that has been passed but which has yet to be fully implemented, as well as opportunities through the development of the Family Act to lobby for improved protections related to IPV.

### 4.4.2 Linking Emergency to Longer-term Programming

Where a key challenge to sustainable approaches arises most clearly is in the question of how UNICEF intends to link its GBVI work to its development agenda. State fragility and the threat of ongoing violence means that stability in South Sudan is not assured, such that strategies must be introduced to support a development agenda even in the context of emergency response in order to ensure there is some measure

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103 Internal UNICEF PPT on Capacity Building Project.
104 UNICEF was active in passing the Child Act 2008 and has since made efforts to make some written copies of the Child Act available. UNICEF also supported the Ministry of Gender to develop a Strategic Framework to operationalize this at five levels – institutional, systems, professional, community and child levels, but it has “got stuck” for 2-3 years and hasn’t gone to the Council of Ministers (whose priorities have more recently been related to military/defence, leaving Social Welfare as the lowest funded Ministry).
of continuity in development assistance in spite of on-going emergencies in specific geographical areas. According to one senior UNICEF SSCO colleague,

“We are hoping that with the peace agreement there will be some stability. For programming even now, our mechanisms need to change—even when we do emergency we do it in a way that sets foundations—more recovery, more longer-term work that we really need to define. I would see GBV evolving in the same way as well: looking at building systems...”

UNICEF underscored its sense of the importance of linking emergency and development approaches in its 2016 CPD:

A key lesson from the country’s first United Nations Development Assistance Framework (UNDAF), 2011–2016, is the need to maintain core development programming, even during acute humanitarian crises, to prevent further erosion of the already limited capacity to deliver public services. As important is investing in capacities of subnational governments and communities to promote service continuity during crises and ensuring that conflict-sensitivity and peacebuilding are mainstreamed in all interventions. (p 8)

The CPD goes on to contend, in relation to context of GBV, “the need for programme continuity from the current cycle, given that indicators across the programme spectrum remain largely unchanged and, in some instances, have worsened as a result of the conflict.” The evaluation team strongly supports a dual approach that will enable the GBV team to focus on long-term systems-building approaches that are critical to advancing the safety of girls and women, while also employing strategies to address emergent/on-going crises. Ensuring that UNICEF’s GBVIE work continues in its development programme is also important to preparedness, which is a major area for growth in UNICEF’s GBV programming, and in GBV programming generally.105

4.5 Coordination

The extent/nature of UNICEF CO programming contribution to realizing GBV-sector strategies/plans/priorities and how UNICEF has added value to/been affected by the GBV sector response within the CO and across the response as a whole.

4.5.1 UNICEF’s Added Value to the GBV Sector

UNICEF supports I/NGO coordination partners in Jonglei and Upper Nile (Nile Hope), Western Equatoria (CMMB), Central Equatoria (IsraAid), and also leads GBV coordination in Upper Nile State, which has reportedly produced many positive outcomes in bringing partners such as health providers and UNPOL together for a more unified response. The value of UNICEF’s coordination leadership in Upper Nile was most recently illustrated through its management of the very rapid and effective GBV-related response to the Malakal crisis, described in detail above.

At the national level, the UNICEF GBV team participates in the GBV SC (and serves as the UN representative of 6 organizations that make up the Strategic Advisory Group of the SC), the GBVIMS Task Force, the RH CMR WG, the MARA WG and the JTWG on CRSV. UNICEF’s participation in these coordination mechanisms has contributed to enhanced sector plans and policies, and has also facilitated

105 While there is some guidance on preparedness available for both GBV specialized programming and for mainstreaming, in general the field has not developed broad-based recommendations for how to undertake preparedness planning related to GBV in humanitarian settings.
UNICEF’s effort to clarify its own value-added in the overall GBV response in South Sudan. Examples include:

- UNICEF contributed “significantly”\(^{106}\) to the drafting and implementation of the 2014-2016 GBV SC strategy as well as the implementation plan for the Joint Communique.
- UNICEF is part of the team that peer reviews proposals to be submitted to the CHF.
- UNICEF has led the development of the WGFS Guidelines on behalf of the GBV SC. GBV SC members agreed to adopt these as SC guidelines.
- The GBV SC national partner members were involved in developing UNICEF’S capacity building strategy and many of the members are also benefiting from it through their partnerships with UNICEF. Any tools and lessons learnt from this programme will also be shared with the GBV SC to further inform future programming.
- UNICEF represents the GBV SC as a focal point in the WASH cluster.
- UNICEF plays a “very important role”\(^{107}\) in the GBV SC related to facilitating information sharing, undertaking collective advocacy with GBV partners, and mobilizing resources for GBV.
- UNICEF has been very engaged in designing the standardized CMR training through the RH CMR WG.

UNICEF’s has also developed a terms of reference for the Special Police Unit (SPU) Working Group in an effort to promote strategies for providing more holistic support to the SPUs following an assessment of the SPUs undertaken by DFID. The WG is not yet functioning.

UNICEF’s leadership and standard setting is further evidenced in the agency’s drafting of advocacy notes, such as “Dos and Don’ts for SitReps.” These notes outline critical issues not just for South Sudan, but for all humanitarian GBV programming, and have been shared at the global level for inclusion in the revised Coordination Handbook.

Notwithstanding UNICEF’s significant contributions to various coordination efforts that have resulted in improved leadership and standard setting for the entire GBV community in South Sudan, there has been a history of tension within the GBV SC between UNICEF and UNFPA. Several partners noted that UNICEF has been excluded—some asserted intentionally—from cluster planning processes related, for example, to the CHF, the HRP, etc. They were also not included in the GBVIMS task force until 2016, despite being a global member of the GBVIMS. While that history appears to be resolving now, tensions risk reasserting themselves in the absence of clear terms and criteria related to organizations’ roles and value-added.

This is also true with regard to the Protection Cluster (PC), where issues have arisen when the PC acts as a gatekeeper or supervisor in terms of determining priorities for GBV programming, e.g. forcing reporting on certain indicators; promoting partners to work on GBV who may not have the expertise; etc.\(^{108}\) Because UNICEF is the largest operational UN actor addressing GBV, and because coordination is a key component to good GBV programming, UNICEF’s leadership role in coordination activities (whether as the formal lead or not) is critical.

One possibly under-utilized area of coordination identified by the evaluation team relates to UNICEF’s ability to promote synergies between the MARA WG and the MRM WG. UNICEF supported multiple

\(^{106}\) KII, UN.
\(^{107}\) KII, UN.
\(^{108}\) KII, UN.
missions of the GBVIMS global surge team that included development of the MARA addendum to the GBVIMS information sharing protocol. UNICEF’s leadership of the MRM WG means that UNICEF has an existing linkage with UNMISS in terms of their joint responsibilities to the MRM. UNICEF has also facilitated a large network of agencies contributing to the MRM, which enhances diversity in sources of reports and strengthens verification efforts by improving access to affected populations. MRM data has been “critical for UNICEF’s sustained advocacy, including public statements by the Executive Director and regular briefings with officials from the Government and the Sudan People’s Liberation Army in Opposition (SPLA-iO); and with donors and other key influencers.” The links between the MARA and MRM could be strengthened through a wider ISP between UNICEF, UNMISS, and MARA in order to improve capacity to monitor and address cases of sexual violence. This might also support UNICEF’s advocacy work related to the MARA, as it has with the MRM, as well as its ability to influence UNMISS in key areas, such as the importance of regular, reliable firewood patrolling.

4.6 Efficiency

*Measure of outputs versus inputs in terms of having appropriate levels of financial and human resource capacity in place, both within UNICEF and via implementing partners, and how well these have been used to generate outputs.*

4.6.1 Funding

While the scope of humanitarian needs has grown in the last several years, the budget for humanitarian response appears to be diminishing. As of March 2016, only 6% of humanitarian appeal funding had been met. UNICEF’s GBV programme has funding until 2017 through the USAID project, which has allocated 2M USD to GBV-specialized programming support (out of a 10M USD extension grant for 2015-2017), but the funds are restricted, and it is anticipated that those funds will be spent before the end of 2016. UNICEF’s total GBV programme budget was 2,493,000USD as of December 2015. The funding gap for 2016 is significant, particularly in terms of funding for IPS, as illustrated below.

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\(^{109}\) COAR 2015.

\(^{110}\) SSCO RAM Template 2016. For International Women’s Day, the UNICEF’s Director noted that in 2015, the MRM collected 1,054 reports in which 20,433 children were affected by grave violations—8,527 (43%) were girls. A majority of these are children whose access to school was disrupted. In terms of other violations, girls were particularly affected by abduction, sexual violence, and killing. The number of reported girls affected by these three violations was more than five times larger than in 2014 (358 girls in 2014 against 1,951 girls in 2015).
Reliance on one major donor puts the programme in a highly vulnerable position, especially in the context of the shrinking funding noted by donors and the GBV team. Several donors, most notably DFID, who have a large pot for GBV funding, prefer to give money directly to INGOs.\textsuperscript{111}

Importantly, two donors interviewed acknowledged that there might be innovative ways to obtain additional funding, such as through joint programmes such as the WASH-GBV initiative. To date, there has not been a strong strategy from the GBV SC to obtain funding through partnership, and UNICEF has not engaged in any joint-funding projects. This approach may be another potential selling point for donors. \textbf{The issue of funding is urgent and requires CO leadership support.}

4.6.2 Human Resources

There was wide consensus among the evaluation team as well as among interviewees (including donors) that UNICEF’s current GBV staffing levels are the minimum necessary for the scale of the GBV problem in South Sudan; the low level of government capacity and relatively few international non-governmental organisations (INGO) working on GBV in South Sudan; and the nature of GBV prevention and response programming in South Sudan, which is particularly human resource intensive given the great need for capacity building/ongoing mentoring of national partners. That the UNICEF SSCO has committed to maintaining a GBV team was recognized by donors and IPs alike as a critical element of their success in supporting GBV programming. One donor commented that they “like that UNICEF is not reducing staff”; another noted that UNICEF “wouldn’t be able to do what they are doing without dedicated capacity.” Several IPs felt that the ability of the GBV team to provide the degree of nuanced capacity strengthening might be improved with additional staff, but would unquestionably be compromised with less staff.

However, the growing issues with funding are affecting human resources, particularly among national NGOs. High operational costs are a major concern, related to high inflation. In addition to increasing the cost of implementing activities, inflation is having a negative impact on implementing partners. For instance, the limited availability of foreign currency and the fluctuation of exchange rates make it difficult for partners to cost and plan their activities accurately. National NGOs in particular struggle to retain their staff, particularly those who are highly skilled and experienced.\textsuperscript{112}

4.6.3 Value for Money

There is no mechanism for computing value for money of UNICEF’s GBV interventions. In fact, UNICEF’s approach to capacity building might not appear to reflect value for money because of the higher investment of human and financial resources required to roll out the approach than would be required to only deliver discrete trainings. However, the evaluation team feels this approach does in fact represent value for money, insofar as the investment is focused on achieving long-term and lasting change. By supporting service provider and community capacity over the longer term, UNICEF can generate a multiplier effect that will eventually reap higher dividends than more widespread but less intensive partner support. In relation to this investment, one KII from a national NGO noted:

“\textit{Compared with other donors and partners, UNICEF understand the need to really look at the content and impact of the programme rather than generating large numbers and making numbers the focus. I admire the team in UNICEF – in order to create sustainability, you have to build systems which work and that takes time.}”

\textsuperscript{111} KII, Donor.
\textsuperscript{112} USAID Donor Report, 2015.
4.6.4 Partnerships

UNICEF was widely recognized by partners as having a high degree of technical competence and efficiency in their approach in terms of quick follow up to partner concerns and needs. The fact that UNICEF staff do not rotate quickly was also identified as a significant contributor to the efficiency of UNICEF’s GBV programme. Partners were overwhelmingly positive about UNICEF’s “unique” approach, not just in terms of capacity building, but also the way in which UNICEF brings partners together to make decisions using participatory methods. A key example of this was when UNICEF engaged in a team process with IPs to gather their inputs related to UNICEF’s strategic value in the context of South Sudan’s as part of developing UNICEF’s 2016 GBV Strategic Plan. IPs were consulted on the plan and encouraged to provide input. Having a strategic plan has reportedly been very helpful in articulating priorities to donors and other key audiences, not just for UNICEF, but also for UNICEF’s partners. In the view of various partners:

“UNICEF stands alone in quality of the support and genuine partnership.”

“UNICEF is genuinely building local NGO capacity.”

“The strongest part of UNICEF is having a GBV specialist at the field level to support us. We first started working with Kevin—and that was so important. Now we are working with Eric—he’s also maintaining the programme...it’s really good to solve problems when he’s there.”

“Even at Juba level it is very easy to come in and get support—I come in almost every week. I really feel supported. I find that UNICEF is very flexible when coming up with activities—they are very open. And it’s really easy to adapt and revise PCA. When we flag a gap they immediately respond.”

“UNICEF is doing a beautiful job—they support us, and give us incentives. About the trainings, it’s the most important thing we should be doing. These training are very important.”

“UNICEF provide something very distinctive: they are both donors and partners.”

Some efficiency concerns were raised by partners related to late payments and short-term contracts, which have resulted in challenges with programme implementation as well as retention of staff. One KII felt that short-term contracts also have the effect of discouraging IPs from thinking “big picture.” Several partners deemed the reporting requirements of biweekly reports as well as a monthly report result a repetition of reporting and unnecessary work. However, in the view of the evaluation team, and given the nature of the intensive mentoring model of capacity strengthening, this level of reporting is appropriate and part of the capacity strengthening process.

One IP felt that UNICEF was “not out there” in terms of their GBV priorities; in other words, the partner felt it was not clear what UNICEF’s focus was on GBV, making it challenging for the partner to know when and if they should or could pursue funding opportunities with UNICEF. Another IP observed that in terms of UNICEF’s resource allocation “I don’t feel the GBV programme is given the needed attention—most of the resources go to CP and education.” The evaluation team observed several KIIIs perceived that UNICEF’s GBV work focused on violence against children, which is an important misperception to clarify for the humanitarian community in South Sudan.

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[113 Kevin and Eric were and are, respectively, the international GBViE Specialists deployed to Malakal.]
As described in section 2.2 above, PSEA is outside the scope of this evaluation. However, given the recent high profile cases involving UNICEF in the Central African Republic (CAR), the team were asked to include a few questions on the existence of clear policies and guidelines in the CO, and levels of familiarity among CO staff of these, should SEA allegations be made. Also, in countries where allegations have been made of UNICEF staff and partners, whether SEA victims are referred to existing GBV services.

Many interviewees were familiar with one or two cases of PSEA reported in South Sudan, and several suggested that SEA is a much greater issue than reported cases suggest. However, none knew of the outcomes of any case(s) (understandable given issues of confidentiality). The SRSG has requested quarterly reports on PSEA. According to one interviewee SEA “figures hugely” for organizations in South Sudan, but there is no uniform understanding about reporting or how to provide support to individual victims or those at risk.

UNICEF RO with HQ has developed a draft PSEA training package which has been reviewed by several members of the GBV team. Training was scheduled for last year but was not completed at the national level, although the UNICEF GBV specialist in Malakal has conducted training with staff there, and has also developed posters on the code of conduct which were displayed in UNICEF offices. With UNICEF support, IMC in Malakal is also conducting community awareness about reporting and access to services. The UNICEF Deputy Representative provided inputs on the PSEA Task Force TOR for South Sudan and is drafting a paper on PSEA for the UNCT and UNMISS, encompassing INGOs and NGOs, in order to support a system of response. In 2015 the Secretary General’s bulletin was shared throughout UNICEF and with IPs, and focal points have been identified within UNICEF.

Even so, there is no in-country focal point network. The reporting channels are not well-defined and it is not clear how survivor response to PSEA can and should be linked to GBV service delivery. In Malakal, in the absence of community-based complaints mechanisms, PSEA messages are included in basic messages about accessing services in the POC. PSEA messages and information about accessing PSS and CMR services are also included in GBV awareness carried out in the Malakal POC by IMC.

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### GOOD PRACTICE CASE STUDIES

- Coordination in Upper Nile, including Malakal response
- Joint WASH-GBV project

### CONCLUSIONS

**Successes**

1. UNICEF’s GBV-specific programming in South Sudan is informed by regular assessments and monitoring to enhance the ability of programmes to meet the needs of beneficiaries. A focus on prevention, risk mitigation and response has been prioritized in line with a South Sudan Country Office (SSCO) GBV strategic plan relevant to the needs of South Sudan and in line with the GBV Subcluster (SC) strategy. **UNICEF’s focus is also highly consistent with global good practice for addressing GBV in emergencies as well as core UNICEF strategies and UNICEF’s draft GBViE Programme Resource Pack.** (Relevance)
2. UNICEF’s WASH-GBV project not only represents a model for good practice in integrated programming, it is a strategic approach to generating funds for GBV programming insofar as donors report enthusiasm for supporting integrated initiatives. The WASH-GBV initiative facilitated strong relationships between the WASH and GBV teams because of the need to plan and write joint donor proposals, and has also raised the profile of the value of integrated approaches within the UNICEF SSCO. (Relevance)

3. UNICEF has developed a number of contextually responsive and innovative approaches that not only contribute to overall effectiveness of its GBV interventions in South Sudan, but also represent models for good practice that could be replicated globally. These include participatory approaches in designing and implementing its GBV strategy, graduated capacity building of local implementing partners through a tiered model of support, systems building through training and support to police and social workers, monitoring and evaluation mechanisms and community-based prevention work. (Effectiveness and Sustainability/Connectedness)

4. UNICEF employs flexible strategies to improve coverage in the highly challenging environment of South Sudan, including the tiered capacity building approach of local partners and mobile Clinical Management of Rape [CMR] training teams. (Coverage)

5. UNICEF has a good relationship with the Government of South Sudan (GoSS) and a history of working successfully on legal and policy reform (e.g. the Child Act of 2008) that positions the office well for scaling up efforts to support the government to develop a legal and policy framework for GBV which is aligned with international good practice, as well as to support the government to endorse and implement the Standard Operating Procedures (SOPs) for GBV. (Relevance and Sustainability/Connectedness)

6. UNICEF has the largest UN programme focusing on GBV and is a leader in standard-setting initiatives that provide critical guidance and serve to establish a performance baseline in South Sudan, such as supporting the development of the CMR training and developing Women and Girls Friendly Space (WGFS) Guidelines. (Coordination)

7. Given UNICEF’s significant contributions to GBV work in South Sudan, UNICEF’s leadership role in coordination activities has been critical. UNICEF participates in many coordination fora at the national level that ensure its support to a variety of GBV-related initiatives. UNICEF’s leadership in coordination at the state level in Upper Nile has resulted in effective and efficient response to GBV needs in Malakal, most recently illustrated in the rapid re-establishment of GBV-related services following fighting and looting in the Protection of Civilian (PoC) site that resulted in the destruction of a third of the PoC and the displacement of an estimated 30,000 IDPs. (Coordination)

8. UNICEF also has a leading role in coordinating Protection from Sexual Exploitation and Abuse (PSEA) response in the Malakal POC, where UNICEF has facilitated training and has conducted community awareness-raising through its GBV programmes on access to services for complainants.

9. UNICEF has been able to achieve its GBV successes because of its investment in GBV staffing, including one P4 position. The current GBV staffing levels (3 internationals staff and 1 national staff) are the very minimum necessary to implement its GBV programme in South Sudan given the huge scope of the problem; the low level of government capacity and relatively few international non-governmental organisations (INGO) working on GBV in South Sudan; and the nature of GBV prevention and response programming in South Sudan, which is particularly human resource intensive given the great need for capacity building/ongoing mentoring of national partners. (Efficiency)

10. Support from the GBViE Specialist at UNICEF headquarters has also been a contributor to the South Sudan CO’s successes in GBV programming. The GBV team in South Sudan has received multiple support missions; fundraising support; technical review of key documents and resources (e.g. the
capacity-building strategy); bi-weekly consultations linked to the Communities Care programme implementation, etc.

11. **UNICEF is a highly valued GBV partner in South Sudan** among the international and national community alike because of their technical competence and their participatory and partnership approaches. (Efficiency)

**Gaps/Challenges**

12. **Due to an array of contextual challenges such as lack of infrastructure, limited functioning of government, few implementing partners, the need to prioritize care for sexual violence in the emergency response, etc., there are significant gaps in some programme areas, while others which are addressed are very limited in scale and geographic coverage.**

   - UNICEF’s support to a multi-sectoral approach does not yet include strategies for legal justice work, which is a service area of very limited capacity across all of South Sudan.
   - UNICEF’s support to systems building of police and social workers has been limited to two sites.
   - UNICEF (and other GBV actors) have not yet supported programming to address intimate partner violence (IPV) and child marriage, both of which are significant concerns in South Sudan.

13. **Again due to contextual challenges and prioritization of sexual violence response, specialized GBV prevention work on GBV in South Sudan has been limited,** with most prevention work focusing on community messaging. Importantly, however, UNICEF’s Communities Care social norms GBV prevention and response programme is currently being piloted in South Sudan (and Somalia) in two “green states”—meaning stable humanitarian sites. Several implementing partners (IPs) have recently been encouraged by UNICEF to adapt some aspects of Communities Care for use in their community outreach, but this is not yet being done in a standardised way. UNICEF has also drafted a terms of reference for support to standardize the community engagement to ensure good practice. (Relevance and Effectiveness)

14. **Targeted integrated risk reduction programming across UNICEF sections has been undertaken most comprehensively in the WASH-GBV project, with some other notable strategies for integration in the global Peacebuilding, Education and Advocacy (PBEA) programme and in proposals linked to DDR and justice for children.** Other **UNICEF sections have not evidently integrated GBV risk mitigation measures as recommended in the revised 2015 IASC GBV Guidelines** (though they may be undertaking some risk mitigation work but not capturing it in any reporting). **As well, GBV has not been integrated into two UNICEF structures that have the greatest monitoring reach in South Sudan: the Rapid Response Mechanism (RRM)** and the state-level CP staff. This represents a significant missed opportunity for improving GBV-related protections for girls and women. (Relevance)

15. Although adolescent girls are a group which is at very high risk of GBV in general and particularly in South Sudan, **GBV programming (both specialized and integrated) has not adequately focused on the needs of adolescent girls,** including in WFS and Demobilization, Disarmament, and Rehabilitation (DDR) initiatives. CMR trainings currently include only basic information about caring for child and adolescent survivors. (Relevance)

16. **WGFS are not functioning optimally to meet the needs of participants, particularly their livelihoods needs.** Reportedly due largely to the need to generate income, women and girls are regularly leaving

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114 Many of these gaps and challenges are not specific to the SSCO, but are inherent challenges in working on GBV generally, and in working on GBV in the extremely complex environment of South Sudan.

115 The Rapid Response Mechanism has reportedly come to an end since the evaluation; however, the finding remains in order to highlight the value of integrating GBV monitoring in this mechanism if/when it is reinstated.
the POCs to collect firewood to sell, which puts them at risk of sexual violence. Challenges in mobilizing the United Nations Mission in South Sudan (UNMISS) patrols to accompany the women when they leave the sites is a major contributor to this situation. There is no programming for alternative fuel. (Effectiveness)

17. Different and non-comparable assessment tools used by IPs and other protection partners contribute to challenges in collating data on the nature and scope of GBV, including for key guidance documents such as the Humanitarian Needs Overview. In addition, measuring and reporting on programme results remains a significant challenge in terms of the GBV team’s ability to illustrate the importance, value and impact of their work. This is a problem inherent to GBV programming, which the GBV team is trying to address in some measure by standardizing indicators for partners’ reporting, but which requires more attention and support from the GBV AoR community at the global level. (Effectiveness-Data)

18. Although there is a recognition in the SSCO of the value of linking emergency GBV work to the development agenda, there is to-date no clear plan for establishing and maintaining this link. A more explicitly articulated emergency/development strategy will allow UNICEF’s GBV programmes to continue to meet emergency needs as they arise, but to also accelerate programming approaches (e.g. legal reform and building multi-sectoral systems) critical to advancing the sustained safety of girls and women. (Sustainability/Connectedness)

19. There have been challenges in GBV Subcluster coordination at the national level which can be linked in part to the absence of clear terms and responsibilities of key GBV actors.

20. UNICEF leadership of the Monitoring and Reporting Mechanism (MRM) for grave violations against children has resulted in the development of monitoring systems to capture data on conflict-related sexual violence against children. UNICEF has also provided support to the Monitoring, Analysis, Reporting and Accountability (MARA) mechanism by contributing extensively to a draft information sharing protocol on the MARA as well as an annex in the GBVIMS ISP dedicated to when/how GBVIMS data can feed into MARA. However, UNICEF has not yet linked its leadership of the MRM to support the MARA mechanism. Nor has UNICEF exploited its relationship with UNMISS through the MRM to conduct advocacy around accountability for POC firewood patrols. (Coordination)

21. Limited support for the GBV programme has been provided from the Regional Office as, until recently, there has been no Gender or GBV Advisor who could provide technical assistance or support to the CO to mobilise additional resources for GBV. This led to missed opportunities for sharing good practice. (Coordination)

22. The funding to overall programming in South Sudan, and particularly protection programming, is declining, while needs are increasing. The SSCO’s reliance on one major donor for the majority of its GBV programme makes the GBV programme highly vulnerable. Although joint partnerships are often a useful way to generate donor support, particularly for large-scale programming, to date UNICEF has not engaged in any joint partnerships for GBV programming. (Efficiency)

23. While some efforts have been made to improve Protection from Sexual Exploitation and Abuse (PSEA) in the UNICEF SSCO and among IPs and the community in the Malakal POC, understanding by staff interviewed in Juba about mechanisms for support to complainants through GBV referrals appears limited. The reporting channels are not well-defined for the SSCO and it is not clear how survivor response to PSEA can and should be linked to GBV service delivery.
RECOMMENDATION 1. Build on the SSCO’s existing GBV specialized programming approaches in order to improve prevention and response programming across the emergency to development continuum.

  c. In the short term, with a focus on emergency response in order to improve effectiveness and quality of existing programming:
    
    v. Lead rollout of the new WGFS Guidelines and use the rollout as an entry point for monitoring effectiveness of WFS to meet needs of participants, especially adolescent girls and survivors of IPV. Where expertise and resources permit and in line with the new Guidelines, identify and implement feasible livelihoods (e.g. soap-making) and basic skills development in WGFS to reduce women’s and adolescent girls’ protection risks linked to income generation, particularly in relation to firewood collection.
    
    vi. Undertake an assessment to determine the value of reintroducing fuel-efficient stove strategies in the PoCs, while also joining with other protection partners (e.g. UNFPA and UNHCR) to conduct advocacy with UNMISS to meet their responsibilities in leading firewood patrols outside the PoCs.
    
    vii. Strengthen integration of specialized approaches to caring for child and adolescent survivors in case management and CMR training and make sure that drugs are procured for child dosages as per guidance in the UNICEF/IRC Inter-agency GBViE Case Management Guidance and Toolkit (to be released before end of 2016).
    
    viii. Develop and implement a strategy for rolling out select components (e.g. the social norms prevention component, and, in some contexts, the community-based care component) of the Communities Care programme in emergency-affected locations through an adapted approach relevant to the specific settings.

  d. In the longer-term, with an eye to developing a more comprehensive approach to GBV in relatively stable areas of South Sudan:
    
    v. Using UNICEF’s leverage with the GoSS, and in collaboration with the GBV SC, vitalize the approval process for the national Standard Operating Procedures (SOPs) and roll them out at state level, using the rollout as an opportunity to identify additional geographic areas for priority support.
    
    vi. Take police training to scale by introducing GBV into the national police college training curriculum.

    vii. Capitalize on strong relationships with the GoSS to support legal reform and bring it in line with international good practice, particularly in relation to a law against IPV. Support the implementation of GBV elements of the Child Act of 2008.

    viii. Undertake an assessment (building existing research) followed by a preliminary test project on child marriage to identify key drivers as well as safe and ethical approaches to address the issue and feasibility of scaling up prevention initiatives across South Sudan. Consider a joint project to address child marriage with UNFPA and other partners, taking advantage of and learning from UNFPA and UNICEF’s global partnership on this issue.

Lead responsibility: CP GBV Team
When: 2016-2017

Recommendation 2: Strengthen integration of GBViE across all UNICEF sectors in line with the 2015 IASC GBViE Guidelines recommendations, with the objective of each sector proactively leading integration in all phases of the programme cycle.
Use the rollout of the 2015 IASC GBV Guidelines in South Sudan during 2016 as a catalyst for all UNICEF sections to adopt relevant recommendations from the Guidelines on systematic integration of GBV prevention and risk mitigation strategies in their humanitarian response, with indicators to be monitored regularly in the Results Assessment Module (RAM).

Ensure Chiefs of Section identify a focal point to work with a dedicated (short-term) GBV specialist to support this systematic integration across programmes.

Maximise existing entry points for each sector to strengthen GBV risk mitigation, e.g. scaling up integrated elements of the WASH-GBV joint project across all UNICEF-supported WASH interventions; ensuring successes from the PBEA project are carried forward into the regular education programme and that additional strategies (e.g. lifeskills) are introduced into Education programming to address the protection needs of adolescent girls; supporting implementation of the GBV elements in the national HIV policy and ensuring health supply lines preposition key CMR supplies; ensuring DDR and any work with Children Associated with Armed Forces and Armed Groups (CAFAAG) includes attention to girls at risk or survivors of GBV; etc.

Routinely integrate GBV into the Rapid Response Mechanism (RRM) missions by ensuring at least one member of that team is trained on CMR and the team carries a stock of drugs (PEP, EC, etc.) in case a survivor comes forward for help (and also for the safety of the team). Also ensure the TORs of CP staff at state level include specific safe and measurable activities to enhance coverage and facilitate identification of GBV needs in underserved areas.

Lead responsibility: Chief CP; GBViE Specialist; Chiefs of Sections; Deputy Representative
When: 2016 and ongoing

RECOMMENDATION 3. Ensure ongoing UNICEF commitment to GBV and adequate levels of dedicated staffing for the GBV team in order to facilitate prevention, risk mitigation, response and coordination that is in line with global UNICEF mandates and guidance.

Ensure that the current level of staffing, including one P4 and two P3s (one specifically focused on capacity building of local partners, including capacity in adapting Communities Care work in emergency affected locations), is retained.

Introduce a dedicated (short-term) GBV specialist to the team to work with section focal points to facilitate integration of GBV across UNICEF sectors as per the revised 2015 IASC GBV Guidelines.

Clarify UNICEF corporate commitments on GBV within the CO to all staff, and the respective areas of focus of the GBV and Violence Against Children (VAC) approaches. Through the leadership of the CP team at UNICEF HQ, work with them to finalize and distribute an internal briefing paper as part of the clarification process for circulation around all staff in the CO, as well as an external advocacy note clarifying UNICEF’s areas of focus and commitment to addressing GBV in South Sudan.

Explicitly link GBViE programming to longer-term development programming within country programme documents and in the SSCO GBV Strategy for 2017. Highlight specific preparedness activities for GBV which the SSCO will undertake for ongoing and future emergencies.

Formalize UNICEF’s role in national and state-level coordination by supporting the national GBV SC to develop a strategy with clear roles and responsibilities of key partners at national and state levels. Consider assuming coordination leadership at the state level in underserved locations (i.e. Western Equatoria, Western Bahr-el Gazal).

Establish a dedicated GBV position at the East and Southern Africa Regional Office to provide technical support to SSCO GBV programming and support in mobilising additional funding, as well as conducting advocacy at the regional level and facilitating regional coordination of GBV partners.

Ensure UNICEF leadership at the country and regional level prioritise the identification of funds to support immediate and long-term GBV programming.
**RECOMMENDATION 4. Strengthen the evidence base to improve understanding of need as well as to demonstrate programme effectiveness.** Collate and disseminate the evidence of need as well as good programme practice nationally, regionally and globally.

g. Work with UNICEF GBV partners to standardize assessment tools and data collection measures in order to consolidate monitoring data and strengthen shared knowledge of the nature and scope of the problem of GBV in South Sudan as well as effective interventions. Support the GBV SC to also undertake this work as a core function.

h. Work with UNICEF GBV partners and the GBV SC to develop a few key messages (that include South Sudan and global data on GBV) to increase all GBV partners’ ability to speak with one voice around key issues of concern and have the messages clearly heard by national and international actors.

i. Build on the UNICEF 2015 *Situational Assessment of Children, Adolescents and Women* with more targeted analysis on GBV issues, particularly intimate partner violence and child marriage, with an eye to identifying factors linked to an enabling environment to address these issues, so to determine the most feasible entry points for programming.

j. Leverage UNICEF’s leadership of the MRM and its support to the MARA to develop linkages among the MRM, MARA and UNMISS in documenting, reporting and conducting advocacy on conflict-related sexual violence (CRSV) through an Information Sharing Protocol (ISP) that includes MARA, MRM, and UNMISS. Also ensure MRM training includes capacity-building on providing basic psychological first aid (PFA) for survivors.

k. In coordination with RO and HQ, dedicate staff time to document innovative and best practice programmes, such as the tiered approach to capacity building, and disseminate these regionally and with other COs and with the Child Protection Section in New York. Consider bringing in a consultant to support this documentation.

l. Continue standard setting through publication in professional journals of the monitoring and evaluation outcomes prioritized in the UNICEF SSCO 2016 GBV Strategy, such as results from the Communities Care programme and the integrated WASH-GBV project.

**Lead responsibility: GBviE Specialist, RO Gender Advisor**

When: Immediately and ongoing

**RECOMMENDATION 5. Scale up leadership on PSEA and strengthen understanding in the CO on appropriate responses and processes.**

d. **Through support from a short-term PSEA specialist training consultant who is under the supervision of senior management,** and in collaboration with the UNICEF CO PSEA focal points, finalize training materials on PSEA. Engage the GBV team to include information about safe and ethical referral pathways in the training. Roll out to all staff and IPs, with more specialized training for the PSEA focal points and for GBV IPs on receiving reports and providing referrals.

e. Advocate with the HC/RC to revive the PSEA In-country Focal Point Network.

f. Complete guidance note for the HCT related to PSEA responsibilities.

**Lead responsibility: Deputy Representative, Human Resources Chief**

When: Immediately
Annex 1: Evaluation Questions

Relevance
1. To what extent is UNICEF GBVIE programming for care, support, protection, and risk reduction based on:
   a. assessed needs and data analysis? (Are the different needs of needs of women, adolescents, and children considered separately?)
   b. established good practice for GBVIE service provision, risk reduction and prevention? (Is UNICEF employing the most appropriate strategies to ensure further violence is reduced and survivors provided with appropriate services and support?)
2. To what extent has risk reduction been integrated into other UNICEF sector programmes?
3. To what extent do GBVIE programmes adapt to changing needs, and how well are the changing needs documented?
4. How well have views of survivors and other high risk groups (adolescent girls, women, children) been reflected in programme assessment, design, implementation and monitoring? (covers AAP)
5. Are programmes built on a clear Theory of Change for GBVIE programming? To what extent is this consistent with a corporate/regional Theory of Change and with UNICEF standards and guidelines expressed through the CCCs or elsewhere?)
6. To what extent has a HRBA been taken in design, implementation, and monitoring of GBVIE programming?

Effectiveness
7. To what extent have UNICEF GBVIE programmes improved survivors' access to quality, life-saving, multi-sectoral services for care and support?
8. How quickly has UNICEF been able to establish services at the scale required?
9. To what extent has the programme contributed to preventing and mitigating risks of GBV for women, adolescents and children?
10. Are programme objectives clear and specific for different GBVIE areas of programming? How far have programme objectives been achieved / likely to be achieved?
11. Which have been the most/least effective programmes? Why?
12. How systematically have results been captured/used/learned from?
13. How and how effectively has 1) UNICEF leadership and 2) technical support from HQ, regional and country levels contributed to the effectiveness of UNICEF GBVIE programming? Including ensuring that GBVIE is included in the earliest response strategies and funding priorities?

Connectedness and Sustainability
14. How, and how effectively does UNICEF GBVIE programme design and implementation link emergency programming with UNICEF’s longer-term programming to prevent and respond to GBV? Is UNICEF’s approach to GBVIE built into its conceptualisation and implementation of sustainable resilience programming?
15. How effectively have partnerships with civil society and government been built to address planned GBVIE outcomes?
16. How and to what extent has the capacity of local and national partners been strengthened through the programme?
17. To what extent has UNICEF's internal and external advocacy contributed to improved GBV response and prevention? (Including clarifying UNICEF’s specific programme and leadership roles?)

Coordination
18. To what extent are programmes consistent with good practice (Resource Pack and revised GBVIE Guidelines)
19. Does/how does UNICEF add value to the GBVIE response (through leadership, standard setting, coordination)?

Coverage
20. Are there any gaps in GBVIE programming (specialised and integrated) in terms of geographical and demographic coverage? - how has UNICEF (a) identified the gaps and (b) taken action to close the gaps?

Efficiency
21. To what extent have UNICEF financial and human resource inputs been commensurate/adequate to the task of meeting GBV programming need?
22. To what extent have UNICEF inputs achieved value for money outputs?
### Annex 2: Interviews/Workshops participants

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**UN Agencies**

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**Implementing Partners**

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**Other Partners**

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**Donors**

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**Focus Group Discussions**

**Mahad IDP Camp** (Urban IDPs in Juba)

FDG Confident Children from Conflict: 13 women Aged from teenage (with children) – 16yrs + to mothers of adolescents

**Gumbo IDP camp**, outside Juba

Adolescent boys: 4 (Ages 22,20,17,15)

These adolescents were not part of CCC awareness raising activities as they work with women and girls, but they had had some discussions on GBV.

Adult women: 13-16 (varied) mostly 20’s, some older (40’s?)

**Malakal IDP Camp**

IMC WFS Focus Group Discussion: adult women 25 Nuer and Shiluk

**Final Meeting**

Thelma Majela: Education Specialist (PBEA)
Vedasto Nsanzugwanko: Chief, Child Protection Section
Saptono Priyadi: Planning, Monitoring & Evaluation Specialist
Athieng Riak: Child Protection (Gender-Based Violence) Officer
Biar Kuai Biar: WASH Officer
Solla Asea: Child Protection Officer
Martha Kyaklika: Child Protection Specialist/RRM
Lillian Okwirry: Chief, WASH Section
Kemish Alier: Health Officer
Christine Heckman: Child Protection (Gender-Based Violence) Specialist

**Nutrition was not represented.**
Annex 3: Mission Itinerary

### JUBA ITINERARY

#### Monday 7 March 2016

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<td>Arrival in Juba Egypt Air flight 9am</td>
<td>Juba airport</td>
<td>Christine</td>
<td>0956280101</td>
</tr>
<tr>
<td>1000</td>
<td>Transfer to hotel -- Tulip Inn, Hai Tomping</td>
<td>hotel</td>
<td>Airport driver (Tombe)</td>
<td>0959002734</td>
</tr>
<tr>
<td>1030</td>
<td>check-in/freshen up</td>
<td>hotel</td>
<td>Airport driver (Tombe)</td>
<td>0959002734</td>
</tr>
<tr>
<td>1230</td>
<td>Working lunch with GBV team</td>
<td>hotel restaurant</td>
<td>Christine</td>
<td>0956280101</td>
</tr>
<tr>
<td>1430</td>
<td>Security briefing</td>
<td>UNICEF office</td>
<td>Security</td>
<td></td>
</tr>
<tr>
<td>1500</td>
<td>Welcome by CP management (Anthony, OIC)</td>
<td>UNICEF office</td>
<td>Christine</td>
<td>0956280101</td>
</tr>
<tr>
<td>1530</td>
<td>Meeting with IMC</td>
<td>UNICEF office</td>
<td>Awet</td>
<td>0927000497</td>
</tr>
<tr>
<td>1630</td>
<td>Admin issues (visa, internet, domestic travel, etc.)</td>
<td>UNICEF office</td>
<td>Admin/ICT</td>
<td>N/A</td>
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</table>

#### Tuesday 8 March 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>0830</td>
<td>Meeting with WASH section (programme staff and M&amp;E consultant)</td>
<td>UNICEF (GBV or Maryam's office)</td>
<td>Maryam &amp; Brian 0954098595 (Brian)</td>
</tr>
<tr>
<td>1000</td>
<td>Meeting with Rep and Dep Rep</td>
<td>UNICEF (Rep's office)</td>
<td>Christine 0956280101</td>
</tr>
<tr>
<td>1100</td>
<td>Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1100</td>
<td>Meeting with Education section</td>
<td>UNICEF (Education office)</td>
<td>Nolan 0922188293</td>
</tr>
<tr>
<td>1145</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1145</td>
<td>Meeting with Nutrition section</td>
<td>UNICEF (Nutrition meeting room)</td>
<td>Joseph 0914360124</td>
</tr>
<tr>
<td>1230</td>
<td>Working lunch with Resource Mobilization</td>
<td>UNICEF canteen</td>
<td>Faika</td>
</tr>
<tr>
<td>1330</td>
<td>Meeting with Health section</td>
<td>UNICEF (Ketema's office)</td>
<td>Chantal 0926123000</td>
</tr>
</tbody>
</table>
**Wednesday 9 March 2016**

**NOTE:** You will need an ID (passport, national ID card, etc.) to access UN House. You should be on the list of authorized visitors but if you have any trouble at the gate, call Erica (0950 994 561).

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
<th>Contact</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>0830</td>
<td>Meeting with Protection Cluster Coordinator</td>
<td>UNHCR</td>
<td>Joan</td>
<td>0927 725 520</td>
</tr>
<tr>
<td>0915-1000</td>
<td>Drive to UN House</td>
<td></td>
<td>Driver TBC</td>
<td></td>
</tr>
<tr>
<td>1000-1100</td>
<td>Meeting with GBV SC coordination team</td>
<td>UNFPA</td>
<td>Evelyn</td>
<td>0927 000 630</td>
</tr>
<tr>
<td>1100-1200</td>
<td>Meeting with UNFPA (RH team and GBV)</td>
<td>UNFPA</td>
<td>Erica</td>
<td>0950 994 561</td>
</tr>
<tr>
<td>1200-1300</td>
<td>Meeting with UNMISS Senior Women's Protection Advisor</td>
<td>UN House Bldg 5, ground floor</td>
<td>Fatou</td>
<td>0955026182</td>
</tr>
<tr>
<td>1300-1330</td>
<td>Lunch at UN House canteen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1330-1400</td>
<td>Drive to Tomping</td>
<td></td>
<td>Driver TBC</td>
<td></td>
</tr>
<tr>
<td>1400-1500</td>
<td>Processing ID cards</td>
<td>UNMISS Tomping</td>
<td>Athieng</td>
<td>0955313165</td>
</tr>
<tr>
<td>1515-1545</td>
<td>Meeting with SRDA</td>
<td>UNICEF</td>
<td>Michael</td>
<td>0955560525</td>
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**Thursday 10 March 2016**

<table>
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<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
<th>Contact</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>0830</td>
<td>Pick up at Tulip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0845-1000</td>
<td>Meeting with CCC</td>
<td>CCC interim care centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1015-1045</td>
<td>Meeting with CP sub-cluster coordinator</td>
<td>UNICEF</td>
<td>(Totto Chan side)</td>
<td></td>
</tr>
<tr>
<td>1045-1100</td>
<td>Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1115-1200</td>
<td>Meeting with MoGCSW (Regina)</td>
<td>Ministry of Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1215-1300</td>
<td>Meeting with IsraAid</td>
<td>Rainbow Hotel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1300-1345</td>
<td>Lunch</td>
<td>Rainbow Hotel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1400-1530</td>
<td>Meeting with Child Protection management (Anthony &amp; Vedasto)</td>
<td>UNICEF</td>
<td>(NPA side)</td>
<td></td>
</tr>
</tbody>
</table>

**Friday 11 March 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
<th>Contact</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>0830-0930</td>
<td>Meeting with Child Protection management (Anthony &amp; Vedasto)</td>
<td>UNICEF</td>
<td>Anthony</td>
<td>0955 170 038</td>
</tr>
<tr>
<td>0930-1015</td>
<td>Meeting with SPPME team</td>
<td>UNICEF</td>
<td>Maki</td>
<td>0956524107</td>
</tr>
<tr>
<td>1030-1300</td>
<td>Field visit with IsraAid</td>
<td>Juba IDP sites</td>
<td>Ophelie</td>
<td>0956394780</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
<td>Venue</td>
<td>Person Responsible</td>
<td>Contact Number</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------</td>
<td>------------------</td>
<td>--------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>1300 - 1345</td>
<td>Lunch</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>1400 - 1445</td>
<td>Meeting with OFDA</td>
<td>Rainbow Hotel</td>
<td>Emily Dakin</td>
<td>0912118115</td>
</tr>
<tr>
<td>1030 - 1115</td>
<td>Meeting with MoGCSW</td>
<td>Ministry of Health</td>
<td>Regina</td>
<td>0955919651</td>
</tr>
<tr>
<td>1130</td>
<td>Pickup from Tulip</td>
<td></td>
<td>UNICEF driver</td>
<td>095902734</td>
</tr>
<tr>
<td>1330</td>
<td>Flight to Malakal for Jeanne</td>
<td></td>
<td></td>
<td></td>
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</table>

### Monday 14 March 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Person Responsible</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1300</td>
<td>Jeanne returns from Malakal</td>
<td>Rainbow Hotel</td>
<td>Emily</td>
<td>0912118115</td>
</tr>
<tr>
<td>1300 - 1400</td>
<td>Lunch with Emily Dakin (OFDA)</td>
<td>Rainbow Hotel</td>
<td>Emily</td>
<td>0912118115</td>
</tr>
<tr>
<td>1415 - 1500</td>
<td>Meeting with Norway</td>
<td>Norwegian embassy</td>
<td>Therese</td>
<td></td>
</tr>
<tr>
<td>1500 - 1545</td>
<td>Meeting with Education section</td>
<td>UNICEF (Education office)</td>
<td>Nolan</td>
<td>0922188293</td>
</tr>
<tr>
<td>1600 - 1645</td>
<td>Meeting with WASH cluster</td>
<td>UNICEF (GBV office)</td>
<td>John</td>
<td>0921544858</td>
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</tbody>
</table>

### Tuesday 15 March 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Person Responsible</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>900 - 1000</td>
<td>Meeting with CCC Programme Staff</td>
<td>CCC centre</td>
<td>John</td>
<td>0956862217</td>
</tr>
<tr>
<td>1000 - 1500</td>
<td>Visit to CCC project sites in Juba (including lunch with CCC social workers)</td>
<td>Gumbo &amp; Lologo IDP settlements</td>
<td>John</td>
<td>0956862217</td>
</tr>
<tr>
<td>0930 - 1030</td>
<td>Meeting with UNICEF Justice for Children Officer</td>
<td>UNICEF canteen</td>
<td>Solla</td>
<td></td>
</tr>
<tr>
<td>1100 - 1230</td>
<td>Service providers meeting with IsraAid</td>
<td>Totto Chan</td>
<td>Ophelie</td>
<td></td>
</tr>
<tr>
<td>1230</td>
<td>Lunch</td>
<td>UNICEF canteen</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1400 - 1445</td>
<td>Meeting with HRSS</td>
<td>UNICEF</td>
<td>Angelina</td>
<td></td>
</tr>
<tr>
<td>1500</td>
<td>Meeting with Nile Hope</td>
<td>UNICEF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1600 - 1645</td>
<td>Meeting with IRC</td>
<td>IRC</td>
<td>Pamela and Dash</td>
<td>0954808157 (Pamela)</td>
</tr>
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</table>

### Wednesday 16 March 2016
### Thursday 17 March 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Person Responsible</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Janey flight @ 1110 (check in by 9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jeanne prepare PPT</td>
<td></td>
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</table>

### Friday 18 March 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Person Responsible</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900 - 1130</td>
<td>Final workshop</td>
<td>UNICEF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TBC</td>
<td>Jeanne flight (afternoon)</td>
<td></td>
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</table>

### MALAKAL ITINERARY

#### 11-Mar-16

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Focal person</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:00-14:30</td>
<td>Meeting with UNICEF's Chief of Office (CFO)</td>
<td>CFO office</td>
<td>Eric</td>
</tr>
<tr>
<td>14:35-15:35</td>
<td>Meeting with GBV Specialist (Eric)</td>
<td>UNICEF office</td>
<td>Eric</td>
</tr>
<tr>
<td>15:40-16:40</td>
<td>Meeting with UNICEF's colleagues (CP, Education &amp; WASH specialists)</td>
<td>UNICEF office</td>
<td>Eric</td>
</tr>
<tr>
<td>17:00-17:45</td>
<td>Meeting with OCHA chief (Kenny)</td>
<td>OCHA office</td>
<td>Eric</td>
</tr>
</tbody>
</table>

#### 12-Mar-16

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Focal person</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:30</td>
<td>Meeting with IMC GBV program manager (Kibrom)</td>
<td>UNICEF office</td>
<td>Eric/Kibrom</td>
</tr>
<tr>
<td>9:45-11:00</td>
<td>Meeting with GBV team at the WFS (Elizabeth/Zachariah/Achol/Angelina)</td>
<td>WFS 1 or 2</td>
<td>Eric/Kibrom</td>
</tr>
<tr>
<td>11:00-13:00</td>
<td>Women's center activities &amp; FGD with women/girls</td>
<td>WFS 1 or 2</td>
<td>Eric/Kibrom</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-15:00</td>
<td>Walk around the PoC (old and new facilities)</td>
<td>old and new PoC</td>
<td>Eric/Kibrom</td>
</tr>
<tr>
<td>15:30-16:30</td>
<td>Meeting with WASH cluster members (Cecile-SI/Tefera-IOM/Camille-SI)</td>
<td>UNICEF office</td>
<td>Eric</td>
</tr>
</tbody>
</table>

#### 13-Mar-16

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Focal person</th>
</tr>
</thead>
<tbody>
<tr>
<td>13:00-14:00</td>
<td>Meeting with protection colleagues (UNHCR, HDC and DRC)</td>
<td>UNICEF office</td>
<td>Eric</td>
</tr>
<tr>
<td>14:30-15:30</td>
<td>Meeting with CMR partners (IMC/MSF/IOM)</td>
<td>UNICEF office</td>
<td>Eric</td>
</tr>
<tr>
<td>15:45-16:45</td>
<td>Meeting with HRD/UNPOL</td>
<td>UNICEF office</td>
<td>Eric</td>
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</tbody>
</table>

#### 14-Mar-16

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Focal person</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-12:00</td>
<td>Any postponed or left over meeting/preparation for departure</td>
<td>UNICEF office</td>
<td>Kibrom/Eric</td>
</tr>
<tr>
<td></td>
<td>Department</td>
<td></td>
<td></td>
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</tbody>
</table>
Annex 4: Bibliography

**IASC Guidelines for Integrating Gender-based Violence in Humanitarian Action, 2015**

Draft GBViE Programme Resource Pack, CPS, UNICEF


GBV Subcluster Gender-based Violence Factsheet, Nov 2015.

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