

**CAPTURING THE IMPACT OF
GENDER-BASED VIOLENCE INTERVENTIONS
IN PHILIPPINE EMERGENCY CONTEXT
USING INNOVATION &
HUMAN-CENTERED DESIGN**

**From Tropical Storm Washi to Marawi Siege
(December 2011 - September 2019)**



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Lessons Learned and Opportunities Document

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Capturing the Impact of Gender-based Violence Interventions in Philippine Emergency Context Using Innovation and Human-Centered Design

Covering TS Sendong (December 2011) to Marawi Siege (September 2019)

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EXECUTIVE SUMMARY

The project was the country's first impact assessment study done on the programming of gender-based violence (GBV) in emergency context. It covered the five (5) major natural disasters and armed-conflicts which happened in the Philippines from the period of 2011 to 2017. It included (a) Tropical Storm Sendong/Washi - December 2011; (b) Typhoon Pablo/Bopha - December 2012; (c) Zamboanga Siege - September 2013; (d) Super Typhoon Yolanda/Haiyan - November 2013; and (e) Marawi Siege - May-October 2017. It focused on the GBV prevention and response actions including mainstreaming and information management which were provided by government agencies, local government units and humanitarian organizations. Its project sites were limited to six (6) regions and fifteen (15) cities/municipalities. It provided safe spaces for affected communities, vulnerable populations, service providers and humanitarian actors to voice out their views and perspectives on the impact of GBV programming during emergency situations.

To capture the changes influenced by the GBV programming in emergencies (GBViE programming), the study heavily employed qualitative data gathering methods such as focus group discussions, interviews and narrative stories, and also utilized quantitative method such as survey to produce, analyze and validate data comprehensively. Through innovation and human-centered design, the study refined and calibrated existing impact measurement tools to become more appropriate and suitable for research respondents. This included the (a) GBV Ecological Framework; (b) GBV Theory of Change; (c) GBV Tree and Tree of Hope; (d) Brief Resilience Scale; and (e) Community Score Cards. From March - October 2019, the study was able to cover 658 participants.

There were four (4) major sets of evaluation questions answered by the study:

Question #1: What is the level of resiliency among the victim-survivors of GBV in emergency context? What were the factors that facilitated or hindered their capacity for resilience? What were the coping mechanisms or strategies adopted to become resilient? The first set of questions were aimed at victim-survivors of GBV in emergency context. The study observed research ethics and GBV guiding principles.

Question #2: What is the relevance and effectiveness of the GBV programming in emergency context? What GBV interventions and services worked and did not work? Were they based on empirical data and needs of the affected communities? Were they inclusive, age-appropriate and culture-sensitive? Were the affected communities consulted? The second set of questions were directed at the affected communities and vulnerable sectors such as the LGBTQI+, indigenous people, persons with disabilities and elderlies.

Question #3: How did the GBViE programming experiences made an impact in national and local policies, programs and structures? What were the lessons learned, major gaps and challenges experienced in designing and implementing GBViE interventions and services? How did the GBV programming change or improve the situation of the affected communities especially the vulnerable sectors? The third set of questions were addressed to the service providers, humanitarian responders and community leaders and volunteers.

Question #4: What GBViE information management mechanisms were put in place? Were there existing good practices on reporting, recording, monitoring and evaluating GBViE interventions and services? What were the challenges encountered in measuring the prevalence of

GBV in emergency context and how were they addressed? Were the information management mechanisms inclusive and adhering to survivor-centered approach? The last set of questions were meant for government agencies, local government units and humanitarian organizations.

In response, the study identified fourteen (14) key findings. However, no generalizations were made given the scope and limitations of the study. Instead, the study offered a microscopic view that can be used as reference or guide for future GBViE programming. The following were the major findings:

Finding #1: Results of the GBViE Tree showed that participants have reached a certain level of awareness and understanding on what GBV was all about and why it happened during emergencies. However, the term violence against women and children (VAWC) remained to be widely known at the community level instead of GBV. Women and girls were more familiar with GBV rather than with men and boys.

Finding #2: Results of the Brief Resilience Scale showed that majority of the surveyed GBV victim-survivors had obtained normal resilience level with the help and support of others rather than coping on their own.

Finding #3: GBViE victim-survivors who were between the ages of 15-17 years old, who only reached primary education and who were dependent on others for financial support were the ones with low resilience as compared to respondents with normal resilience who belonged in the age group of 50 years old and above, who have reached or graduated from college, and who were economically independent.

Finding #4: Results of the ecological framework showed that the strength of GBViE programming in Philippine context were (a) a mixture of existing and new prevention and response measures; (b) a combination of protective mechanisms mostly concentrated at the individual, community and societal levels; while the relationship level needed further attention; (c) an interaction of GBV-specific and mainstreaming strategies; and (d) a reflection of the need to strengthen more GBViE programming efforts that are specific to the protection needs of the vulnerable sectors.

Finding #5: Using the results of the community score cards, the top ten (10) interventions and services that were highly scored by the FGD participants were: (1) economic recovery programs; (2) health services; (3) shelter and household needs; (4) community organizing; (5) safe spaces and facilities; (6) relief goods; (7) community-based protection measures; (8) educational interventions; (9) provision of multi-sectoral response; and (10) awareness-raising and learning sessions.

Finding #6: Discrimination, politics, weak consultation process and insensitivity to victim-survivors were some of the major issues found in accessing and availing of GBV interventions and services in times of emergencies.

Finding #7: The Philippine government has expanded its legal and policy frameworks based on GBViE programming experiences, learnt lessons and established good practices. Likewise, the local government units have also enacted policies and plans on GBV in emergency context.

Finding #8: Because of the strengthened partnerships between the national govern-

ment, local government units and humanitarian organizations during emergencies, key prevention and response measures were established as GBViE minimum initial package. However, innovations and refinements are required especially when issues of inclusion, culture and emergency context intersect.

Finding #9: Resilience, awareness and preparedness have been acquired and cultivated in the many years of building back better and in seizing opportunities for change.

Finding #10: There remains no harmonized data on GBV. Involved government agencies such as DSWD, PNP, DOH, DOJ, DILG and LGUs have their respective ways of recording and reporting GBV cases given their specific mandates. However, ongoing efforts are being made to address this major gap.

Finding #11: Though there was scarcity of data on GBV in emergency context, the government and humanitarian organizations were not deterred from addressing GBV.

Finding #12: No impact assessment initiative was done before on GBV programming in emergency context due to lack of leadership, non-prioritization and absence of MEAL plan in the national disaster response plans.

Finding #13: In the conduct of measuring the impact of GBViE programming in the Philippine context, the Consortium encountered the following key challenges: (a) getting the right research team for the project; (b) defining the parameters of the study; (c) appropriateness of framework and reliability of measurement tools; (d) balancing the perspectives of the respondents; and (e) deciding on the appropriate research methodologies.

Finding #14: In translating the results of the impact assessment study into better GBViE programming in the Philippine context, the following are perceived to be the key challenges: (a) mobilization of networks and resources; (b) identification of high-level GBViE champion/s to take the lead at the national level; (c) addressing the capacity gaps; and (d) strengthening of the Consortium.

The GBViE programming implemented from the early response up to post-recovery and rehabilitation played a significant role in putting in place protective factors to reduce risks and vulnerabilities, and increase the resiliency of the affected populations. However, the application of innovation and human-centered design are needed to improve future GBViE programming especially in dealing with the specific needs and concerns of vulnerable sectors such as persons with disability, elderly, indigenous people and LGBTIQI+ who were least prioritized. Issues of discrimination, politics, weak consultation process and insensitivity to victim-survivors can be addressed if adherence to humanitarian principles and GBV guiding principles are practiced and observed by all stakeholders for a shared accountability and responsibility.

Though there was scarcity on reported GBV data during emergencies, ongoing efforts are being made by the key government agencies. The harmonized intake form that is being piloted by the PNP currently can include vulnerability profile of the victim-survivor and can indicate if it is within the emergency context. The GAD database as well as the performance standards and impact assessment tools are potential entry points for the integration of GBViE in order to generate more evidences for programming, planning and policy-making.

In order to move forward, a high-level national leadership is demanded from the

government; an increased prioritization of GBViE from the humanitarian community is urgent; a heightened mobilization of local actors including non-traditional GBV partners is encouraged; and the integration of the GBViE indicators and tools on the ongoing development of MEAL component for the national disaster response plans should be lobbied. This research study can be a starting point in identifying key GBViE indicators using the theory of change as presented here; and in generating creative impact assessment measurement tools as introduced in this initiative.

The study identifies key recommendations and innovation opportunities to better design GBViE programming and improve information management system. Specific recommendations are also made by the communities.

a. For better GBViE programming

- Continuous learning and knowledge-building for the development of GBViE materials;
- Identification of new and enhancement of existing GBViE prevention and response actions that are inclusive, culture-sensitive, age-appropriate and gender-responsive; and
- Strengthen leadership and build the national and local technical capacities of GBV actors including non-traditional and vulnerable sectors.

b. For the improvement of GBV information management system

- Provide technical support to the ongoing development and piloting of the government on the harmonized intake form that could identify vulnerability profile of the GBV victim-survivor in terms of disability, ethnic affiliation, gender identity and emergency context. Such data will feed into the PNP's Crime Incident Reporting and Analysis System wherein the generation of the data can be immediately performed;
- Explore opportunities with the National Disaster Risk Reduction and Management Council or Office of the Civil Defense on how to integrate the findings of the study into the MEAL component of the National Disaster Response Plans;
- Discover indigenous knowledge and creative ways for developing impact measurement tools that are appropriate for people with disabilities, elderlies, ethnic minorities and LGBTQI+ community;
- Review and explore how government's existing GAD database, tools and indicators can incorporate GBViE; and
- Promote the use of the innovative impact assessment tools that were introduced in the study.

c. Specific recommendations from the vulnerable populations

- Conduct of an inclusive census of all children/youth/persons with disabilities for a database of useful to policy-making, planning and programming;
- Work for Dolho-Bato Badjao state citizenship in partnership and collaboration of public and private sectors;
- Make humanitarian aid for elderlies and PWDs more appropriate in terms of WASH facilities, assistive devices, trainings for disaster preparedness, shelter, among others. Separate the shelters for elderlies with no care givers away from noisy and cruel crowds; and
- Sensitize humanitarian aid workers in dealing with vulnerable sectors; and ensure compliance to Prevention of Sexual Exploitation and Abuse.

LIST OF ACRONYMS

BARMM	Bangsamoro Autonomous Region in Muslim Mindanao
BRS	Brief Resilience Scale
CCCM	Camp Coordination and Camp Management
CFS	Child Friendly Space
CIRAS	Crime Incident Reporting and Analysis System
CP	Child Protection
CSO	Civil Society Organization
DILG	Department of Interior and Local Government
DOH	Department of Health
DOJ	Department of Justice
DRRM	Disaster Risk Reduction and Management
DSWD	Department of Social Welfare and Development
FGD	Focus Group Discussion
GAD	Gender and Development
GBViE	Gender-based Violence in Emergencies
GBVIMS	Gender-based Violence Information Management System
IASC	Inter-Agency Standing Committee
INGO	International Non-Government Organization
LCAT-VAWC	Local Council on Anti-Trafficking and Violence Against Women & Children
LCPC	Local Council for the Protection of Children
LGBTQI+	Lesbians, Gays, Bisexuals, Transexuals, Queers, Intersex & Plus
LGU	Local Government Unit
LNGO	Local Non-Government Organization
MEAL	Monitoring, Evaluation, Accountability and Learning
PNP	Philippine National Police
PO	People's Organization
ToC	Theory of Change
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VAC	Violence Against Children
VAW	Violence Against Women
VAWC	Violence Against Women and Children
WASH	Water, Sanitation and Hygiene
WCPD	Women and Children's Protection Desk
WFS	Women Friendly Space

I. INTRODUCTION

1.1 The Philippine Experience on Gender-based Violence Programming in Emergency Context

The Philippines ranks third in the 2018 World Risk Index of most disaster-prone countries in the world.¹ The country is prone to almost all forms of disasters like typhoons, earthquakes, floods and volcanic eruptions with numerous pockets and major armed conflict encounters. Such exposure has displaced and affected millions of Filipino families especially the vulnerable populations.

In the past eight years, the Philippines has been a battleground of devastation and survival fighting off the negative impacts and effects brought about by various disasters and conflicts; and aiming to build back better and become resilient at the same time. Illustration 1 showed the major natural disasters and armed conflicts which shook the country from 2011-2017: (a) Tropical Storm Washi/Sendong on December 2011; (b) Typhoon Bopha/Pablo on December 2012; (c) Zamboanga Siege on September 2013; (d) SuperTyphoon Haiyan/Yolanda on November 2013; and (e) Marawi Siege on May-October 2017.

During emergencies, families and children get separated; basic services, structures and systems break down; and community protection mechanisms are disrupted. Because of these, vulnerability increases and exposure to violence, abuse and exploitation heighten particularly for children, adolescents, youth, and women, among others. According to the World Health Organization, women and children accounted for more than 75 percent of displaced persons.² One of the high-protection risks and life-threatening issues that affected women and children in emergency setting was gender-based violence (GBV).³ GBV was further exacerbated when other forms of discrimination intersected such as ethnicity, disability, sexual orientation and religion.

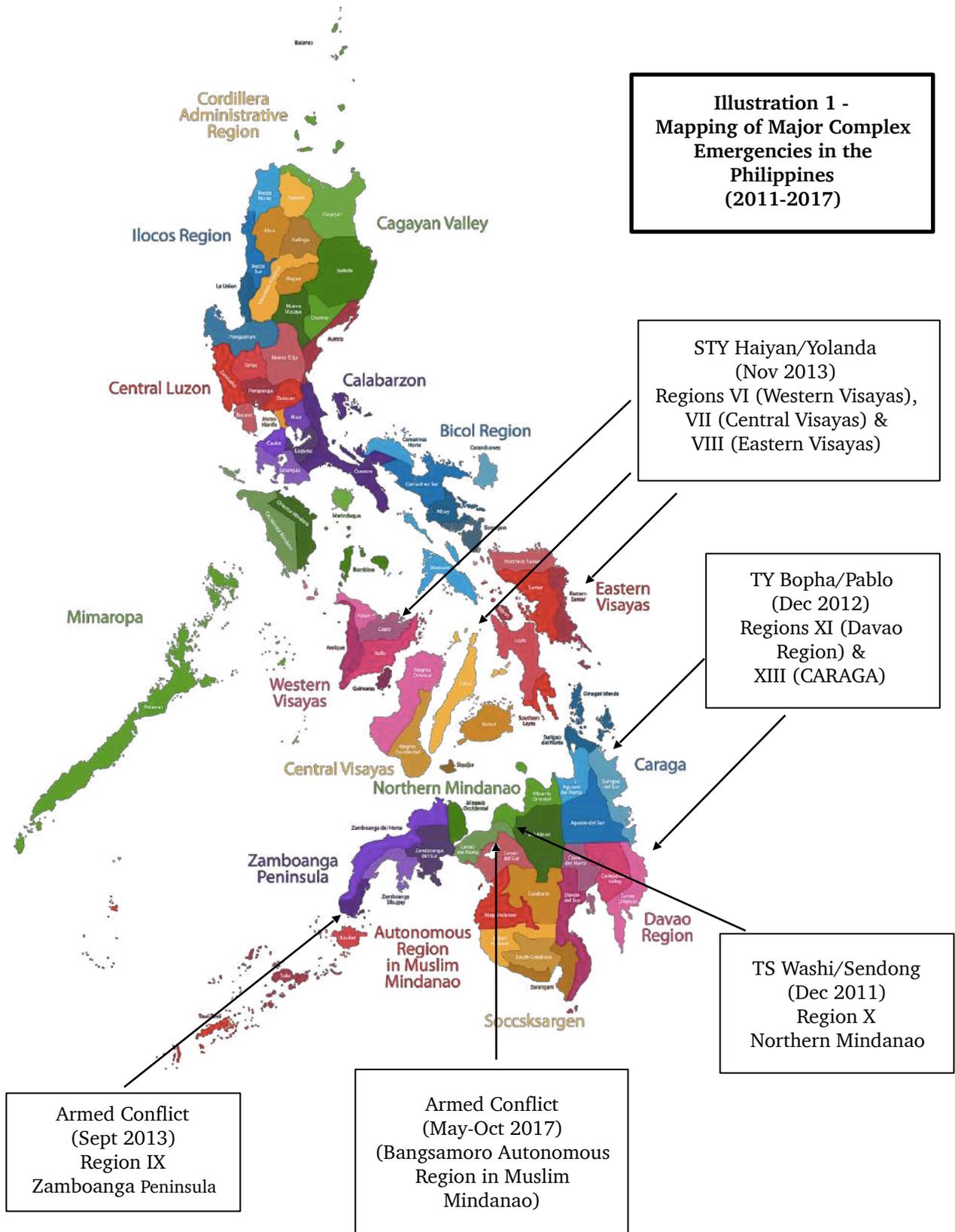
Among the specific GBV interventions implemented were: the activation of the field-based GBV Sub Clusters; the establishment of women- and child-friendly spaces; the strengthening of community-based referral pathways; the conduct of awareness-raising sessions; and the putting up of help desks in evacuation centers that were supervised by female police officers.

Concrete efforts were also made to mainstream GBV in other sectors such as the inclusion of GBV in the promotion of sexual and reproductive health; the promotion of safety and protection measures in WASH facilities; the representation and mobilization of women in camp committees and camp management; and the provision of emergency employment initiatives for economic recovery.

The country's extensive GBV programming experiences in emergency have strengthened the partnership between the government and humanitarian organizations; the collaboration of the multi-disciplinary teams; the mobilization of the communities; and the resiliency of the affected populations. However, though gains were made in the past eight years, there remained gaps and challenges on GBV prevention and response. These included the weak implementation and monitoring of compliance to GBV-related laws; the scarcity of data on GBV in emergency context; the non-functionality of referral system and coordination structures at the local level; the non-prioritization of vulnerable populations; the lack of consultation process; and so on.

Despite the gains and pains in GBV programming, few evaluation studies were conducted

to determine the impact, both positive and negative, of the interventions and services. Seeing this huge gap and the need to generate evidence-based data for future programming, planning and policy-making, the GBViE Consortium - Visayas, in partnership with HIF/ELRHA, have taken the initiative to undertake the *country's first impact assessment study on GBV programming in emergency context using innovation and human-centered design.*



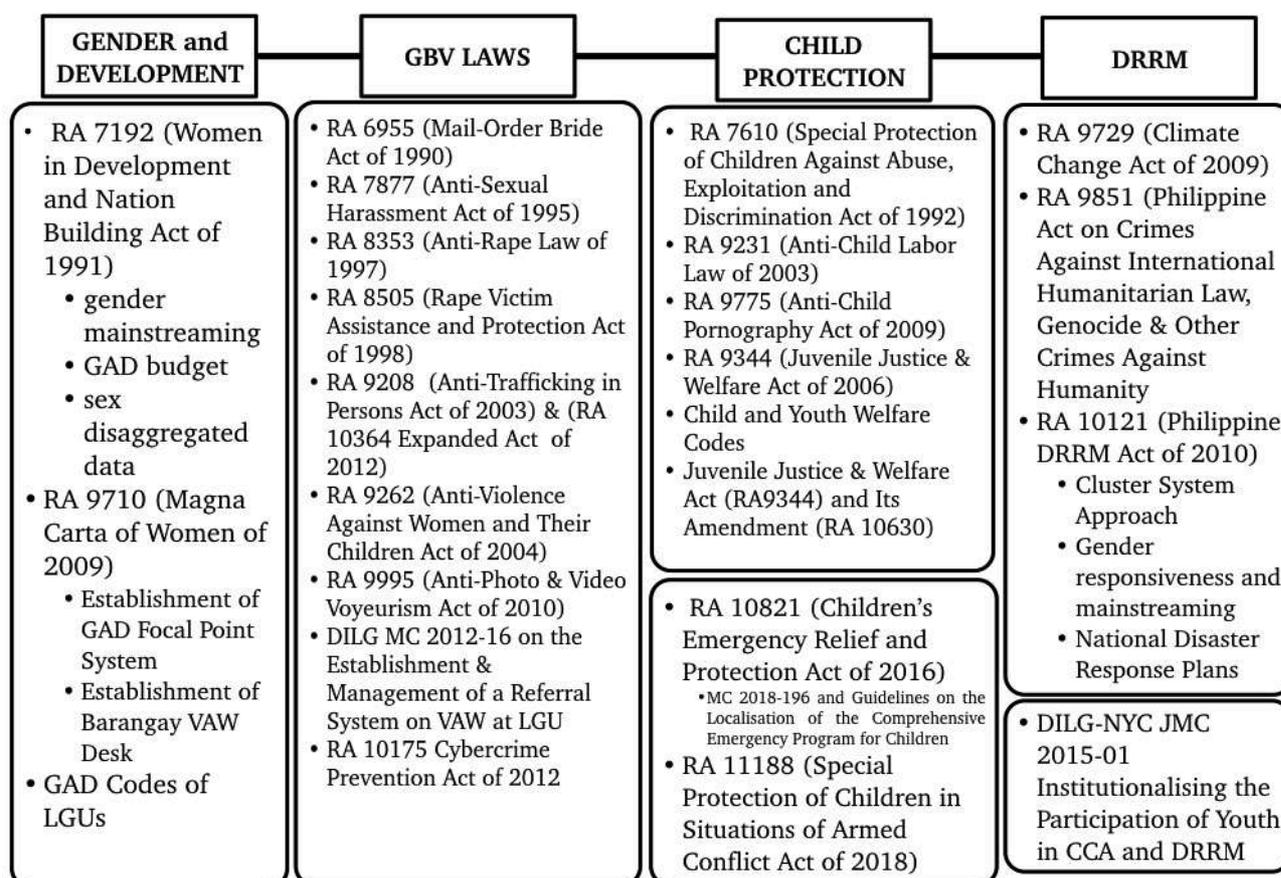
1.2 The Legal and Policy Framework on GBV in Emergency Context

The Philippines has a very strong and progressive legal and policy framework when it comes to GBV prevention and response. As shown in Illustration 2, GBV is an interaction of various existing national laws and policies on gender and development (GAD), on specialized laws on the different types of GBV, on child protection (CP) and on disaster risk reduction and management (DRRM). This framework has paved the way for the creation and institutionalization of programs, plans and projects that would eliminate GBV.

The laws were enacted in compliance to various international instruments and agreements in which the Philippines is a signatory of. Some of them were the Universal Declaration of Human Rights (UDHR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC) and the International Humanitarian Law (IHL).

Because of the presence of laws and policies that addressed GBV, various interventions and services have been tapped, applied and calibrated to cater to the specific needs and concerns of the affected communities and displaced families in times of emergencies. However, because of the opportunities created during emergencies, new GBV interventions and services were developed. And within the span of eight years of responding to major complex emergencies, the country was able to enforce new laws, policies and guidelines for stronger GBV programming.

Illustration 2. Mapping of Laws and Policies Pertaining to GBV Prevention & Response



In addition, sector-specific laws were passed and legislative bills are being proposed to protect vulnerable populations from violence and discrimination. These include: (a) Republic Act No. 8371 or known as the “Indigenous People’s Rights Act of 1997”; (b) Republic Act No. 7277 or the “Magna Carta for Disabled Persons”; (c) Republic Acts No. 7432/9257/9994 or the “Senior Citizens Act” and its expansion laws; and the Sexual Orientation and Gender Identity or Expression (SO-GIE) legislative bills.

One of the laws that clearly highlighted the need to provide protection for women especially in emergency context is the Magna Carta of Women or RA 9710. It defines “*Violence Against Women (VAW)*” as any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life.⁴ Though the word GBV has been used in RA 9710, the term itself was not clearly defined. So far, definitions of GBV can be found in the implementing guidelines of women and child-friendly spaces; and in the Special Protection of Children in Situations of Armed Conflict or RA 11188.

For purposes of the research, using the definition provided in the Implementing Guidelines of Women and of Child-Friendly Spaces, it shall define GBV as “*violence that is directed at a person on the basis of gender or sex. GBV is an umbrella term encompassing a wide range of human rights violations and can be directed at adult women and men and male and female children. GBV takes the form of rape, domestic violence, sexual assault and harassment, trafficking of women, girls and boys and several harmful traditional practices including female genital mutilation/cutting, early marriage, and bride inheritance*”.⁵

Furthermore, RA 11188 defines acts of GBV within the context of armed conflict setting to include “*physical or sexual violence other than rape, and psychosocial harm that is committed against a person as a result of power inequities that are based on gender roles. These include, among others battering, sexual slavery and abuse of children, female genital mutilation, prostitution, forced marriage, forced pregnancy or forced sterilization*”.⁶

GBV and VAW are interchangeably used because most of the victim-survivors of GBV are women and girls. Also, in the communities, VAW is widely known as compared to GBV. However, the study has discovered untold stories of adult men and boys being violated during emergencies. Thus, the term GBV shall be consistently used in this project to cover adult women and men, boys and girls; and can be in the form of physical, sexual, psychological and economic violence.

II. BACKGROUND

2.1 Purpose of the Study

The Study aims to produce a Lessons Learned and Opportunities Document that will:

1. Generate evidences on the impact made with the implementation of various GBV interventions and services in different complex emergencies experienced in the Philippines;
2. Serve as a safe space for the voices of the GBViE survivors, vulnerable populations and affected communities; and
3. Provide new insights, learnings and opportunities to better enhance GBViE programming and its impact measurement practices through the application of inclusion, innovation and human-centered design.

2.2 Project Objectives

The general objective of the Study is to conduct the country's first impact assessment study on GBViE programming by introducing the use of creative impact measurement tools.

Specifically, it aims to:

1. Assess current GBViE interventions and services in order to identify its impact and needs for improvement;
2. Generate ideas with the affected communities and displaced populations on how to measure the impact of GBViE programming; and
3. Identify other means that increase resilience of communities against GBV as well as responsiveness of the service providers and humanitarian actors.

2.3 Significance of the Study

1. To demonstrate how complex emergency situations can create opportunities or can serve as entry points to introduce significant changes and promote empowerment and equality especially in the field of planning, programming, policy-making and information management;
2. To cite good practices, stories, lessons learned and recommendations for better humanitarian response especially in dealing with GBViE survivors, vulnerable sectors and affected communities; and in putting in place a responsive information management system; and
3. To contribute to the growing body of knowledge and literature on GBViE programming at the local and global levels.

2.4 Scope and Limitations

1. **On Geographical Coverage.** Though the study covered five major complex emergencies in the last eight years, not all affected areas were explored. The project sites were selected purposively on the basis of access, security, political climate and willingness of the communities to participate in the research. In addition, the budgetary constraints and project timeline were also considered.
2. **On the Research Respondents and Participants.** No generalizations can be made but rather, the study offered a microscopic view on the impact of GBViE programming. Likewise, since the emergencies covered in this study took place 2 to 8 years ago, the views and opinions of the research respondents and participants were based on what can be remembered and recalled from the early response up to post recovery and rehabilitation stage to present.
3. **On the Application of the Impact Assessment Tools Used.** The study employed existing tools and methods to capture the impact of GBViE programming but they were calibrated to fit the Philippine context; and to incorporate innovation and human-centered design. The application of the creative impact assessment tools is further encouraged for testing and refinements to validate its effectiveness and reliability at any given setting and emergency context.
4. **On the Coverage of GBViE Interventions and Services.** The study did not limit its coverage to the GBViE programming of the government agencies and local government units. It considered all those provided by the United Nations agencies, international and local non-government organizations, civil society organizations and people's organizations, business sector, faith-based organizations and even private individuals. This was in recognition of the collective efforts made when the country was in crisis situations.

2.5 Project Sites

The selection of project sites were based on the following criteria: (a) activation of the field-based GBV Sub Clusters during the emergencies; (b) access and willingness of the LGU and international/local NGO partners to participate together with the affected communities; and (c) areas that have been nominated by the TWG members because of their known good practices on GBViE programming. Presented in Table 1 is a list of cities/municipalities/provinces/regions covered by the study, and the assigned areas of each member of the Consortium.

In summary, the study covered five (5) complex emergencies; six (6) affected regions; fifteen (15) areas at the provincial, city and municipal levels. It should be noted though that other areas were purposively selected to highlight good practices and to engage with vulnerable sectors such as indigenous cultural communities, elderlies, persons with disability and LGBTQI+. To gather the national perspective on GBViE programming and information management, key government agencies at the national level were also included.

Table 1. List of Project Sites

PERIOD OF OCCURRENCE	HUMANITARIAN EXPERIENCES	AFFECTED REGIONS	PROJECT SITES	MEMBER IN-CHARGE
December 2011	TS Sendong/ Washi	Region X Northern Mindanao	1. City of Iligan, Lanao Del Norte	SCHERZ
			2. City of Cagayan De Oro, Misamis Oriental	
December 2012	TY Pablo/Bopha	Region XIII CARAGA	3. Province of Agusan Del Sur	SCHERZ
			4. Municipality of Veruela, Agusan Del Sur	
			5. Municipality of Bunawan, Agusan Del Sur	
September 2013	Armed Conflict	Region IX Zamboanga Peninsula	6. Zamboanga City, Zamboanga Del Sur	RDII/ULIKID
November 2013	STY Yolanda/ Haiyan	Region VIII Eastern Visayas	7. City of Tacloban, Leyte	RDII
			8. City of Ormoc, Leyte	
			9. Municipality of Basey, Samar	
		Region VI Western Visayas	10. Municipality of Guian, Eastern Samar	NSCMN
			11. Municipality of Lavezares, Northern Samar	
			12. Municipality of Concepcion, Iloilo	
13. Municipality of Estancia, Iloilo				
14. City of Roxas, Capiz				
May - October 2017	Armed Conflict	Bangsamoro Autonomous Region of Muslim Mindanao (BARMM)	15. Islamic City of Marawi, Lanao Del Sur	SCHERZ
		NATIONAL LEVEL	National Government Agencies	SCHERZ

2.6 The GBViE Consortium - Visayas and Its Research Process

The Gender-based Violence in Emergencies Consortium - Visayas, Philippines or GBViE Consortium was created during the second half of 2018 with technical support from the Philippines TUKLAS Innovation Labs and was spearheaded by Plan International Philippines. It was formalized through a Letter of Intent to undertake a major research project in response to the GBV funding call of HIF/ELRHA - “Taking a local perspective on measuring the impact of GBV Programming”.

The Consortium is led by the Rural Development Initiatives in the Islands of Leyte, Inc.

(RDII) that is based in Ormoc City, Leyte. Two of its members, the Scherz Indigenous Creations Enterprises (SCHERZ) and the ULIKID Parents Organization, Inc. (ULIKID) are both based in Iloilo City, Iloilo; while the Northern Samar Children's Ministries Network (NSCMN) is in Lavezares, Northern Samar. Below are their respective organizational profiles:



The **Rural Development Initiatives in the Islands of Leyte, Inc. (RDII)** was organized in 1995 and initially registered at SEC in 1996 but was re-registered in 2014 due to lost of documents brought about by STY Haiyan. Its goal is to strive for the genuine empowerment and disaster preparedness of marginalized sectors, peoples and communities. It has supported Haiyan-affected barangays in Leyte through various programs and projects including the incorporation of gender-based violence in emergencies.



The **Northern Samar Children's Ministries Network, Inc. (NSCMN)** was created in 2010 and registered at SEC and Provincial Government of Northern Samar. Its programs and services include child protection in emergencies, child sexual abuse, child trafficking, child labor, children in conflict with the law, neglected and abandoned child. It promotes foster family care and educational and awareness raising in combating online sexual exploitation and addressing disaster risk reduction in partnership with various networks.

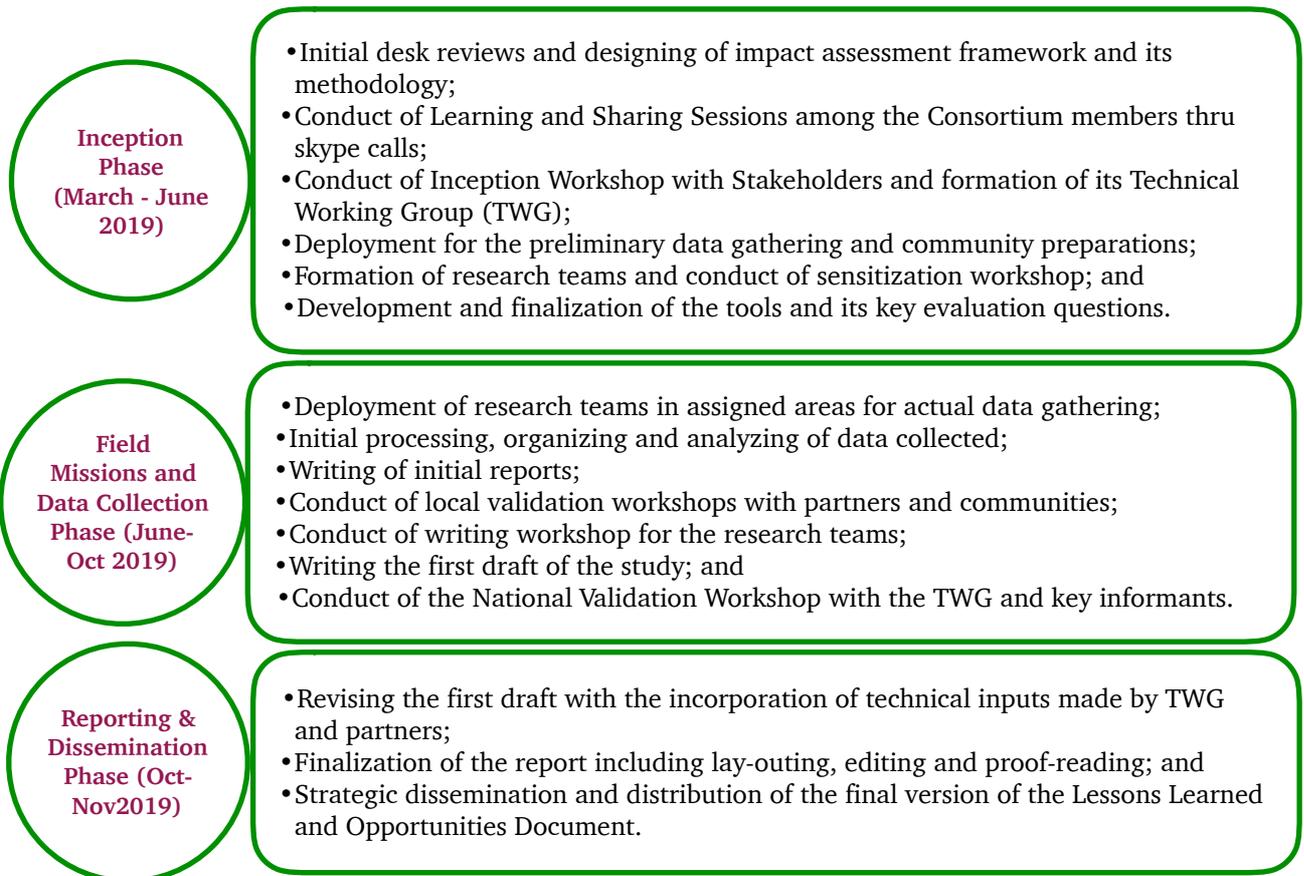


The **SCHERZ Indigenous Creations Enterprises** was established on December 2015 and registered at the Department of Trade and Industry. As a start-up social enterprise, its mission is to build, nurture and cultivate empowered and resilient communities through creative social innovations and products, and responsible business solutions. It was one of the Top 10 Innovations in Visayas that was supported by Philippines TUKLAS Innovation Labs in 2018 and has developed modules including child protection and GBV in emergencies in partnership with the indigenous and vulnerable young people in Tapaz, Capiz.



The **ULIKID Parents Organization, Inc.** or ULugyon nga Inisyatiba sang may mga Kasablagan agud Itib-ong ang ila Dignidad was established in 2003 and registered at SEC and DSWD Field Office VI. ULIKID means 'United Initiative of Persons with Disabilities to Uplift their Dignity'. It is an Ilonggo term which means "concern/care" for children with disabilities and their families. Its mission is to provide proper habilitation, rehabilitation and development programs and services towards the realization of children with disabilities and their families' independence and become proactive members of society.

To carry out the research tasks within the project timeline, the following were the key activities and deliverables of the Consortium in each phase:



III. METHODOLOGY

3.1 Key Evaluation Questions

The key evaluation questions were formulated in consultation with the (a) TWG composed of duty bearers and service providers; (b) research teams of the Consortium; and (c) communities during the preliminary data gathering. The study wanted the research to be an empowering exercise to all and not just an extraction of data and information. To capture the different lenses of stakeholders, the study crafted 4 sets of evaluation questions:

Question #1: What is the level of resiliency among the victim-survivors of GBV in emergency context? What were the factors that facilitated or hindered their capacity for resilience? What were the coping mechanisms or strategies adopted to become resilient? The first set of questions were aimed at victim-survivors of GBV in emergency context. The study observed research ethics and GBV guiding principles.

Question #2: What is the relevance and effectiveness of the GBV programming in emergency context? What GBV interventions and services that worked and did not work? Were they based on empirical data and needs of the affected communities? Were they inclusive, age-appropriate and culture-sensitive? Were the affected communities consulted? The second set of questions were directed at the affected communities and vulnerable sectors such as the LGBTQI+, indigenous people, persons with disabilities and elderlies.

Question #3: How did the GBViE programming experiences made an impact in national and local policies, programs and structures? What were the lessons learned, major gaps and challenges experienced in designing and implementing GBViE interventions and services? How did the GBV programming change or improve the situation of the affected communities especially the vulnerable sectors? The third set of questions were addressed by the service providers, humanitarian responders and community leaders and volunteers.

Question #4: What GBViE information management mechanisms were put in place? Were there existing good practices on reporting, recording, monitoring and evaluating GBViE interventions and services? What were the challenges encountered in measuring the prevalence of GBV in emergency context and how were they addressed? Were the information management mechanisms inclusive and adhering to survivor-centered approach? The last set of questions were meant for government agencies, local government units and humanitarian organizations.

3.2 Data Collection Methods

The study heavily employed qualitative data gathering methods but also applied quantitative method in order to produce, analyze and validate data comprehensively. The selection of research methods were based on the target respondents, the type of information needed, and the level of appropriateness. The three major data collection methods used were (1) survey, (2) focus group discussion (FGD) and (3) key informant interview. All these methods were performed in all project sites.

However, to further enrich the information gathered, supporting methodologies were applied such as the narrative stories and ethnographic study. This was to emphasize stories, good practices and unique cases.

In compliance with the research ethics and GBV guiding principles, all community-based sessions and activities especially those with minors were administered with consent forms prior to note-taking, recording, photo-taking and disclosure of confidential information.

Below are the descriptions of the data collection methods used:

Survey. This method was applied to gather data from the victim-survivors of GBV during the emergency situation using the Brief Resilience Scale (BRS) of Smith, B.W. and company (2008). BRS shall be further discussed in Section 3.3. The GBViE victim-survivors were given two options. First, they answered the questionnaire privately at their own pace. When accomplished, the assigned research team collects. Second option was the direct interview of the researcher to the concerned survivor. Survey respondents were selected based on the referrals of the local service providers or NGOs, after the conduct of brief orientations and upon signifying willingness to participate.

The questionnaire was divided into five parts: (a) socio-demographic profile, (b) BRS on resiliency from within, (c) BRS on resiliency with external and social support, (d) personal thoughts and ideas on GBV interventions and services, and (e) feedback on the appropriateness of the method and questions. There were 12 surveyed respondents.

Focus Group Discussions. FGDs were carried out to gather the voices, views and experiences of the affected or displaced communities. In every project site, at least four FGDs were conducted to segregate participants by age and sex. One FGD was for adult women whose ages ranged from 25 years old and above; another FGD for adult men; another for young girls whose ages ranged from 15-24 years old; and another FGD for young boys. In some areas, separate FGD sessions were conducted for every targeted vulnerable sector. In general, about 6-7 participants per FGD was observed. A total of 58 FGDs were conducted.

The FGD questionnaire was divided into five parts: (a) profile of participants/respondents, (b) understanding of GBViE using the GBViE Tree as the assessment tool, (c) mapping of GBViE interventions and services received using either the Tree of Hope or the Community Score Card tools, (d) open-ended questions on their experiences on GBViE programming as beneficiaries or recipients, and (e) feedback on the appropriateness of the method and questions.

The FGD questionnaire for adults was slightly different from the FGD questionnaire for the young people. An additional question on spousal relationship was included noting the potential impact in power relations.

Key Informant Interviews. This method was employed to gather data from the service providers, government agencies, local government units, UN agencies, international and local NGOs, civil society organizations, people's organizations and community leaders and volunteers. Some sessions were administered either on a one-on-one basis, in pairs or in groups. Other sessions were conducted in round table discussions while email-survey was used for former humanitarian staff/consultants who took part in previous emergency responses.

A separate set of questionnaire was formulated consisting of four parts: (a) profile of participants, (b) roles and contributions in GBViE prevention and response, (c) experiences on GBViE programming, implementation and monitoring and evaluation, and (d) feedback on the appropriateness of the questions and method. A total of 176 respondents were interviewed.

Narrative Stories. These methods were applied to examine unique his/her stories and cases. Stories were either focused on (a) personal experiences in accessing or availing GBViE interventions and services; (b) potential good practices and successful stories that can be replicated and scaled up; or (c) personal situations that can be sources of new learnings and insights. Key findings in these stories have substantiated the results found in other research methods.

Ethnography. An innovation was made in capturing the experiences of an indigenous group, the Badjaos in Dolho-Bato, Leyte. Having an anthropologist in the research team, knowledge and information were obtained through unstructured, conversational and interactive dialogue. The case of Badjaos demonstrated how stateless people can be at high risk of protection issues including GBV.

In addition, *secondary data* like statistics, laws, policies and project reports were collected to further provide evidences on the impact of GBViE programming experiences.

Below is a table summarizing the number of participants for every major data collection method in every emergency situation. As illustrated, a total of 658 participants were covered by the impact assessment study using different research methods.

Table 2. Summary of Research Respondents by Emergency Situation

	TS Sendong/Washi (R10/Northern Mindanao)	TY Pablo/Bopha (R13/CARAGA)	Zamboanga Siege (R9/Zamboanga Peninsula)	STY Yolanda/Haiyan (R8 & 6 - Visayas)	Marawi Siege (BARMM)	National Level	Total
No. of GBViE Survivors Interviewed	2	2	4	12	0		20
No. of Adult Women in FGDs	9	18	12	132	7		178
No. of Adult Men in FGDs	12	9	11	80	8		120
No. of Young Girls in FGDs	8	4	5	26	14		57
No. of Young Boys in FGDs	7	6	5	24	7		49
No. of Key Informants	29	28	8	85	20	6	176

3.3 Creative Impact Assessment Tools

The study explored available GBV tools that can be used for measuring impacts in innovative and creative ways. To do away with the traditional practices of collecting data from respondents, the study refined and calibrated existing tools to become more engaging, process-conscious and learning, and suitable for the target communities. To capture the impact of GBViE programming, the following measurement tools were employed:

a. The GBV Ecological Framework in Emergency Context

The GBV Ecological Framework, as introduced by Heise (1998), was first used to analyze the risk factors that influenced the likely occurrence of violence at various levels: individual, relationship/family, community and societal levels. The overlapping of rings showed the interplay of risk factors that either perpetrate violence or that allow an individual to experience violence. Such framework has guided the GBV prevention and response actions at different and across multiple levels.⁷

The framework was used in the study to put into perspective the manner of organizing the GBV interventions and services. The initial mapping took place during the inception workshop

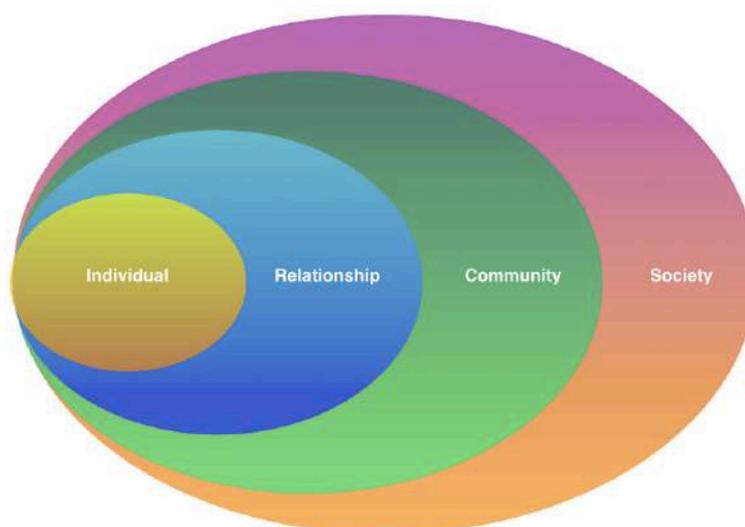
with the members of the TWG. Since the various emergencies occurred 2 to 8 years ago, the reflection and recollection process was guided by UNFPA's Minimum Standards for Prevention and Response to GBV in Emergencies. All answers were arranged into 3 groups: (a) Foundational Standards; (b) Mitigation, Prevention and Response Standards; and (c) Coordination and Operational Standards.⁸

After identifying all GBViE interventions and services using the Minimum Standards, the TWG proceeded to rearranging the items using the GBV Ecological Framework. Each item was assessed in terms of its target outcomes either at the individual, family/relationship, community, or societal level. In some cases, interventions cut across or overlapped. Through this engaging process, it can be learned where the humanitarian actors concentrated for GBViE programming.

The results of the GBV Ecological Framework were used in designing the data collection instruments including the framing of key evaluation questions as well as the development of theory of change in order to determine what and how to capture the perceived impacts. However, the framework needed strengthening to bring out the emergency context. Thus, this was further populated in consultation with the affected communities in all project sites.

The following definitions were used in arranging interventions and services every level using the GBV Ecological Framework:⁹

Illustration 3:
GBV Ecological Framework



Individual Level: These are direct interventions and/or services that addressed the needs and rights of GBV survivors to facilitate recovery and reintegration; and the needs and rights of individuals to increase protective factors that reduce risks or prevent GBV from taking place esp. in times of emergencies.

Relationship/Family Level: These are direct interventions and/or services that increase prevention strategies through parenting or family-focused prevention programs, mentoring and peer programs. They are designed to reduce conflict, foster problem solving skills, and promote healthy relationships.

Community Level: These interventions mobilise communities to recognise, promote and protect the rights of women and children; and local systems are developed that support effective GBV prevention and response.

Society Level: Systems and strategies are put into place to protect, respond and monitor when rights are breached. This is done through the enforcement of international and national laws and instruments and through the exercise of customary laws that protect human rights, and especially the rights of women and girls.

b. The GBV Theory of Change (ToC) in Emergency Context

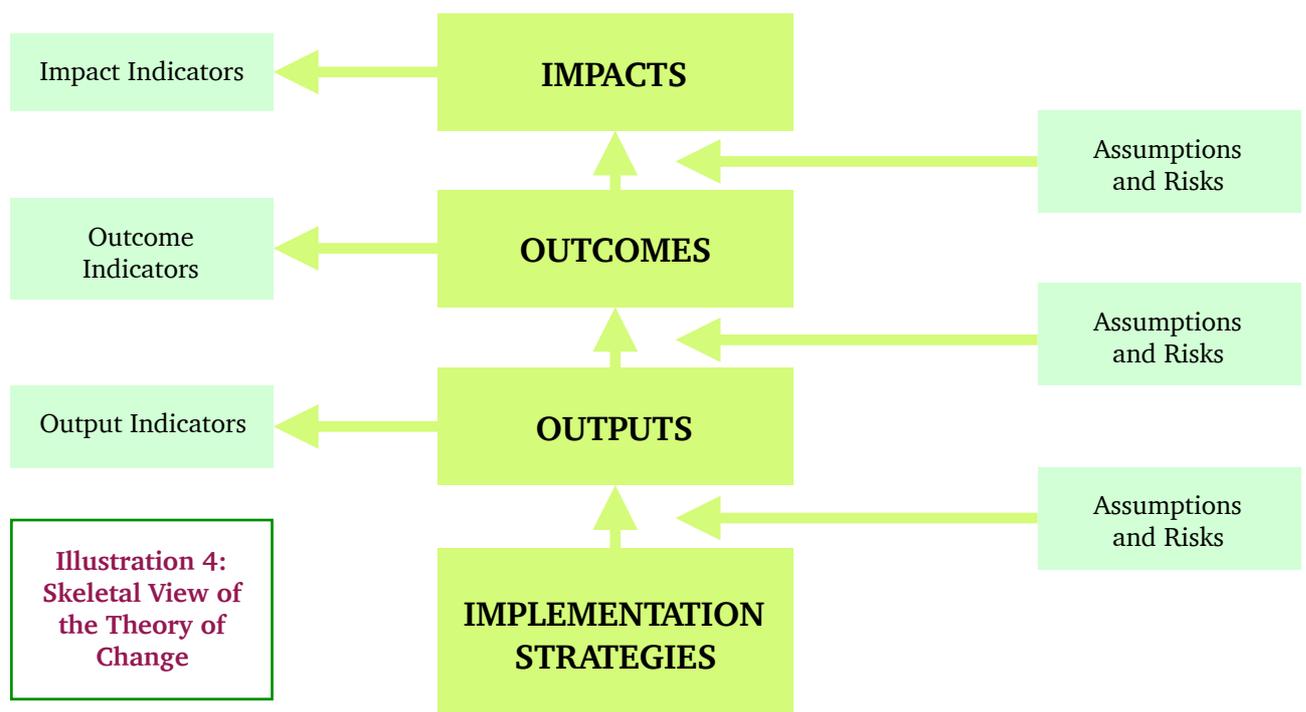
Guided by UNICEF’s Methodological Briefs on Impact Evaluation, the study constructed for the first time a ToC on GBV in Philippine emergency context using the cluster approach. According to Patricia Rogers, a “theory of change can explain how activities are understood to produce a series of results that contribute to achieving the final intended impacts”.¹⁰ The GBViE ToC was a reflection of all the interventions and services implemented not only by the government agencies and local government units, but also by the humanitarian organizations such as UN, I/LNGOs, CSOs and POs.

The first attempt to develop the GBViE ToC was made in consultation with the TWG. This was further enhanced during the actual data gathering and conduct of validation workshops. It was found to be useful in brainstorming with the duty bearers and service providers because it allowed them to see how each agency or organization with specific mandate can contribute to achieving the intended impacts in a complementing and collaborative manner. As pointed out during the workshop, the ToC was a healthy exercise because it made them realize that in programming, it should be focused on the results leading to impacts, and not on the activities.

The study (re)constructed a ToC based on previous humanitarian responses covering the period of TS Washing/Sendong to Marawi Siege. The ToC aimed to cover both natural disasters and armed conflicts. The initial results of the mapping exercise on GBViE interventions and services were matched with the ToC in terms of strategies and activities. The ToC also followed the different levels of interventions similarly to that of the GBV Ecological Framework.

After going through a very engaging and learning process of putting together the very first ToC on GBV in Philippine emergency context, the desired impact statement focused on “resiliency, accountability, responsiveness and preparedness of individuals, families, communities and institutions in promoting safe, healthy and peaceful environment in emergency context”.

Below is a skeletal view of ToC as presented in UNICEF Methodological Briefs:

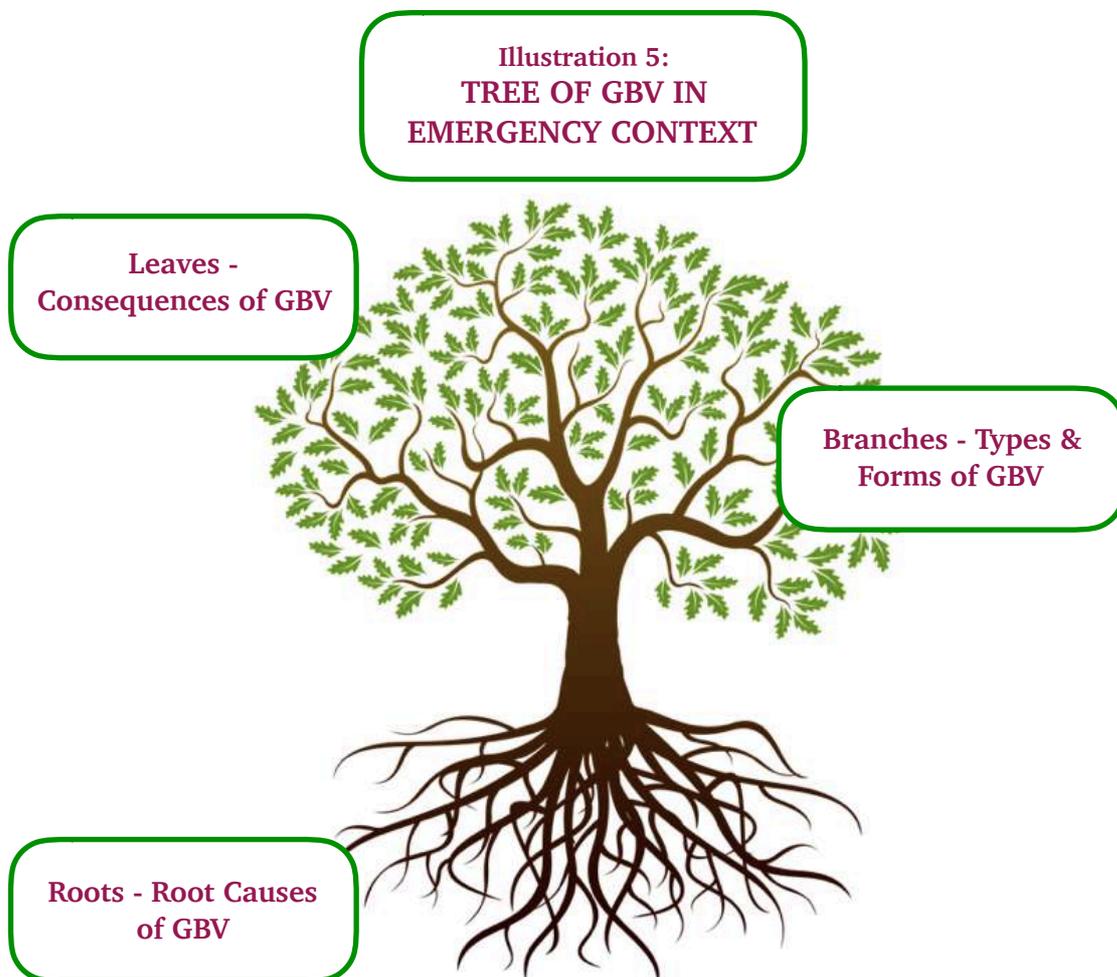


c. The Tree of GBV in Emergency Context and The Tree of Hope

As discussed earlier, Philippine laws use GBV and VAW interchangeably. The term VAW is widely known at the community level than the term GBV. Visual learning is more appreciated at the community especially in discussing technical concepts. Group activities will make the learning process more engaging, creative and fun. All these were considered in planning the conduct of focus group discussions that have targeted affected communities and vulnerable populations. To do away with the traditional practices of conducting FGDs, the study introduced an innovation to capture the understanding of the communities on GBV in emergency context. The Tree of GBV tool was used.

The GBV Tree is a simple way of understanding GBV. The entire tree symbolizes GBV. The roots of the tree are the root causes of GBV; the branches are the different types of GBV; while the leaves are the consequences of GBV for survivors, families and communities.¹¹ In some project sites, participants were asked to draw their own version of the GBV Tree. In some areas, research teams prepared printed GBV Tree already. When the group was done in identifying the roots, branches and leaves, one of them will share what their GBV Tree was all about. Afterwards, processing of workshop outputs took place.

The entire process was empowering because it provided safe spaces for the participants to discuss freely and creatively among themselves what GBV was all about. It also allowed the research teams to raise the level of consciousness and awareness among the communities. It was also an opportunity to deepen their understanding on how GBV can be prevented and responded to in times of emergencies. It became a two-way process.



Another innovation made by this study was the introduction of the Tree of Hope. This creative tool was meant to capture the GBViE interventions and services they received and how those have protected them, their families and communities from GBV. In the Tree of Hope, the entire tree symbolizes positive change or growth. The roots represent the interventions and services received; the trunk symbolizes the implementation process; the branches reflect the changes at various levels; and the leaves represent the interventions sustained by their communities. They were encouraged to add more items to symbolize protective factors such as fruits, sun, water, fences, among others. They were also asked to put symbols that threatened the tree like pesticides which symbolized security risks for example.

The Tree of Hope was meant to capture what worked and did not work from among the interventions and services they received; and what changes or impacts were achieved from their perspective. The tool was meant to draw out the facilitating and hindering factors as represented by symbols of protection and risks/threats. The participants were encouraged to be creative in making their Tree of Hope beautiful and safe.

The same process was applied. The groups were given opportunities to present their workshop outputs. Research teams processed the results by linking the Tree of Hope to the Tree of GBV and its relevance in emergency context and in building resilience. The FGD questionnaire contained probing questions that can further deepen the sharing and discussions. Such exercise was empowering too because it captured the views and opinions of the affected communities on the impact of the GBViE interventions and services received.

However, it was observed that FGD participants had the tendency to share interventions received that were not clearly linked to GBViE programming. When this happened, follow up questions and clarifications were made, and correct and accurate information were provided by the research teams.

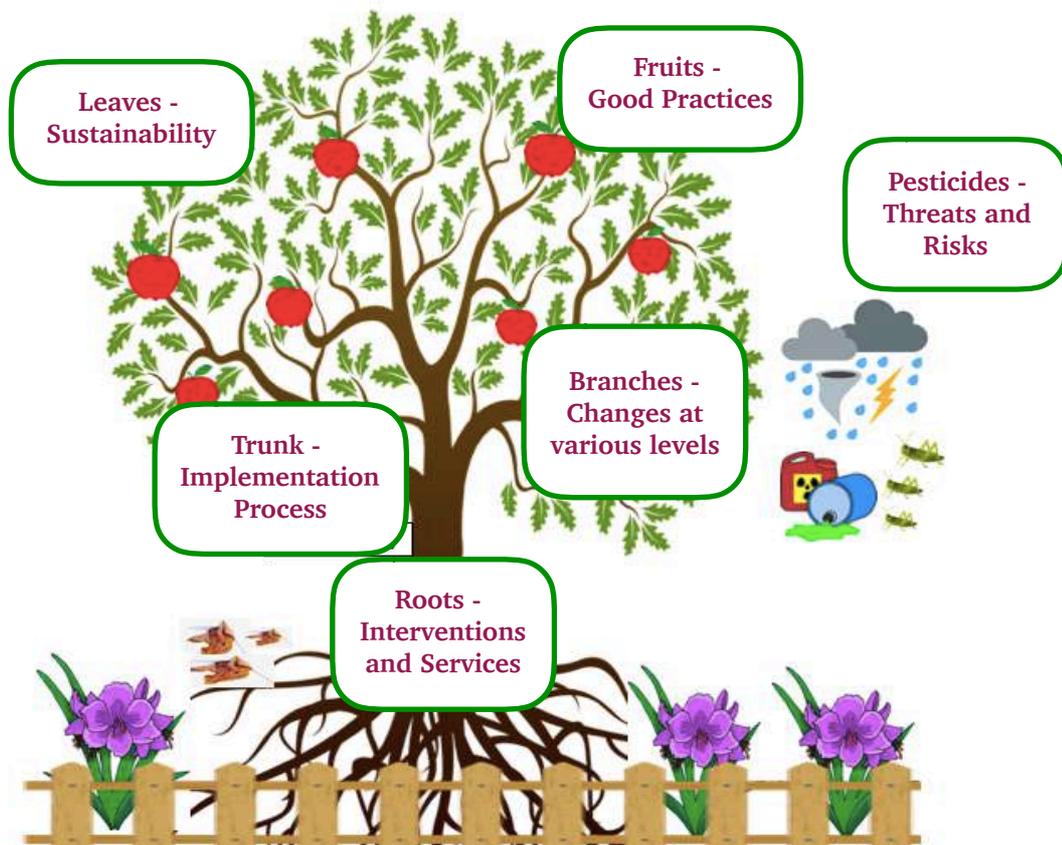
One interesting experience that was encountered was the process of introducing the GBV Tree and Tree of Hope to the Badjao community. Unlike the other FGDs that steered and set the use of the Tree tools to ignite discussions, “sample trees” were presented to Badjao culture-sharing group few weeks after the emersion process took place. The research team needed to gain their trust and confidence first. When this was earned, a FGD was conducted. Since some of the participants cannot read nor write, the “sample trees” facilitated the recalling or digging up of their issues and concerns. Such technique aided both the research teams in imparting key messages, and the Badjaos in understanding what GBV was all about and why it happened in emergencies.

Conduct of a focus group discussion with the Badjaos using the GBV Tree and Tree of Hope

Photo taken courtesy of the RDII-Leyte Research Team



**Illustration 6:
TREE OF HOPE**



d) The Brief Resilience Scale (BRS)

The study employed the use of Brief Resilience Scale, a tool developed by Smith, B. W. and company (2008), to assess the ability to bounce back or recover from stress.¹² Originally, the BRS was composed of 6 items. It can be observed that BRS Nos. 1, 3 and 5 were positively framed; while BRS Nos. 2, 4 and 6 were negatively worded.

In measuring the scale, the following were used for BRS Nos. 1, 3 and 5: (1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Neutral*, 4 = *Agree* and 5 = *Strongly Agree*). This was reversed for BRS Nos. 2, 4 and 6: (1 = *Strongly Agree*, 2 = *Agree*, 3 = *Neutral*, 4 = *Disagree* and 5 = *Strongly Disagree*). To determine the score, all responses were added for the six items. A range of 6-30 will be the result. Divide the total sum by the total number of questions answered. If the score is between 4.31 to 5.00, it means there is high resilience; if between 3.00 - 4.30, it is normal resilience; but if the score is between 1.00 - 2.99, there is low resilience.

To further calibrate the tool for victim-survivors of GBV in an emergency context, an innovation was made by preparing two sets of tables. The first set was to measure resiliency from within and the second set was to measure resiliency with external and social support. The following tables demonstrated the deviations made from the original version of the BRS:

Table 3. Original version of Brief Resilience Scale by Smith, B.W. and colleagues (2008)

Please respond to each item by marking one box per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly after hard times	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 2	I have a hard time making it through stressful events.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
BRS 3	It does not take me long to recover from a stressful event.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 4	It is hard for me to snap back when something bad happens.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
BRS 5	I usually come through difficult times with little trouble.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 6	I tend to take a long time to get over set-backs in my life.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

Table 4. Brief Resilience Scale with Innovation - Resiliency from Within

Please respond to each item by marking one box per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly <i>by myself</i> after hard times.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 2	I have a hard time making it through stressful events <i>by myself</i> .	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
BRS 3	It does not take me long to recover <i>by myself</i> from a stressful event.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 4	It is hard for me to snap back <i>by myself</i> when something bad happens.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
BRS 5	I usually come through difficult times with little trouble <i>by myself</i> .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 6	I tend to take a long time to get over set-backs in my life <i>by myself</i> .	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

Table 5. Brief Resilience Scale with Innovation - Resiliency With External and Social Support

Please respond to each item by marking one box per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 7	I tend to bounce back quickly after hard times <i>with the help of others</i> .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 8	I have a hard time making it through stressful events <i>even with the help of others</i> .	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

Please respond to each item by marking one box per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 9	It does not take me long to recover from a stressful event <i>with the help of others.</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 10	It is hard for me to snap back when something bad happens <i>even with the help of others.</i>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
BRS 11	I usually come through difficult times <i>with the help of others</i> with little trouble.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 12	I tend to take a long time to get over set-backs in my life <i>even with the help of others.</i>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

e) Community Score Card

To determine what worked and what did not work from the perspective of the affected communities, the Community Score Card as an innovation was introduced. All interventions and services identified using the GBV ecological framework were given with corresponding scores by the participants in accordance to their likes and dislikes following the range of scores: 5 - most helpful, 4 - very helpful, 3 - helpful, 2 - least helpful, and 1 - not helpful.

The scores of all FGDs for every item will be added. For example, there are ten FGDs conducted. In each FGD, the group gave a score of 5 to the livelihood program. Adding all the scores of the 10 FGDs would give a total of 50. This means that livelihood is highly favoured by the respondents. If the sum of all scores for Barangay VAW Desk is 10, it means that the VAW desk is not helpful to them. Using this method, the top 10 interventions and services can be identified.

Obtaining the scores was dependent on the preference and creativity of the research teams. Some made use of the Tree of Hope. Others used symbols like heart, angry face, and thumbs-up sign, among others. Some used colour codes while some used number cards.



Scoring of GBV interventions and services using colour codes. Participants were from Zamboanga City.

Photo taken courtesy of Philip Ariane Oledan, Research Volunteer of RDII-Leyte & NSCMN

IV. KEY FINDINGS AND ANALYSIS

Section IV will present key findings and analysis as it addresses the four major sets of evaluation questions. Each set of questions has its own target respondents. Question #1 was directed to GBViE victim-survivors measuring their level of resiliency and how the GBViE programming had supported them. Question #2 was a set of questions focused on the perspective of affected communities particularly the vulnerable sectors on the relevance and effectiveness of the GBViE programming. Question #3 was a set of questions answered by the service providers and humanitarian organizations and agencies on the impact of GBViE programming experiences in policies, programs and structures. And Question #4 was answered by key government agencies on the GBViE information management mechanisms.

In answering the research questions, the study would provide a profile background of the respondents; and would cite stories, practices and cases to highlight success stories, learned lessons and valuable insights. At this point, the study would like to emphasize again that because of its scope and limitations as mentioned earlier, no generalizations can be made. Instead, the study offered a microscopic view of the impacts made on GBViE programming.

4.1 Defining GBViE from the Perspective of Affected Communities

The term VAWC or Violence Against Women and Children was widely known and understood at the community level as compared to GBV. The term GBV was interchangeably used with VAW in Philippine laws, referral services and reporting mechanisms. GBV was considered to be more of a women's issue than men because evidences showed that more women were victim-survivors of GBV. Regardless of terminologies, communities should be made aware of GBV including GBV in emergency context for a heightened prevention and mitigation actions.

In order to capture the perspective of the research respondents on how they looked at GBV, the study used the 'Tree of GBV' as an impact assessment tool to bring out their understanding and knowledge on GBV especially the root causes, the types and forms, and the negative consequences of GBV. Emphasis was made to make the trees more of an emergency setting. Illustration 7 details the summary of all results of GBV Trees made by women & men, girls & boys.

Finding #1: Results of the GBViE Tree showed that participants reached a certain level of awareness and understanding on what GBV was all about and why it happened during emergencies. However, the term VAWC remained to be widely known at the community level instead of GBV. Women and girls were more familiar with GBV rather than with men & boys.

On the Root Causes of GBV. The risk factors that exposed individuals to experiencing violence or perpetrating violence were identified. According to participants, there were root causes found at the (1) individual level (such as lack of education, low self confidence/esteem, loose moral values, limited knowledge on laws/human rights, lack of personal faith/belief); (2) family/relationship level (such as family problems, rido/family feud, infidelity, jealousy, negative peer influence, lack of parental guidance); and (3) community and societal levels (such as poverty, unemployment, perception that women are weak, lack of respect for women, discrimination, influence of alcohol and illegal drugs, irresponsible use of social media, harmful traditional practices, social exclusion, social injustice, interpretation of religion/doctrine).

Illustration 7. Summary of All Results of GBV Trees Made



What made it interesting was that participants were able to identify risk factors that contributed to the occurrences of GBV during emergencies such as: displacement or dislocation caused by disaster, armed-conflict and war; lack of protection measures in evacuation centers; lack of safety and security; comfort rooms and bathrooms were not segregated by sex, no locks from the inside, and pathways were not properly lighted; no privacy in evacuation centers; presence of lawless elements and armed groups; hunger or lack of food security; the power over displaced individuals and vulnerable sectors; separation of families and children; abandoned and neglected children.

On the Types and Forms of GBV. Participants were aware that GBV can be in various types and forms other than physical and sexual violence. The Tree of GBViE showed that it can be psychological violence, economic violence, verbal abuse and online abuse and exploitation too. Concrete examples were given like intimate partner violence, pornography, prostitution, rape, incest, sexual harassment, sexual molestation, sexual abuse and human trafficking.

There were also forms of GBV against children such as school violence, child labour, child abuse and exploitation, forced marriage, early/child marriage and bullying.

In armed conflict setting, participants were able to identify other types of GBV such as sexual assault and gender harassment in public places like evacuation centers; and increased vulnerability due to recruitment and use of women and children as cooks, helpers and human shield by armed groups.

One of the issues raised by some of the participants was the vulnerability of displaced women, youth and children to humanitarian aid workers who were in the guise of providing humanitarian assistance but were actually exploiting them in the form of soliciting sexual favours in exchange of food items and mobile loads, among others. This was raised in several project sites.

On the Negative Consequences of GBV. Participants believed that GBV has health, emotional, psychological and social consequences. The worst were suicide and death. Health consequences were (1) physical (such as injury, disability, malnourishment, loss of appetite, vices); (2) reproductive health (such as unwanted pregnancy, early marriage, abortion, STI/HIV/AIDS); and (3) mental (such as depression, trauma, stress, denial of problem). Emotional and psychological effects included depression, trauma, anxiety, fear, suicidal thoughts, mental illness, stress, rebellion, shame, insecurity. Social consequences included school dropout, poor work performance, broken family, social isolation, social stigma, and exclusion in receiving relief operations.

The results of the Tree of GBViE showed that participants had a clear understanding on what was and why GBV took place during emergency situations. It was also pointed out that age, disability, ethnicity and gender orientation can increase vulnerability and worsen GBV experiences. However, the exercise also was a realization that women and girls were more familiar with GBV rather than with men and boys. Such observation has an implication on GBV programming.

4.2 Question #1: What is the Level of Resiliency Among the Victim-Survivors of GBV in Emergency Context?

Critical to the impact assessment study were the voices of victim-survivors of GBV in emergency context. Their recovery, healing and reintegration experiences gave the study a glimpse on how they were able to recover after going through stressful or traumatic events. Their stories would demonstrate protective factors that increased resiliency; and risk factors that increased vulnerability.

To determine if they had high, normal or low resiliency, the study made a survey using the Brief Resilience Scale (BRS) introduced by Bruce W. Smith, Jeanne Dalen, Kathryn Wiggins, Erin Tooley, Paulette Christopher, and Jennifer Bernard in 2008. BRS is a reliable means of assessing or measuring resilience as the ability to bounce back or recover from any stressful events in life.¹³ Originally, it was only composed of 6 items. However, the study innovated by developing 2 sets of categories to have a comparison between the victim-survivors' ability to bounce back quickly *on their own* and their ability to bounce back quickly *with the help of others*. The Scale has a total of 12 items.

This section will respond to Key Evaluation Question #1: What is the level of resiliency among the victim-survivors of GBV in emergency context? This was further supported with two more questions: (1) What were the factors that facilitated or hindered their capacity for resilience? and, (2) What were the coping mechanisms or strategies adopted to become resilient?

In order to answer these questions, the study was able to interview 12 GBViE victim-survivors in 4 project sites. They were all female respondents. Graph 1 showed that majority of the surveyed respondents came from one of the STY Yolanda/Haiyan-affected areas, the Province of Leyte, with 6 GBViE victim-survivors. Two respondents came from Agusan Del Sur (TY Pablo/Bopha); another 2 from Lanao Del Norte (TS Sendong/Washi); and another 2 from Iloilo (STY

Yolanda/Haiyan). All areas were affected by natural disasters. Out of the 12 participants, 5 of them were living in relocation sites.

Surveyed respondents were either referred to by the local service providers or NGOs and in coordination with the social welfare and development offices. They gave their written informed consent after the orientations on the research project were made and after affirming confidentiality in any disclosure of information that could put them at risk. Interviews were voluntary.

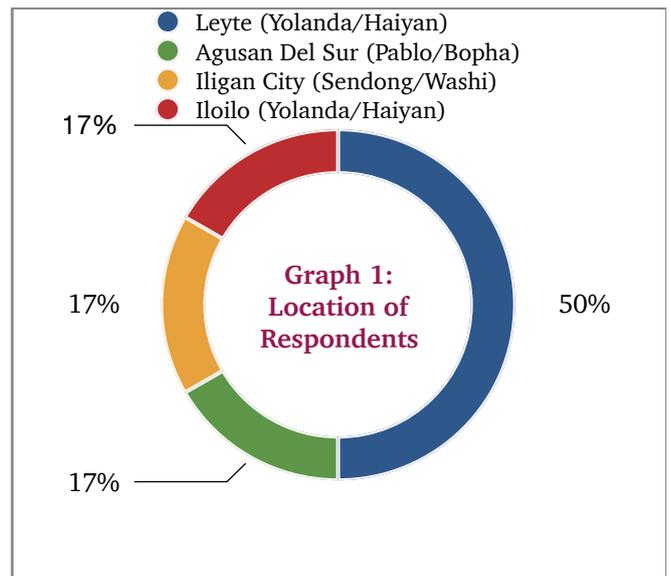
As demonstrated in Graph 2, majority of the participants were survivors of intimate partner violence with 5 cases; followed by 4 sexual violence cases (rape, incest, prostitution, forced sex); 1 physical violence in the form of bullying; and 2 respondents admitted experiencing multiple types of gender-based violence.

Four of the surveyed respondents were from the age group of 15-17 years old; and another four from the age group of 25-49 years old. There were three participants whose ages were 50 years old and above; and there was 1 survivor who was from the group of 18-24 years old. See Graph 3.

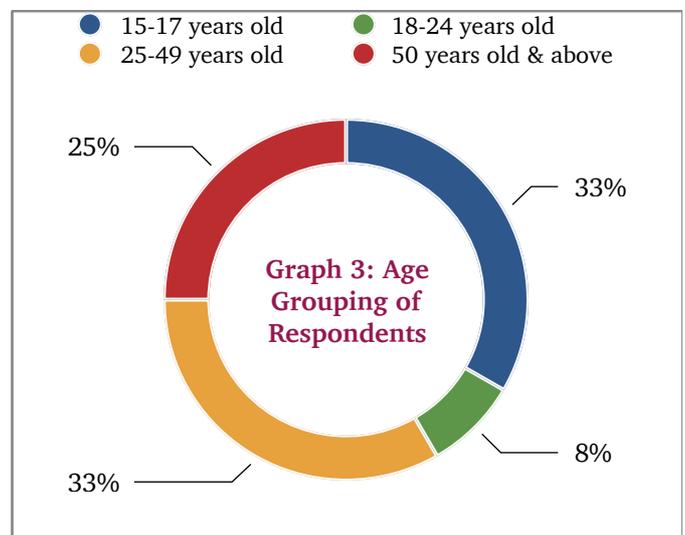
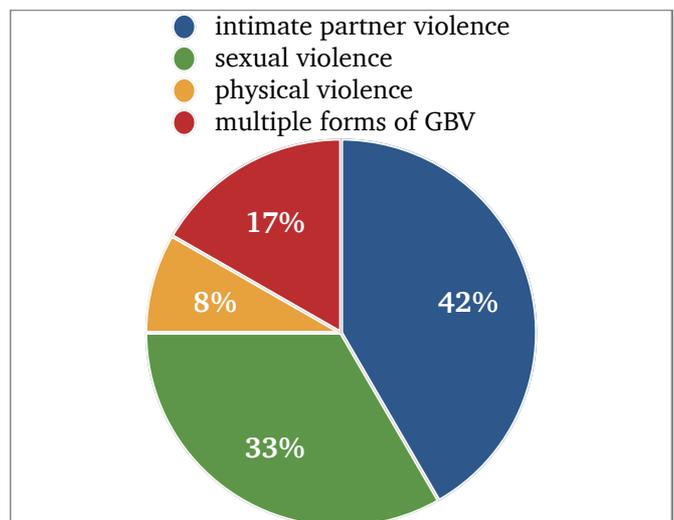
Majority of the surveyed respondents were single with 5 cases; while 4 were married or live-in arrangement, 2 were separated, and 1 in a complicated relationship as illustrated in Graph 4.

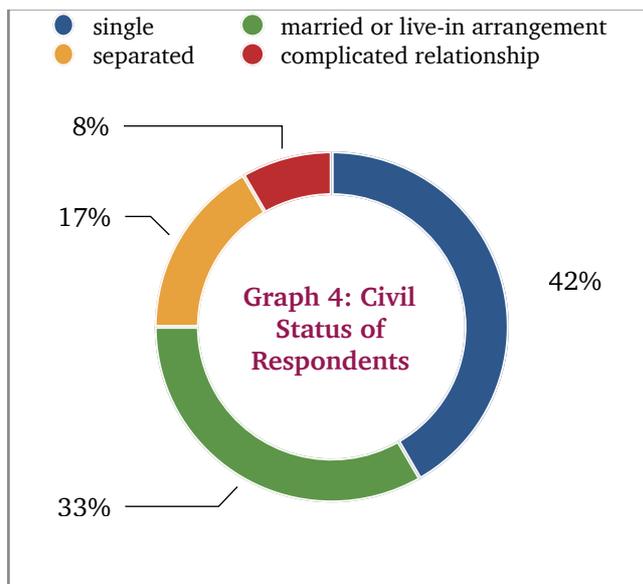
Four of them were in college level, another 4 from secondary, 2 reached elementary level and 1 enrolled in vocational course. One was unknown. See Graph 5.

In Graph 6, the employment status were identified except for 1 that cannot be determined. Five of them were in full-time jobs and 1 seasonal worker; while 4 were students and 1 housewife.



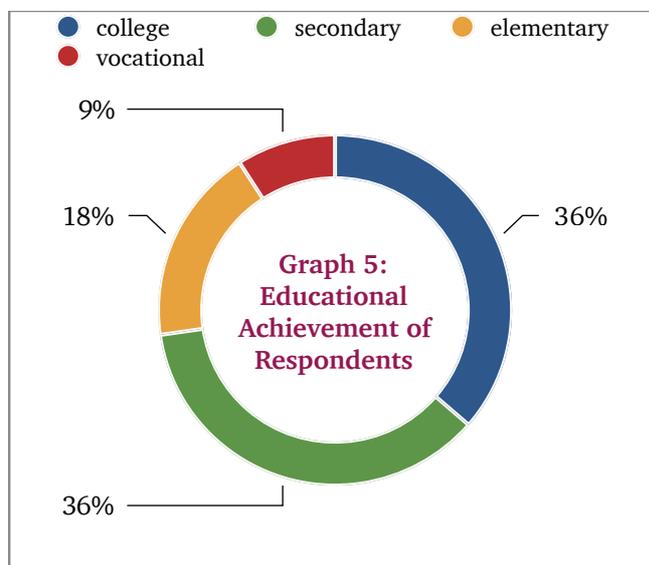
Graph 2: Types of GBV Experienced





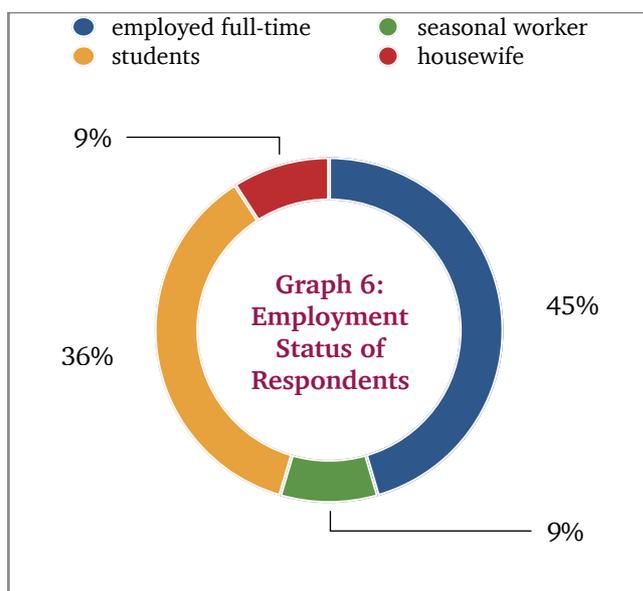
Finding #2: Results of the Brief Resilience Scale showed that majority of the surveyed GBV victim-survivors obtained normal resilience level with the help and support of others rather than coping on their own.

To determine the BRS scores, the process was to add the responses varying from 1-5 for the first set of 6 items per respondent. The highest score would be 30 and the lowest would be 6. Divide the total sum by the total number of questions answered. The score would be the BRS score of every respondent. There should be two sets of scores for every respondent. First is the BRS score for their capacity to bounce back on their own; and the other BRS score is for their capacity to bounce back with the help of others.



Using the interpretation scale of Smith and colleagues, the following would be read as follows: 1.00 - 2.99 is low resilience; 3.00 - 4.30 is normal resilience; and 4.31 - 5.00 is high resilience.

On one hand, survey results showed that 8 out of 12 victim-survivors of GBViE had normal resilience scores with an average score of 3.01. This means that majority can bounce back quickly on their own with the highest score of 3.67 and lowest at 1.83.



On the other hand, 9 out of the 12 respondents indicated ability to bounce back quickly with the help of others. The average score of 3.18 demonstrated normal resilience with 4.17 being the highest score and 1.83 being the lowest.

Below is a comparative table of the results of resilience from within and resilience with external and social support. It can be observed that there was a significant difference of 0.17 between the mean score of 3.01 (without help) and the mean score of 3.18 (with help). Thus, GBV victim-survivors obtained normal resilience with the help of others.

Table 6: Comparison of BRS Scores Without Help versus With Help

CODING	BRS WITHOUT HELP	RESILIENCE LEVEL W/O HELP	BRS WITH HELP	RESILIENCE LEVEL WITH HELP
R1	3.33	Normal	3.50	Normal
R2	3.00	Normal	2.67	Low
R3	2.17	Low	3.83	Normal
R4	3.50	Normal	4.17	Normal
R5	2.83	Low	3.33	Normal
R6	2.83	Low	2.33	Low
R7	1.83	Low	1.83	Low
R8	3.00	Normal	3.00	Normal
R9	3.67	Normal	3.33	Normal
R10	3.17	Normal	3.33	Normal
R11	3.50	Normal	3.33	Normal
R12	3.33	Normal	3.50	Normal
TOTAL	36.16		38.15	
MEAN	3.01		3.18	

Resilience can be influenced by a number of factors. It can be based on personal experiences, characteristics and social environment. To determine factors that facilitated and hindered their capacity for resilience, the study examined the following: personal profile such as age, education, employment; and protective factors such as family support, spiritual beliefs, peer group and community-based protection mechanisms.

Finding #3: GBViE victim-survivors who were between the ages of 15-17 years old, who only reached primary education, and who were dependent on others for financial support, were the ones with low resilience as compared to respondents with normal resilience who belonged in the age group of 50 years old and above, who have reached or graduated from college, and who were economically independent.

In comparing the BRS scores between the young (15-17 years old) and the old (50 years old & above) (see Table 7), young survivors have low resilience (2.96) compared to the older (3.22) ones. Though both have normal resilience with the help of others or external support, the young ones displayed a significant lower score.

Table 8 showed that GBViE victim-survivors with low education have low resilience scores, both for resilience on their own and with the help of others. Those who reached secondary education or received a vocational course, have displayed low resilience on their own but obtained normal resilience with support from others. Those with college education showed normal resilience both on their own and with external support.

Table 7: Influence of Age in Resilience Level

CODING	AGE	BRS WITHOUT HELP	BRS WITH HELP	CODING	AGE	BRS WITHOUT HELP	BRS WITH HELP
R3	17	2.17	3.83	R2	55	3.00	2.67
R6	16	2.83	2.33	R4	57	3.50	4.17
R11	16	3.50	3.33	R10	53	3.17	3.33
R12	17	3.33	3.50	TOTAL		9.67	10.17
TOTAL		11.83	12.99	MEAN		3.22	3.39
MEAN		2.96	3.25				

Economic independence contributed to achieving resilience. Table 9 illustrated that those who depend on others for survival and schooling, have low resilience; but those with work or employment, have normal resilience.

Survey results showed that young age group, those with low education and those with no source of income have low resilience scores, meaning, they found it hard to bounce back on their own and even with the help of others. Although, an exceptional case was observed among the young people who displayed ability to bounce back quickly with the help of others.

Table 8: Influence of Education in Resilience Level

CODING	EDUCATION	BRS WITHOUT HELP	BRS WITH HELP
R2	elementary	3.00	2.67
R7	elementary	1.83	1.83
TOTAL		4.83	4.50
MEAN		2.42	2.25
R3	secondary	2.17	3.83
R6	secondary	2.83	2.33
R11	secondary	3.50	3.33
R12	secondary	3.33	3.50
R5	vocational	2.83	3.33
TOTAL		14.66	16.32
MEAN		2.93	3.26
R1	college	3.33	3.50
R8	college	3.00	3.00
R9	college	3.67	3.33
R10	college	3.17	3.33
TOTAL		13.17	13.16
MEAN		3.29	3.29

Table 9: Influence of Income in Resilience Level

CODING	INCOME	BRS WITHOUT HELP	BRS WITH HELP
R1	employed	3.33	3.50
R2	seasonal	3.00	2.67
R5	employed	2.83	3.33
R8	employed	3.00	3.00
R9	employed	3.67	3.33
R10	employed	3.17	3.33
TOTAL		19.00	19.16
MEAN		3.17	3.19
R3	student	2.17	3.83
R6	student	2.83	2.33
R7	housewife	1.83	1.83
R11	student	3.50	3.33
R12	student	3.33	3.50
TOTAL		13.66	14.82
MEAN		2.73	2.96

Out of the 3 cases of sexual violence involving young people, 2 of them demonstrated normal resilience with the help of others; while the other one demonstrated consistent low resilience. In examining further the 3 cases, it was found out that access to and availability of institutional yet comprehensive interventions made a huge difference. Because of the help and consistent support received by the 2 young survivors, their capacity to deal with life challenges increased. But the other survivor who received hardly any intervention, displayed low resilience. Below is a table of their BRS scores:

Table 10: Comparison of BRS Scores of Young Respondents

CODING	AGE	BRS WITHOUT HELP	BRS WITH HELP
R6	16	2.83	2.33
R11	16	3.50	3.33
R12	17	3.33	3.50
TOTAL		9.66	9.16
MEAN		3.22	3.05

Results of BRS showed that surveyed GBViE victim-survivors had a normal resilience level with the capacity to bounce back with the help and support of others. Factors that either facilitated or hindered resiliency were age, education and economic independence.

To determine other protective factors, the study uncovered untold stories of individuals who went through the painful experiences of their lives, yet, they did not give up. They wanted their stories to be known to serve as inspiration to others and as sources of life lessons. The stories were also meant to demonstrate how the help and support of others can build their capacities to bounce back; and what can be done for those who are in similar situations.

In protecting their identities, real names were withheld. Before any disclosure took place, proper coordination was made, orientations took place, and signed forms of informed consent were acquired. The valuable learnt lessons of their stories can guide future GBViE programming including child protection.

HerStory 1: “My Past Cannot Dictate My Future” - Azie

Azie, a Tausug, got married at an early age when she was 14 years old. She was a victim-survivor of intimate partner violence and silently suffered the abuses inflicted on her by her husband for 24 years. She has 5 daughters, one is with disability but was given away by her husband at an early age, and the other one is living with her sister-in-law.

Her husband subjected her to bullying and embarrassment during gatherings with relatives and friends. According to her, “...my former husband was an alcoholic. When he was drunk, he would force me to have sex with him even if I was tired. I would get beaten if I refuse him.” Having witnessed what their father was doing to her, her children also lived in fear. He would hurt and shout at them. The house was covered with so much violence and terror.

Little did she know that things will change after the Zamboanga City crisis. The siege turned out to be an opportunity to free herself from the chains of sufferings and violence. While staying at the evacuation center, she got exposed to several trainings given by the humanitarian organizations. She learned what GBV was and became aware of the services that she can availed of. Though living in evacuation centers were not comfortable, she seized the opportunity to turn her life around for the better.

Azie is now divorced from her husband. She finally got the freedom she desired. All her children, except the one who is with her sister-in-law, are living with her. All of them are in school except her special child. She encourages her children to focus on finishing their studies first before getting involved in any romantic relationship.

“Being a solo parent is better than keeping a relationship that is not based on respect” according to Azie. With the help of the livelihood programs given to affected families, she was able to provide for her children and send them to school. In fact, one of them is already a 2nd year college student taking up BA Education.

Also, Azie voiced out her concern that the assistance given to families in resettlement areas were not enough. Though there were monitoring visits being done, little actions were taken to address their problems. She also felt that politics has influenced the provision of support to a selected few.

Despite living in a resettlement site with challenges, Azie is grateful that she has a job and has become a parent leader. Most importantly, from being a GBV victim-survivor, she became an advocate of women empowerment. Azie did not let her past dictate her future.

HerStory 2: “I Survived Because Help Was Sent” - Nova

Everything changed when Super Typhoon Yolanda hit her town in Samar. In order to survive, Nova’s mother went to Tacloban City to look for a job as a household helper. She was left on her own to look after her father who was sick with tuberculosis and ulcer. Nova never thought that her father would harm her that completely betrayed her trust. At 14 years old, her father attempted to rape her. From the eyes of the child, Typhoon Yolanda was to be blamed.

Nova was rescued by the Municipal Social Welfare and Development Office and Women and Children’s Protection Desk. They brought her to a Crisis Center but did not stay long due to the bullying of some staff. Fortunately, a foster parent temporarily adopted her and assistance was given to her for healing and recovery. Because help was sent to her at the right time, she was able to cope up and became resilient. Nova, who is now 19 years old, has a child of her own and is in a relationship.

Aside from the GBV-focused stories, the study encountered one child protection case - a child in situation of armed conflict. His story served as an eye opener on the linkage of child protection to GBV.

HiStory 3: “Caught in Conflict, How to Get Help? - Eton

As a child, Eton witnessed how his mother suffered from physical abuse that was inflicted by his father for many years. He had no formal education. Unfortunately, things worsened when Zamboanga City was attacked by the Moro National Liberation Front (MNLF) armed forces. He recalled how fearful he was while crawling through a hole on the ground under their house while government military troops and MNLF exchanged gunfires and bombings endlessly.

Caught in the situation of armed conflict, he and his mother were held captives by the MNLF armed forces. Eton was made to fetch water while her mother served as cook. They had no choice but to obey for fear of being punished or killed. He was grateful though that after 19 days of war, the siege ended.

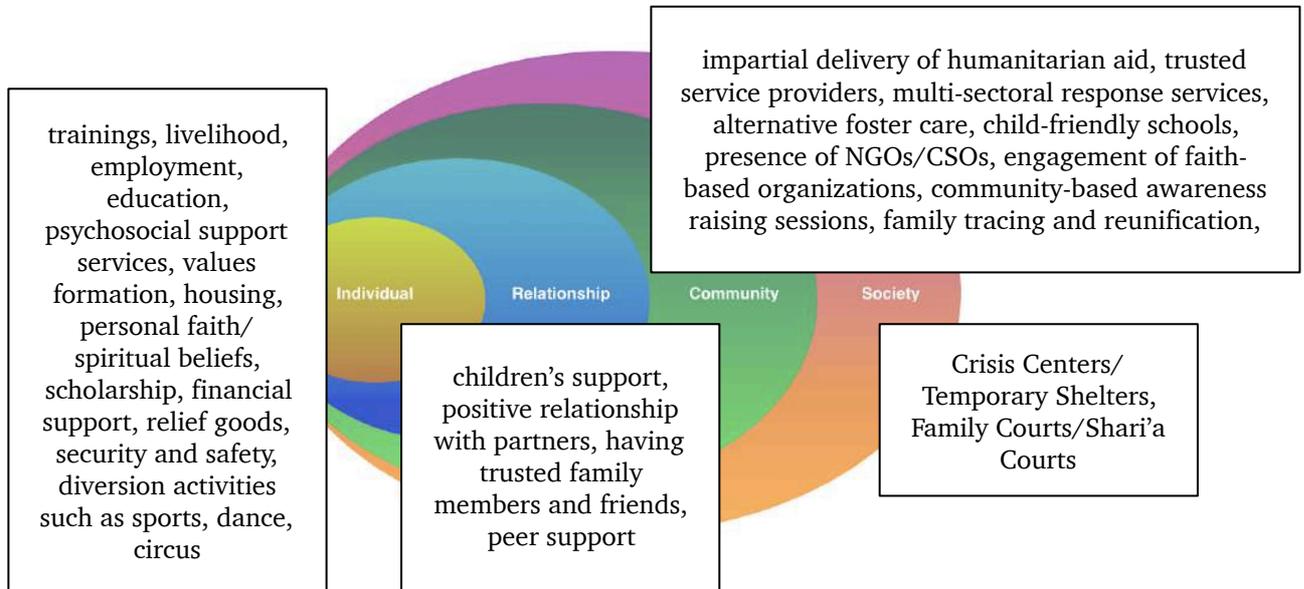
According to Eton, he cannot remember receiving any support or assistance during that time. He just went on with his life trying to cope up on his own. He focused on looking for a job so he could support himself and his mother.

Eton is 21 years old already and is working as a porter in Zamboanga City. He has a live-in partner and with a child. He works around the clock so he could support both of his family and mother. He is grateful that his mother is now separated from his father who is a policeman. However, he dreams of going to school someday but has no idea where to begin.

From the 3 stories narrated above, new opportunities emerged even in emergency situations that positively influenced life changes. For example, Azie managed to free herself from an abusive relationship through various interventions. Nova, at a very young age, was able to cope up because of the help she received when she needed most. Eton who showed resiliency on his own is surviving and able to move forward with his family. His mother got separated from a violent relationship as well.

However, building resiliency is affected whenever politics interfere in humanitarian aid; when the people you trust violate you; and when no service has reached you. Likewise, Eton's case has provided insights on how to reach the vulnerable populations who are young, who cannot read nor write, and who had been captives of armed conflict situations. With the presence of new laws on child protection, family tracing and reunification can be further strengthened in an armed conflict setting.

From the survey results and stories, the protective factors that promote resiliency were:



Characters in the photo do not represent any of the stories mentioned above. This scene was taken in Buggoc Transitory Site, Zamboanga City. Photo taken by Philip Oledan, Research Volunteer, RDII-Leyte and NSCMN

4.3 Question #2: What is the Relevance and Effectiveness of the GBV Programming in Emergency Context?

In programming for GBV in times of emergencies, the prevention and response actions as standalone and mainstreamed should be prioritized. With or without reports of GBV incidents, the humanitarian community must act at the onset of emergency response. Such move will ensure protective factors are in place for the internally displaced populations especially for the women, adolescents, children and other vulnerable populations.

This section will populate further the GBViE Ecological Framework presented earlier to reflect the mapping of the various interventions and services carried out during the previous 5 complex emergencies covered by the study. Its impact on the affected communities will be measured by answering Question #2: What is the relevance and effectiveness of the GBV programming in emergency context? To further support this, additional questions were raised: What GBV interventions and services that worked and did not work? Were they based on empirical data and needs of the affected communities? Were they inclusive, age-appropriate and culture-sensitive? Were the affected communities consulted?

To assess the GBViE interventions and services from the perspective of the affected communities and vulnerable populations, below were the profiles and background information of research respondents.

Table 11 indicated that a total of 404 participants were captured through the conduct of 58 FGDs that were spread out in the 5 complex emergencies covered. Majority of the participants were adult women (44%) and adult men (30%). The study was able to engage vulnerable populations across all regions.

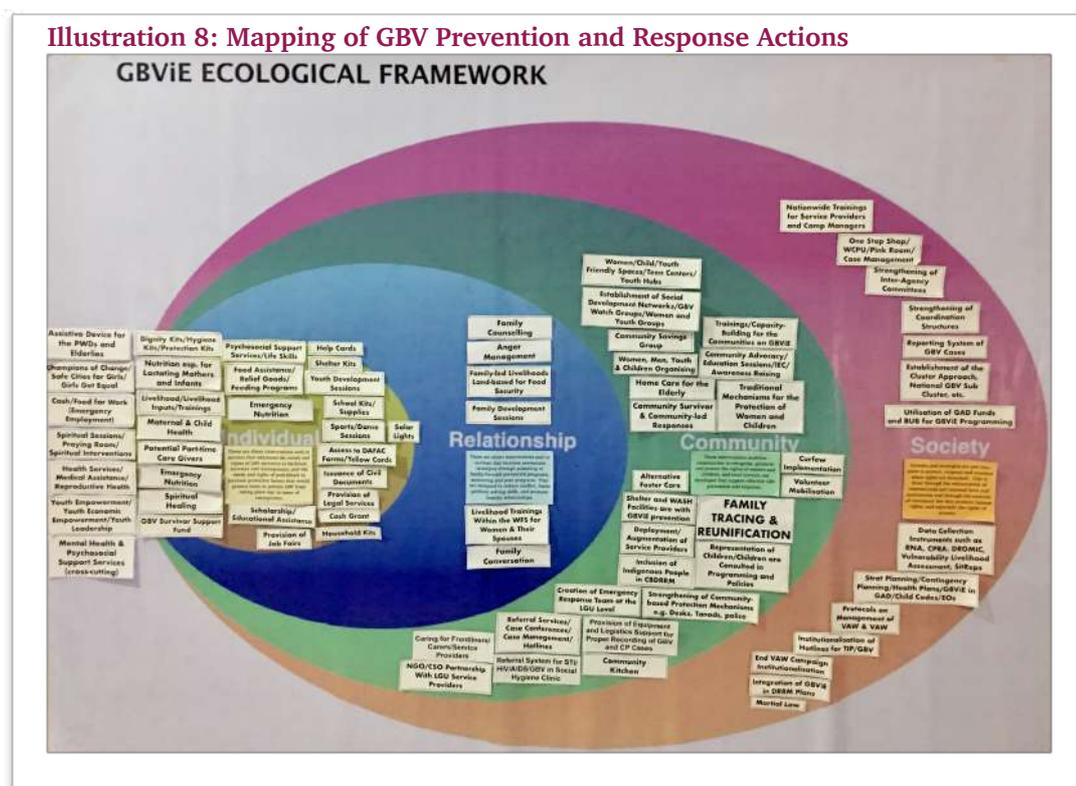
Table 11: Profile of FGD Participants By Emergency Situation

	TS Sendong/ Washi (R10/ Northern Mindanao)	TY Pablo/ Bopha (R13/ CARAGA)	Zamboanga Siege (R9/ Zamboanga Peninsula)	STY Yolanda/ Haiyan (R8 and 6 - Visayas)	Marawi Siege (BARMM)	Total
No. of Adult Women in FGDs (25 yrs. old-above)	9	18	12	132	7	178
No. of Adult Men in FGDs (25 yrs. old-above)	12	9	11	80	8	120
No. of Young Girls in FGDs (15-24 yrs. old)	8	4	5	26	14	57
No. of Young Boys in FGDs (15-24 yrs. old)	7	6	5	24	7	49
Total No. of FGD Participants	36	37	33	262	36	404
Total No. of FGDs Conducted	4	6	4	40	4	58

Great importance was made on the voices of the vulnerable populations. As defined by WHO (2002), *vulnerability* refers to the degree to which a population, individual or organization is unable to anticipate, cope with, resist and recover from the impacts of disasters.¹⁴ For this research, the study highlighted the stories of the vulnerable populations; and looked into the intersection of discrimination on the basis of ethnicity, sexuality, disability, religion and age.

To determine the relevance and effectiveness of the GBViE programming, FGD participants were asked to remember and recall all the interventions and services they received during the emergency situations. They were asked to rank them accordingly based on their perception of what were helpful and what were not. The process gave the study a skeletal view of the overall humanitarian response for GBViE.

Using the ecological framework, the following prevention and response actions were identified by the FGD participants:



Finding #4: Results of the ecological framework showed that the strength of GBViE programming in Philippine context were (a) a mixture of existing and new prevention and response measures; (b) a combination of protective mechanisms mostly concentrated at the individual, community and societal levels; while the relationship level needed further attention; (c) an interaction of GBV-specific and mainstreaming strategies; and (d) a reflection of the need to strengthen more GBViE programming efforts that are specific to the protection needs of the vulnerable sectors.

An immediate impression on the presented ecological framework would assume that the identified interventions and services in various levels were being provided already in normal times. This observation is true. Because of the presence of laws and policies that addressed GBV, the existing interventions and services were tapped, applied but calibrated in times of emergencies to cater to the specific needs and concerns of the affected communities and displaced families.

However, because of the opportunities created during emergencies, new GBV interventions and services were developed. And within the span of eight years of responding to major complex emergencies, the country enforced new laws, policies and guidelines for better GBV programming. Thus, the framework contained existing and new GBV interventions and services but there were specific measures that were only implemented during emergency response. Table 12 itemized GBViE programming in terms of normal times and during emergencies:

Table 12: List of Interventions and Services in all Levels

	INDIVIDUAL	RELATIONSHIP	COMMUNITY	SOCIETY
EMERGENCY CONTEXT	cash/food for work (emergency employment); shelter kits; household kits; dignity kits/hygiene kits/protection kits; access to DAFAC forms/yellow cards; cash grant; emergency nutrition		women/child/youth-friendly spaces, shelter and WASH facilities are with GBViE preventive measures, capacity-building of service providers and volunteers on camp management, help desks in evacuation centres/transitory sites, augmentation of service providers, FTR, GBV watch groups, community kitchen	institutionalization of the cluster system approach, data collection instruments for emergencies; integration of GBViE in plans, programs, policies and local budgets
NORMAL TIMES BUT APPLIED ALSO IN EMERGENCIES	cash grant; sports/dance sessions; health services/medical assistance/reproductive health; scholarship/educational assistance; school kits/supplies; champions of change/safe cities for girls/girls get equal; youth empowerment/youth economic empowerment/youth leadership; spiritual sessions/praying room/spiritual interventions; youth development sessions; food assistance/relief goods/feeding programs; solar lights; mental health & psychosocial support services/life skills; provision of legal services; GBV survivor support fund; livelihood/livelihood inputs/trainings; provision of job fairs; issuance of civil documents; help card; assistive device for PWDs/elderly; nutrition; maternal/child health; values formation	family-led livelihoods land-based for food security; family development sessions; livelihood trainings within the WFS for women and their spouses; family conversation; family counselling; anger management	community saving groups; alternative foster care; establishment of social development networks/GBV Watch Groups/Women and Youth Groups; trainings/capacity-building for the communities on GBViE; community advocacy/education sessions/IEC/awareness-raising; women/men/youth and children organising; volunteer mobilisation; curfew implementation; referral services/case conferences/case management/hotlines; NGO/CSO partnership with LGU service providers; referral system for STI/HIV/AIDS/GBV in Social Hygiene Clinic; strengthening of community-based protection mechanisms e.g. desks, tanods, police; caring for carers; donation of laptops for proper recording of GBV cases; creation of emergency response team at the LGU level; representation of children/children are consulted in programming and policies; inclusion of indigenous people in CBDRRM; traditional mechanisms; caring for frontliners/service providers; provision of equipment/logistics support; homecare for elderly	reporting system of GBV cases; strengthening of inter-agency committees; strengthening of coordination structures; utilisation of GAD funds and BUB for GBViE programming; martial law; strat planning/contingency planning/health plans; institutionalisation of hotlines for TIP/GBV; nationwide trainings for service providers and camp managers; end VAW campaign institutionalisation; One Stop Shop/WCPU/Pink Room/Case Management; Protocols on Management of VAW and VAC

All items identified were made in consultation with the research participants. Because of the limitations of the research, it cannot be concluded that the GBViE Ecological Framework reflected all interventions and services provided by the humanitarian community in the five covered complex emergencies. The framework provided a bird's eye view on what was done for GBViE programming. This can be further populated.

Another observation can be made at the ecological framework was the favourable concentration of GBViE programming at the individual, community and societal levels; while less was given at the relationship level. Individual-based interventions were focused on basic survival needs; economic recovery strategies; educational assistance; health services particularly mental health and psychosocial support services, maternal and newborn health, nutrition and reproductive health services; spiritual-based interventions; and multi-sectoral response services to victim-survivors of GBViE. At the community level, interventions were focused on the provision of safe spaces and facilities; mainstreaming efforts; mobilization and enhancement of the capacities of service providers, partner organizations and volunteers; community organizing; and innovative community-based protection measures. At the societal level, development of responsive information management system; improvement of emergency needs assessment instruments; and putting policies, plans and structures in place.

Though there were few interventions identified at the relationship level, this needs improvement. One of the key findings identified in building the resilience of the GBViE victim-survivors was the role of families, friends, peers and trusted people in providing support so they can easily bounce back after a stressful event in their lives. Likewise, normal resilience was achieved because of the help of others and access to external support. Given these findings, direct interventions and/or services are encouraged that would increase prevention strategies through parenting or family-focused prevention programs, mentoring and peer programs, and building positive relationships. They should be designed to reduce conflict especially in armed-conflict setting, foster problem solving skills, and promote healthy relationships between couples, parents and children, peers, among others.

The ecological framework also indicated an interaction of GBV-specific strategies and mainstreaming interventions in other humanitarian clusters like WASH, Economic Recovery, Health, Shelter, Camp Management, Education, Nutrition and a closer relation with Child Protection. The mainstreaming efforts demonstrated that GBV is a cross-cutting protection concern. They were also a reflection of how GBV actors advocated for GBV prevention and response in other coordination groups.

For example, GBV advocates during the Zamboanga siege worked with the Health Cluster to conduct awareness-raising and learning sessions to most-at-risk populations and for them to access reproductive health services especially those provided at the City's Social Hygiene Clinic. This likewise paved the way for the establishment of the social development networks. The WASH Cluster, in various humanitarian responses, also worked with the GBV Sub Cluster in ensuring latrines and bathing facilities and its pathways were with GBV preventive measures. This included the training of WASH patrols and volunteers. The Protection Cluster, including the GBV and Child Protection, partnered with the Camp Management and Camp Coordination Committees in many responses to capacitate camp managers and formed IDP committees on GBV prevention including the referral pathways. In Agusan Del Sur, the GBV advocates allied with the affected schools in raising consciousness on the prevention of GBV and child protection in times of emergencies. In Iligan and Tacloban Cities, joint monitoring initiatives were undertaken by various clusters.

More so, the ecological framework sent a clear message on the need to bring out more GBViE programming efforts specific to the protection needs of the vulnerable populations such as the indigenous people, ethnic minorities, people with disability, elderly and LGBTQI+. So far, the study documented interventions like provision of assistive devices to PWDs and elderlies, inclusion of indigenous people in community-based DRRM, home care for the elderly and mobilization of local NGOs serving vulnerable groups. During the STY Yolanda/Haiyan emergency response, one of the international NGOs on disability capacitated LGUs in addressing the needs of the PWDs in times of emergencies. In some areas, LGBTQI+ were organized and mobilized as community volunteers and leaders. Medical missions in indigenous cultural communities were also conducted in Capiz led by a local NGO.

In the course of data gathering, a potential model on the integration of GBV prevention in economic recovery was identified in Samar.

BANIG WOMEN WEAVERS: SUCCESS RISING FROM A TRAGEDY

The Basey Association for Native Industry Growth or **BANIG** is a federation of 29 local women associations involved in *banig* (literally means hand-woven sleeping mat) hand-craft making that is based in the Municipality of Basey, Province of Samar. The Municipality was badly hit by Super Typhoon Yolanda in 2013 that destroyed their primary source of income and livelihood. The source of raw material for mat weaving which is *tikog* (a kind of tall grass that looks like rice that grows in wet areas along rice fields), was flooded and soaked-rotten by sea waters. All processed raw materials and supplies were damaged, and finished products were lost and stolen. This devastated the women weavers including their families.

The first humanitarian organization that came and distributed relief goods in 30 barangays of Basey was the *Pambansang Koalisyon ng mga Kababihan sa Kanayunan* or PKKK-National Coalition of Rural Women. As its mother unit, PKKK immediately mobilized its chapter-members and volunteers in Basey and conducted needs assessment. The top most priority need of the displaced mothers was livelihood development.

With the support of international humanitarian organizations such as OXFAM, CARE-Philippines, Christian Aid, Canada Fund and Action Aid, their social enterprise was restored. In reviving the industry from the scratch, only 18 women embarked on weaving again. For lack of space to weave on, they wove inside the Saob Caves of Barangay Basiao. For a year, business was slow. No quality *tikog* materials could be found. The men who were the husbands of Basey Association members were paid for planting *tikog*. They needed to work double time to plant *tikog* and *buri* to cope up with the scarcity of raw materials.

Aside from the enterprise development, humanitarian organizations provided various capacity-building exercises on leadership, management and disaster preparedness. In 2014, a fresh capital input had been given that turned BANIG into a full blown enterprise. After 5 years of rebuilding the social enterprise, more than 1,499 women members are now provided with sustainable source of income. Their products have reached as far as Europe, Canada, US, Asia, and counting more.

The livelihood program was not the only thing restored for the Basey Association. Because of the interventions and services provided by the humanitarian aid organizations, the GBV Watch Group was re-established and strengthened on March 2014. It is a community watch structure and security group that works in coordination and collaboration with the Barangay and Municipal Development Councils. Its main function is to ensure that GBV prevention and response actions are carried out. It has assisted in responding to GBV incidents and conducted community-based information drive on GBV.

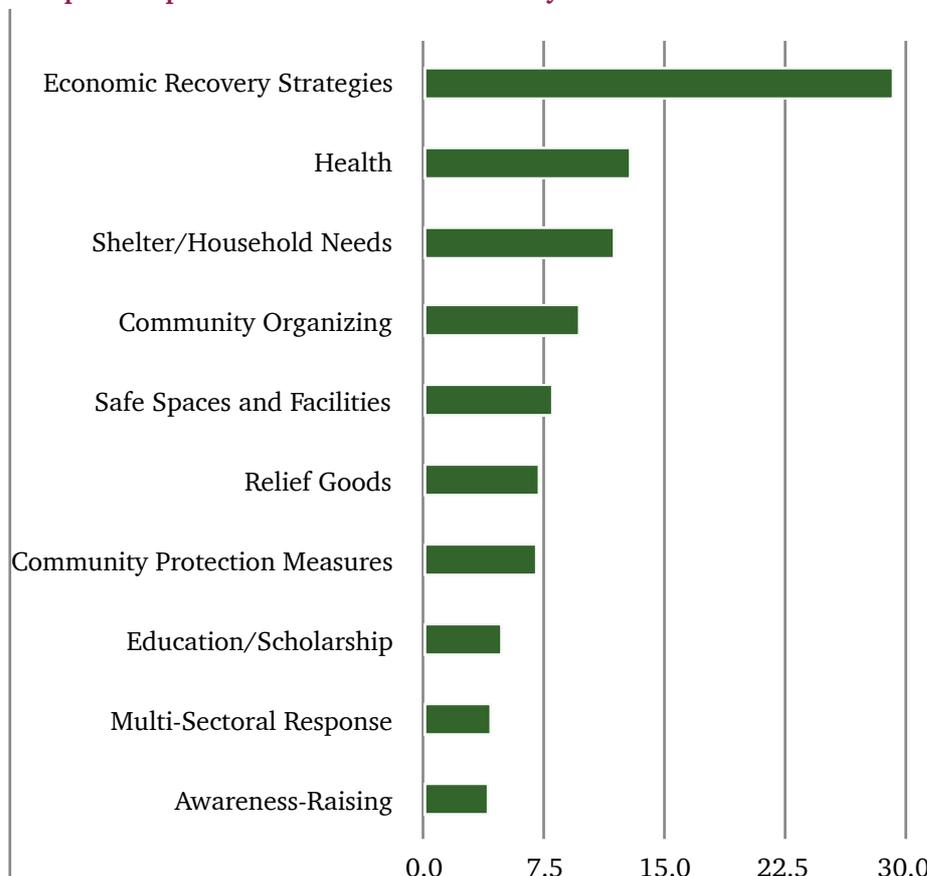
The success story of Basey Association demonstrated how tragedy can be an entry point for better opportunities, and how GBV can be addressed through livelihood program. It promoted participation thru women organizing; served as a coping strategy for building resilience; mobilized community resources for GBV prevention and response; and allowed for representations at the local government. Basey Association is a rural-based social enterprise that continuously empower women as they work hard to bring their families out of poverty situation.

With the many interventions and services captured in the GBViE ecological framework, it would be interesting to know what worked and did not work from the perspective of the affected communities and vulnerable sectors.

Finding #5: Using the results of the community score cards, the Top 10 interventions and services that were highly scored by the FGD participants were: (1) economic recovery programs; (2) health services; (3) shelter and household needs; (4) community organizing; (5) safe spaces and facilities; (6) relief goods; (7) community-based protection measures; (8) educational interventions; (9) provision of multi-sectoral response; and (10) awareness-raising and learning sessions.

FGD participants were asked to rank each intervention or service as reflected in the questionnaire with the following scoring scheme: 5=most helpful; 4=very helpful; 3=helpful; 2=least helpful and 1=not helpful. Out of the 58 FGDs conducted, only 46 were processed. Not all were ranked by the participants especially if they did not receive any such. In some areas, respondents expressed their desire not to rank the items since for them, all were helpful. The data on score cards cannot also be disaggregated by age and sex because some FGDs were conducted with mixed groups. All interventions were clustered thematically.

Graph 7: Top 10 Interventions Identified by the Affected Communities



Interventions and services with low scoring points were usually specific needs-based interventions such as GBV survivor support fund, issuance of civil documents, provision of help cards and legal services, and alternative foster care.

Here are some good practices on GBViE programming coming from the perspective of the affected communities:

The Power of Young People in Times of Emergencies *Cagayan De Oro City, Misamis Oriental*

When people were suddenly homeless and displaced because of Tropical Storm Sendong, when surrounded by women, children and fellow youth crying for help, and when communities needed volunteers to serve, the young people can be the actors, resources and partners needed for humanitarian response especially on GBV and reproductive health. This was demonstrated by the Youth for Reproductive Health Awareness or YOUR HEALTH in Cagayan De Oro City.

When the Family Planning Organization of the Philippines (FPOP) looked for youth volunteers, some members of YOUR HEALTH became the first batch of volunteers and were supported by UNFPA. They went around the evacuation centers in Cagayan De Oro City to distribute hygiene kits, conduct peer education trainings, support the reproductive health missions and perform education and awareness-raising sessions on issues of family planning, maternal health, STI/HIV/AIDS, use of contraceptives and GBV.

Such volunteerism was also demonstrated when they volunteered during the period of Typhoon Pablo and SuperTyphoon Yolanda. They acted as facilitators of peer education sessions and were deployed to support the conduct of rapid needs assessment of pregnant women, lactating mothers and assessing the needs of young people.

YOUR HEALTH is committed to protect, educate and help young people.

At present, the young volunteers are now professionals. Despite their careers, they managed to sustain the peer education sessions and made it into a regular program of their organization. They partnered with the local government units, civil society organizations, schools and other networks. They went around schools and barangays to continue raising awareness and educating young people on various topics of adolescent sexual and reproductive health including GBV.

YOUR HEALTH has more than 100 members coming from the different areas of Misamis Oriental, Cagayan De Oro City, Iligan City, among others. Some of their members were also sent for international events in Thailand, Indonesia, and London to represent the Filipino youth sector.

They continue to be inspired especially when they see changes in the lives of their participants. One example given was when one barangay captain thanked them for their efforts especially when his barangay had a zero teenage pregnancy case. According to them, girls learned to open up and report incidents of bullying and harassment. The LGBTQI+ community was also active in attending sessions.

It was the dedication of individuals and willingness to volunteer that have sustained the group and that made young people a force of change in times of emergencies.

Accelerated Efforts of VAWC Desk Officers Roxas City, Capiz

One of the frontline GBV response services at the community level is the VAWC desk. The establishment of a VAWC desk in every barangay has been mandated by RA 9710 - Magna Carta of Women. It is a facility that addresses VAWC cases in a gender-responsive and child-friendly manner.

Cited as one of the best barangays in the entire Philippines in terms of VAWC desk establishment and implementation, Barangay Banica in Roxas City, Province of Capiz, became a model of good practice that attracted other local government units to visit for educational and learning purposes.

At the height of Haiyan emergency response, the VAWC desk officers were among those who led immediate interventions to address GBV in emergencies. With the presence of several humanitarian organizations, various capacity-building activities were conducted. This included the Capiz-wide training provided by DILG and UNICEF to all Barangay VAWC Desk Officers. Such opportunity increased the technical capacity and confidence of the officers in responding to GBV cases, and in acting as facilitators of the child and women-friendly spaces that were put up in evacuation centers and schools.

On November 2014, the Association of VAWC Desk of Roxas City was established after a city-wide training of 47 women volunteers with the assistance of the Roxas City LGU. Though VAWC desk officers are co-terminus of the local chief executives, those brave women have taken the responsibilities wholeheartedly in their desire to protect women and children from any form of violence and abuse. They implemented several programs and projects already that the Association was given due recognition at the provincial, regional and national levels.

Because of their dedicated efforts, a certain level of awareness on GBV and child protection was achieved; a referral pathway was put in-place for children-at-risk and children in conflict with the law (CICL); the Children's Code and the GAD Code were updated; the development of operations manual for the Crisis Center for abused women and CICL was supported; toy libraries were established for children to encourage them to go back to book reading; and several rescue operations for battered wives and abused children were conducted.

This year, the Association was commended by the Regional Office of the Ombudsman thru the GAD Office of Roxas City by having a successful story of GBV prevention and response. Local government units across the country are encouraged to replicate the Association of VAWC Desk Officers to accelerate efforts of eliminating GBV.



Concepcion's Ride to the Crest *Concepcion, Iloilo*

On November 2013, Super Typhoon Yolanda struck the island barangays and coastal areas of the Municipality of Concepcion, Province of Iloilo. Located at the northeastern part of the Panay Island, Concepcion has 25 barangays, 11 of which are island barangays. Fishing is the main source of income for most of the families in the Municipality.

When Typhoon Yolanda struck, many families lost their sources of income. But because of the assistance and support given by international and local humanitarian organizations, communities were able to rebuild their lives and bounced back quickly. Among those who helped the Municipality was UNFPA. Several capacity-building activities were provided to women volunteers who became the GBV Watch Group. They supervised the establishment and operations of women and child-friendly spaces.

Concepcion was also supported by child protection organizations such as Save the Children - Panay, UNICEF, BIDLISIW and Iloilo Children Welfare Foundation. Its local service providers and community leaders and volunteers received various trainings and seminars particularly on children's rights, social accountability, and life skills development for adolescents and young people. Because of increased technical capacity, Concepcion was able to revise its Children's Code in 2018 incorporating CPiE prevention and mitigation actions. A community-based referral pathway was developed, translated into the local dialect and displayed in all barangays.

In strengthening its capacity for disaster risk reduction and management, the Municipality utilized its own fund sources. The Municipality tapped the Bottoms Up Budgeting (BUB) and KALAHIs funds for the establishment of evacuation centers in all 25 barangays. At the town proper, the Municipal Evacuation Center was installed with separate comfort rooms for women, men and persons with disability. Safe and comfortable family rooms are part of the building design along with a community kitchen. Such facility is in compliance with the government's standards for resilient evacuation centers.

Finding #6: Discrimination, politics, weak consultation process and insensitivity to victim-survivors were some of the major issues found in accessing and availing of GBV interventions and services in times of emergencies.

Generally, the Top 10 interventions and services had put in place protective measures at various level that supported individual and community resiliency as well as prevention of and response measures to GBV. However, FGD results showed that discrimination, politics, weak consultation process and insensitivity of service providers to GBV victim-survivors were some of the major issues found in accessing and availing of GBViE programming.

On Discrimination. Various sentiments were aired by the research respondents on the issue of discrimination. In the process of accessing humanitarian aids, some vulnerable sectors felt they were left behind. Below are stories of LGBTQI+, person with disability, elder and Badjao community to illustrate the intersection of GBV with sex, gender, disability, age and ethnical identity.

A JOURNEY TO THE RAINBOW MANSION

*"I've got a mansion just over the hilltop
In that bright land where we'll never grow old
And someday yonder we will never more wander
But walk on streets that are purest gold"
- Lyrics from Elvis Presley's Song -*

Dreaming of putting up a safe space for poor, aged, abandoned and sickly elderly LGBTQI+ on top of the hill that would be called 'Rainbow Mansion' - was a commitment he made to himself in helping out those who suffered discrimination and gender-based violence because of their sexuality and gender identity.

The LGBTQI+ community was not exempted from the ire of Super Typhoon Yolanda. When they were displaced and forced to live in evacuation centers, their vulnerability increased and suffered multiple forms of discrimination including gender-based violence. Below are some excerpts from the interviews conducted showing their sentiments on the injustices made against them:

"Our families find it hard to accept us. They treat us like we are invisible. They are ashamed of us. When disaster struck, we were either served last or not served at all during relief distributions."

"People think that as gays and lesbians, we are cursed. They blamed us for bringing the disaster to Leyte."

"We were disqualified as recipients of relief services because the shelter and cash grants were for families only even if we live with our partners."

Aside from the social stigma, they also experienced bullying, sexual harassment and molestation almost everywhere. As one of the respondents recalled:

"We were easy targets of verbal and sexual harassment. People shouted at us and pulled us out of the distribution line or pushed out of the queue. While we were lined up, someone from behind me forced my pants down and tried to stick his penis inside my anal. We sought help from authorities. We approached the barangay officials, barangay tanods and even the policemen. Instead of helping us, we were insulted and ridiculed. They said we deserved that because we flirted with them."

"We heard of a 14-year old lesbian who was raped by her grandfather to make her a true woman"

"We were made to entertain the IDPs while we were staying inside the evacuation centers. Some law enforcers compelled the gays to perform lewd dance moves. If we refuse, we became their instant punching bags."

A lesbian-respondent shared that some lesbians, bisexual girls and transgender (boys and girls) students were physically fondled and touched by young men when they learned of their sexuality and gender identities. Just for fun, they became targets of sexual advances - *"... the young men would just grab their butts, boobs, private parts just to see if they were real..."*

The LGBTQI+ experiences, regardless of age, were continued patterns of isolation, exclusion and marginalization. Such discrimination can lead to school drop outs, easy prey of human trafficking, cybersex and drug trafficking. Instead of being able to bounce back, their vulnerabilities increased and put them in high risk situations especially in times of emergencies. As a result, instead of bouncing back quickly, there would be low resilience, low self-esteem and lack of confidence among the LGBTQI+. With this story, GBV actors can gain insights on what protective factors along with interventions and services that can be put in place to help the LGBTQI+ community obtain resiliency, dignity and security.

I WAS BORN DIFFERENT

Edgar (not his real name) is 29 years old with visual disability. He is a victim-survivor of GBV particularly of physical, economic, sexual and psychological violence.

Edgar did not have fond memories of his childhood. He was maltreated and abandoned when he was 9 years old. Because of his disability, his 59-years old live-in partner, Maldy (not her real name), was taking advantage of him for almost two years now. Edgar has tolerated all the abuses and violence inflicted on him by his partner. He was completely controlled and manipulated by her. He wanted to get out of the relationship but do not know how because his disability limited him. He tried to escape her but was only pulled back in again.

Edgar arrived Ormoc City from Cebu in the mid-2016, when post-recovery and rehabilitation interventions to Yolanda's rage were at the aid and service providers' busiest of implementation. Edgar could have been qualified as a housing beneficiary if it were not for his disability. He was not given access to because he cannot attend meetings and cannot provide labor counterpart in the construction of the house. More importantly, housing awardees should belong to a family. Edgar lived "alone" during the time of the qualifying and needs assessment.

Food and non-food items were provided to persons with disabilities in Ormoc City, although on a case-to-case basis, especially during the post recovery stage. Edgar recalled that he was provided a bag of rice twice, boxes of clothes, blankets, and housewares, braille most of which were sold/bartered by Maldy for cash. During the Yolanda disaster, the City Social Welfare and Development Office linked up with the Philippine Ports Authority in Ormoc City in response to their need for a space at the port area for their use in pursuing their livelihood activities.

Because Edgar is blind, his eyes are Maldy's. Since he was abandoned, he had no family to turn for support. Unfortunately, he was being exploited by his live-in partner. Such case demonstrated everyday exposure to risks, violence and abuse. Regardless of age and types of disability, people with disabilities are often overlooked in humanitarian action including GBViE programming.

There is a need to ensure the inclusion of children/youth/persons with disabilities in humanitarian response to address the multiple and intersecting forms of discrimination related to gender, age and disabilities. The Consortium, particularly ULIKID Parents Organization, Inc. and RDII-Leyte, are pushing for making disability inclusion an agenda in GBViE programming.



Discrimination on the basis of one or more intersecting identities may cause a person to be left behind even in times of emergencies. People are left behind because of exclusion or bias particularly in accessing humanitarian aid or services due to their identities such as gender, age, income, ethnicity, religion, disability, sexual orientation as well as displaced status. According to UNDP in its Discussion Paper on "What Does It Mean To Leave No One Behind?" (July 2018), "whenever a group or population is marginalized or excluded, the risks of being left behind increase".

This heightens the risks of gender-based violence toward vulnerable populations such as persons with disability, elderlies, indigenous people, ethnic minorities and LGBTQI+ during emergency situations. The study hopes to make inclusion an urgent agenda in GBViE programming.

I HAVE A PROBLEM WALKING AND SITTING

Elders are a vulnerable population in much the same way as children. Like children, the elderly are often unable to advocate for their own interests because of physical deficiencies and rational limitations. A child cannot do anything unless with the support of an adult. But most elders are perfectly capable of caring for themselves under normal circumstances. But when disaster strikes, they find themselves cut off from their usual support system, placing them at a higher risk.

Sexual abuse against children and elderly is a part of the overall maltreatment of the vulnerable population. Regrettably, the sexual abuse of elders, mostly women, is disappointingly unheard of and kept invisible. The elderly victim of sexual abuse often have other problems relative to difficulties communicating – in sharing intimate sex act believed to be taboo; confusion – unstable or disordered mind set; and momentary memory loss. All of these have interfered with Lola Elena's (not her real name) ability to report the abuse, especially that her main perpetrator was her intimate partner.

Lola Elena is now 70 years old, who at the height of Typhoon Yolanda decided to leave Lolo Mario (not his real name), her 68-year old intimate partner for 16 years. Lola Elena now lives in Ormoc City with her daughter TinTin (not her real name) who tends to her needs since the "forced separation" from Lolo Mario who inflicted physical, emotional and sexual violence on Lola Elena for the last 10 years. Lolo Mario lives with his children in Tacloban City who, from time to time moved from sons to daughters, because of added problem of alcohol abuse.

Lola Elena was 52 years old when they decided to live together as a couple. Lola Elena recalled, *"I was subjected to a battery of physical abuse because of his overly jealous, suspicious and mistrustful character. Sometimes, sex act was wild after physical abuse. I just let this happen for many years, my bruises and infections were gone anyway,"* which are indicators of unheard and invisibility of the violence. Then Lola Elena added that *"besides sex is unmentionable act, it is taboo."*

As Lola Elena got older, she also experienced emotional abuse which according to Nanay TinTin, was often more difficult to detect because it left no physical injury. *"This form of abuse included yelling, belittling, embarrassing her or threatening her in any way, should Mama leave him."* Nanay TinTin remembered how in several attempts she tried to "rescue" Lola Elena but failed. *"Manoy Mario socially isolated Mama and hid her from us. This type of abuse was so 'silent' as well because of Mama's expressed fear of him."*

Then, as Lola Elena approached her 60s, the problem of sexual abuse became more brutal that escalated out of control. *"Engaging in sexual intercourse (often under the influence of alcohol) with or without my consent, was always an intense pain of mind and body - my genitals bled that I had to lie in bed for days because I had problems walking or sitting."* Lola Elena revealed. *"I did not purposely seek health services because I did not like others to know my tight spot. I preferred to suffer silently,"* explained Lola Elena.

Then, Yolanda came. Lola Elena and Lolo Mario were housed in an evacuation center in Tacloban when Lola Elena broke her silence to daughter TinTin. Even in a crowded public place, Lolo Mario would ask Lola Elena for a "short-time" to which Lola Elena had violently fought against. Violence against Lola Elena can be the continuation of a pattern of abuse over the course of a lifetime, which began in her old age. Lolo Mario as the alcoholic-perpetrator increased the severity and frequency of their violent and risky relationship over time.

Consistently, Lola Elena refused to get any kind of GBV intervention, Nanay TinTin thought otherwise. She sought a lawyer's help and planned to bring Lola Elena's case to the DSWD in Ormoc but later decided against doing it because Lolo Mario needs professional help himself. Whatever the consequences of Lolo Mario as the perpetrator can leave him isolated, depressed and demoralized, and can be considered a form of elderly abuse, *"we just leave the case to the DSWD"*. Although after two years, an elderly organization called COSE provided Lola Elena with access to medication and treatment.

A STATE OF THE STATELESS PEOPLE

The RDII-Leyte research team spent almost 6 weeks of engaging and interacting in an unstructured, conversational and interactive dialogue with the Badjaos in Dolho-Bato, Leyte. Ethnography was used as a method for an in-depth interview and observation with the *culture-sharing group* to see visible and invisible information. The case of Badjaos demonstrated how stateless people can be at risk to protection issues including GBV.

The Badjaos were peace-loving land-dwelling people, who due to ethnic clashes had to continuously run for their lives whether in land or sea as narrated by the culture-sharing group:

Little did the government nor any service organization know *“how our adversaries wracked our boat-houses and wrecked our lives. Unhappy with our ‘no name status,’ and no identity of any sort, we started building our houses on stilts over waist-deep shoreline waters. We felt hungrier, further rejected, neglected, and displaced than we were at any place we have been to.”* These chain of events signalled a violent force to contend with and endless wandering.

Now extending and sailing across the entire nation from coast-to-coast, the Badjaos as a people **remains at risk as stateless people**. In particular, they are **denied of their right** and nationality as Filipino citizens. *“We were resolved to live as land-dwellers the moment we set foot on the soil of Leyte; however, objective condition did not allow us. We had no papers to back us up as individuals and as a people... as Filipinos.”*

“With few boat-houses left and no land to build shacks on, we had no alternative; without permit we built houses on stilts in the coastline waters of Dolho-Bato, Leyte, where we settled as sedentary water-dwelling community, until Typhoon Yolanda smashed us in 2013”.

*“Badjao life has never changed. The form of violence has changed but the essence is still there. Our life as a people has always been paired with shame and rejection, risks and threats, ours is a **tragic struggle for survival and an endless search to belong.**”*

“We belong to nowhere.” Unable to find a space and place *“as Badjaos we wandered and wondered why we do not exist like other people and cannot co-exist with people.”*

Powerless (in strength and resources) as the Badjaos grew in age and number, they were incapable to freely move from island to island. *“Due to **socio-economic disparities**, Badjaos as a people are **resource poor** and often beyond the reach of government and non-government organizations – often **denied services** during disasters.”* Children who were enrolled in public schools cannot be considered *“officially enrolled”* due to problems relative to their identity. As a result, most of the Badjaos remained illiterate and poorly educated. Young girls were being arranged to marry at an early age. Public transport services rejected them even when a child’s life was at risk.

As Badjaos remain undocumented and are wanderers, they can easily fall prey to violence and exploitation. The multiple marginalization experienced by Badjaos has been going on for generations. Without citizenship, no legal protection and access to basic services can be provided to stateless people. *How do we move from here?*

It was fortunate that during the conduct of the National Validation Workshop on October 2019, the case of Badjaos in Leyte was presented. One of the workshop participants was from UNHCR who is responding to Marawi/Mindanao humanitarian response. The issuance of civil documents is one of their flagship programs in partnership with the Philippine government. Upon learning of the situation of the Badjaos, several actions have been taken since then to bring the much needed services to them.

On Politics. Politics had been identified as a hindering factor to accessing humanitarian aid services. This was a consistent key finding in all project sites. Because of political interference, not everybody was able to receive the needed interventions and services. Politics prioritized their allies and supporters only.

On Weak Consultation Process. For vulnerable populations, they believed that if they were consulted on their needs and concerns, humanitarian aids would have been more appropriate and responsive.

For example, elderlies with no-caregivers wanted to have their own place - a shelter separate or away from the noisy cruel crowd. One of the elderlies also said that *“radio transceivers were not helpful to us. A mobile phone or transistor radio could have been better or an “arinola” like a hospital bed pan, is handy and convenient. We could use “arinola” to pooh and urinate, day or night. It could have helped us better”*.

One young respondent from Marawi City said *“we want to be consulted because it boosts our confidence to share our thoughts, ideas and solutions to the problems we face”*.

The stories and sentiments expressed in the study were meant to help humanitarian aid workers especially GBV actors to look into how the intersection of disability, age, gender orientation, ethnic identity and religion can affect or influence protection programming in emergencies. Likewise, it also identified the pain points and irritants found in availing and accessing humanitarian services. However, opportunities present themselves to introduce innovations in society's issues that were unheard of before.

4.4 Question #3: How did the GBViE Programming Experiences Made an Impact in National and Local Policies, Programs and Structures?

To capture the perspectives of the service providers and humanitarian community, the study conducted key informant interviews, group interviews, round table discussions and email surveys to a total of 176 key informants representing government agencies, local government units, humanitarian organizations, and community volunteers and leaders.

Majority of the service providers interviewed were police personnel (25); followed by social workers (16) and health personnel (4). Unfortunately, the study had no informant from the legal/justice sector despite being invited to participate.

In normal and emergency times, the multi-disciplinary teams or multi-sectoral service providers are also supported by essential GBV actors as mandated in various national laws and local policies. To capture those sectors, the study was able to interview - (a) 47 barangay service providers composed of lady councillors, VAWC desk officers and GBV Watch Groups; (b) 42 community service providers like youth volunteers and parent leaders; (c) 27 staff and former consultants of UN agencies, INGOs, local NGOs and CSOs; and (d) 15 key local officers from the offices of DILG, DRRM, GAD and Chief Executives, among others.

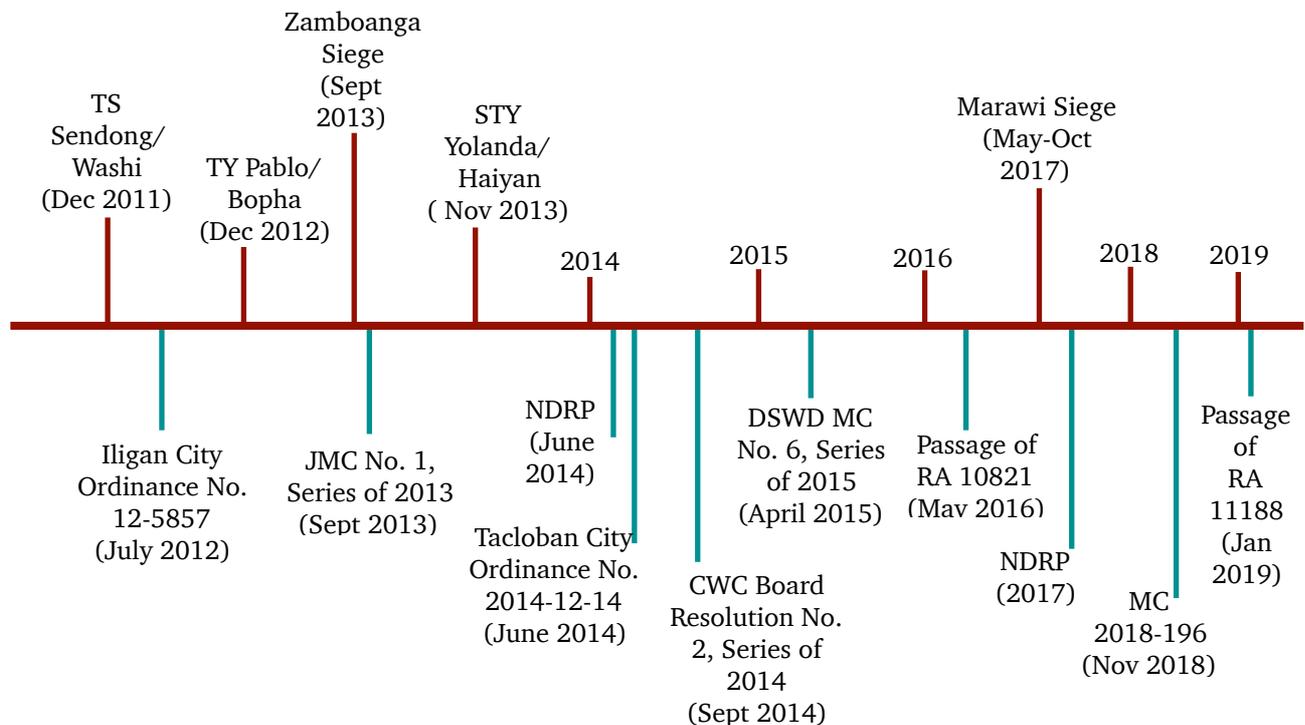
This section would focus on answering Question #3: How did the GBViE programming experiences made an impact in national and local policies, programs and structures? What were the lessons learned, major gaps and challenges experienced in designing and implementing GBViE

interventions/services? How did the GBV programming change or improve the situation of the affected communities esp. the vulnerable sectors?

Finding #7: The Philippine government has expanded its legal and policy frameworks based on GBViE programming experiences, learnt lessons and established good practices. Likewise, the local government units have also enacted policies and plans on GBV in emergency context.

Desk reviews and key informants indicated that significant gains were made from 2012 to present in terms of the passage of new laws and policies in pushing further the GBViE agenda. Learning from the previous experiences of complex emergencies, the government enacted new major laws; developed disaster response plans to include terrorism; promulgated guidelines promoting GBViE prevention; and mobilized local governments to do the same. To show the expansion of legal and policy frameworks on GBViE, Illustration 9 mapped out new laws and policies enacted every after complex emergency, while Table 13 provided their brief descriptions.

Illustration 9: Mapping of New Laws and Policies Based on Humanitarian Experiences



In addition, there were local government units which incorporated GBViE in their respective Gender and Development (GAD) and Children’s Codes such as Ormoc City in the Province of Leyte, Concepcion in the Province of Iloilo, and Veruela in the Province of Agusan Del Sur. There were also LGUs which utilized the GAD and Bottom-Up-Budgeting (BUB) for GBViE-related interventions and services. GBViE victim-survivors were provided with livelihood programs using the local sources of funds in Iligan City. The Integrated Population, Gender and Development Office (IPGDO) in Ormoc City was established using GAD and BUB budgets as well. Executive Orders were also enacted for the establishment of P/C/MDRRMCs with Protection Committees usually chaired by the Social Welfare and Development Offices of the LGUs.

Table 13: Brief Descriptions on Enacted New Laws and Policies

Year	Laws/Policies/Guidelines	GBViE-related Provisions
2012	<i>Iligan City Resolution No. 12-516</i> An Ordinance Creating the Local Council on Anti-Trafficking and Violence Against Women and Their Children (LCAT-VAWC) Council in Iligan City, And For Other Purposes	<ul style="list-style-type: none"> This is the very first local Ordinance enacted mandating the establishment of LCAT-VAWC Council and to expand its functions to include GBV and child protection in emergencies. The passage of such policy was a result of the partnership between the local government and local NGO (Iligan City Council of Women) at the early recovery stage of the humanitarian response.
2013	<i>Joint Memorandum Circular (JMC) No. 1, Series of 2013</i> Guidelines on Evacuation Center Coordination and Management	<ul style="list-style-type: none"> This document was jointly made by the DepEd, DSWD, DILG and DOH. The guidelines cover all activities before, during and after evacuation of families affected by natural and human-induced disasters including armed conflict. Found in Section VIII (Evacuation Center Management), Chapter 4 (Basic Services), specific provisions on GBV were itemized including the setting up of women-friendly space, preventive measures against types of GBV and disaggregation of data to include vulnerable sectors.
2014	<i>National Disaster Response Plan (NDRP) as of June 2014</i>	<ul style="list-style-type: none"> This is the Philippine Government's response to hydro-meteorological hazards. It identifies the Protection Camp Coordination and Management (PCCM) as one of the nation's response clusters to be led by DSWD. The document contained the PCCM's Operations Protocol.
	<i>Tacloban City Ordinance No. 2014-12-14</i> An Ordinance Instituting Policies and Program for the Special Protection of Children in Emergency and/or Disaster Situations and Providing Funds Thereof	<ul style="list-style-type: none"> This is the very first local Ordinance that provided special protection to children during disasters from all forms of abuse, neglect, cruelty, exploitation and other conditions prejudicial to their development as stated in Section 2.
	<i>Council for the Welfare of Children (CWC) Board Resolution No. 2, Series of 2014</i> Philippine National Implementation Guidelines for Child-Friendly Spaces in Emergencies	<ul style="list-style-type: none"> The CWC, being the Chairperson of the National Child Protection Working Group, approved the Guidelines to standardize the CFS operations and approach. Aside from psychosocial support intervention, CFSs also serve as venues for identifying vulnerable and at-risk children, and for facilitating referrals for immediate and proper response.
2015	<i>DSWD Memorandum Circular No. 6, Series of 2015</i> Guidelines in the Institutionalization of Women Friendly Space (WFS) in Camp Coordination and Camp Management	<ul style="list-style-type: none"> The guidelines promote WFS as an integral part of the camp coordination and camp management that provides different services including the facilitation of case management.

2016	Republic Act No. 10821 Children's Emergency Relief and Protection Act	<ul style="list-style-type: none"> The law aims to establish and implement a comprehensive and strategic program of action to provide the children and pregnant and lactating mothers affected by disasters and other emergency situations with utmost support and assistance necessary for their immediate recovery and protection against all forms of violence, cruelty, discrimination, neglect, abuse, exploitation and other acts prejudicial to their interest, survival, development and well-being.
2017	National Disaster Response Plan (NDRP) for Consequence Management for Terrorism-Related Incidents	<ul style="list-style-type: none"> With the growing threats of terrorism in the Philippines, the NDRP was formulated. This plan recognizes the critical role of the IDP Protection Cluster led by DSWD in putting in place effective mechanisms to prevent and respond to child protection and gender-based violence issues and concerns in armed conflict settings.
2018	Memorandum Circular 2018-196 Guidelines in the Localisation of the Comprehensive Emergency Program for Children (CEPC)	<ul style="list-style-type: none"> Pursuant to Section 4 of RA 10821, this Circular enjoins all LGUs for the localization of their CEPCs and integration into their Comprehensive/Local Development Plans, Annual Investment Programs, Local Disaster Risk Reduction and Management Plans and Local Disaster Risk Reduction and Management Funds as well as contingency plans.
2019	Republic Act No. 11188 Special Protection of Children in Situation of Armed Conflict	<ul style="list-style-type: none"> The law provides special protection to children in situation of armed conflict from all forms of abuse, violence, neglect, cruelty, discrimination and other conditions prejudicial to their development, taking into consideration their gender, cultural, ethnic and religious background.

Though Philippines has a well-established legal and policy framework for GBViE; has institutionalized the cluster system approach up to the local level through the DRRM Councils; and has mobilized existing coordination structures such as the LCAT-VAWCs and LCPCs for GBV in emergencies, the implementation remains poor and faced with challenges.

Finding #8: Because of the strengthened partnerships between the national government, local government units and humanitarian organizations during emergencies, key prevention and response measures were established as GBViE minimum package. However, innovations and refinements are required especially when issues of inclusion, culture and emergency context intersect.

From the five complex emergencies that were covered by this project, the following were found as the common strategies for GBV prevention and response:

Help Desks and Deployment of Security Forces. Help Desks are established in the evacuation centers and transitory sites and supervised by female and male police officers. Desks are made visible to IDPs to ensure peace and order, and to provide immediate access for reporting and response. It is meant to be a deterrent for any commission of crime or disturbance. Further, Barangay Tanods, Barangay Peacekeeping Action Teams and trained IDP-volunteers are deployed to provide additional security forces around evacuation centers and during at night. Aside from the help desks, VAWC Desks are re-established. For areas known to be entry, transit and exit points

of human trafficking such as Zamboanga City, Ormoc City, some parts in Capiz, Iloilo, Northern Samar and Agusan Del Sur, Anti-Trafficking in Persons (ATIP) Desks are established in seaports, bus terminals and airports.

According to one of the key informants, the visibility of uniformed security personnel within and around evacuation centers has increased security and gave a sense of ‘safety and protection’ among the IDPs.

Women- and Child-Friendly Spaces/Centers. The establishment of WFS and CFS at the start of early response was already institutionalized with the passage of the national guidelines. The immediate function of the friendly spaces is to provide psychosocial support services to IDPs especially children, adolescents, youth and women. Such spaces link vulnerable populations to major protection services such as health, livelihood, education and referral services. In some cases, the safe spaces are used for dance or sports activities, spiritual interventions and other recreational activities.

Establishment of the Community-based Referral Pathways. The community-based referral pathway is a strategy to identify trustworthy leaders and service providers whom displaced populations can approach for help and assistance. In consultation with the community members, the most trusted persons are the social workers, the doctors, the female police officers, the barangay captains, the teachers, the tribal leaders, the council of the elders, the camp managers and the humanitarian aid workers. Their names and contact details are usually written on the referral pathways and are displayed in strategic areas. The referral pathways are always linked with the formal referral system of the multi-sectoral response. Its visibility in evacuation centers, transitory sites and affected barangays are meant to encourage reporting for immediate intervention. Guidelines have been developed by the GBV actors. The one-stop-shop of the multi-disciplinary teams in some project sites are also observed and practiced in times of emergencies.

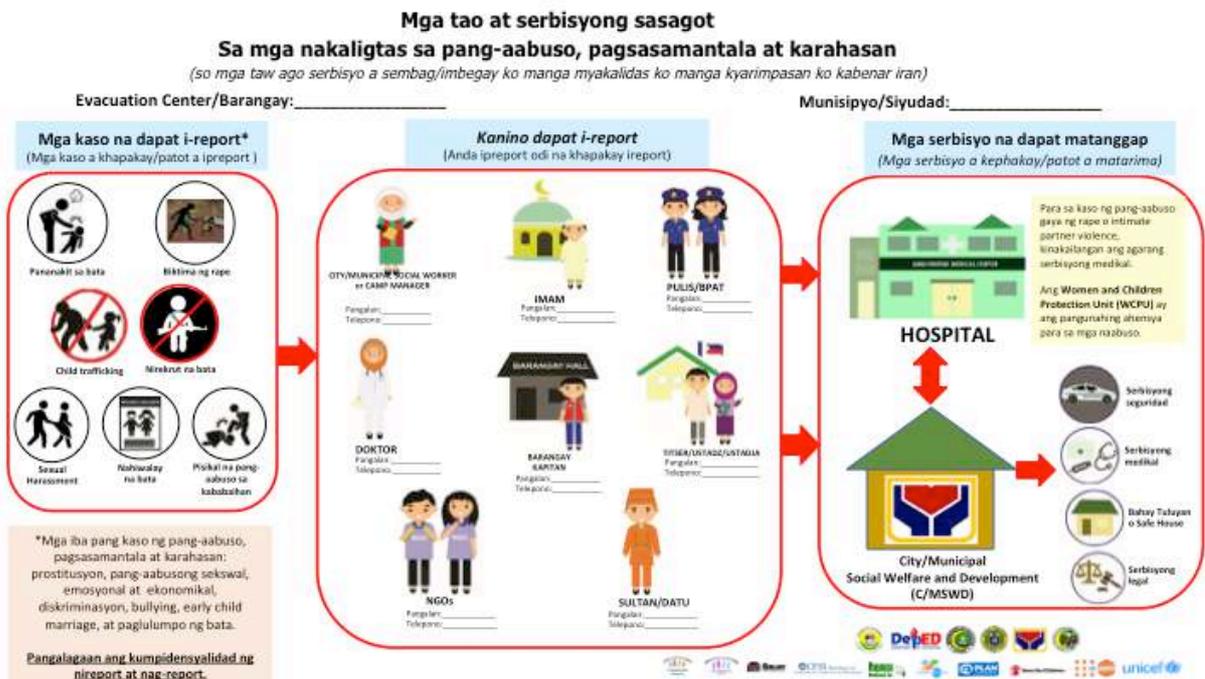


Illustration 10: Community-based Referral Pathway in Marawi City

Mobilization and Organizing of IDP-Turned Volunteers. One strategy of bringing back ‘normalcy’ and building resilience is through community organizing and empowerment. For example, displaced young people were organized and trained by UNFPA and its implementing partners to become youth volunteers. They were tasked to distribute dignity and hygiene kits, conduct reproductive health medical missions and facilitate awareness raising sessions including GBV. Likewise, the facilitators of women-friendly spaces were usually IDP volunteers. They were trained on the different laws on women’s rights and on GBViE; and were expected to conduct information sessions, referrals if needed and other WFS services. Male IDPs were also organized, trained and perform advocacy sessions on the prevention of GBV and their roles. Mobilizing the IDPs to become volunteers is very empowering because of the opportunity to help others, to become productive and to learn new things.

Community-based Awareness Raising and Education Sessions. Learning sessions on GBV laws, women and children’s rights and referral services are provided by humanitarian organizations in partnership with the LGUs such as the social welfare and development offices, PNP particularly the Women and Children’s Protection Desks and Police Community Relations, and Barangay VAWC Desks. These sessions, according to key informants, corrected some misconceptions or wrong beliefs like “it is normal for husbands to beat their wives”, “husbands can demand to have sex with their wives and wives cannot say no”, and the victim-blaming syndrome. Before, intimate partner violence was treated as a private matter. But with the passage of the anti-rape law, it is already a public crime. Learning sessions also informed IDPs on what to do to protect themselves while staying in evacuation centers, and what to do should they encounter GBV.

Male Involvement. Realizing the need to engage men in GBV prevention and advocacy even in times of emergencies, the government’s schemes in organizing and mobilizing male displaced populations such as the **MOVE** (Men Opposed to Violence Against Women Everywhere), **ERPAT** (Empowerment and Reaffirmation of Paternal Abilities) and **KATROPA** (Kalalaking Tapat sa Responsibilidad at Obligasyon sa Pamilya) are employed. These are existing government programs that aim to promote male involvement in eliminating VAW, promoting maternal and child health and responsible parenting. Trained male advocates facilitated the conduct of education sessions with their fellow male IDPs. This direction was undertaken after realizing that most advocacy initiatives were focused on women.

Capacity-Building of Service Providers and Community Volunteers. With heightened presence of humanitarian organizations in affected areas, the gaps in the delivery of GBV prevention and response measures were immediately identified. One of those was the need to strengthen or increase the capacity of service providers such as social workers, police, doctors and lawyers; and the capacity of community-based service providers such as Barangay VAW Desk officers, rural health unit personnel, peacekeeping forces, barangay officials, school personnel, CSOs, POs, tribal leaders, and community leaders and volunteers. Such strategy indicates a multi-sectoral and multi-level response on GBViE.

An increased capacity and understanding on GBViE also resulted to the crafting of action plans such as the case of Agusan Del Sur wherein they developed a strategic action plan on GBV after being trained at the national level; and such was the case of Iligan City wherein a DRRM Health Plan was proposed with a reproductive health component in it.

Another outcome was the improvement in the conduct of case management and conferences. According to key informants, the multi-disciplinary team members operated in silos before. After the joint trainings, they were able to conduct case conferences together.

Reactivation/Strengthening of Coordination Structures. The functions of the field-based GBV Sub Clusters were performed by the coordination structures and/or inter-agency coordinating councils when ‘normalcy’ was restored or even at the onset of the response. This included the Local Committees on Anti-Trafficking and Violence Against Women and Their Children (LCAT-VAWCs) and the Local Councils for the Protection of Children (LCPCs). In some cases, LGUs reactivated or strengthened their LCAT-VAWCs or LCPCs thru the passage of Executive Orders or Ordinances. Some LGUs included provisions on GBViE and CPiE into their policies, plans and programs. However, the full implementation remains to be a battleground.

Mainstreaming GBViE in Other Clusters/Sectors. As reflected in the GBViE Ecological Framework and in the results of the Top 10 interventions with high ranking scores, humanitarian actors from various clusters were also mobilized for GBV prevention and response. Here are some of the examples:

Economic Recovery Interventions. Strategies such as cash/food for work, cash grant, livelihood trainings, livelihood inputs and equipment, enterprise development, provision of job fairs and other emergency employment are the common strategies used by humanitarian actors in regaining normalcy back into the lives of the affected families. However, future research initiatives can provide evidences on how economic recovery strategies have taken advantage of the situation to address GBV and eliminate gender inequality. For example, there is a need to measure the effectiveness of cash grants in terms of reduced risks and vulnerabilities faced by women in emergencies and in terms of the positive or negative protection outcome.¹⁵

Health Services. The mainstreaming of GBV in health services in times of emergencies is carried out through the provision of Minimum Initial Service Package (MISP) on Sexual and Reproductive Health Services wherein prevention and management of the consequence of sexual violence is addressed; wherein STI/HIV/AIDS prevention is advocated; and wherein maternal and newborn health services are prioritized. This is led by the Department of Health (DOH), UNFPA and health organizations.

Another mainstreaming of GBV prevention and response is in mental health and psychosocial support services as well as in nutrition services. These health services are provided in safe spaces, schools and even during medical missions. There are instances wherein victim-survivors of GBV are detected during the medical check-ups of pregnant women and lactating mothers; and young people needing medical support. These cases are referred to GBV service providers for appropriate response actions.

WASH. Among the interventions of WASH that prevented GBV from taking place especially in evacuation camps and transitory sites are the (a) separation of latrines and bathroom facilities for boys and girls with locks from the inside and are properly lit and labeled; (b) water points are ensured with accessibility and safety; and (c) mobilization of barangay tanods or volunteers to monitor the WASH facilities to increase the safety of women and girls. However, GBV actors and even the communities noted of the many GBV incidents that took place in WASH facilities.

CCCM. The Cluster provides leadership and takes the initiative to ensure that GBV-specific protection interventions are consciously carried out by camp managers and by the IDP leaders. GBV actors are invited to perform trainings on their IDP committee leaders. Sex and age disaggregated data as well as vulnerability profile of the evacuation camps are displaced in their stations and regularly updated. The national guidelines on camp management included already that evacuation centers should have women-friendly spaces and protection measures.

With the technical guidance of the international humanitarian community, the capacities and awareness of the local service providers, government personnel and local NGOs and CSOs became aware of the possible exacerbation of GBV in times of emergencies if not attended at the start of the early response. The capacity to respond went beyond relief packing and relief distribution. Because of this, the transfer of social technology on effective programming for GBV prevention and response in emergency context, has been obtained.

Further, such humanitarian experiences led to strengthened partnerships between the government agencies, local government units, international humanitarian community and local NGOs, CSOs and POs. It also led service providers and local NGOs to assist and support other local government units and communities. This happened in Iligan City.

In 2011, the City was hit by TS Sendong/Washi and the very first field-based GBV Sub Cluster was established. This particular humanitarian response gave birth to the piloting of women-friendly spaces and community-based referral pathway. An attempt to establish the “one-stop-shop” was made wherein all multi-sectoral response services were in one place. Because of this experience, Iligan City service providers augmented response during the Marawi Crisis in 2017 especially when it became a host community of displaced Maranao families. According to the interviewed respondents, they were able to apply what they learned and experienced in TS Sendong/Washi.

Leave no one behind was the mission of all humanitarian actors. The 3/4/5Ws and coordination structures as well as the cluster approach had been implemented to ensure that the farthest were reached and the most vulnerable were served. In GBV prevention and response actions, with or without reports on GBV incidents, interventions and services must be put in place immediately. However, one of the lessons learnt that was captured by the study was the need to ensure that GBViE programming should be inclusive, culture-sensitive and context-based.

For example, WFS facilitators in Marawi City raised concerns on the need to have a Fatwah on GBV instead of using the national laws only which is more acceptable to the Maranao community. The DSWD’s Disaster Assistance Family Access Card or DAFAC should be calibrated to reflect the number of wives allowed in their culture. Health-related interventions should also be sensitive on what is allowed and not allowed, and what is respectful and not respectful in physical contact between a man and a Maranao woman. The use of cultural lens is needed to understand how cultural communities or ethnic minorities treat the issue of GBV.

Another concern raised was the need to be more innovative and human-centered in programming for the specific needs of vulnerable populations such as the indigenous people, elderly, persons with disabilities and even LGBTIQI+. The issue of discrimination faced by them need to be addressed in accessing humanitarian aid.

The security of the service providers in performing their roles and responsibilities, the safety of the displaced populations as well as the security of the GBV victim-survivors and their families in armed-conflict setting was also raised during the interviews. One of the informants said that - *“The response of Sendong/Washi was different in Marawi due to security risks of service providers, IDPs and Iliganons since Maute groups mixed with the crowds. To respond, strict security checks, martial law, curfews and security clearance should be acquired prior to visit in evacuation camps. Unlike in Sendong, one can go in and out of the evacuation centers as long as you coordinate with the camp managers and IDP leaders”*. The interventions for natural disaster affected areas may not be appropriate for armed-conflict affected areas; and vice versa.

Finding #9: Resilience, awareness and preparedness have been acquired and cultivated in the many years of building back better and in seizing opportunities for change.

A country tested many times by the recurrence of natural disasters and uprising of terrorist groups has matured and became wiser. With the eight years of programming for GBV prevention and response in emergencies, existing capacities were enhanced; new opportunities were created; and pathway to empowerment opened up.

According to key informants, with the increased technical capacity of the service providers and humanitarian organizations to address GBV in emergencies, protective factors at the individual, relationship and community levels have been put in place that contributed to the resilience of the affected populations. Non-traditional partners of GBV such as the faith-based organizations have demonstrated how spiritual interventions supported the promotion of resiliency and positive adaptation especially for victim-survivors of GBV. The presence of a number of organized women/youth/children/men's groups, civil society organizations, people's organizations and non-government organizations have increased human resource that can be tapped for GBV in emergencies provided that proper training and support from the government are received.

A certain level of awareness and understanding has been reached by the affected communities in recognizing that GBV can happen even in emergencies. This is one of the key findings of the study. Such awareness can be attributed, but not solely, to the community-based awareness and learning sessions and advocacy works conducted by the government, humanitarian community and its partners. The increased number of reported GBV cases can mean increased awareness of the communities, increased access of referral services and increased trust on service providers. However, there remains gaps and challenges which need to be addressed.

New opportunities were also created. The enactment of new laws, policies and guidelines have created pathways towards empowerment. The eight years of GBViE programming experiences in the Philippines created a growing and potential pool of local GBV experts and specialists who can be tapped if needed. For example, UNFPA Philippines partnered with Ateneo De Manila University for the creation of an Executive Certificate Course on Gender-based Violence in Emergencies.¹⁶ A Training Manual on Republic Act 10821 and the Minimum Standards for Child Protection in Humanitarian Action (version 1.0)¹⁷ has been developed by the Council for the Welfare of Children in partnership with UNICEF Philippines, Save the Children, among others.

With the institutionalization of the cluster system thru Republic Act 10121, the creation of the IDP Protection Cluster was made possible. With the government's guidelines on camp management as well as the national disaster response plans in place, preparedness can be done. With the establishment of the National GBV Sub Cluster led by DSWD, with the Joint Regional Child Protection and Gender-based Violence Working Group at the Bangsamoro Autonomous Region in Muslim Mindanao led by the Ministry of Social Services and Development, with the local councils and coordinating committees on the ground, and with the presence of humanitarian organizations, GBV prevention and response actions can be immediately rolled out whenever emergencies strike. With the country's first impact assessment study on GBViE programming, successful stories, good practices and lessons learned can be shared across the country and to the rest of the world.

4.5 Question #4: What GBViE Information Management Mechanisms Were Put in Place?

To understand the current picture of the Philippine GBV Information Management System (GBVIMS), the study examined how GBV cases in previous complex emergencies were reported and recorded; and if they were used in policy-making, planning and programming. The study also attempted to discover existing impact measurement tools on GBViE programming, if there were. In the process of doing so, ongoing initiatives were revealed; old and new challenges became known; and innovation opportunities were identified.

This section focused on Question #4: What GBVIMS mechanisms were put in place? Additional questions were: Were there existing good practices on reporting, recording, monitoring and evaluating GBViE interventions and services? What were the challenges encountered in measuring the prevalence of GBV in emergency context and how were they addressed? Were the information management mechanisms inclusive and adhering to survivor-centred approach?

Finding #10: There remains no harmonized data on GBV. Involved government agencies such as DSWD, PNP, DOH, DOJ, DILG and LGUs have their respective ways of recording and reporting GBV cases given their specific mandates. However, ongoing efforts are being made to address this major gap.

Philippines struggled for many years to capture an accurate data describing the prevalence of GBV in non-emergency context. In fact, because of the multi-sectoral response to GBV, a holistic and coordinated approach is being implemented by key government agencies to ensure that the services needed by the GBV victim-survivors are taken cared of. Such services are being provided (but not limited to) by the Department of Social Welfare and Development (DSWD) for psychosocial services; by the Philippine National Police - Women and Children's Protection Desk (PNP-WCPD) for investigatory services or procedures; by the Department of Health (DOH) for medical or hospital-based services; by the Department of Justice (DOJ) for legal or prosecution services; and by the Department of Interior and Local Government (DILG) or specifically the Local Government Units (LGUs) for anti-VAW services at the barangay, municipal, city and provincial levels. There are also NGOs and civil society organizations which provide support and assistance to GBV victim-survivors.

Because of the multi-sectoral response and involvement of many agencies and organizations, each actor developed respective mechanisms of recording and reporting GBV cases from the barangay level up to the national level. Based on the study done by the Association for Progressive Communication (March 2013), the processing and recording of VAWC cases were problematic. The consolidation and comparison of data sets across agencies were difficult.¹⁸ On-line search on VAW or GBV statistics will lead you to the website portal of the Philippine Commission on Women (PCW).

PCW, as a policy-making body and an oversight agency in the promotion of gender equality and empowerment of all women and girls, maintains a Gender and Development (GAD) database which are collected from various agencies. Statistics are processed, organized and packaged into factsheets that support policy-making, planning and programming. One of the components is Violence Against Women.

Likewise, key informants from DSWD and PNP also attested to the challenges of harmonizing and consolidating data on GBV. Because of their respective mandates, PNP records GBV per

incident; while DSWD records GBV per service provided. For example, if there are five girl-children rescued from a human trafficking case, DSWD would record the services provided for each child; while PNP records it as one incident of human trafficking violation.

Despite the challenges on data reporting and recording, ongoing efforts are being made by key government agencies. One of those is the harmonization of all intake forms. Led by PCW, a new intake form was developed together with the DSWD, PNP and Commission on Human Rights. Currently, it is being tested.

One of the good practices that the study encountered in the course of gathering data was the PNP's Crime Incident Reporting and Analysis System or CIRAS. Piloted in 2016, CIRAS is the enhanced e-Blotter & Geographical Information System (GIS) which contains the initial report and updates of all reported incidents/crimes. It is a real-time and web-based platform that captures all crime incidents that have happened and reported to police stations. In every police station, the Crime Registrar or the PNCO (Police Non-Commission Officer) who is under the supervision of the Chief Investigator, is responsible for encoding the data needed. Crime registrar is a non-uniformed personnel of PNP. Alternatively, if the crime registrar is not available, the CIRAS PNCO personnel takes over. All crime incidents need to be encoded within 24 hours upon receipt of the report. CIRAS is used not only for decision-making on crime prevention. It is also utilized for monitoring purposes of case progress.

Incidents of VAW and VAC are captured and recorded separately in CIRAS. The term GBV is not used. Nevertheless, CIRAS is a reliable source of data. The GBV incidents that took place from the period of Sendong/Washi (2011) to Yolanda/Haiyan (2013) were not reflected in CIRAS because it was only implemented in 2016. However, all police stations were asked to enter previous crime reports to CIRAS. Many are still in the process of updating.

To demonstrate, the study requested for statistical data to capture the number of incidents that took place in the 6 regions covered by this study. For purposes of having a glimpse of how CIRAS records VAW and VAC, Table 14 reflects the 2016 VAW data; and Table 15 provides the 2016 VAC information.

The data generated from CIRAS shows how VAW and VAC are defined and categorized using the laws as basis. It gives the total number of incidents in every region and in every type of crime. It is informative in identifying which region has the highest number of incidents and which region has the lowest. But conclusions cannot be made. A high number of VAW and VAC incidents do not necessarily mean high prevalence. It could mean a reflection of the increased awareness of the communities, an effective implementation of interventions, and an improved delivery of referral services. Similarly, a low number of VAW and VAC incidents do not necessarily mean low occurrence of GBV. It could mean that GBV incidents remain unreported and underreported. It could also be an indication of low awareness and lack of interventions and services. But comparing data of three years, for example, will identify the increasing or decreasing trend of GBV in every region.

CIRAS can generate statistical information on GBV based on age, sex, number of victims and number of perpetrators, among others. However, CIRAS has its own limitations and challenges. It will be interesting to see how other variables like disability, ethnicity, sexual identity, and emergency context can be included. With the testing of the new harmonized intake form this year, statistical data on GBV in emergencies and the vulnerability profile can now be captured. Thus, CIRAS has great potential to improve the country's recording system.

TABLE 14: DATA ON VIOLENCE AGAINST WOMEN GENERATED FROM CIRAS (CRIME INFORMATION REPORTING AND ANALYSIS SYSTEM)						
COVERED PERIOD: JANUARY-DECEMBER 2016						
AS OF SEPTEMBER 3, 2018						
CASES	PRO 6	PRO 8	PRO 9	PRO 10	PRO 13	PRO ARMM
ABORTION						
ABUSES AGAINST CHASTITY				2		
ACTS OF LASCIVIOUSNESS	245	64	36	57	39	5
BIGAMY	3				1	
CONCUBINAGE	19	6	9	6	5	
FORCIBLE ABDUCTION	2	1		3		5
ANTI-SEXUAL HARASSMENT ACT (R.A. 7877)	3		5	2	3	2
ANTI-TRAFFICKING IN PERSONS (R.A. 9208)	4	1	6	2	1	21
ANTI-VIOLENCE AGAINST WOMEN & THEIR CHILDREN (R.A. 9262)	4716	714	576	1377	881	84
RA 9995 (ANTI-PHOTO AND VIDEO VOYEURISM ACT OF 2009)	8	1	1		1	
RA 8042 as amended by RA 10022 (Migrant Workers and Overseas Filipinos Act of 1995)						
Anti-Mail Order Bride Act (RA 6975)						
The Indigenous People's Rights Act of 1997 (RA 8371)						
RA 7277 (as Amended by RA 9442 otherwise known as Magna Carta for disabled persons)	3					
RA 9994 (Expanded Senior Citizens Act of 2010)				1		
RA 8505 (Rape Victim Assistance and Protection Act of 1998)						
RAPE	227	105	103	118	72	12
QUALIFIED SEDUCTION	1			1		
SIMPLE SEDUCTION	2				2	
RA 10361 (Domestic Workers Act)						
INTENTIONAL ABORTION		1				
GRAND TOTAL	5233	893	736	1569	1005	129

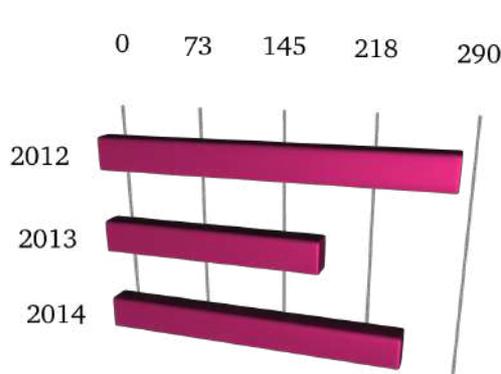
Tables 14 and 15 illustrated that Region VI has the highest VAW and VAC incidents while ARMM has the lowest record. On one hand, it can be observed that sexual violence and intimate partner violence (RA 9262) were the common violations committed against women. On the other hand, the VAC data showed that child abuse in relation to RA 7610 has the highest number of incidents and followed by sexual violence which was mostly recorded as rape. CIRAS also reflected crimes against children within the context of RA 9262. These were the biological children of the abused women or other children under her care. Though reporting and recording of GBV data from the barangay level up to national level are with gaps and challenges, data generated from CIRAS can be used for policy-making, planning, programming and monitoring.

TABLE 15: DATA ON VIOLENCE AGAINST CHILDREN GENERATED FROM CIRAS (CRIME INFORMATION REPORTING AND ANALYSIS SYSTEM)						
COVERED PERIOD: JANUARY-DECEMBER 2016						
AS OF FEBRUARY 6, 2019						
CASES	PRO 6	PRO 8	PRO 9	PRO 10	PRO 13	PRO ARMM
CHILD ABUSE ACT (R.A. 7610)	2822	486	458	706	526	31
INTER-COUNTRY ADOPTION ACT OF 1995 (R.A. 8043)						
DOMESTIC ADOPTION ACT OF 1998 (R.A. 8552)						
RA 9231 (ANTI-CHILD LABOR ACT OF 2003)	1	1			1	
RA 9775 (ANTI-CHILD PORNOGRAPHY ACT OF 2009)		1				
ABANDONING A MINOR	2		1			
ABORTION						
ACTS OF LASCIVIOUSNESS	120	58	32	37	36	1
FORCIBLE ABDUCTION	3	3	2	7	3	3
INFANTICIDE					1	
CONSENTED ABDUCTION	8	10	3	6	3	1
ANTI-SEXUAL HARASSMENT ACT (R.A. 7877)	3				3	
ANTI-TRAFFICKING IN PERSONS (R.A. 9208)	9	5	3	4	3	1
ANTI-VIOLENCE AGAINST WOMEN & THEIR CHILDREN (R.A. 9262)	90	35	20	34	33	4
RA 9995 (ANTI-PHOTO AND VIDEO VOYEURISM ACT OF 2009)	9	2		1		
ANTI-MAIL ORDER BRIDE ACT (RA 6975)						
The Indigenous People's Rights Act of 1999 (RA 8371)						
RA 8505 (Rape Victim Assistance and Protection Act of 1998)		1	1		3	
RAPE	504	317	277	241	184	33
KIDNAPPING AND FAILURE TO RETURN A MINOR	6	1	1	3	1	2
INDUCING A MINOR TO ABANDON HIS HOME						
EXPLOITATION OF CHILD LABOR						
ABANDONMENT OF MINOR BY PERSON ENTRUSTED WITH HIS CUSTODY; INDIFFERENCE OF PARENTS				1		
EXPLOITATION OF MINORS						
QUALIFIED SEDUCTION	2			1		
SIMPLE SEDUCTION	14	1	1	2	1	
SPECIAL PROTECTION OF CHILDREN AGAINST ABUSE EXPLOITATION AND DISCRIMINATION ACT	59		1	2	7	
SWINDLING A MINOR	1					
RA 7277 as Amended by RA 9442 otherwise known as Magna Carta for disabled persons						
RA 10175 (CYBERCRIME PREVENTION ACT OF 2012)	4				1	
RA 10361 (Domestic Workers Act)						
GRAND TOTAL	3657	921	800	1045	806	76

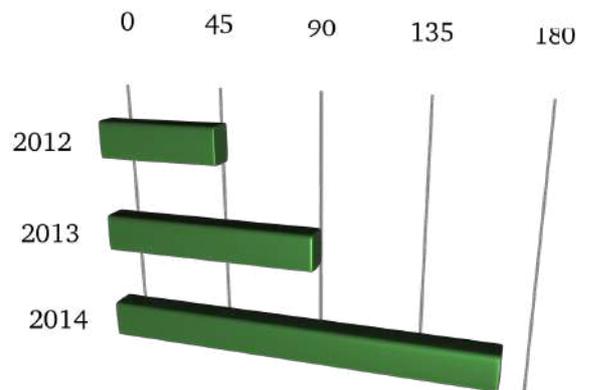
Finding #11: Though there was scarcity of data on GBV in emergency context, the government and humanitarian organizations were not deterred from addressing GBV.

There is no way that data on GBV in emergencies can be extracted from the present system of recording GBV incidents unless someone will go through the case documents manually and search for them one-by-one. This was the sentiment expressed by PNP and LGU key informants. There is no agency that acted as sole repository of all GBViE information. The database of PCW that is accessible online do not contain data on GBViE. The Philippine Statistics Authority (PSA) publishes data on GAD-related indicators but do not include data on GBViE.¹⁹ Though there was scarcity of data on GBV in emergency context, and most of what can be researched were anecdotal reports, the government agencies and humanitarian organizations were not deterred from taking action to address GBV. As mentioned before, with or without reports, GBV actors are to carry out prevention and response actions at the start of the early response to ensure protective measures are in place to protect vulnerable populations.

An exemption was noted in Agusan Del Sur. Through the initiative of the Provincial Police Office, the province was able to capture GBV incidents during the period of TY Pablo/Bopha. A comparative data on VAW and VAC before, during and after the emergency was made. Interpretations and analysis of the data were used as basis of the provincial government in its strategic planning to eliminate GBV and in the development of executive and legislative agenda. Below are Graphs 8 and 9 illustrating the VAW and VAC incidents respectively from 2012 (before) to 2013 (during) and 2014 (after):



Graph 8: Violence Against Women From 2012-2014 Covering the 12 Municipalities Affected by the Disaster of Agusan Del Sur
Source: Provincial Police Office



Graph 9: Violence Against Children From 2012-2014 Covering the 12 Municipalities Affected by the Disaster of Agusan Del Sur
Source: Provincial Police Office

The data on violence against women (VAW) shows a significant decrease of reported cases from 2012 to 2014. Most of the violations were of RA9262 or violence against intimate partners. In 2012, there were 281 reported cases; in 2013, there were 185 and in 2014, there were 250. These figures only reflected the 12 affected municipalities of the Province.

Graph 11 shows that there was a significant increase of reported cases of VAC prior to the occurrence of the typhoon towards the first two years (2013-2014) of recovery. Data on VAC showed that majority of the reported cases were violations of RA 7610 particularly physical abuse and rape. In 2012, there were 53 cases reported; 94 in 2013 and 170 in 2014.

The case of Agusan Del Sur served as an example of how GBViE data can influence policies, plans and programs. It assisted the duty bearers on how to improve the delivery of services and referrals in a coordinated manner. The Provincial LCAT-VAWC expressed that because of the data as well as the training they received during the humanitarian response, they were able to improve the referral system on GBV; and gaps in the provision of the multi-sectoral response were addressed like the (a) provision of medico-legal, (b) the conduct of case management conferences, (c) the partnership with the prosecutors, (d) the provision of support to victim-survivors and their families, (e) the joint conduct of capacity-building exercises, and (f) the awareness-raising sessions.

Finding #12: No impact assessment initiative was done before on GBV programming in emergency context due to lack of leadership, non-prioritization and no developed MEAL plan with GBViE.

No impact assessment study was carried out by the government and humanitarian community to cover all implemented GBV prevention and response actions during the previous complex emergencies because of a number of reasons:

First, there was no leadership from the DSWD Central Office championing the GBViE agenda and leading the National GBV Sub Cluster.

In the Philippines, the National GBV Sub Cluster was formed as early as 2009 in response to previous typhoons that have hit the country prior to TS Sendong/Washi. The Sub Cluster was led by DSWD and co-led by UNFPA. DSWD was consistent in deploying their focal persons in emergency-stricken areas along with UNFPA's GBV Coordinators to provide technical assistance and support to field-based GBV Sub Clusters. With the occurrence of national and local elections, with the change of administration and department secretaries, and because of political climate, the DSWD Central Office was not spared of changes within its own organizational structures and leadership. This affected the National GBV Sub Cluster.

Key informants revealed that the separation of DSWD's DReAMB (Disaster Response Assistance and Management Bureau) from its mother unit, the DSWD's PMB (Program Management Bureau), has created confusion as to which bureau should be taking over the Sub Cluster. This confusion led to the inactiveness of the Sub Cluster for a while. However, upon interview, DReAMB has already identified a focal person for Protection which includes GBV and Child Protection Sub Clusters. Activities have been lined up for the GBV Sub Cluster with the support of UNFPA. However, what needs to be addressed is the lack of high-level leadership from DSWD Central Office to champion the GBViE agenda and to lead the National GBV Sub Cluster.

Second, key informants expressed that a conduct of an impact assessment on GBViE programming was not a priority due to other competing priorities, limited financial resources and technical capacity.

One of the key findings made in the study on "Responding to Typhoon Haiyan: Women and Girls Left Behind" (November 2015), said that "*GBV and the specific needs of women and girls were not consistently taken into account. At every stage of the response and across every sector, addressing VAWG was considered to be a secondary concern - rather than a life-saving priority for women, girls and communities*".²⁰ Likewise, the delivery of wide array of services and programs to people are

given utmost importance and priority as compared to GBV and impact assessment. This also explains the prioritization on the use of limited available financial resources.

Several attempts were made before to put up GBV Information Management System but such efforts were not sustained due to limited resources. For example, DSWD piloted a Protective Services Information Management System but encountered challenges like poor wifi connection, hardware and workforce. The PNP's CIRAS needs to find ways on how to ensure that every police station has a computer and internet access, how to expand the limited storage capacity and address the slow performance reading.

Another limitation found is the lack of technical capacity to perform an impact assessment on GBViE programming. Government and humanitarian organizations know the importance of MEAL (Monitoring, Evaluation, Accountability and Learning) component in the entire program cycle management. In fact, each agency or organization has their respective monitoring and evaluation mechanisms. The coverage though is limited to their respective programs and projects and covered sites. When it comes to available performance and assessment tools on GBV, PCW developed quite a number of tools for government agencies and LGUs to determine and assess their compliance to national policies particularly on VAW laws and GAD indicators. But GBViE is a missing component.

However, one of the gaps identified in this study is the need to develop a MEAL plan for GBV programming in emergency context. Such plan should be based on the overall national disaster response plans. The lack of MEAL plan in DRRM was pointed out in one of the validation workshops. Having a plan will help in identifying key indicators and develop tools that will guide the conduct of impact assessment or evaluation studies especially on GBViE. Fortunately, ongoing efforts are being done to develop the MEAL component of the national disaster response plans but there is a need to ensure that GBViE indicators and tools are incorporated. The research project can be the take-off point for this endeavour.

Likewise, in increasing the technical capacity of the government and humanitarian community on GBViE programming and MEAL, capacity-building exercises should be conducted on the existing international standards on GBV prevention and response as well as on GBV mainstreaming. Though UNFPA's Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies was used in this study as a guide in the mapping exercise of GBViE interventions and services, the members of the Consortium and TWG admitted of the need of such capacity building especially for GBV champions at the regional and local levels as well as of local and international NGOs and CSOs. GBViE should also include non-traditional GBV actors such as faith-based organisations, elderly groups, organizations serving people with disabilities, youth groups, LGBTQI+, indigenous people and ethnic minority groups. With the eight years of GBViE programming experiences, perhaps a localized version of the international standards on GBViE can be developed; and the MEAL component can be strengthened.

4.6 Challenges, Learned Lessons and Insights on Measuring the Impact of GBViE Programming

This particular section would highlight the experiences and insights of the Consortium in doing the country's first impact assessment study on GBViE programming.

Finding #13: In the conduct of measuring the impact of GBViE programming in the Philippine context, the Consortium encountered the following key challenges: (a) getting the right research team for the project; (b) defining the parameters of the study; (c) appropriateness of framework and reliability of measurement tools; (d) balancing the perspectives of the respondents; and (e) deciding on the appropriate research methodologies.

The Consortium's journey in conducting the country's first impact assessment on GBViE programming led us to the following key challenges:

(a) Getting the right research team for the project. Doing an impact assessment study on GBViE programming is highly technical and rigorous. It requires a combination of different specializations, skills, knowledge and experiences to be able to see the various applications and complementations of lenses such as gender, culture, age, inclusion and the wider protection perspective. It demands full attention and time as well as commitment in order to be consistent in every research stage of the project.

(b) Defining the parameters of the study. In order for the study to be concise, focused and comprehensive, an impact assessment study should define the boundaries of what should be covered and what should not be covered given the richness of data that can be gathered in the field. This can include:

- GBViE programming for men and boys - Though evidence-based data pointed to women and girls as the majority of the victim-survivors of GBV, it cannot be ignored that GBV against men and boys is happening even in emergency situations. The study encountered untold stories of GBV experienced by men and boys wherein disability, old age and gender identity intersected.
- GBViE programming not only of the government but also of the humanitarian organizations - Any measured impact cannot be attributed solely to one agency or organization, or to one intervention or service especially in a cluster system approach, in a multi-sectoral and multi-level response. Further, the study did not make any comparison to affected-communities that have addressed GBViE without external support from the international humanitarian organizations such as the UN agencies and INGOs.
- GBViE programming in disaster-affected areas as opposed to armed conflict-settings - Does a heightened security risk affect GBViE programming? One of the limitations of the study is that there was no comparison between the two scenarios. Future research undertakings are encouraged to focus on BARMM conflict-affected areas that have displaced vulnerable populations because of the occurrence of protracted armed conflicts, typhoons and recently, earthquakes. BARMM was not covered much by the study, except Marawi, given the limited time and resources.

- Specific GBViE programming versus GBViE mainstreaming. The study was not able to focus extensively on mainstreaming initiatives because it concentrated more on the specialized GBViE programming and with traditional GBV actors. Thus, future GBViE impact assessment studies can focus on discovering good practices and successful stories of GBV mainstreaming from the field level and even existing MEAL tools and practices from the other clusters or sectors.

(c) Appropriateness of framework and reliability of measurement tools. The first challenge encountered by the Consortium was to find an appropriate theoretical or conceptual framework that can be used for assessment. Questions like - should the study measure the impact against the IASC's Minimum Standards on GBViE; or against the compliance to national laws on GBV/VAW/VAC; or, should the study focus on building resilience; or in changing norms, beliefs and harmful traditional practices - were the inquiries thrown at the table. It was at this point when the term theory of change was highly considered. Developing the ToC was quite challenging. It tried to back track 2 to 8 years ago; and identified what were the desired impacts at the height of the response. Because of the consultations made with the stakeholders, the ToC was developed and validated as the study progressed.

After constructing the ToC, the next challenge was to craft key evaluation questions in support of the theory. Then, the outcome indicators that needed to be captured in the field were identified; and the tools used were developed.

The impact assessment tools used in the study need further refinements, testing and validation. However, the commitment to introduce innovation and human-centered design was achieved. The tools were calibrated to fit the Philippine context; and the community profile.

(d) Balancing the different perspectives of the respondents. The study serves as a safe space for the voices of the vulnerable populations to be heard. At the same time, the study also gathered the insights and inputs of the government and humanitarian organizations. In the course of analysis, the study aimed to strike a balance between the perspectives of the affected communities and the perspectives of the humanitarian community.

(e) Deciding on the appropriate research methodologies. The strength of the team was on qualitative research methods in order to capture real stories and putting human faces in the study instead of numbers and figures. However, it was agreed on the importance of employing both the quantitative and qualitative methods for triangulation and validation purposes. However, specialized skills and approaches were needed in getting information from vulnerable sectors such as those with disabilities and who were from indigenous communities such as the Badjaos.

Finding #14: In translating the results of the impact assessment study into better GBViE programming in the Philippine context, the following were perceived to be the key challenges: (a) mobilization of networks and resources; (b) identification of high-level GBViE champion/s to take the lead at the national level; (c) addressing capacity gaps; and (d) strengthening of the Consortium.

At the start, the project was intended to become more than a research exercise. The process that it took, the engagement of various stakeholders, and the raising of consciousness that it did, not only among the humanitarian actors but also in the affected communities, were all leading to one thing: **better ways of protecting the vulnerable, the most-at-risk and those left behind.**

Better ways of programming for GBV in emergency context means better ways of dealing with challenges. In translating the results of the impact assessment study, the following are the perceived challenges:

(a) Mobilization of Networks and Resources. What is next? The study has created interests among the government agencies, local government units, service providers, humanitarian organizations and even the communities on knowing what worked, what did not work and why, and what other opportunities are there for improvements when it comes to GBViE programming and information management. That ‘captured interest’ should be capitalized and taken advantage of. For it to trigger concrete steps and actions, a **strategic action plan** with budgetary requirements needs to be developed by the Consortium, lobby to donors for funding, and implement within the next 6 - 9 months especially that Philippines is experiencing earthquakes in Mindanao and Luzon lately.

The action plan is meant to identify the key people and ways to bring the study into high-level discussions at the national and local levels with duty-bearers, service providers, humanitarian actors and communities; as well as into scholarly gatherings/fora/conferences to generate awareness, create demand and build a strong base of GBViE advocates.

(b) Identification of High-Level GBViE Champion/s to Take the Lead at the National Level. In order to move the GBViE agenda, the country needs a high-level champion or champions to direct key government agencies, in collaboration with humanitarian actors, to work on the (1) integration of GBViE data into GAD Database; (2) inclusion of GBViE into the existing performance standards and indicators as well as of assessment tools; (3) utilization of the GAD budget for GBViE programming; (4) standardizing GBViE minimum prevention and response actions; and (5) ensure the Nation’s Disaster Response Plans have MEAL components with GBViE.

(c) Addressing Capacity Gaps. The capacity gaps found at the national and local levels should be properly addressed. This would require technical experts not only on GBViE programming but also in building a responsive information management system. Likewise, the capacity of the local NGOs, CSOs, POs, faith-based organizations and groups serving the vulnerable sectors should be capacitated on the prevention of and response to GBV in emergencies. There is a need to standardize the training manual for GBViE.

(d) Strengthening of the Consortium. What is next for the Consortium is a big question given the (1) different priorities and agenda of members; (2) limited resources in terms of personnel, finance and capacities; (3) limited area of coverage; (4) lack of access to information technology; and (5) lack of presence at the national level. It is the responsibility of the Consortium to disseminate the study to serve a greater purpose. However, the ‘how’ is problematic. Capitalizing on the Consortium’s available resources, experiences, strengths and commitment, several opportunities can be grabbed to take the first few steps. One of those is to explore how the Consortium can be strengthened further. It can be thru resource mobilization, networking, partnerships and development of new projects in relation to GBViE. What matters most is the next step.

V. CONCLUSIONS

The conclusion statements will validate if the GBViE Theory of Change (ToC) is a useful tool in capturing the impact of GBViE programming, and in guiding the humanitarian clusters for a collaborative effort to achieve the desired impact. Such approach shifts the focus from the activity-based approach to impact-measurement approach.

The study generated evidences on the impacts made at various levels. It identified what worked and what did not; and what can be done in promoting resiliency and creating a protective environment. It examined not just the perspective of the implementors but also the affected communities particularly the vulnerable populations. With new insights and innovation opportunities identified, future GBViE programming and information management practices can be enhanced.

By employing innovative and human-centred design impact measurement tools, the study was able to capture the impact, both positive and negative, at the following levels:

Individual and Family Levels. Age, education and income are both resilience and vulnerable factors. However, an emergency situation can either increase resiliency or vulnerability depending on the presence of protective and risk factors as well. This is the part where the GBViE prevention and response actions are crucial. Findings of the study pointed out that resilience was obtained when help and support from other people were provided especially in an emergency context. Making the interventions and services available and accessible can help in putting in place a protective circle in the middle of a stressful environment.

However, the needs and concerns of the specific vulnerable sectors were left behind. The study served as a safe space for the voices of the elderlies, persons with disabilities, indigenous communities and LGBTQI+ to be heard and acted on. Their views and insights can provide new ideas or opportunities for better GBViE programming calibrated specifically for their needs. This is where their organizations or groups should be engaged. Their capacities for GBViE prevention and response should be built along with the other non-traditional GBV actors who can create a strong base support for GBViE prevention.

Community Level. The level of awareness, understanding and appreciation of the communities on GBV in emergency context would indicate prioritization and resources put into to implement prevention and response measures. The GBViE programming that was carried out in the previous complex emergencies was a mixture of existing and new interventions; a combination of protection mechanisms at various levels; and an interaction of specialized and mainstreamed GBV actions.

However, gaps and challenges were identified. For example, there is a need to calibrate further the GBV prevention and response actions into more survivor-centred, gender-responsive, culture-sensitive, age-appropriate and disability-friendly. The issue of sustainability should be discussed so that promising and working interventions can go beyond the emergency response. Mobilization of community-based organizations and people's groups including faith-based organizations and traditional councils of the elders are potential resources for GBV action groups. All these are possible if dialogues, feedback mechanisms and consultation process that adhere to humanitarian principles of impartiality, neutrality, independence and humanity, are put in place and supported by all stakeholders for a shared accountability and responsibility.

Societal Level. Opportunities that emerged during emergencies were capitalized to strengthen the supply and increase the demand side for better GBViE programming. With the eight years of GBViE programming experiences, the Philippines managed to build strong partnerships with the humanitarian community that resulted to: the building of GBViE minimum initial package on prevention and response; enactment of new laws, policies and implementing guidelines; increased pool of technical personnel to support GBViE programming; and created awareness on the exacerbation of GBV in times of emergencies.

Leadership, prioritization and resources are required for the full and proper implementation of GBViE-related policies, plans and programs including improvements in the information management system. There is also the need to bring in more non-traditional GBV partners in order to mainstream GBV in all sectors and clusters; and to strengthen existing inter-agency councils and coordination structures instead of creating new ones. An agency that can act as sole repository of all GBViE information is needed.

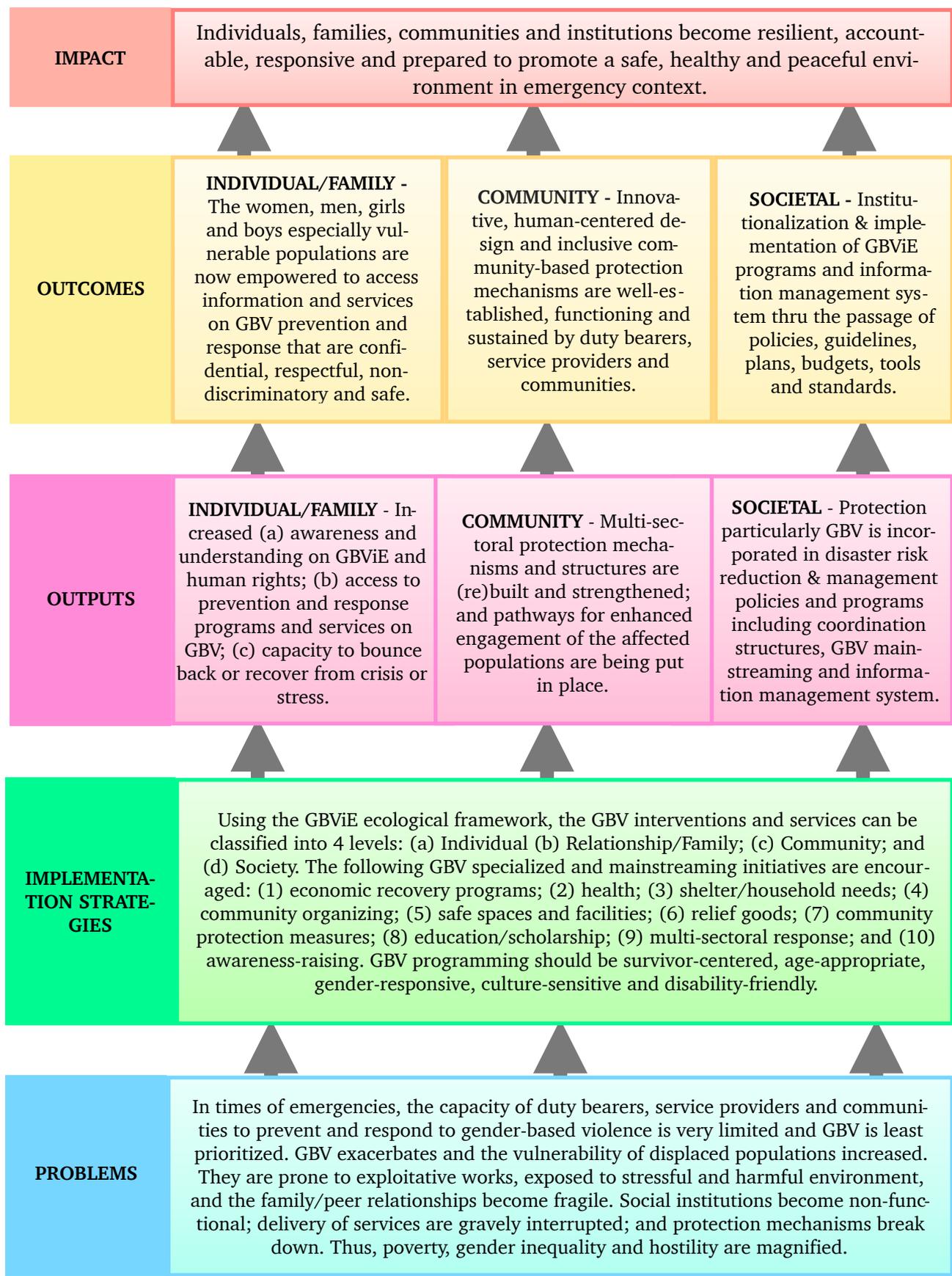
Weighing all the key findings of the study, it can be said that so much had been done, achieved and learned before in previous complex emergencies; yet, so much are still to and can be done for GBV prevention and response in emergency. There is also the need to reiterate the GBV guiding principles of safety, confidentiality, non-discrimination and respect to all GBV actors including service providers.

Likewise, in assessing the impact of GBViE programming, determining whose perspective would have implications on the development of key evaluation questions, measurements tools, research methodologies and the kind of data needed to be captured. Government agencies have assessment tools to determine their adherence to national laws and policies. Humanitarian organizations can assess their performance too using international minimum standards on GBV. However, the study opted to assess the impact from the perspective of the communities. But the picture needed to be complete. Thus, the study ended looking at the perspectives of the duty-bearers, service providers, affected communities and vulnerable populations using resilience as basis.

The GBViE Theory of Change as demonstrated in Illustration 11, was very helpful in framing the assessment study. It is a tool that can be shared to any group or cluster of GBV actors working collectively and collaboratively. It is hoped that this would be adopted and revise accordingly by GBV actors to encourage the next impact assessment study. The study offers its refined version of the theory taking off from its key findings.

In order to serve its greater purpose, the study needs to be disseminated strategically at the local and national levels using the bottom-up approach. Concrete steps and actions are needed in order to realize the key recommendations of the study. GBV in emergency context should be highly seen as a life-threatening issue and a violation of human rights. It could cripple the capacities of individuals and communities to be resilient if GBV is set aside. In leaving behind no one, inclusion should be part of the GBViE agenda. In generating evidences, similar research undertakings and improvement of the GBV information management system should be made. In preparing for future emergency events, investments should be made in strengthening the capacity of the duty-bearers, service providers and communities.

**Illustration 11:
GBV THEORY OF CHANGE IN PHILIPPINE EMERGENCY CONTEXT**



VI. RECOMMENDATIONS

This section offers key recommendations and innovation opportunities to better design GBViE programming and improve information management system. The section will also include specific recommendations made by the communities.

a. For better GBViE programming

- Continuous learning and knowledge-building for the development of GBViE materials including the (a) localization of IASC's Minimum Standards for the Prevention of and Response to GBV in Emergencies and the Guidelines for Integrating GBV Interventions in Humanitarian Action; (b) standardization of a training manual on GBViE; (c) development of fatwah against GBV for Muslim communities; and (d) development of Standard Operating Procedure on GBV in emergency context wherein the minimum prevention and response actions as experienced in the Philippines will be packaged;
- Identification of new and enhancement of existing GBViE prevention and response actions that are inclusive, culture-sensitive, age-appropriate and gender-responsive to the unique experiences of vulnerable sectors such as persons with disability, indigenous people, elderly and LGBTQI+; and
- Strengthen leadership and build the national and local technical capacities of GBV actors including non-traditional and vulnerable sectors.

b. For the improvement of GBV information management system

- Provide technical support to the ongoing development and piloting of the government on a harmonized intake form that could identify vulnerability profile of the GBV victim-survivor in terms of disability, ethnic affiliation, gender identity and emergency context. Such data will feed into the PNP's Crime Incident Reporting and Analysis System wherein the generation of the data can be immediately performed;
- Explore opportunities with the National Disaster Risk Reduction and Management Council or Office of the Civil Defense on how to integrate the findings of the study into the MEAL component of the National Disaster Response Plans;
- Discover indigenous knowledge and creative ways for developing impact measurement tools that are appropriate for people with disabilities, elderlies, ethnic minorities and LGBTQI+ community;
- Review and explore how government's existing GAD database, tools and indicators can incorporate GBViE; and
- Promote the use of the innovative impact assessment tools that were introduced in the study.

c. Specific recommendations of the communities

- Conduct of an inclusive census of all children/youth/persons with disabilities. Latest data on the number of children with disabilities was based on 2010 census of the Philippine Statistics Authority. A database will be useful for policy-making, planning and programming;
- Work for Dolho-Bato Badjao state citizenship in partnership and collaboration of public and private sectors including accessibility and availability of protection services such as employment, education, health, housing and safety;
- Make humanitarian aid for elderlies and PWDs more appropriate in terms of WASH facilities, assistive devices, trainings for disaster preparedness, shelter, among others. Separate shelter facilities for elderlies with no caregivers. It should be away from noisy and cruel crowds; and
- Mandatory sensitization of all humanitarian aid workers on the respectful, non-discriminatory and non-degrading treatment of the internally displaced people or evacuees particularly the PWDs, elderlies, ethnic or religious minorities and LGBTQI+; and strict compliance on the Prevention of Sexual Exploitation and Abuse policy.

In pursuing the identified recommendations, it is suggested that the bottom-up approach be applied. The strength of the Consortium is in community mobilization. The dissemination of the study should serve as entry points for the duty bearers, service providers and communities to have interactive dialogues that can translate recommendations into concrete actions and commitments at the local level. In turn, it will generate demand, create awareness and draw support.

From generating evidences and building knowledge, the Consortium moves up to the next level of performing advocacy works to realise the practical and strategic recommendations of the study. Given their autonomy, the local government units can enact policies, programs and projects based on the needs and concerns of their communities. Also, NGOs, CSOs, POs and faith-based organizations present in the localities can reinforce the call for better GBViE programming with technical guidance from the Consortium.

From bottom-led initiatives, the national government has to respond too. The Consortium has identified potential entry points for national mobilization. One is thru the high-level dissemination of the study with the National Inter-Agency Council on Violence Against Women and Children (IAC-VAWC) as the target participants. Second is to capitalize on the partnerships established with key government agencies at the regional and national levels such as DSWD and PNP. Third is thru the National GBV Sub Cluster that is led by DSWD and co-led by UNFPA. Fourth is thru existing networks, partnerships and affiliations including legislative branch of the government.

Through these efforts, better GBViE programming and information management can be institutionalized.

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VIII. ANNEXES

8.1 Representations of the GBViE Consortium - Visayas

Lead Convenor

Josefa Roces-Pizon is the Executive Director of the Rural Development Initiatives in the Islands of Leyte, Inc. (RDII-Leyte) since 2000. She is a degree holder of Bachelor of Science in AgriBusiness (Major in Business Management) and with units earned in Master of Arts in Public Administration. She has a significant number of years of experiences in performing emergency responses, early recovery & rehabilitation planning, mainstreaming gender in emergencies, community organizing, capacity-building & networking. She is also actively involved in a number of women and DRRM organizations and affiliations based in Ormoc City & Eastern Visayas.

Lead GBViE Technical Specialist and Technical Writer

Mary Scheree Lynn V. Herrera is the Founder of a start-up social enterprise called SCHERZ Indigenous Creations Enterprises. She is a degree holder of Bachelor of Arts in Sociology and Master of Arts in Women and Development Studies at the University of the Philippines, Diliman. She has 6 years of work experience at the Philippine House of Representatives wherein she provided technical support to the House Committee on Women for the enactment of GBV-related laws including Magna Carta of Women. She has 8 years of development programming and humanitarian work experiences under UNFPA and UNICEF Philippines specializing on gender, GBV, child protection and adolescents in emergencies. She is presently into social enterprise development introducing an innovative concept of ‘social entrepreneurship in emergencies’.

Research Consultant & Adviser

Teresita Mallonga is presently the Technical Adviser of the ULIKID Parents Organization (ULugyon nga Inisyatiba sang may mga Kasablagan agud Itib-ong ang ila Dignidad). She has 15 years of work experience as a Social Impact Assessment/IEC Specialist for heavy industry in the conduct of Environmental Impact Assessments. She has been involved in the children’s sector for 11 years now initially starting as North B Sector Coordinator for CFC-ANCOP Child Sponsorship Program and later, as an Advocacy Officer for Cameleon Association (a NGO focused on the elimination of child sexual abuse). She is also a member of the Bata Muna Network - Panay.

Child Protection Advocate

Merlyn Q. Medala is the incumbent President of the Northern Samar Children’s Ministries Network, Inc. (NSCMN) who holds a degree of Bachelor of Science in Business Administration (Major in Accounting). She is the focal person for the project called “Break the Silence on the Prevention of Child Sexual Abuse” in Region VIII being a member of the Stairway Foundation, Inc; and for the Youth For Safety - Visayas with Philippine Children’s Ministries Network. She is a licensed foster parent who supported three child survivors of abuse and of Super Typhoon Haiyan. She had been engaged in various needs assessment and MEAL exercises of the NSCMN.

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8.3 Questionnaire for GBViE Survivors

In selecting victim-survivors of gender-based violence in emergency context, the following shall serve as guide:

- All research participants/respondents should be **18 years old and above** upon the interview
- Can be a **female** and a **male**
- Includes GBV cases that have taken place **during and after** the emergency situation; or that have been responded to during the emergency setting but GBV has taken place **prior** to emergency
- Should have given his/her **informed consent** in writing
- Should be properly coordinated with the **social worker or case manager** prior to any conduct of interview
- Proper **orientation** should be made and upon **willingness** to participate or on a **voluntary-basis** only

PART I. Socio-Demographic Profile

Code Name (for confidentiality purposes): _____ **Current Age:** _____ **Sex:** _____

Address: Region _____ Province: _____ Municipality/City: _____ Barangay _____

If staying in an evacuation centre, transitory site, temporary shelter, or with relatives since displacement, kindly specify location name: _____ **Length of Stay:** _____

Civil Status: _____ Single _____ Married _____ Live-in Partner _____ Others, Specify: _____

No. of Children/Dependents: _____ Not Applicable

Educational Level: _____ No education _____ Primary _____ Secondary _____ Vocational _____ College

Employment Status: _____ Housewife/Houseband _____ With Full-Time Job _____ With Part-Time Job
 _____ Self-Employed _____ Seasonal Job _____ Students _____ Others

Vulnerabilities: (Please check all that applies):

_____ Disaster Survivor _____ Armed-Conflict Survivor _____ Both Disaster and Armed Conflict

_____ Person w/ Disability _____ Elderly _____ LGBTQI+ _____ Ethnic Minority/Indigenous People

_____ GBV Survivor - Specify Type/Form of GBV Experienced: _____

_____ Others, Specify _____

PART II. Measuring the Impact of GBViE in Terms of Resiliency From Within Brief Resilience Scale (BRS) - 'Coping on Their Own'

Please respond to each item by marking one box per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly <i>by myself</i> after hard times.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 2	I have a hard time making it through stressful events <i>by myself</i> .	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
BRS 3	It does not take me long to recover <i>by myself</i> from a stressful event.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 4	It is hard for me to snap back <i>by myself</i> when something bad happens.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
BRS 5	I usually come through difficult times with little trouble <i>by myself</i> .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 6	I tend to take a long time to get over set-backs in my life <i>by myself</i> .	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

PART III. Measuring the Impact of GBViE in Terms of Resiliency With Social Support
Brief Resilience Scale (BRS) - ‘Coping With the Help of Others’

Please respond to each item by marking one box per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 7	I tend to bounce back quickly after hard times <i>with the help of others.</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 8	I have a hard time making it through stressful events <i>even with the help of others.</i>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
BRS 9	It does not take me long to recover from a stressful event <i>with the help of others.</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 10	It Is hard for me to snap back when something bad happens <i>even with the help of others.</i>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
BRS 11	I usually come through difficult times <i>with the help of others</i> with little trouble.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
BRS 12	I tend to take a long time to get over set-backs in my life <i>even with the help of others.</i>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

PART IV. Capturing Thoughts and Ideas on GBV Prevention and Response

- As GBViE survivor, how were you able to cope up or deal with such tragedy in your life? (*Bilang GBV survivor, paano mo nalampasan ang trahedyang na iyong naranasan?*)
 - Who helped you? (*Sino ang tumulong sa iyo?*)
 - What helped you cope up? (*Ano ang nakatulong sa iyo para makabangon muli?*)
 - How were they able to help you? (*Paano sila nakatulong sa iyo?*)
- What advise can you give people who have suffered the same thing or might suffer the same experience that you had? (*Ano ang maipapayo mo sa mga taong maaaring nakaranas at makaranas ng parehong trahedyang?*)
- What advise or recommendations can you give the government to improve their services? (*Ano ang maimumungkahi mo sa gobyerno para mapabuti pa ang kanilang serbisyo?*)
- What was the most effective intervention/service that you received and which do you think should be provided also to others? (*Ano ang pinakamagandang interventions/serbisyo ang natanggap mo at ano dapat ang matanggap din ng iba?*)

PART V. Feedback on the Appropriateness of the Data Collection Method

- Among the questions asked, which was the hardest to answer and why? (*Alin sa mga tanong ang nahirapan kang sagutin? Bakit?*)
- Among the questions asked, which was the easiest to answer and why? (*Ano naman mga tanong ang madali mong nasagutan? Bakit?*)
- Is there any question that you would like to suggest to better understand GBViE? (*May nais ka bang idagdag na katanungan para mas maunawaan ang issue ng GBViE?*)

8.4 Questionnaire for FGD Participants - Young Participants (15-24 years old)

- Participants should be relatively similar to one another in terms of age, culture and sex to increase group comfort level. For this particular research, each team is expected to conduct at least one FGD for boys, one FGD for girls, one FGD for adult women and one FGD for adult men per municipality/city. Given the sensitivity of the topic, participants will be separated by age and sex. For young boys and girls, the age range should be between 15-24 years old. For adult men and women, the age range should be 25 yo and above. In some areas, FGDs will be conducted for vulnerable sectors such as persons with disabilities, elderly, LGBTQI+ and ethnic minorities/indigenous people. Segregation by sex and age should be strictly observed.
- In identifying FGD participants, the following criteria should be met: (a) have received any GBV intervention or service and (b) have knowledge or understanding on what is GBV in general. Likewise, research teams are encouraged to link up with the members of Consortium's Technical Working Group or through LGUs to identify participants.
- FGD moderator should give a brief introduction of her/himself and the team. S/he should explain the purpose of the discussion, how the Consortium plans to use the information gathered, the rules to be imposed (e.g. one-mouth rule, respect the opinions of others, avoid interrupting when someone is speaking, confidentiality, etc.) and clearly state the expectations of the team and of the participants.
- The moderator should emphasize that participants need NOT disclose personal information about themselves or of people they know of. FGD moderator should be alert in case there are self-disclosures within the group. The research team should be familiar with the existing referral system in the area for immediate action in case there is a need to.
- Make participants understand that their participation is completely voluntary; and that they may choose to leave anytime during the discussion. Make them aware that their participation will receive no tangible benefit or token.
- The ideal size for a FGD is 8-10 participants. The venues for the conduct of FGDs should be with privacy so that participants may speak without being overheard or seen by others who are not participants. Avoid noisy sites where it will be difficult for everybody in the discussion to hear each other.
- Seating arrangement should be in circle if possible to entice participation, interaction and sense of being part of the group. This way, participants and moderator can see each other.
- In using tape recorders and cameras, ensure that each participant has signed the consent and media forms. Assure them that everything will be used solely for research purposes, advocacy works and media dissemination. Confidentiality shall be observed at all times.
- Research teams are expected to be consistent in the use of the Tree of GBV, Tree of Hope and Body Mapping in measuring their level of understanding of GBV and capturing the impact in innovative way.
- Research teams should be ready to provide technical inputs or to respond to inquiries or questions raised by the participants on GBV in emergency context. If not sure on how to respond, inform the participants that you will get back at them with the right response upon consultation of the Consortium. Never leave the area with pending questions.
- Research teams are encouraged to apply innovative methodology in introductions of participants, in getting their feedback, in rating themselves, in synthesizing or summarizing at the end of the discussion.
- If possible, all-female groups should be led by female moderators and all-male groups should be led by male moderators. If mixed, there should be both a male and a female moderator.
- The research teams are not to judge nor provide or offer their opinions. Rather, the research teams are there to provide facts and figures. Inform participants that there are no right or wrong answers. The teams should listen attentively and be observant esp. on what is not being said and on body language.

PART I. Profile of Participants

FGD Group: ___ Adult Women ___ Adult Men ___ Young Girls ___ Young Boys

___ Vulnerable Sectors, Specify: _____

Date Conducted: _____ Time Started: _____ Time Ended: _____

Address: Region _____ Province: _____ Municipality/City: _____
Barangay _____

If staying in an evacuation centre, transitory site, temporary shelter, or with relatives since displacement, kindly specify location name: _____

Total No. of Participants: _____ (Ensure participants have filled up the Attendance Sheets)

Name of Lead Moderator: _____ Name of Organization: _____

PART II. Key FGD Questions

1. What GBV issues you are aware of or familiar with in your community during the emergency situation? (*Ano ang mga GBV issues na iyong narinig o nalaman sa iyong lugar noong panahon ng kalamidad?*) (Note: In bringing out their understanding of GBViE, use the Tree of GBV or Body Mapping exercise. Ensure that drawing materials are available. Emphasize to identify GBV issues which have happened during the emergency phase up to post-recovery and rehabilitation stage.)
2. What were the GBViE interventions or services that you received or were provided in your communities immediately after the disaster/conflict or during the early or post recovery and rehabilitation stage? (*Anu-ano ang mga GBV interventions/services na natanggap o naibigay sa inyong lugar (city or municipality) pagkatapos ng trahedya hanggang sa muling pagtataguyod ng inyong komunidad?*) (Note: You may use the Tree of Hope for this question and the succeeding ones. Please ensure that the scoring per intervention/service received will be strictly observed.)

Interventions	Most Helpful 5	Very Helpful 4	Helpful 3	Least Helpful 2	Not Helpful 1
Individual Level					
Intervention 1:					
Intervention 2:					
Relationship Level					
Intervention 3:					
Intervention 4:					
Community Level					
Intervention 5:					
Intervention 6:					
Societal Level					
Intervention 7:					
Intervention 8:					

3. What made you say that those were the GBViE interventions/services that have helped you the most? (*Bakit niyo nasabi na ito ang pinaka-nakatulong sa inyo?*)

3.a. What mechanisms, ways or processes used in the implementation of those interventions/services that you liked the most? How were they implemented? (*Anong pamamaraan o proseso sa pagbibigay o pag-implement ng interventions/services ang nagustuhan niyo? Paano naimplement?*)

4. What made you say that those were the GBViE interventions/services that have helped you the least? (*Bakit niyo naman nasabi na ang mga ito ay hindi gaanong nakatulong sa inyo?*)

4.a. What mechanisms, ways or processes used in the implementation of those interventions/services that you did not like? (*Anong pamamaraan o proseso sa pagbibigay o pagimplement ng interventions/services ang hindi niyo nagustuhan?*)

5. How did your circumstance or your situation in the community got affected or changed by the interventions/services you received? (*Paano nabago nang mga natanggap niyong tulong ang inyong katayuan o komunidad?*)

6. Among the interventions/services that you received and liked the most - (*Sa mga nagustuhan niyong interventions*) -

6.1 Which of them would you like to be continued? (*Ano ang nais ninyong ipagpatuloy?*)

6.2 Which of them can be shared or applied in other municipality or city? (*Ano ang pwedeng tularan ng ibang munisipyo/city?*)

7. Among the interventions/services that you received but did not help you so much, what would you recommend so that it can be improved or enhanced? (*Sa mga hindi gaanong nakatulong na interventions, ano ang dapat gawin para ang mga ito ay mapabuti?*)

8. What preparations are being done by you or by your community so that GBV issues can be prevented and responded to in case there is another emergency? (*Ano ang inyong ginagawang paghahanda para mapigilan at matugunan ang mga posibleng GBV issues sa inyong lugar, kung sakaling magkaroon ng panibagong emergency?*)

PART III. Feedback of Participants on the Data Gathering Method

1. Among the questions raised, which do you find easy to answer? Why? (*Anong mga tanong ang madali mong nasagutan? Bakit?*)

2. Among the questions raised, which do you find difficult to answer? Why? (*Alin sa mga tanong ang nahirapan kang sagutan? Bakit?*)

3. Do you have additional questions that you want to be included to better understand the issue of GBViE? (*May gusto ba kayong idagdag na katanungan na makakatulong para mas maunawaan natin ang issue ng GBViE?*)

4. Do you have any suggestion or recommendation on how to gather or collect information or data to better understand the issue of GBViE? (*May gusto ba kayong imungkahi na paraan sa pagkalap ng impormasyon para mas maunawaan ang issue ng GBViE?*)

8.5 Questionnaire for FGD Participants - Adult Participants (25 yrs. old & above)

- Participants should be relatively similar to one another in terms of age, culture and sex to increase group comfort level. For this particular research, each team is expected to conduct at least one FGD for boys, one FGD for girls, one FGD for adult women and one FGD for adult men per municipality/city. Given the sensitivity of the topic, participants will be separated by age and sex. For young boys and girls, the age range should be between 15-24 years old. For adult men and women, the age range should be 25 yo and above. In some areas, FGDs will be conducted for vulnerable sectors such as persons with disabilities, elderly, LGBTs and ethnic minorities/indigenous people. Segregation by sex and age should be strictly observed.
- In identifying FGD participants, the following criteria should be met: (a) have received any GBV intervention or service; and (b) have knowledge or understanding on what is GBV in general. Likewise, research teams are encouraged to link up with the members of Consortium's Technical Working Group or through LGUs to identify participants.
- FGD moderator should give a brief introduction of her/himself and the team. S/he should explain the purpose of the discussion, how the Consortium plans to use the information gathered, the rules to be imposed (e.g. one-mouth rule, respect the opinions of others, avoid interrupting when someone is speaking, confidentiality, etc.) and clearly state the expectations of the team and of the participants.
- The moderator should emphasize that participants need NOT disclose personal information about themselves or of people they know of. FGD moderator should be alert in case there are self-disclosures within the group. The research team should be familiar with the existing referral system in the area for immediate action in case there is a need to.
- Make participants understand that their participation is completely voluntary; and that they may choose to leave anytime during the discussion. Make them aware that their participation will receive no tangible benefit or token.
- The ideal size for a FGD is 8-10 participants. The venues for the conduct of FGDs should be with privacy so that participants may speak without being overheard or seen by others who are not participants. Avoid noisy sites where it will be difficult for everybody in the discussion to hear each other.
- Seating arrangement should be in circle if possible to entice participation, interaction and sense of being part of the group. This way, participants and moderator can see each other.
- In using tape recorders and cameras, ensure that each participant has signed the consent and media forms. Assure them that everything will be used solely for research purposes, advocacy works and media dissemination. Confidentiality shall be observed at all times.
- Research teams are expected to be consistent in the use of the Tree of GBV, Tree of Hope and Body Mapping in measuring their level of understanding of GBV and capturing the impact in innovative way.
- Research teams should be ready to provide technical inputs or to respond to inquiries or questions raised by the participants on GBV in emergency context. If not sure on how to respond, inform the participants that you will get back at them with the right response upon consultation of the Consortium. Never leave the area with pending questions.
- Research teams are encouraged to apply innovative methodology in introductions of participants, in getting their feedback, in rating themselves, in synthesizing or summarizing at the end of the discussion.
- If possible, all-female groups should be led by female moderators and all-male groups should be led by male moderators. If mixed, there should be both a male and a female moderator.
- The research teams are not to judge nor provide or offer their opinions. Rather, the research teams are there to provide facts and figures. Inform participants that there are no right or wrong answers. The teams should listen attentively and be observant esp. on what is not being said and on body language.

PART I. Profile of Participants

FGD Group: _____ Adult Women _____ Adult Men _____ Young Girls _____ Young Boys
 _____ Vulnerable Sectors, Specify: _____

Date Conducted: _____ Time Started: _____ Time Ended: _____

Address: Region _____ Province: _____ Municipality/City: _____
 Barangay _____

If staying in an evacuation centre, transitory site, temporary shelter, or with relatives since displacement, kindly specify location name: _____

Total No. of Participants: _____ (Ensure participants have filled up the Attendance Sheets)

Name of Lead Moderator: _____ Name of Organization: _____

PART II. Key FGD Questions

1. What GBV issues that you are aware of or familiar with in your community during the emergency situation? (*Ano ang mga GBV issues sa inyong lugar na inyong narinig o nalaman noong panahon ng kalamidad?*) (Note: In bringing out their understanding of GBViE, use the Tree of GBV or Body Mapping exercise. Ensure that drawing materials are available. Emphasize to identify GBV issues that have happened during the emergency phase up to post-recovery and rehabilitation stage.)
2. What were the GBViE interventions or services that you received or were provided in your communities immediately after the disaster/conflict or during the early or post recovery and rehabilitation stage? (*Anu-ano ang mga GBV interventions/services na natanggap o naibigay sa inyong lugar (city or municipality) pagkatapos ng trahedya hanggang sa muling pagtataguyod ng inyong komunidad?*) (Note: You may use the Tree of Hope for this question and the succeeding ones. Please ensure that the scoring per intervention/service received will be strictly observed.)

Interventions	Most Helpful 5	Very Helpful 4	Helpful 3	Least Helpful 2	Not Helpful 1
Individual Level					
Intervention 1:					
Intervention 2:					
Relationship Level					
Intervention 3:					
Intervention 4:					
Community Level					
Intervention 5:					
Intervention 6:					
Societal Level					
Intervention 7:					
Intervention 8:					

3. What made you say that those were the GBViE interventions/services that helped you the most? (*Bakit niyo nasabi na ito ang pinaka-nakatulong sa inyo?*)

3.a. What mechanisms, ways or processes used in the implementation of those interventions/services that you liked the most? How were they implemented? (*Anong pamamaraan o proseso sa pagbibigay o pagimplement ng interventions/services ang nagustuhan niyo? Paano naimplement?*)

4. What made you say that those were the GBViE interventions/services that helped you the least? (*Bakit niyo naman nasabi na ang mga ito ay hindi gaanong nakatulong sa inyo?*)

4.a. What mechanisms, ways or processes used in the implementation of those interventions/services that you did not like? (*Anong pamamaraan o proseso sa pagbibigay o pagimplement ng interventions/services ang hindi niyo nagustuhan?*)

5. How did your circumstance or your situation in the community get affected or changed by the interventions/services you received? (*Paano nabago ang katayuan nyo sa lipunan/komunidad dahil sa mga natanggap na tulong?*)

6. *What were the changes or effects that you observed in terms of your relationship with your intimate partners after receiving those GBViE interventions? (Ano ang pagbabago o epekto ng mga interventions na ito sa relasyon ninyo ng inyong partner/spouse?)*

7. Among the interventions/services that you received and liked the most - (*Sa mga nagustuhan niyong interventions*) -

7.1 Which of them you would like to be continued? (*Ano ang nais ninyong ipagpatuloy?*)

7.2 Which of them can be shared or applied in other municipality or city? (*Ano ang pwedeng tularan ng ibang munisipyo/city?*)

8. Among the interventions/services that you received but did not help you, what would you recommend so that they can be improved or enhanced? (*Sa mga hindi gaanong nakatulong na interventions, ano ang dapat gawin para ang mga ito ay mapabuti?*)

9. What preparations are being done by you or by your community so that GBV issues can be prevented and responded to in case there is another emergency? (*Ano ang inyong ginagawang paghahanda para mapigilan at matugunan ang mga posibleng GBV issues sa inyong lugar, kung sakaling magkaroon ng panibagong emergency?*)

PART III. Feedback of Participants on the Data Gathering Method

1. Among the questions raised, which do you find easy to answer? Why? (*Ano naman mga tanong ang madali niyong nasagutan? Bakit?*)

2. Among the questions raised, which do you find difficult to answer? Why? (*Alin sa mga tanong ang nahirapan kayong sagutan? Bakit?*)

3. Do you have additional questions that you want to be included in the questionnaire to better understand the issue of GBViE? (*May gusto ba kayong idagdag na katanungan na makakatulong para mas maunawaan natin ang issue ng GBViE?*)

4. Do you have any suggestion or recommendation on how to gather or collect information or data to better understand the issue of GBViE? (*May gusto ba kayong imungkahi na paraan sa pagkalap ng impormasyon para mas maunawaan ang issue ng GBViE?*)

8.6 Questionnaire for Key Informants

- Participants can be at the provincial, municipal/city and barangay levels who have contributed to the prevention of and response to GBV in times of emergencies. This can be but not limited to: social workers, female/male police officers, medical/health officers, Barangay VAW Desk Officers, DRRM Council Focal Points/Protection Officers, Legal Officers, DILG, GAD Focal Points, Planning Officers, among others.
- In identifying key participants, informants should have contributed to the prevention of and response to GBV during emergency times until the recovery and rehabilitation stage, development and preparedness phase.
- The research team should give a brief introduction of themselves and of the project. They should explain the purpose of the discussion, how the Consortium plans to use the information gathered, the rules to be imposed (e.g. one-mouth rule, respect the opinions of others, avoid interrupting when someone is speaking, confidentiality, etc.) and clearly state the expectations of the team and of the participants.
- The moderator should emphasize that participants need NOT disclose personal information about their clients or of people they know. The moderator should be alert in case there are disclosures within the group. The research team should be familiar with the existing referral system in the area for immediate action in case there is a need to.
- Make participants understand that their participation is completely voluntary; and that they may choose to leave at anytime during the discussion. Make them aware that their participation will receive no tangible benefit or token.
- The ideal size for a group interview is 3-5 participants. The venues should be with privacy so that participants may speak without being overheard or seen by others who are not participants. Avoid noisy sites where it will be difficult for everybody in the discussion to hear each other.
- Seating arrangement should be in circle if possible to entice participation, interaction and sense of being part of the group. This way, participants and moderator can see each other.
- In using tape recorders and cameras, ensure that each participant has signed the consent and media forms. Assure them that everything will be used solely for research purposes, advocacy works and media dissemination. Confidentiality shall be observed at all times.
- Research teams should be ready to provide technical inputs or to respond to inquiries or questions raised by the participants on GBV in emergency context. If not sure on how to respond, inform the participants that you will get back at them with the right response upon consultation of the Consortium. Never leave the area with pending questions.
- Research teams are encouraged to apply innovative methodology in introductions of participants, in getting their feedbacks, in rating themselves, in synthesizing or summarizing at the end of the discussion.
- The research teams are not to judge nor provide or offer their opinions. Rather, the research teams are there to provide facts and figures. Inform participants that there are no right or wrong answers. The teams should listen attentively and be observant esp. on what is not being said and on body language.

PART I. Profile of Participants

Group Interview/KII: ___ Social Welfare Sector ___ Security/Protection Sector ___ Health Sector
 ___ Legal Sector ___ Barangay Level ___ DRRM Council ___ DILG
 ___ GAD Offices ___ Others, Specify: _____

Date Conducted: _____ **Time Started:** _____ **Time Ended:** _____

Areas Covered: Region _____ Province: _____ Municipality/City: _____
 Barangay _____

For I/LNGOs, UN, CSOs & Alike: ___ UN Agencies ___ INGOs ___ LNGOs/CSOs
 ___ Community-based Groups, Sector - _____

Total No. of Participants: _____ (Ensure participants have filled up the Attendance Sheets)

Name of Lead Moderator: _____ **Name of Organization:** _____

PART II. Key Informant Questions

1. What was your role or contribution during the humanitarian response of _____ particularly on GBV prevention and response? *(Ano ang naging parte o tungkulin mo noong panahon ng _____ humanitarian response lalo na pagdating sa pagprevent o pagresponde sa GBV?)*
2. What GBV issues and concerns in your locality/community which were given interventions/services during the early to post recovery response including the rehabilitation stage? *(Ano ang mga GBV issues at concerns sa inyong lugar na nabigyan ninyo ng interventions o serbisyo sa panahon ng early hanggang post recovery response kasama ang rehabilitation stage?)*
3. What GBViE interventions/services were provided by your office/organization to the affected/displaced communities esp. the vulnerable sectors during the _____ humanitarian response? *(Anu-ano ang mga GBV interventions/services ang naibigay ng inyong opisina o organisasyon sa mga naapektuhan o nadisplaced na komunidad lalong-lalo na sa mga vulnerable sectors natin sa panahon ng _____ humanitarian response?)* (Note: Use Checklist as reference)

Interventions	Most Helpful 5	Very Helpful 4	Helpful 3	Least Helpful 2	Not Helpful 1
Individual Level					
Intervention 1:					
Intervention 2:					
Relationship Level					
Intervention 3:					
Intervention 4:					
Community Level					
Intervention 5:					
Intervention 6:					
Societal Level					
Intervention 7:					
Intervention 8:					

4. What were your objectives/goals/aims/desired impact when you designed or programmed those interventions? *(Ano ang nais mong makamit o anong pagbabago ang nais mong makita noong dinesenyo o isinagawa mo ang mga interventions o services na iyon?)*
5. How did you come up with those interventions? Were there consultations from the affected communities? Were there needs assessments or profiling done? Were all communities served with GBV prevention and response interventions? *(Ano ang naging basehan sa paggawa ng mga GBViE interventions o services? Nagkaroon ba ng konsultasyon sa mga naapektuhang komunidad? Nagsagawa ba ng needs assessment o profiling? Nabigyan ba ng GBViE interventions/services ang lahat ng naapektuhan na communities?)*

6. Do you think you have achieved your goals/aims/objectives/desired impact? What evidences can we collect to prove such achievement? (*Sa tingin mo ba nakamit ang pagbabagong nais makita? Anong mga ebidensiya ang pdeng makolekta bilang pagpapatunay nito?*)

Going back to the Checklist, ask participants to rate them in terms of most to least helpful before proceeding to the next set of questions.

7. What made you say that those were the GBViE interventions/services that helped your locality/community the most? (*Bakit niyo nasabi na ito ang pinaka-nakatulong sa inyong lungsod/munisipyo/probinsya?*)

7.a. What mechanisms, ways or processes used in the implementation of those interventions/services that you liked the most? How were they implemented? (*Anong pamamaraan o proseso sa pagbibigay o pag-implement ng interventions/services ang nagustuhan niyo? Paano na-implement?*)

8. What made you say that those were the GBViE interventions/services that helped your locality/community the least? (*Bakit niyo naman nasabi na ang mga ito ay hindi gaanong nakatulong sa inyong lungsod/munisipyo/probinsya?*)

8.a. What mechanisms, ways or processes used in the implementation of those interventions/services that you did not like? (*Anong pamamaraan o proseso sa pagbibigay o pagimplement ng interventions/services ang hindi niyo nagustuhan?*)

9. How did the circumstances or situations of _____ in your community got affected or changed by the GBViE interventions/services that you provided or have given to them? (*Paano nabago ang katayuan ng mga _____ dahil sa mga ibinigay niyong programa at serbisyo sa GBViE?*)

9a. Women (*Kababaihan*)

9b. Men (*Kalalakihan*)

9c. Children (*Bata*) (below 18 years old)

9d. Young People (*Kabataan*) (10 years old - 24 years old)

9e. Vulnerable Sectors (PWDs, Elderly, IPs/Ethnic Minorities, LGBTs, etc.)

10. Among the interventions/services that you have given and liked the most - (*Sa mga nagustuhan niyong interventions*) -

10.1 Which of them you continued? (*Ano ang inyong ipinagpatuloy?*)

10.2 Which of them you would like to share/be replicated or adopted by the other localities? (*Ano ang pwedeng ipagmalaki o nais niyo na gayahin o i-adopt ng ibang probinsiya/lungsod/munisipyo?*)

11. Among the GBViE interventions/services that were completed or closed already, which of them you have hoped or wanted to be continued? Why? (*Sa mga natapos na ang implementasyon, ano ang inyong nais magpatuloy sana? Bakit?*)

12. Among the GBViE interventions/services that were not effective, what do you think should be done? (*Sa mga hindi epektibong GBViE interventions o services, ano ang sa tingin ninyo ang dapat gawin?*)

13. What were the challenges that you encountered when implementing the GBViE interventions/services? Why? (*Ano ung mga pagsubok o balakid ang inyong nakaharap sa pagpapatupad ng GBViE interventions/services? Bakit?*)

14. How were GBViE interventions/services monitored and evaluated? Were they done quarterly, monthly, weekly, daily? By whom? What tools were used? *(Paano niyo namonitor at na-evaluate ang mga GBViE interventions at services? Ang M&E ba ay ginagawa niyo quarterly, monthly, weekly o daily? Sino ang gumawa nito? Anong tools ang ginamit?)*
15. What were the challenges encountered in the implementation of M&E on GBViE interventions and services? *(Anu-anong mga pagsubok o balakid ang inyong nakaharap sa pagsasatupad ng M&E ng GBViE interventions at services?)*
16. What do you do with the M&E data you collected? *(Ano ang ginagawa niyo sa mga impormasyon o datos na nakalap sa pamamagitan ng M&E?)*
17. What preparations are being done by you or by your LGU or organization so that GBV issues can be prevented and responded to in case there is another emergency? *(Ano ang iyong o inyong ginagawang paghahanda bilang LGU o organisasyon para mapigilan at matugunan ang mga posibleng GBV issues sa inyong lugar, kung sakaling magkaroon ng panibagong emergency?)*
18. Do you have any recommendations to improve the GBViE programming? Do you have any recommendations to improve the M&E of GBViE? *(Mayroon ba kayong rekomendasyon para mapalakas o ma-improve ang GBViE programmes? Mayroon ba kayong rekomendasyon para mapalakas o ma-improve ang M&E ng GBViE?)*

PART III. Feedback of Participants on the Data Gathering Method

1. Among the questions raised, what do you find easy to answer? Why? *(Anong mga katanungan ang madali ninyong nasagutan? Bakit?)*
2. Among the questions raised, what do you find difficult to answer? Why? *(Alin sa mga katanungan ang nahirapan kayong sagutan? Bakit?)*
3. Do you have additional questions that you want to be included in the questionnaire to better understand the issue of GBViE? *(May gusto ba kayong idagdag na katanungan na makakatulong para mas maunawaan natin ang issue ng GBViE?)*
4. Do you have any suggestion or recommendation on how to gather or collect information or data on GBViE? *(May gusto ba kayong imungkahi na paraan sa pagkalap ng impormasyon para mas maunawaan ang issue ng GBViE?)*

Thank you for your time.

Rest assured that all information given and shared with us will be respected and kept confidential at all times.