Cross-sectoral good practice

The DRC case study

DRC was the only country that had **fully met or met+ HNOs and HRPs across the four sectors.** As such, it represents an encouraging practice to scale across countries. The most significant progress is that, in 2021, **DRC allocated 1% of budget allocation to GBVRM and PSEA. It was the first time that an entire country committed to a specific budget allocation on cross-cutting themes – which represents a promising practice to scale.**

Good practices in overall integration process:[1]

- **Initiation:** DRC embraced an incremental GBVRM integration approach first initiated in 2019 by the CP AoR coordinator who acted as a de facto GBV focal point (first unofficially) and sought to scale GBVRM in DRC beyond the CP AoR.
- **Roll-out process**:
  - The observation and assessment period in 2018 revealed that nothing was done on GBVRM despite substantial needs (e.g. Ebola and PSEA).
  - The protection section of UNICEF sought to strengthen GBVRM activities and developed a work plan (end of 2019 / early 2020). It focused on rapid response mechanisms with three priorities: trainings, referral pathways, and GBV focal points.
  - The CP AoR coordinator first raised awareness on the importance of GBVRM by developing a toolkit adapting global tools to the DRC context.
  - The CP AoR coordinator, with the support of the GBV specialist of GCCU, then advocated and worked with the sectors towards the end of 2020 during the HNOHRP process.
  - During the HNOHRP process, pragmatic workshops took place with all sectors (one day per sector). In these sector-specific workshops, good practices from other countries were examined (using global tools and case studies) and relevance to the DRC context was discussed. A powerpoint shared by GCCU's GBV specialist with examples of activities and indicators from previous HPC was deemed particularly useful. The nutrition cluster's recorded webinar was also used. The CP AoR coordinator also referred to the thematic areas guides and checklist from the IASC guidelines for integrating GBV.
  - In 2021, the focus is now placed more on training focal points and diving deeper into the practice.
- The next stage will be to focus on implementation as important gaps remain between HRP and operationalization.

Outcomes and good practices in HNOHRPs:

- As a result of the above process, HNOs and HRPs strongly incorporated GBVRM in 2021.
- DRC's HNOs (to the relative exception of WASH) demonstrated solid risk and barrier analysis and gender analysis. Only CP, however, included a good analysis on coping mechanisms (nutrition did so partially).
- DRC's HRPs demonstrated a very strong focus on GBV risk mitigation including PSEA across CP, Education, Nutrition and WASH. Safety audits were included in CP and nutrition. Training/sensitization of cluster partners on GBV and PSEA were included across the sectors. Joint programming was also prioritized by all sectors. Capacity-strengthening of women-led organizations was included in CP and partially in nutrition.
- DRC was also one of the only countries to have both sectoral objectives and corresponding indicators in Education and CP HRPs. However, while strategies were comprehensive in nutrition and WASH, relevant indicators were missing in these HRPs.
- **DRC allocated 1% of budget allocation to GBVRM and PSEA.**
- HRPs were consistent with HNOs across the sectors (WASH HRP was slightly stronger than the WASH HNO).

Key enablers:

The DRC case highlighted the catalytic and pivotal role played by several enablers:

- **Role of a committed CP AoR coordinator with previous GBVRM experience:** The CP coordinator had experience in GBVRM from previous assignments and led GBVRM integration processes not only in the CP AoR but also across all sectors. The coordinator acted as an informal GBV focal point for all sectors before becoming the official GBV focal point. Relying on these key actors is important to scale good practices across countries.
- **Role of in-country UNICEF GBV or CP specialist:** The above observation illustrates the catalytic role that an in-country specialist can play in triggering GBVRM processes across sectors. Interviews in South Sudan and Afghanistan also highlighted the pivotal role of the UNICEF in-country GBV team. DRC, Afghanistan, and South Sudan were some of the strongest countries across sectors.
- **External support:** The support provided by the global level in providing guidance and tools in the integration process was also pivotal.

Remaining challenges:

- High staff turnover weakens the GBV capacity.
- Lacking understanding of GBVRM and how to address it, plus limited time available to work on it.
- Some confusion exists around the differences and links between GBVRM, PSEA, gender, and GBV. It is important to avoid siloes within the same theme.
- The main remaining challenge is the lack of operationalization/implementation of GBVRM beyond the HNOHRP. More support is needed in that area.

Lessons learned and ways forward:

- More guidance on how to monitor implementation is needed to embrace the next stage.
- One of the top priorities of the CP AoR (as GBVRM lead in DRC) is to advocate with donors to reinforce the capacity of women-led organizations for them to be eligible for funding. A consortium of women-led organizations is recommended to gain more visibility and weight vis a vis partners and donors.

1 From presentation facilitated by CP AoR coordinator during stocktaking workshop (June 2021) and subsequent interview with CP AoR Coordinator.