THE INTER-AGENCY

MINIMUM STANDARDS

for Gender-Based Violence in Emergencies Programming

Gender-Based Violence AoR
Global Protection Cluster

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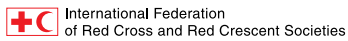
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of Red Cross and Red Crescent Societies

International
Medical Corps

INTERSOS

IOM
UN MIGRATION

IPPF

Irish Consortium
on Gender Based
Violence
MOVING
BEYOND

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actalliance

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PLAN
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COMMISSION

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Organization

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INTRODUCTION

Gender-based violence (GBV) is a horrifying reality and human rights violation for women and girls globally. During emergencies, the risk of violence, exploitation and abuse is heightened.[1] At the same time, national systems, including health and legal systems, and community and social support networks weaken. This breakdown of systems can reduce access to health services, including sexual and reproductive health services, and legal services, leading to an environment of impunity in which perpetrators are not held to account. When systems and services are disrupted or destroyed, women and girls face even higher risk of human rights violations such as sexual violence, intimate partner violence, exploitation and abuse, child marriage, denial of resources and harmful traditional practices. GBV has significant and long-lasting impacts on the health, and psychosocial and economic well-being of women and girls, and their families and communities.[2]

"Gender-based violence" is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private.[3] The term "GBV" is most commonly used to underscore how systemic inequality between males and females, which exists in every society in the world, acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls.[4] The term "gender-based violence" also includes sexual violence committed with the explicit purpose of reinforcing gender inequitable norms of masculinity and femininity.[5]

Under international human rights law, acts of GBV are considered violations, as articulated in international conventions, particularly the Convention on the Elimination of All Forms of Discrimination against Women.[6] Furthermore, the United Nations Declaration on the Elimination of Violence against Women defines violence against women 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".[7] The Declaration emphasizes that violence is "a manifestation of historically unequal power relations between men and women, which have led to the domination over and discrimination against women by men and to the prevention of the full advancement of women".[8]

GBV is a violation of human rights

GBV violates international human rights law, humanitarian law and principles of gender equality.[9] International humanitarian law establishes protections for civilians, including women and girls, during times of conflict.[10] Successive UN Security Council resolutions have specifically prohibited the use of sexual violence as a weapon of war.[11] The full exercise of human rights and fundamental freedoms by girls and women is a prerequisite for sustainable development and peace.[12] Humanitarian actors have an ethical imperative to prevent and respond to GBV. It is morally unacceptable to fail in our duty to prevent and respond to this violence, or worst, to provide humanitarian support in ways that increase the risk.[13]

Prevention and mitigation of, and response to, GBV are classified as life-saving interventions in humanitarian settings.[14] All agencies involved in humanitarian response have a responsibility to protect those affected by GBV. This includes implementing programme interventions to reduce the risk of GBV, designing initiatives to promote community resilience to GBV, supporting survivors and other women and girls at risk to access care and support services, and strengthening local and national capacities (government, other authorities and civil society) to establish systems to prevent and respond to GBV in a sustainable manner.

What is the purpose of these Minimum Standards?

This resource presents 16 Minimum Standards for GBV prevention and response programming in emergencies. As a whole, the 16 Minimum Standards define what agencies working on specialized GBV programming need to achieve to prevent and respond to GBV, and deliver multisectoral services.

> *"Adequate quality" means (1) reflecting good practice and (2) not causing harm.*

The objective of the Minimum Standards is to establish a common understanding of what constitutes **minimum** GBV prevention and response programming in emergencies. "Minimum" means "of adequate quality"; for the purposes of this resource, **adequate quality** means (1) reflecting good practice and (2) not causing harm. As such, each Standard in this resource represents common agreement on what needs to be achieved for that specific programmatic element to be of adequate quality. When a GBV programme actor decides to implement a programmatic element outlined in the Standards, that intervention must be implemented according to the Standard at a minimum.

The actions outlined in these Minimum Standards apply to actors working to deliver GBV-specialized programming and coordination across humanitarian crises. The standards are universal; they are relevant for all emergency contexts, although they must be contextualized (see "Applying the Minimum Standards in Context" below). There may be times when certain standards are prioritized over others. Prioritization does **not** mean that some Minimum Standards are inherently more important than others; rather, prioritization means that strategic focus may be needed based on analysis of the context, including the potential for harm or shortfalls in the quality of certain services. Prioritization also means implementing GBV services safely, in line with the GBV Guiding Principles (see Standard 1) and the principle of "do no harm".[15] According to the life-saving criteria of the United Nations

Central Emergency Response Fund (CERF), supporting health providers and ensuring a range of appropriate psychosocial interventions are established and accessible are first priorities.[16]

The 16 Minimum Standards aim to enhance accountability among GBV-specialized actors, improve programme quality, and guard against practices that may cause harm (e.g., put survivors or others at risk). Through the standards, the global GBV Area of Responsibility aims to provide GBV programme actors with practical guidance to ensure effective action on GBV prevention and response in humanitarian settings. The standards emphasize that women and girls are key actors in their own protection and must be active partners in identifying protection risks and solutions throughout the programme cycle. Engagement of women and girls is critical to establishing quality GBV response services. As such, women's and girls' participation from the onset of an emergency will result in better humanitarian outcomes.

This resource is designed to be useful for all GBV practitioners, including those who have limited experience in implementing GBV programming. For more on the structure of the resource, please see the section below entitled "Applying the Minimum Standards in Context".

Applying an intersectional approach to GBV programming

Intersectionality[17] is a framework for understanding that people experience overlapping (i.e., intersecting) forms of oppression, discrimination and marginalization based on their co-existing identities (e.g., inequality based on gender and/or ethnicity). Effective and accountable GBV programming must pay attention to diverse and intersecting forms of structural oppression, discrimination and inequality that women and girls experience in a given context.

Although all women and girls face discrimination in the context of global patriarchy, not all women and girls experience oppression and inequality in the same ways. Multiple inequalities may shape their risks and experiences of GBV. Women and girls who face intersecting inequalities include women and girls with disabilities, adolescent girls, older women, women and girls with diverse sexual orientations and gender identities, women and girls living with HIV and AIDS, and women and girls from ethnic and religious minorities. Other forms of discrimination that lead to increased risk of GBV include socioeconomic status, birth country and legal status, including asylum status.

In practical terms, applying an intersectional lens means engaging community members and, in particular, diverse women and girls, from the onset of a crisis, to identify, analyse and determine strategies to address intersecting forms of structural oppression that exacerbate the risk of GBV, and create barriers to accessing GBV response services, and meaningful and safe inclusion and participation.[18]

Centring women and girls in GBV prevention and response

GBV-specialized programming focuses on women and girls due to structural and systemic gender inequality and discrimination that lead to their documented higher risk of GBV, and their lack of safe and equitable access to humanitarian assistance.[19] Women and girls experience multiple forms of GBV and face many additional barriers to accessing services and recovering from GBV due to systemic gender inequality and other forms of intersectional discrimination. For this reason, the Minimum Standards use female pronouns except in sections that apply specifically to men and boys.

The Minimum Standards also pay particular attention to ensuring child and adolescent girl and boy survivors of sexual violence access appropriate and age-sensitive response services in close collaboration with child protection actors and in line with existing guidance.[20]

Some actors use the term "gender-based violence" to describe violence perpetrated against women, girls, men, boys with diverse sexual orientations and gender identities as well as non-binary individuals because it is "driven by a desire to punish those seen as defying gender norms".[21] GBV programme actors should address the specific barriers and risks faced by women and girls with diverse sexual orientations and gender identities.

Men and boys also experience sexual violence. These Minimum Standards, aimed primarily at the prevention, mitigation and response to violence against women and girls, provide guidance to support male survivors' timely access to services that meet their needs. Men and boys may be targeted for abuse because of reduced power and status based on age, disability, sexual orientation, gender identity and other intersecting inequalities. Homophobia, bi-phobia, and transphobia increase the risk of violence, including sexual violence. Men and boys with disabilities also face an increased risk of violence, including sexual violence.[22]

Gender norms can also contribute to certain types of sexual violence against males in conflict settings. In these instances, men may be targeted for "emasculation" such that gender-inequitable norms related to masculinity and femininity increase their exposure to some forms of sexual violence; this violence against males is based on socially constructed ideas of what it means to be a man and exercise male power.[23]

Although GBV programming focuses primarily on violence against women and girls, GBV programme actors should coordinate with other actors, including in health care, child protection and protection, to ensure access to lifesaving support for male survivors of sexual violence and abuse.

Gender equality and women's and girls' empowerment

Gender inequality at individual, community and societal levels manifests as GBV. Women and girls everywhere are disadvantaged in terms of social power and influence, control of resources, control of their bodies and participation in public life – all as a result of socially determined gender roles and systemic inequality.[24] GBV occurs in the context of this imbalance. Gender inequality is manifest in almost every sphere of life. These structural inequalities result in the abuses of power that women experience in the form of violence perpetrated by individuals, families, communities and the State.

Addressing gender inequality is a foundational aspect of GBV and all humanitarian programming. Incorporating gender equality in humanitarian action enhances the impact of humanitarian strategies and interventions.[25] It is critical that all humanitarian practitioners, agencies and programmes address gender inequality, and use sex- and age-disaggregated data to inform programming in humanitarian emergencies. The *Gender in Humanitarian Action Handbook* highlights humanitarian actors' responsibility and accountability to ensure that the rights of women and girls to basic services, protection and opportunities are upheld.[26]

Gender equality programming is essential to any long-term efforts to address GBV and should be initiated from the start of any humanitarian intervention. It is important for all actors,

including GBV programme actors, to understand that gender equality and GBV programming are complementary, not interchangeable. Gender equality and women's empowerment are cross-cutting issues that should be integrated into every aspect of GBV programming. Effective integration of gender equality and women's and girls' empowerment programming into sectoral work enhances GBV prevention and response efforts.

Conditions related to humanitarian emergencies may exacerbate the risk of many forms of GBV that existed before the onset of an emergency; however, the underlying causes of violence are associated with attitudes, beliefs, norms and structures that promote and/or condone gender-based discrimination and unequal power, whether during emergencies or times of greater stability.[27] Linking GBV to its roots in discrimination and gender inequality necessitates not only working to meet the immediate needs of affected populations, but also implementing strategies – as early as possible in humanitarian action – that promote long-term social and cultural change towards gender equality. Key to responding to violence against women and girls and maintaining their safety and well-being is an understanding of the gendered nature of the violence as well as its causes and consequences, and providing services within an environment conducive to women's empowerment.

Strengthening national systems

States hold primary responsibility and must take action to protect their citizens; in emergencies, however, mandated United Nations agencies act to support national authorities to meet their responsibilities to provide protection and humanitarian assistance to affected populations.[28] Strengthening national systems through engaging national partners and local organizations is an integral part of an effective GBV response and particularly important during emergencies. A "national system" refers primarily to government systems (at national, subnational and local levels) and may include other stakeholders such as non-governmental, community-based and civil society organizations who contribute to functioning health, protection and legal systems. Direct advocacy and working in partnership with national authorities can ensure that measures to protect women and girls are prioritized in national emergency response planning, programmes and budgets, and that interventions reflect international best practice.

The 16 Minimum Standards may be used to help engage and strengthen the capacity of national partners, including local women's movements, to develop, extend

Refugees are persons who are outside their country of origin due to a well-founded fear of persecution or because a conflict, generalized violence or other circumstances that have seriously disturbed public order. These persons, as a result, require international protection.

Asylum seekers are persons whose refugee status has not yet been determined by the authorities but whose asylum application entitles them to protection on the basis that they could be refugees.

Returnees are former refugees who have returned to their country of origin but have not yet been fully (re)integrated.

Internally displaced people are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or natural or human-made disasters, and who have not crossed an internationally recognized state border.

and/or scale up existing programmes, and ensure continuity of services post-emergency. In some instances, national authorities may not adhere to humanitarian principles and may obstruct protection or perpetuate abuse. Given this range of contexts, it is important that the specific approach to working with national systems is based on a thorough understanding of the context to ensure that assistance is provided in line with both humanitarian principles and a "do no harm" approach.

Local partners also play a vital role in humanitarian contexts, including measures to prevent, mitigate and respond to GBV. The Minimum Standards highlight this role in line with the New Way of Working, which calls for partnering with local and national actors, and reinforcing existing national and local capacities. The 2016 World Humanitarian Summit recognized that localization is fundamental to the delivery of a dignified and effective humanitarian response, and specifically, that humanitarian action should be "as local as possible, as international as necessary".[29] The associated Grand Bargain emphasized the need to make more deliberate and explicit efforts to better engage with, empower and promote the work of local actors. For GBV prevention and response actors, partnership with local women's movements, women-led civil society and women's rights networks offers an opportunity to support and sustain localized action to address GBV against women and girls in humanitarian action.

Coordination

To ensure good coordination when emergencies occur, the Inter-agency Standing Committee (IASC), the primary mechanism for coordination of humanitarian assistance, has established the cluster approach. Clusters are groups of humanitarian organizations, both UN and non-UN entities, in each of the main sectors of humanitarian action, such as water, health and logistics. At the global level, GBV coordination is led by the GBV Area of Responsibility, headed by UNFPA, within the Global Protection Cluster. The GBV Area of Responsibility, through the development of these Minimum Standards, aims to promote a coherent, comprehensive and coordinated approach to GBV at the field level, including response, care and recovery for survivors and prevention and perpetrator accountability. In refugee contexts, the United Nations High Commissioner for Refugees (UNHCR) is mandated to lead and coordinate the refugee response and coordinate international protection, assistance and solutions at the country, regional and global levels. The Refugee Coordination Model includes a clear coordination structure covering thematic areas and sectors of response.[30] Depending on the context and capacity, other agencies, partners or the government may co-lead the GBV subworking group in coordination with UNHCR.

What is an "emergency"?

An emergency is any situation in which the life or well-being of civilians affected by natural disaster, conflict or a public health threat has been or will be at risk unless immediate and appropriate action is taken, and that demands an extraordinary response and exceptional measures.[31]

GBV Guiding Principles and approaches

The following guiding principles and approaches underpin all of the Minimum Standards and are referenced throughout the Minimum Standards as the "GBV Guiding Principles":

- **Survivor-centred approach:** A survivor-centred approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. A survivor-centred approach is based on the following guiding principles:
  - **Safety:** The safety and security of survivors and their children are the primary considerations.
  - **Confidentiality:** Survivors have the right to choose to whom they will or will not tell their story, and any information about them should only be shared with their informed consent.
  - **Respect:** All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.
  - **Non-discrimination:** Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or any other characteristic.
- **Rights-based approach:** A rights-based approach seeks to analyse and address the root causes of discrimination and inequality to ensure that everyone has the right to live with freedom and dignity, safe from violence, exploitation and abuse, in accordance with principles of human rights law.
- **Community-based approach:** A community-based approach ensures that affected populations are engaged actively as partners in developing strategies related to their protection and the provision of humanitarian assistance. This approach involves direct involvement of women, girls and other at-risk groups at all stages in the humanitarian response, to identify protection risks and solutions, and build on existing community-based protection mechanisms.
- **Humanitarian principles:** The humanitarian principles of humanity, impartiality, independence and neutrality should underpin the implementation of the Minimum Standards, and are essential to maintaining access to affected populations and ensuring an effective humanitarian response.
- **"Do no harm" approach:** A "do no harm" approach involves taking all measures necessary to avoid exposing people to further harm as a result of the actions of humanitarian actors.
- **Principles of Partnership:** The Principles of Partnership comprise a framework for all actors in the humanitarian space to follow principles of equality, transparency, a results-oriented approach, responsibility and complementarity. The principles strive to highlight the role of local and national humanitarian response capacity, and enhance the effectiveness of humanitarian action based on accountability to affected populations.[32]
- **Best interests of the child**: Child and adolescent girl and boy survivors of sexual abuse have the right to have their best interests assessed and determined, and taken as a primary consideration in all decisions that affect them.[33]

The above guiding principles and approaches are linked to the overarching humanitarian responsibility to provide protection and assistance to those affected by crisis. They serve as the foundation for all humanitarian actors when planning and implementing GBV-related programming. It is important to underscore that:

- GBV encompasses a wide range of human rights violations. Preventing and mitigating GBV involves promoting gender equality, and beliefs and norms that are respectful and non-violent.
- Safety, respect, confidentiality and non-discrimination in relation to survivors and those at risk are vital considerations at all times.
- GBV-related interventions should be context-specific in order to enhance outcomes and "do no harm".
- Participation and partnership are cornerstones of effective GBV response and prevention.[34]

Who should use these Minimum Standards?

The Minimum Standards are intended for actors and agencies implementing GBV-specialized programming. GBV programme actors are personnel who have received GBV-specific training and/or have experience working on GBV programming; a GBV agency is one that implements targeted programmes for the prevention of and response to GBV.[35]

The Minimum Standards may be used in the following ways:

- To establish common agreement and measurable expectations regarding the minimum quality of GBV programming in emergencies.
- To enhance quality programming and monitor the effectiveness of interventions.
- To increase accountability among all stakeholders.
- To train staff or partners.
- To conduct advocacy.

GBV programme actors may also use the Minimum Standards as a tool to fulfil commitments made under the Call to Action on Protection from Gender-Based Violence in Emergencies, Outcome 5, which calls for "specialized GBV prevention and response services implemented in each phase of an emergency, from preparedness and crisis onset through transition to development".[36]

> *The GBV Guiding Principles and approaches serve as the foundation for all humanitarian actors when planning and implementing GBV-related programming.*

What does each Minimum Standard contain?

The 16 Minimum Standards represent the various elements required to effectively address the needs of those who survive and/or are at risk of GBV. The Minimum Standards are interrelated and interdependent, and, therefore, designed to be understood as a **comprehensive** set of interventions. They are grouped in three parts: Foundational Standards, Programme Standards and Process Standards:

FOUNDATIONAL STANDARDS The three **Foundational Standards** are critical individually and also fundamental to the implementation of **all** the Minimum Standards; they must underpin all programme elements and actions.	GBV Guiding Principles
	Women's and Girls' Participation and Empowerment
	Staff Care and Support
PROGRAMME STANDARDS The 10 **Programme Standards** provide guidance to respond to, mitigate and prevent GBV in emergencies. They reflect core GBV programming elements.	Health Care for GBV Survivors
	Psychosocial Support
	GBV Case Management
	Referral Systems
	Women's and Girls' Safe Spaces
	Safety and Risk Mitigation
	Justice and Legal Aid
	Dignity Kits, Cash and Voucher Assistance
	Economic Empowerment and Livelihoods
	Transforming Systems and Social Norms
PROCESS STANDARDS The three **Process Standards** provide guidance on critical processes for implementing elements of GBV programming.	Collection and Use of GBV Survivor Data
	GBV Coordination
	Assessment, Monitoring and Evaluation

Each standard contains the following elements: introductory text, Key Actions, Indicators, Guidance Notes, and Tools and Resources. The text that follows the Standard itself defines key concepts and why the standard is important.

Although there is overlap between the prevention and mitigation of GBV, prevention generally refers to taking action to stop GBV from first occurring (e.g., scaling up activities that promote gender equality or working with communities to address practices that contribute to GBV). Mitigation refers to reducing the risk of exposure to GBV (e.g., ensuring that reports of "hot spots" are immediately addressed through risk-reduction strategies). The IASC has established responsibilities for all humanitarian actors to take measures to address GBV in the *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery* (IASC GBV Guidelines).[37]

Standard: The Standard statement at the start of each Minimum Standard defines what agencies working on specialized GBV programming need to do to prevent and respond to GBV, and deliver multisectoral services to survivors in humanitarian settings. The Minimum Standards are universal and are to be applied in **all** contexts.

Key Actions: The Key Actions are activities to achieve the Standard and also a means to contextualize implementation. Although the Standard applies in all settings, some actions may not apply to all settings or to all stages of a humanitarian response. In addition, effective implementation of a particular Key Action may look slightly different from one context to another. The Key Actions include suggestions for the stage in an emergency in which they are most likely to be taken: preparedness, response or recovery. Although some actions are specific to one stage, most actions are conducted at all times.

- **Preparedness**: Given the increased frequency of complex emergencies and their capacity to destabilize societies, preparedness is critical to ensure response is quick and functional across settings. Many essential actions must be undertaken in a coordinated manner from the earliest stages of emergency preparedness. Emergency preparedness efforts should focus on ensuring adequate capacity and knowledge, while reinforcing the ability to anticipate, respond and recover from the impact of emergency situations.
- **Response**: Emergency response involves the provision of emergency services and public assistance during or immediately after a humanitarian crisis to save lives, reduce health impacts, ensure public safety and protection, and meet the basic needs of women, girls, boys and men in the affected population.[38] This stage can range from a few days or weeks to many months and even years, particularly in protracted insecurity and displacement contexts.[39]
- **Recovery**: Recovery is the process following relief and supports the transition into long-term reconstruction and development. Recovery actions are most effective if anticipated and facilitated from the very outset of a humanitarian response.[40] Recovery involves the restoration and improvement of facilities, livelihoods and living conditions of crisis-affected communities, including efforts to reduce risks brought on by the crisis.

Indicators: The Indicators provided in this resource are samples that may be adapted by practitioners to their particular context. Indicators are signals that show whether or not a Standard has been achieved and is of adequate quality.

Guidance Notes: The Guidance Notes provide further information and advice on priority issues relating to the Standard or practical suggestions on overcoming specific challenges (or taking advantage of specific opportunities) that commonly arise. They also provide good practices and tips.

Tools and Resources: This section provides practical tools and additional resources to fulfil the Standard.

How do these Standards link with other guidelines and standards?

The Minimum Standards are based on international best practice and integrate existing global guidance and technical standards, including the Sphere Project and its *Humanitarian Charter and Minimum Standards in Humanitarian Response*,[41] the *Minimum Standards for Child Protection in Humanitarian Action* developed by the Alliance for Child Protection in Humanitarian Settings,[42] UNFPA's *Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies and the IASC GBV Guidelines.*[43] The Minimum Standards are informed by and complement existing tools and are intended for use with other standards and guidelines (e.g., *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*).

How were the Minimum Standards developed?

The participation of global- and field-level GBV practitioners was critical to developing the Minimum Standards to ensure the resource is a relevant, field-informed tool based on evidence and established or emerging best practice. Consultations held in 14 countries (Bangladesh, Cameroon, Democratic Republic of the Congo, Fiji, Jordan, Mali, Nigeria, the Philippines, Serbia, Somalia, South Sudan, Sudan, Syria and Yemen) between November 2018 and January 2019 yielded structured feedback. A wide range of actors with specialized GBV programming experience (local partners, including government partners where applicable, international and local non-governmental organizations, UN organizations and donors) participated and provided substantive feedback. These efforts served to refine each Standard and capture the most incisive and current evidence.

Applying the Minimum Standards in context

Contextualizing the Minimum Standards is important because: (1) adapting the Minimum Standards to a specific context will result in relevant GBV programming that is survivor-centred, of adequate quality and responsive to the evolving needs of GBV survivors; and (2) as a process, contextualization helps build a strong community of practitioners invested in the development and delivery of quality, accountable GBV prevention and response services.

If a GBV programme actor commits to implementing a programme element from the Minimum Standards, that actor must implement the programme element according to the Standard. All Standards contain a non-exhaustive list of Key Actions to: (1) achieve the Standard and (2) contextualize implementation. Although the Standards are applicable in all settings, all Key Actions may not apply to all settings or to all stages of a humanitarian response.

Effective implementation of each Standard may require flexibility and/or adaptation of its Key Actions. However, the main statement of each Standard – the first sentence in bold – should not be changed. In order to attain each Standard, it may be helpful prioritize Key Actions or make additions to suit the context.

As explained above, the 16 Minimum Standards represent various programmatic elements required to effectively support GBV survivors and women and girls at risk of GBV. Individual GBV actors are not responsible for implementing all 16 standards. Most programme elements will require coordination with other partners. There may be situations, however, where it is necessary for partners working on GBV to consider sequencing some interventions before others. For example, in the acute phase of an emergency, it is recommended to prioritize programme elements that are considered life-saving, such as GBV response services and risk mitigation activities. In a protracted crisis where multisectoral services are in place, the Minimum Standards may be used to achieve or maintain adequate quality. At any point in a humanitarian setting, response services must be established before prevention activities are implemented.

The process of collectively identifying what must be initiated, sustained, strengthened or better coordinated is at the core of contextualization. During this process, GBV programme actors may identify interventions that should be prioritized; these may require concerted effort and support, and potentially also funding. Prioritization does not mean that some standards are inherently more important than others, but means that the focus should be on reducing the risk of harm and addressing programme elements that are not in place or of adequate quality. Prioritization also means ensuring a risk assessment has been completed prior to implementing particular programmatic elements. Those planning and budgeting for GBV programming in humanitarian settings are also encouraged to assess and build organizational capacity to implement GBV services safely in line with the GBV Guiding Principles.

THE 16 MINIMUM STANDARDS

1 GBV GUIDING PRINCIPLES
All aspects of GBV programming are survivor-centred to preserve and promote the confidentiality, safety, non-discrimination and respect for the choices, rights and dignity of women and girls, including GBV survivors.

2 WOMEN'S AND GIRLS' PARTICIPATION AND EMPOWERMENT
Women and girls are engaged as active partners and leaders in influencing the humanitarian sector to prevent GBV and support survivors' access to quality services.

3 STAFF CARE AND SUPPORT
GBV staff are recruited and trained to meet core competencies, and their safety and well-being are promoted.

4 HEALTH CARE FOR GBV SURVIVORS
GBV survivors access quality, survivor-centred health care, including health services for sexual and intimate partner violence and other forms of GBV, and referrals to prevent and/or reduce the effects of violence.

5 PSYCHOSOCIAL SUPPORT
Women and girls safely access quality, survivor-centred psychosocial support focused on healing, empowerment and recovery.

6 GBV CASE MANAGEMENT
GBV survivors access appropriate, quality case management services including coordinated care and support to navigate available services.

7 REFERRAL SYSTEMS
Referral systems are in place to connect GBV survivors to appropriate, quality, multisectoral services in a timely, safe and confidential manner.

8 WOMEN'S AND GIRLS' SAFE SPACES
Women and girls only safe spaces are available, accessible and provide quality services, information and activities that promote healing, well-being and empowerment.

9 SAFETY AND RISK MITIGATION
GBV actors advocate for and support the integration of GBV risk mitigation and survivor support across humanitarian sectors.

10 JUSTICE AND LEGAL AID
Legal and justice actors support GBV survivors to access safe and survivor-centred legal services that protect their rights and promote their access to justice.

11 DIGNITY KITS, CASH AND VOUCHER ASSISTANCE
Women and girls receive dignity kits, and/or cash and vouchers to reduce GBV risk and promote safety and dignity.

12 ECONOMIC EMPOWERMENT AND LIVELIHOODS
Women and adolescent girls access economic support as part of a multisectoral GBV response.

13 TRANSFORMING SYSTEMS AND SOCIAL NORMS
GBV programming addresses harmful social norms and systemic gender inequality in a manner that is accountable to women and girls.

14 COLLECTION AND USE OF SURVIVOR DATA
Survivor data are managed with survivors' full informed consent for the purpose of improving service delivery, and are collected, stored, analysed and shared safely and ethically.

15 GBV COORDINATION
Coordination results in timely, concrete action to mitigate risks, and prevent and respond to GBV.

16 ASSESSMENT, MONITORING AND EVALUATION
Information collected ethically and safely is used to improve the quality of GBV programmes and accountability to women and girls.

Acknowledgments

This resource is the product of inter-agency collaboration and extensive consultation with field-based GBV experts and would not have come to fruition without the time and substantive inputs contributed by GBV programme actors across the globe. There is not adequate space to recognize all contributions; we acknowledge that many of the people listed here consulted internally with colleagues who are not included by name. We truly appreciate all of those who have supported the development of the Minimum Standards.

The Minimum Standards development was directed by a GBV AoR Task Team led by three co-chairs: Emily Krasnor, United Nations Population Fund (UNFPA); Sarah Cornish-Spencer, International Rescue Committee; and Christine Heckman and Catherine Poulton, UNICEF. The Task Team included Jennifer Chase, GBV AoR; Natsnet Ghebrebrhan, Raising Voices; Kevin McNulty, Mercy Corps; Monica Noriega, IOM; Erin Patrick, GBV Guidelines; Alina Potts, The Global Women's Institute, George Washington University; Janis Ridsdel, UNHCR; Elisabeth Roesch, World Health Organization (WHO); Fiona Shanahan, Irish Consortium on Gender Based Violence; Alexandra Shaphren, Plan International; and Micah Williams, International Medical Corps (IMC).

The Minimum Standards were drafted by Inbal Sansani. Emily Krasnor (UNFPA) led the development of the Minimum Standards and provided oversight of the initiative.

Several experts in addition to the Task Team were involved in the development of the Minimum Standards. The Task Team consulted with many subject matter experts to refine each Standard and capture the most incisive and current evidence. Key individuals who took part in these discussions include: Suhaila Aboud, Raya Alchukr, Emmanuelle Compingt, Mira Cuturillo, Dabney Evans, Siobhan Foran, Astrid Haaland, Maria Holtsberg, Mehreen Jaswal, Joanina Karubaga, Leigh-Ashley Lipscomb, Laura Marchesini, Melanie Megevand, Sinéad Murray, Meghan O'Connor, Holly Radice, Sonja Rostogi, Kate Rougvie, Stefanie Ruehl, Alejandro Sanchez, Danielle Cornish-Spencer, Graciela Van der Pol and Masumi Yamashina.

Collecting feedback from field-level GBV practitioners was critical to ensuring the resource is an inclusive, field-informed tool based on evidence and established or emerging best practice. Consultations held from November 2018 to February 2019 in 14 countries (Bangladesh, Cameroon, Democratic Republic of Congo, Jordan, Mali, Fiji, the Philippines, Nigeria, Somalia, South Sudan, Sudan, Syria, Serbia, Yemen) served to collect structured feedback on the Minimum Standards. A wide range of actors with specialized GBV programming experience attended the sessions.

The resource also benefited from contributions from the GBV AoR core membership, the Call to Action Steering Committee, field based GBV Sub-Cluster Coordinators and Regional GBV Advisors (REGA).

The development of the Minimum Standards was generously supported by ECHO, the European Civil Protection and Humanitarian Aid Operations; the Government of Denmark; and the Office of US Foreign Disaster Assistance (OFDA).

Funded by European Commission's Civil Protection and Humanitarian Aid Operations Department

This initiative was implemented with the financial assistance of the European Union. The views expressed herein should not be taken, in any way, to reflect the official opinion of the European Union, and the European Commission is not responsible for any use that may be made of the information it contains.

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THE INTER-AGENCY

MINIMUM STANDARDS

for Gender-Based Violence in Emergencies Programming

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STANDARD

1 GBV Guiding Principles

All aspects of GBV programming are survivor-centred to preserve and promote the confidentiality, safety, non-discrimination and respect for the choices, rights and dignity of women and girls, including GBV survivors.

The GBV Guiding Principles underpin all aspects of GBV programming, and, therefore, all of the Standards outlined in this resource. **Adherence to the GBV Guiding Principles throughout every element of GBV programming is mandatory.** By implementing programmes according to the GBV Guiding Principles, GBV programme actors can minimize harm to women and girls, and maximize the efficacy of GBV prevention and response interventions.

The **survivor-centred approach** comprises four GBV Guiding Principles that apply to all aspects of GBV programming. The survivor-centred approach **creates a supportive environment that promotes the survivor's**[44] **empowerment. It puts her at the centre of the helping process** so that she directs the course of her recovery. Recognizing that experiences of GBV often affect survivors' sense of control, the survivor-centred approach aims to acknowledge and respect the survivor's agency and autonomy by ensuring that she is the primary actor and decision maker throughout the helping process.

A survivor-centred approach emphasizes that service providers' relationships with the survivor have the potential to be a source of support and empathy in her life. This means that helpers must view all of their encounters with the survivor as opportunities to build connection and trust.[45]

A survivor-centred approach highlights the importance of demonstrating positive regard for survivors and communicating to them that service providers believe and do not judge them, their experiences or their

Do No Harm

The concept of "**do no harm**" means that humanitarian organizations must strive to "minimize the harm they may inadvertently be doing by being present and providing assistance". Such unintended negative consequences may be wide-ranging and complex. Humanitarian actors can reinforce the "do no harm" principle by following the GBV Guiding Principles.

Source: *IASC GBV Guidelines*, p. 45.

KEY ACTIONS GBV Guiding Principles	Preparedness	Response	Recovery
GBV-specialized programme staff and volunteers are trained on GBV, gender inequality and the GBV Guiding Principles, and are equipped with attitudes, knowledge and skills to uphold the GBV Guiding Principles at all times.	✔	✔	✔
Systems and protocols for maintaining confidentiality are established and implemented, and GBV programme staff sign confidentiality commitments.	✔	✔	✔
GBV programme staff document GBV survivors' informed consent or assent prior to any aspect of service delivery, including referrals.	✔	✔	✔
Discussions with women and girls are conducted by female staff and volunteers.	✔	✔	✔
Meetings with women and girls, including all interactions with survivors, are conducted in private settings where women and girls can trust they will be provided with confidential and safe services.	✔	✔	✔
Protocols for informed consent and assent with child survivors of sexual abuse[46] and women and girls with disabilities[47] are followed.	✔	✔	✔
GBV programme staff and volunteers who support child survivors of sexual abuse are trained alongside child protection specialized actors on best practices for communicating with children and adolescent girls and boys, and good practice guidelines for supporting child survivors.	✔	✔	✔
Staff share only the necessary information, as requested and consented to by the survivor, with other actors involved in providing assistance.	✔	✔	✔
Staff are aware of the safety and security of the people who are helping the survivor, such as family, friends, community service or GBV and health service workers, and request assistance from camp security, police or other law enforcement authorities, field officers or others as safe and appropriate.	✔	✔	✔
GBV Guiding Principles are displayed in women's and girls' safe spaces and multisectoral service delivery points in local languages, and included in community education efforts and materials.	✔	✔	✔
Listening sessions with women and girls from the wider community and individual client feedback sessions seek regular feedback to ensure GBV-specialized programming adheres to the GBV Guiding Principles. Monitoring is established to detect unintended harmful consequences such as breaches of confidentiality, safety, discrimination or respect.	✔	✔	✔

decisions about what to do. **Service providers trust that survivors are the experts on their situation**. On the contrary, if service providers – who are placed in a powerful position relative to the survivor – impose their support, perspectives, opinions or preferences on the survivor, they may unintentionally create another experience where the survivor feels disempowered, coerced or abused.[48]

A survivor-centred approach involves understanding and accepting each individual survivor's physical, psychological, emotional, social, cultural and spiritual aspects, and building on these to support and facilitate recovery. This strengths-based approach recognizes that survivors have existing ways of coping and problem-solving, and builds on women's and girls' inherent resilience.

GBV Guiding Principles

The GBV Guiding Principles underpin the **survivor-centred approach** and represent survivors' rights; they must be followed so that survivors are supported to access their inherent power.

- **Safety** refers to both physical safety and security and to a sense of psychological and emotional safety.[49] The safety and security of the survivor, her children and other family members, and those assisting her, must be the number one priority for all actors.[50] Women and girls who disclose an incident of GBV or a history of abuse are often at high risk of further violence and reprisal from the perpetrator(s), people protecting the perpetrators, or members of their own families or community due to patriarchal notions of honour and other factors.[51] Intimate partner violence and conflict-related/politically motivated sexual violence may present particularly complex safety risks for the survivor and those around her.[52]

  Throughout these Minimum Standards, key actions draw attention to the importance of risk analyses and engaging directly with women and girls, including to ensure programming activities uphold the overarching humanitarian principle of "do no harm".

- **Confidentiality** refers to a person's right to choose with whom she will or will not share her story. As each survivor is the owner of her own story, the decision to release any information related to the incident or the survivor rests with the survivor alone. Confidentiality promotes and supports safety, trust and empowerment. Confidentiality means that anyone who has access to information about a survivor must not share any of that information without the explicit permission and informed consent of the survivor.[53] Breaching confidentiality can put the survivor and others at risk of further harm. If GBV-specialized actors do not respect confidentiality during prevention and response activities, other women and girls may be discouraged from seeking help. There are some limits to confidentiality, however, which are outlined in Standard 6: GBV Case Management.

- **Respect** for the choices, rights and dignity of women, girls and GBV survivors requires that survivors are the primary actors in all aspects of service delivery.[54] All actions should be guided by respect for the choices, wishes, rights and dignity of the survivor. Respect for the survivor's dignity and self-determination requires GBV programme actors to be non-judgmental of a survivor's choices and uphold her right to choose, including when she decides to decline support services. Even where mandatory reporting requires action, the survivor's choice should guide GBV programme actors' response (see Guidance Note 2 on mandatory reporting in Standard 6: GBV Case Management). The principle of respect for the survivor's decision-making shifts power back into her hands, respects her resilience and her understanding of her own situation, and supports her journey to recovery.

- **Non-discrimination**: GBV programmes must be informed by an intersectional analysis (see Introduction). Staff should be equipped with knowledge, skills and attitudes on inclusive programming. GBV-specialized programming should be tailored to the needs of all women

The survivor-centred approach recognizes that each survivor:

- Should be believed and treated with respect, kindness and empathy;
- Is unique and has different strengths, resources and coping mechanisms;
- Reacts differently to GBV and will have different needs as a result; and
- Has the right to decide who should know about what has happened to her and what happens next.

Source: UNFPA 2012, Module 2.

and girls based on intersectional gender analysis that considers the increased risks to women and girls based on their age, disability, race, skin colour, religion, nationality, ethnicity, sexual orientation, gender identity, HIV status, social class, political affiliation or any other characteristic. Although GBV programming primarily focuses on violence against women and girls, men and boys can also experience sexual violence. GBV programme actors should coordinate with health, child protection, LGBTQI (lesbian, gay, bisexual, transgender, queer, intersex) and disability actors to ensure access to lifesaving support for male survivors of sexual violence and abuse (see Standard 4: Health Care for GBV Survivors and Standard 6: GBV Case Management).

What is intersectionality?

"Intersectionality" situates women's and girls' experiences within an understanding of the ways in which multiple forms of power and oppression, such as gender inequality, heterosexism, racism, ableism and class inequalities, influence exposure to GBV and access to services in relation to violence.

See the Introduction for further discussion.

The GBV Guiding Principles are interrelated and mutually reinforcing. For example, confidentiality is essential to promote safety and respect.

FIGURE 1. Summary of GBV Guiding Principles

Treating survivors with dignity and respect.	*instead of*	Disrespecting survivors and promoting victim-blaming attitudes.
Respecting survivors' right to choose.		Imposing service providers' views or telling survivors how or what to do; contributing to survivors' feelings of powerlessness.
Maintaining privacy and confidentiality.		Disclosing survivors' personal information without permission; enhancing survivors' shame and stigma.
Honouring the principle of non-discrimination.		Discriminating against and excluding women and girls from marginalized groups.
Providing full information to survivors.		Withholding full information from survivors.

Indicators

- Percentage of GBV programme staff, including volunteers and community workers, who are trained on the GBV Guiding Principles, and who demonstrate improved survivor-centred attitudes, knowledge and skills after training.[55]
- Percentage of GBV programme staff, and other staff working directly with GBV survivors, who sign confidentiality commitments (target 100 per cent).
- Percentage of referrals that include documentation of survivors' informed consent (target 100 per cent).

Guidance notes

1. Women and girls who are at increased risk of GBV due to discrimination and other access barriers

Women and girls who are at increased risk of GBV include adolescent girls, women and girls with disabilities, women and girls from ethnic or religious minority groups, women and girls with diverse sexual orientation or gender identities, and older women (see Introduction for further discussion). These groups face increased risks of sexual violence; intimate partner violence; child marriage; denial of opportunities, services and resources; and sexual exploitation and abuse. They are often invisible, face additional barriers to accessing services and joining support networks, and require specific targeted action to benefit equitably from GBV programming. Analysis of intersectional systems of oppression must inform GBV programming and guide GBV programme actors to prioritize reaching women and girls who face increased risk in a humanitarian crisis. Throughout this resource, key actions highlight targeted activities to ensure GBV-specialized programming is accessible to all women and girls.

STOP! Do No Harm.

GBV awareness-raising activities often result in survivors deciding to disclose their experiences of violence. As such, all awareness-raising on GBV must include information on how survivors can access support. In order to respect the principle of "do no harm", it is generally **not** recommended to conduct community awareness-raising activities on GBV in locations where response services have not yet been established.

See Standard 7: Referral Systems.

Adolescent girls

Adolescent girls, from ages 10 to 19, are among the most vulnerable segments of any population in humanitarian contexts; they face the highest protection risks, yet are one of the most invisible populations.[56] During adolescence, girls are in a gradual process of shifting from childhood to adulthood, and many factors impact the speed of their transition into adult roles and responsibilities, including their physical development, social and cultural expectations, economic situation, life experiences, and experiences such as disaster, conflict and displacement.

GBV-specialized actors must target adolescent girls as a distinct population with unique needs due to their high risk of sexual violence, child marriage and/or early pregnancy, female genital cutting and/or mutilation, sexually transmitted infections, unsafe abortion and social/psychological problems.[57] GBV-specialized actors must also recognize that adolescent girls are not a heterogeneous group and commit to seeing the full "universe" of girls,[58] with differences including age (10 to 14 are younger adolescents; 15 to 19 are older adolescents), marital status, separated, unaccompanied or orphan status, HIV status, ethnicity, in or out of school and working in or outside the house, pregnant or lactating, disability, roles as mother or primary caregiver, sexual orientation, gender identity and experience of sexual exploitation.[59, 60] As they enter adolescence, younger adolescent girls begin taking on adult roles and responsibilities, although they do not yet have all the skills or physical and cognitive capacities they may need.[61] GBV-specialized actors should commit to providing compassionate care and services that are accessible, acceptable and appropriate to younger and older adolescent girls.[62]

In collaboration with child protection services, GBV-specialized actors must build the capacity of their teams to appropriately support adolescent girl survivors and place girls' best interests, safety and well-being at the centre of all decisions. Based on an accurate assessment of her development, age and capacity to understand and make decisions about her safety and access to services, GBV-specialized actors must evaluate with the adolescent girl survivor the positive and negative consequences of safety planning and referral for services, choosing the least harmful option and engaging her caregiver when appropriate.

Guiding Principles for Working with Child Survivors

1. Promote the child's best interest
2. Ensure the safety of the child
3. Comfort the child
4. Ensure appropriate confidentiality
5. Involve the child in decision-making
6. Treat every child fairly and equally
7. Strengthen children's resiliencies

Source: IRC and UNICEF 2012, p. 89.

Women and girls with disabilities

Approximately 15 per cent of any community may be persons with disabilities;[63] this rises in humanitarian contexts where conflict and/or natural disasters result in new impairments from injuries and limited access to health care. Rates of violence are 4 to 10 times greater among persons with disabilities than non-disabled persons in developed countries.[64] This has significant implications for women's and girls' protection in humanitarian settings.[65] Women and girls with intellectual disabilities are particularly vulnerable to sexual violence.[66] Those with intellectual, psychosocial or physical disabilities who are isolated in their homes report rape and intimate partner violence.[67] In addition, women and adolescent girls who disproportionately assume caregiving roles in households with persons with disabilities may be exposed to harassment and exploitation when seeking assistance or accessing income. Attitudes of families, GBV service providers and community members can be the biggest barriers or the greatest facilitators for persons with disabilities to access safe and effective services and assistance.[68]

Lesbian, transgender, bisexual and queer women and girls

Women and girls with diverse sexual orientations and gender identities may be among the most isolated and at-risk individuals in a community due to discrimination and threats of family and community rejection and harm. In all humanitarian settings, women and girls who do not conform to proscribed heteronormative gender roles are at risk of persecution, discrimination and violence as a result of their real or perceived sexual orientation, gender identity or gender expression. Caregivers may abuse girls who display non-conforming sexual orientation and gender identities, and force them into heterosexual marriages. Women and girls may also be at risk of sexual violence that is specifically perpetrated as a hate crime and wrongly justified as a "corrective" measure.[69]

2. Child survivors of sexual abuse

Child sexual abuse occurs more often than reported numbers show.[70] Young children and adolescent girls and boys are vulnerable because of their age, size, dependency on adults and limited participation in decision-making processes. Sexual abuse in childhood can occur in the family environment; the perpetrator is often close to the child and someone with

whom the child has a relationship of trust. Girls and boys at heightened risk of abuse include those who have physical and/or mental/developmental disabilities, are internally displaced or refugees, are unaccompanied and/or separated from their families and caregivers, or live on the streets, in a residential care centre or in abusive households.[71] Certain forms of GBV related to age for girls include female genital cutting and/or mutilation and child marriage. It is important that GBV-specialized actors share the GBV Guiding Principles with other actors, such as child protection, education and health actors, to inform their support of young and adolescent girl and boy survivors of sexual abuse. Thorough guidance is provided in *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings.* Throughout these Minimum Standards, key actions and guidance are provided to support GBV-specialized actors to coordinate effectively with child protection actors to collectively meet the needs of child survivors of sexual abuse. For more information also see the Minimum Standards for Child Protection in Humanitarian Action (CPMS), Standard 9: Sexual and gender-based violence.

Informed consent and informed assent

Informed consent means making an informed choice freely and voluntarily by persons in an equal power relationship. A survivor must be informed about all available options, and fully understand what she is consenting to as well as the risks, including the limits of confidentiality, before agreeing. The full range of choices should be presented to the survivor, regardless of the service provider's individual beliefs. The survivor should not be pressured to consent to any interview, exam, assessment, etc. A survivor is allowed to withdraw consent at any time.

Informed assent is the expressed willingness to participate in services. For younger children, who are by definition too young to give informed consent but are old enough to understand and agree to participate in services, the child's "informed assent" is sought.

Source: IRC and UNICEF 2012, p. 16.

3. Adolescent boys and adult men survivors of sexual violence

Sexual violence against boys and men is often committed by other men in the context of armed conflict or ethnic violence as a means of emasculating men and disempowering their families and communities. Boys are also at risk of sexual abuse, usually perpetrated by family members or other men known to the child. Traditional masculine norms may make it difficult for adolescent boys and men to disclose and seek help, and may also result in a lack of compassionate responses from family, friends and service providers.[72]

Men and boys who are at particular risk of sexual violence by other men with increased power and status include men and boys with disabilities, adolescent boys, older men, men and boys with diverse sexual orientations and gender identities, men and boys living with HIV and AIDS, and men and boys from ethnic and religious minorities. Other forms of discrimination that lead to increased risk of sexual violence for men and boys include socioeconomic status, birth country and legal status, including asylum status.

Many of the impacts of sexual violence on men and boys are similar to those experienced by women and girls; however, there are some particular experiences that service providers should understand in order to best serve this population.[73] Organizations primarily set up to provide services to women and girls, and/or that do so through women's and girls' safe spaces, will need to have clear procedures for how to respond to disclosures from boys and men. Protocols need to be in place for referring the case to a service provider with appropriate service entry points for men (for example, a health actor who has been trained in clinical care for male survivors, or another protection or mental health actor). If such options are not available, an organization can work with the survivor in an alternative location, such as a nearby health clinic.[74]

Tools and Resources

Crehan, P. et al. (2015). *Violence Against Women and Girls: Brief on Violence Against Sexual and Gender Minority Women*. Violence Against Women and Girls (VAWG) Resource Guide. Washington, D.C.: World Bank. http://www.vawgresourceguide.org/sites/vawg/files/briefs/vawg_resource_guide_sexual_and_gender_minority_women_final.pdf.

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United Nations Population Fund (UNFPA) (2018). *Young Persons with Disabilities: Global Study on Ending Gender-based Violence and Realizing Sexual and Reproductive Health and Rights.* https://www.unfpa.org/sites/default/files/pub-pdf/Final_Global_Study_English_3_Oct.pdf.

United Nations High Commissioner for Refugees (UNHCR) (2015). *Protecting Persons with Diverse Sexual Orientations and Gender Identities: A Global Report on UNHCR's Efforts to Protect Lesbian, Gay, Bisexual, Transgender, and Intersex Asylum-Seekers and Refugees.* https://www.refworld.org/docid/566140454.html.

STANDARD 2

Women's and Girls' Participation and Empowerment

Women and girls are engaged as active partners and leaders in influencing the humanitarian sector to prevent GBV and support survivors' access to quality services.

Women and girls are key actors in their own protection, and it is critical that they are active partners in identifying protection risks and solutions throughout the GBV programme cycle. Women's and girls' participation from the onset of an emergency results in better humanitarian outcomes and quality GBV response services. Meaningful participation empowers them and promotes a space to share their views and concerns.[75] For example, women's and girls' active participation can support service providers to establish a service in an accessible area, raise awareness about services (see Standard 7: Referral Systems), and evaluate the quality of GBV responses and the entire humanitarian response.

Women's and girls' participation promotes community resilience by building on their existing capacities and resources. Actions by humanitarian actors should consistently promote and help develop existing women-led and community-based protection mechanisms, particularly because formal response systems and services may be weak or non-existent in emergency contexts. Further, communities affected directly by a crisis have skills and competencies that can be extremely important in the response and should be valued, including to help restore women's and girls' dignity, and strengthen individual resilience. The participation of women and girls from the affected community, individually and through local women's movements and groups, enhances local capacity, fosters ownership, builds resilience and improves sustainability.[76]

Women's and girls' participation through regular feedback or accountability mechanisms supports monitoring of any unintended harmful consequences of humanitarian programming that can be addressed through risk mitigation activities and wider community engagement (see Standard 9: Safety and Risk Mitigation). Information gathered by consulting with women and girls from the affected population should inform programmes and support access to services and prevention and mitigation activities. The participation of women and girls, including through finding ways to ensure that those who are marginalized also have a voice, helps to improve the accuracy of monitoring and assessment data for a more effective, contextualized response.[77] To avoid backlash against GBV programming and promote

KEY ACTIONS — Women's and Girls' Participation and Empowerment

	Preparedness	Response	Recovery
Consult quarterly (at minimum) with women and girls on GBV risks and constraints to their participation in and access to aid delivery, services, etc. (e.g., timing, locations, safety of activities, etc.); develop strategies to address these risks, and provide feedback to those consulted and the wider community.	✔	✔	✔
Ensure women and girls inform the design of GBV programming at every stage of the programme cycle by facilitating their participation (e.g., recruiting them as staff and volunteers, providing transportation and translation).	✔	✔	✔
Identify and address barriers and risks to participation through consultations with and services for women and girls, and promote a better understanding of specific barriers and discrimination that create increased risks of GBV for certain women and girls.[78]	✔	✔	✔
Together with women and girls, identify those who face the greatest marginalization and risk, and design approaches to ensure their participation.	✔	✔	✔
Ensure that all focus group discussions and key informant interviews with women and adolescent girls are facilitated by women, and accessible to all women and adolescent girls, with specific physical spaces and tailored focus group discussion questions for adolescent girls.	✔	✔	✔
Respect international participation standards,[79] including: • Women and girls are permitted to express themselves freely, not required to participate if unwilling, and not prompted to provide information in public that may be traumatizing or embarrassing, and; • Staff engaging women and girls must explain the purpose of a consultation, provide opportunities for feedback and ensure confidentiality. Participation must never lead to protection risks.[80]	✔	✔	✔
Support representation of older adolescent girls and older women in community leadership structures, and support the capacity development of female leaders on women's rights, leadership skills, negotiation skills and public speaking.	✔	✔	✔
Identify, partner with and support (e.g., with funding and capacity strengthening, and by amplifying their voices in appropriate coordination forums) local women-led and women's organizations as well as networks of adolescent girls and adolescent girl-led youth groups addressing gender inequality and/or GBV response and prevention in the emergency setting.	✔	✔	✔
Liaise closely with livelihoods actors to engage women and adolescent girls in economic empowerment activities such as vocational training, microenterprises, financial management and natural resource management (see Standard 12: Economic Empowerment and Livelihoods).	✔	✔	✔
Identify and build upon education programmes that provide opportunities to build adolescent girls' empowerment and life skills.	✔	✔	✔
Implement GBV programming that addresses power imbalances explicitly and promotes women's and adolescent girls' leadership and meaningful decision-making.	✔	✔	✔
Engage communities to ensure that communication materials are locally relevant, translated, acceptable and appropriate, such as pictorials for communities with low literacy (see Standard 7: Referral Systems).	✔	✔	✔
Support women and girls to participate at decision-making levels in conflict resolution and peace processes as outlined in Security Council resolution 1325.[81]			✔

acceptance of GBV services, it is useful to engage with men and boys, especially community leaders. Engaging male as well as female decision makers and community members can mitigate backlash by facilitating wider community understanding and support for GBV programming.

Participation is a key aspect of empowerment. Empowerment is a process that means women can take control over their lives, including by making decisions, setting their own agendas, gaining skills (and/or having their skills and knowledge recognized), solving problems and developing self-reliance.[82] Empowerment allows women to control their assets, and influence the policies, processes and institutions that affect their lives (including the structures and institutions that reinforce and perpetuate gender discrimination and inequality). The concept of empowerment has a long history in social change work[83] that emphasizes the importance of gaining the ability to make meaningful choices.[84]

Empowerment must include the processes that lead women and girls to perceive themselves as able and entitled to make decisions equally with men and boys. These processes must involve undoing negative social norms so that women and girls come to see themselves as having the capacity and right to act and influence decisions.[85] To be empowered, women and girls must not only have equal enjoyment of their rights (e.g., right to education and health) and equal access to resources and opportunities (e.g., land and employment), but must also have the agency and safety to exercise these rights, use their capabilities to their fullest potential, and make strategic choices and decisions.[86] Empowerment interventions with women and girls require response services to be in place or established, as empowerment programming often involves difficult discussions on power, control and violence that lead to survivor disclosures.

Addressing gender inequality is a foundational aspect of participation and empowerment programming. All humanitarian practitioners and GBV programmes should address gender inequality, use sex- and age-disaggregated data to inform programming in humanitarian emergencies, and promote gender equality in other sectors (see, e.g., *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery* and the Introduction).

Addressing gender inequality is a foundational aspect of participation and empowerment programming.

GBV prevention and response programming requires identifying and addressing unequal power relationships between women and men and girls and boys, and actively promoting the capacity and self-confidence of women and girls to claim their rights (see Standard 13: Transforming Systems and Social Norms). Understanding these unequal power relationships is critical for applying participatory approaches, and ensuring women and girls are engaged as active partners in the humanitarian response. An empowering environment should always promote a sense of ownership and belonging within wider community life.[87] GBV programme actors should work together to ensure the humanitarian space is an environment conducive to mobilizing

and strengthening women's and girls' participation and leadership so that those affected by crisis influence all aspects of programming. GBV prevention approaches also recognize the importance of increasing women's and girls' agency and widening their spaces to act to transform the systems that maintain inequality. A comprehensive approach to empowerment should encourage women's leadership in safely engaging men and boys to avoid backlash and encourage positive changes towards gender equality. Although barriers to participation should be addressed, community members are not required to participate if unwilling.

Indicators

- Special fora established, in a safe and non-stigmatizing manner, to ensure the meaningful participation of all women and girls who may face increased barriers to access.
- Humanitarian Needs Overview is based on gender analysis, and sex- and age-disaggregated data.[88]
- Direct consultations with local women's organizations have taken place and their inputs integrated into the Humanitarian Needs Overview/Humanitarian Response Plan.[89]
- Percentage of women-led organizations and groups that are active members of the GBV coordination mechanism.
- Percentage of women-led organizations and groups that receive direct funding from country-based pooled funds.

Guidance notes

1. Overcoming constraints to women's and girls' participation

All activities involving women and girls should be informed by them; for example, when scheduling meetings or activities, consideration should be given to the time and location to ensure women and girls can participate safely and easily.[90] Traditional barriers to participation may have changed in the crisis and will evolve as the humanitarian response develops; security concerns may have shifted to either further facilitate or preclude women's and girls' engagement. To overcome constraints to the participation of women and girls, it is necessary to consider several factors:

- Time and location of meetings and activities, and how these are determined and communicated;
- Travel required (Is it safe? Is transportation available and accessible? How can the GBV programme actor support safe travel? Is it necessary to make arrangements so that adolescent girls, older women, or women and girls with disabilities do not travel alone?);
- Mobility (Are women and girls free to move around and leave their homes/shelter? Should mobile units be created rather than expecting women and girls to move?);

- Compensation for time (i.e., in-kind compensation, such as food/drink or non-food items);
- Involvement of "gatekeepers" (e.g., community and religious leaders or others who may inhibit or enable women's and girls' access) to facilitate the participation of women and girls;
- Safety, security and community acceptability of venues;
- Outreach strategies to ensure women's and girls' participation (e.g., involving volunteers from target communities and providing childcare facilities); and
- Facilitation (Which groups of women and girls will feel safe speaking with which facilitators and other group members?).[91]

Women's rights activists have expert knowledge on women's experiences, risks and perspectives that are central to how to approach both services for survivors and models of social change.

Although time and other constraints might make establishing rapport more challenging in emergency settings, efforts should foster trust, as this will increase the active participation of women and girls.[92] For the most marginalized women and girls, including those who are survivors of GBV, it is often necessary to establish special fora such as safe spaces, static or mobile, to facilitate safe participation (see Standard 8: Women's and Girls' Safe Spaces).

The localization of a humanitarian response should focus on strengthening capacity and providing resources and tools for local and national women's movements to define local priorities for addressing GBV in humanitarian settings. Investing in local women's organizations will not only ensure that GBV services are sustainable and viable in the longer term, but that resources – material, intellectual and financial – are transferred to local women's organizations who are best placed to catalyse national action on GBV and ensure the long-term sustainability of services post emergency. Women's rights activists have expert knowledge on women's experiences, risks and perspectives that are central to how to approach both services for survivors and models of social change.[93]

Humanitarian actors should consistently promote and help develop existing women-led and community-based protection mechanisms, particularly because formal response systems and services may be weak or non-existent in emergency contexts.

2. Ensuring the participation of all women and girls

In the rush to provide humanitarian assistance, actors often fail to assess and address the barriers to participation and services for the most marginalized women and girls. Special attention should be paid to those most excluded and marginalized within the affected

population when designing GBV prevention and response programmes (see Introduction). Groups of women and girls who are at greater risk of GBV include women and girls with disabilities, ethnic and religious minorities, older women, adolescent girls, migrants, women and girls living with HIV and AIDS, women and adolescent girls engaged in commercial sexual exploitation, and lesbian, bisexual and transgender women. Men and boys from these marginalized groups are also at increased risk of sexual violence and require specific action to support access to services.[94]

Deprivations of women's and girls' rights are sometimes most severe among the most socially excluded communities. To meet the needs of all women and girls, it is often necessary to deploy different strategies to connect those who are most excluded with information and services. At the same time, targeted assistance should be conducted in a way that that does not stigmatize or isolate particular groups.[95]

For example, women and girls with disabilities are often neglected and excluded during displacement and conflict. They are often not included in data collection and therefore not able to reach essential services. When left uncounted in assessments, they are not considered in programme design, implementation, monitoring or evaluation.[96] The voices of women and girls with disabilities should inform the creation of inclusive GBV prevention and response programmes. Participation does not mean passive inclusion but requires actively reaching out to, and valuing the inputs of, women and girls living with disabilities and the groups that serve their interests.

3. Engaging men and boys to support women's and girls' participation and empowerment

Engaging men and boys in efforts to prevent and respond to GBV is critical for transforming harmful social norms that perpetuate gender inequality, and promoting the health and safety of women and girls.[97] Although some men and boys are perpetrators of GBV, others have the capacity to be partners, advocates and allies. Specific strategies, informed and led by women and girls, should be designed and implemented to engage male leaders and gatekeepers, especially religious and community leaders, to identify strategic allies for prevention of and response to GBV (see Standard 13: Transforming Systems and Social Norms). Once positive male agents of change have been identified, they can model positive gender attitudes and behaviours to challenge discriminatory social norms. It is important to create environments within which men and boys feel supported to step outside of traditional gender norms and practices. Although gender roles and social norms that contribute to GBV are pervasive throughout the life cycle, young men and boys are sometimes easier to reach as partners in preventing GBV as they may be more open to gender equality messages or alternative notions of masculinity.[98]

Male engagement must be accountable to women and girls to be part of comprehensive efforts towards GBV prevention and response. Interventions to engage men and boys must address the roles of men and women as they relate to each other; prevailing attitudes and behaviours toward males and females and their differential access to and control over

> *Women's and girls' participation promotes community resilience by building on their existing capacities and resources.*

resources based on gender roles should be part of these efforts. An emergency context may create new entry points at the individual, community and/or institutional levels in which to work together to promote positive, non-violent interactions and foster collaboration.[99]

4. Monitoring women's and girls' empowerment and participation

The following questions may support monitoring the participation of women and girls throughout the programme cycle:

- Participation/access/leadership: How are women and girls from all marginalized groups participating in the programme? What is the extent of their participation (are the conditions for their participation safe, timely, informed by them)? What barriers to participation are experienced, and how may they be overcome? What actions can enhance the participation of girls and/or women in decision-making or leadership? Are there particularly at-risk subgroups of women and girls who need to be reached?
- Negative consequences/adverse impacts: Is the project worsening the situation for women and girls? In what ways? To what extent? What can change this negative impact?
- Equity: Are certain groups of women, girls or other at-risk groups excluded? Who is not reached?
- Empowerment: Are women and girls empowered by programme interventions? How? To what extent? What else can enhance their empowerment?[100]

Tools and Resources

Abdul Latif Jamal Poverty Action Lab (J-PAL) (2018). *A Practical Guide to Measuring Women's and Girls' Empowerment in Impact Evaluations*. https://www.povertyactionlab.org/research-resource/practical-guide-measuring-women-and-girls-empowerment-impact-evaluations.

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UNICEF & UNFPA (2016). *The Adolescent Girls' Toolkit for Iraq*. https://gbvguidelines.org/en/documents/adolescent-girls-toolkit-iraq/.

STANDARD

3 Staff Care and Support

GBV staff are recruited and trained to meet core competencies, and their safety and well-being are promoted.

GBV programming depends on dedicated staff with specialized knowledge, skills and attitudes. **In this standard, "staff" refers to all GBV programme team members regardless of their employment status.** This includes volunteer staff who play valuable and specialized roles at the community level, especially when emergencies shift into the protracted and/or recovery phases of humanitarian response. These colleagues often experience unique challenges and risks that must be addressed in programme design and implementation.[101]

Human resources should continuously build the capacity of staff to respond to GBV in emergencies, and **all staff** must be trained in the survivor-centred approach (see Standard 1: GBV Guiding Principles) and basic GBV programming concepts. In an emergency, staff working on GBV programming must receive training to meet their context-specific responsibilities (e.g., GBV case management, psychosocial support, GBV prevention, women's empowerment and livelihoods). Managers must invest in staff capacity development by dedicating time for participation in GBV prevention and response training. To ensure quality programming and staff well-being, managers also must provide on-going supervision, mentorship and learning opportunities.

Since GBV programme staff, and particularly community volunteers, face unique threats to their resilience and safety due to the pressure and stress of working on GBV in emergency contexts,[102, 103, 104] organizations have a legal and moral obligation to protect and enhance staff safety and well-being.[105] This includes taking meaningful actions to reduce risks to physical and psychological health and safety. "Duty of care" constitutes a "non-waivable duty on the part of the organization to mitigate or otherwise address foreseeable risks that may harm or injure its personnel".[106, 107] Since great stress can also stem from insufficient support from the organization and management,[108] managers have a fundamental role in creating and sustaining a healthy work environment.

KEY ACTIONS Staff Care and Support

	Preparedness	Response	Recovery
Establish a GBV programme team with sufficient staff, resources and support, including female personnel and ethnic diversity, to facilitate quality programming.	✔	✔	✔
Conduct an internal staff capacity assessment across programme areas to identify gaps in knowledge, capacity and attitudes, and develop a strategy to build staff capacity and address identified needs.	✔	✔	✔
Develop job profiles with specific responsibilities in line with the GBV Core Competency Framework for GBV in emergencies.	✔	✔	✔
Establish regular supervision to provide technical and psychosocial support for all staff delivering GBV response services.	✔	✔	✔
Establish access to psychosocial support for all staff working on GBV, recognizing that support needs will be different[109] based on individual experiences of stress and trauma.	✔	✔	✔
Share GBV training resources with all staff.	✔	✔	✔
Promote staff well-being in emergencies and facilitate a healthy working environment: • Prioritize self-care and safety for staff (e.g., clear job description, systematic on-boarding and operational support, at least one day off per week, clear working hours, appropriate insurance and provisions for medical evacuation, parental leave, rest and relaxation or home leave for staff in complex humanitarian emergencies, staff well-being activities, etc.); • Promote access to health care and psychosocial support for staff;[110] • Create spaces for staff to discuss quality of life and safety concerns.	✔	✔	✔
Ensure the availability of a funded and actionable plan to protect and promote staff well-being within the response context.[111]	✔	✔	✔
Ensure emergency response proposals include appropriate funding for sufficient staff across GBV programming interventions and supervision for all staff responding to the emergency.	✔	✔	✔
Ensure that management staff model openness about the challenges of working on GBV, self-care, stress management techniques and a healthy work-life balance.	✔	✔	✔
Promote an organizational culture in which complaints are taken seriously and acted upon according to defined policies and procedures.	✔	✔	✔
Ensure that specific measures are in place to protect community workers' and volunteers' safety and well-being, recognizing the inherent pressures and risks involved in their dual role as both community members and service providers.[112]	✔	✔	✔

Indicators

- All GBV programme job profiles are aligned with the GBV Core Competency framework.
- All frontline GBV programme staff have access to monthly support and supervision sessions with a GBV specialist to ensure staff safety and service quality.
- All GBV programmes have an actionable plan in place and associated budget to protect and promote staff safety and well-being.
- Percentage of GBV programme staff who receive on-boarding and continued support during the course of their assignment.
- Limits on contact hours per week are established and maintained for all frontline staff (16 contact hours per week).

Guidance notes

1. Contextualizing the GBV core competencies

In 2014, the GBV Area of Responsibility developed Core Competencies for GBV Program Managers and Coordinators in Humanitarian Settings.[113] The framework outlines a set of core competencies that cover the professional and technical skills, abilities and knowledge necessary for effective GBV prevention and response programming (see box below). The framework was developed to support hiring practices based on core competencies,[114] and provides useful guidance for staff recruitment and deployment, capacity development, and performance assessments for GBV programme managers and coordinators. It is also necessary to consider candidates' biases, attitudes and beliefs regardless of their qualifications and experience.

Enforcing standards for the core competencies of GBV programme specialists is important, but does not minimize the value of experience, contextual knowledge, relationships, access to communities and understanding of the affected population. A requirement for advanced degrees, for example, may create a barrier for experienced colleagues in field settings.[115] Local women and organizations are expert "knowers" who understand intimately what women's lives are like, what violence looks like in their communities, how people talk about violence, and how unequal power between women and men is manifested and sustained. Local knowledge supports programming, service provision and advocacy that is relevant and safe.[116] As part of the GBV Core Competency framework, it is critical to understand and strengthen the professional knowledge, competence and skills of local aid workers. They may not initially meet key competencies for various reasons related to access and privilege, but should be supported to contribute their uniquely valuable knowledge and skills relative to the context.

Competencies for GBV Program Managers and Coordinators Working in Humanitarian Contexts

- Understands and applies a survivor-centred approach, including the GBV Guiding Principles.
- Believes in gender equality and applies, promotes and integrates gender analysis into humanitarian programming.
- Demonstrates knowledge of and can implement a multisectoral response to GBV (includes health, psychosocial support, security and legal response).
- Demonstrates knowledge of and engages effectively with the humanitarian architecture.
- Demonstrates knowledge of current GBV prevention theory, and identifies and applies appropriate GBV prevention and behaviour change strategies at different stages of the humanitarian response.
- Locates, adapts and applies key GBV tools to context including: the *Handbook for Coordinating GBV Interventions in Humanitarian Settings* (Gender-based Violence Area of Responsibility, 2019); the Gender-based Violence Information Management System (GBVIMS); World Health Organization (WHO) Ethical and Safety *Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies,* and the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Settings (IASC 2015a).
- Understands and applies concepts of adult learning to build the capacity of GBV programme personnel.
- Applies participatory approaches to engage with and mobilize communities.
- Provides strategic planning for GBV prevention and response, including by applying critical thinking and problem-solving to create innovative GBV programming, and critically analysing context, trends and vulnerabilities related to GBV.
- Demonstrates understanding of effective fundraising for GBV prevention and response, including through key humanitarian funding processes.
- Advocates for GBV prevention and response and in support of GBV survivors.
- Supports other sectors to mainstream GBV prevention and response.
- Understands critical issues – including ethics – with regard to collecting, managing, sharing and applying data.
- Facilitates a collaborative environment to promote effective coordination.
- Uses emotional intelligence, including having and showing empathy and active listening, and presenting and fostering respectful communication.

Source: GBV Area of Responsibility Learning Taskforce Team 2014, pp. 4-5.

2. Enhancing programme quality by supporting staff safety and care

Humanitarian organizations must ensure the physical and psychological health and safety of staff. Staff working on GBV may face additional and unique safety risks due to the nature of their work. For these reasons, their organization's safety and security team must address and respond to any potential threats and protection concerns.

Working with GBV survivors can be particularly stressful. It is common for staff to experience everyday stress, cumulative stress, burnout, vicarious/secondary trauma and critical incident stress. Vicarious/secondary trauma may be identified by a change in the staff member's ability to engage with survivors and a decreased ability to cope with stress. It is typically a cumulative process that builds over time after prolonged exposure to other people's suffering. GBV coordinators and managers should be aware of their staff's stress levels, and establish routine mechanisms for acknowledging and supporting staff safety and well-being. For example, GBV team meetings, individual meetings, case management supervision and clinical supervision may be regular opportunities to check in on well-being.[117]

Supporting GBV programme staff to take care of their physical and mental health can include finding positive activities and outlets to manage stress, all of which will support job performance and overall well-being.[118] Managers should recognize the support needs of various staff will be different based on the level and exposure to stress and trauma, and allocate resources to support individuals facing greater levels of stress. Caseworkers in particular often work closely with GBV survivors, hearing their stories and responding with care, compassion, and concern. Over time, without appropriate support and supervision, caseworkers may begin to feel overwhelmed and tired, and may even feel hopeless and helpless. In order to prevent caseworker burnout and facilitate their capacity to provide the best care and services to survivors, supervisors and organizations must make a commitment to staff well-being and take actionable steps to promote it.[119]

Leadership plays a critical role in creating an organizational culture that prioritizes staff safety and well-being, where all staff working on GBV are safe, able to take care of their physical and mental health, and can seek support when needed. Ensuring self-care and appropriate support for GBV staff is a core responsibility for all managers.[120]

The role of the supervisor and/or manager should be clearly defined before projects start. Policies, protocols and resources should be in place to support staff needs, and managers should be able to identify when staff are experiencing increased stress and/or symptoms of burnout. An organizational environment that fosters team interaction, as well as spaces for debriefing, can lessen the risk of vicarious trauma.[121]

3. Prevention of sexual exploitation and abuse

Protection from sexual exploitation and abuse (PSEA) refers to the responsibilities of international humanitarian, development and peacekeeping actors to prevent and respond to incidents of sexual exploitation and abuse by United Nations, non-governmental (NGO) and intergovernmental organization personnel against beneficiaries of assistance, other members of affected populations[122] and other humanitarian personnel.

All humanitarian aid organizations are required to adapt or develop, fund and implement effective and comprehensive PSEA mechanisms. All staff have the right to be treated with dignity and respect, and to work in an environment free from harassment, sexual harassment, abuse of authority or discrimination. Being safe from sexual exploitation and abuse is a critical part of staff care and support.

The key elements of the Minimum Operating Standards for Protection from Sexual Exploitation and Abuse by Own Personnel follow:

1. Management and coordination: effective policy development and implementation, cooperative arrangements, dedicated department/focal point committed to PSEA.
2. Engagement with and support of local community: effective and comprehensive communication from headquarters to the field on what to do to raise beneficiary awareness of PSEA and how to establish effective community-based complaints mechanisms.
3. Prevention: effective and comprehensive mechanisms to raise awareness of sexual exploitation and abuse among personnel; effective recruitment and performance management.
4. Response: internal complaints and investigation procedures in place.[123]

Managers and human resource staff are responsible for ensuring that all staff are trained in PSEA and have signed a code of conduct. Staff must understand their individual responsibilities to report any suspected incidents and know the mechanisms in place for mandatory reporting.

Survivors of sexual exploitation and abuse are survivors of GBV and should be referred to existing GBV services; no parallel referral pathway should be established. The GBV response system is the appropriate referral system for women and girls to access support if they experience sexual exploitation and abuse perpetrated by humanitarian actors or other duty bearers.

Tools and Resources

Antares Foundation (2012). *Managing Stress in Humanitarian Workers – Guidelines for Good Practice*, 3rd ed. Amsterdam. https://www.antaresfoundation.org/filestore/si/1164337/1/1167964/managing_stress_in_humanitarian_aid_workers_guidelines_for_good_practice.pdf.

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United Nations System Chief Executive Boards (CEB) for Coordination (2018). *Cross-functional Task Force on Duty of Care for Personnel in High Risk Environment Report, CEB/2018/HLCM/17.* https://www.unsceb.org/CEBPublicFiles/2018.HLCM_.17%20-%20Duty%20of%20Care%20Task%20Force%20%E2%80%93%20Progress%20Report_0.pdf.

THE INTER-AGENCY

MINIMUM STANDARDS

for Gender-Based Violence in Emergencies Programming

Programme Standards

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STANDARD 4

Health Care for GBV Survivors

GBV survivors access quality, survivor-centred health care, including health services for sexual and intimate partner violence and other forms of GBV, and referrals to prevent and/or reduce the effects of violence.

This Minimum Standard is for (1) health actors providing care to GBV survivors; and (2) GBV programme actors who provide support and capacity strengthening and coordinate with health actors in collaborative responses to meet GBV survivor needs.

Access to quality, confidential, age-appropriate and compassionate health-care services is a critical component of a multisectoral response to GBV in emergencies. Adequate health services are not only vital to ensuring life-saving care for women, girls and other at-risk groups, but they are also essential for a society to overcome the devastation of a humanitarian emergency.[124]

Health-care providers are often the first and sometimes only point of contact for GBV survivors. They are on the front line of response to GBV in emergencies, and can play a central role in determining protection and other concerns, addressing physical and emotional/psychological needs, developing prevention strategies and providing referrals to other services.[125] Health-care services should be delivered in a confidential, non-judgmental and non-discriminatory manner that considers the survivor's sex, age and specific needs. Special consideration should be given to the unique needs of women and girls who face barriers accessing services, men survivors of sexual abuse and child survivors of sexual abuse who require child-appropriate service provision (see Guidance Notes 1, 2 and 3, and Standard 1: GBV Guiding Principles).

Health Response to GBV: An Overview

1. Survivor-centred care and first-line support (i.e., psychological first aid) to address basic emotional needs.
2. Identification and care for survivors of intimate partner violence.
3. Clinical care for survivors of sexual violence.
4. Training of health workers.
5. Coordination and safe and ethical data collection for service delivery.
6. Mental health care or referral to additional services.

Source: WHO 2017a.

KEY ACTIONS Health Care for GBV Survivors

	Preparedness	Response	Recovery
Preposition supplies to ensure women and girls receive PEP within 72 hours of potential exposure.	✔		
Work with health-care staff to ensure women and adolescent girls have immediate access to reproductive health services at the onset of an emergency (no needs assessment is necessary) as outlined in the MISP.[126]		✔	✔
Work with health-care staff to ensure GBV survivors have access to high-quality, life-saving health care based on World Health Organization (WHO) standardized protocols.[127]	✔	✔	✔
Work with health-care actors to assess health facility readiness and health service provision, and advocate to address gaps to ensure an adequate health response is in place and accessible to survivors.	✔		
Enhance the capacity of health-care providers, including midwives and nurses, to deliver quality care to survivors through training, support and supervision, including on GBV prevention and response, clinical management of rape and intimate partner violence.	✔	✔	✔
Establish and maintain safe referral systems among health and other services and among different levels of health care, particularly where life-threatening injuries or injuries necessitating surgical intervention require referral to a facility providing more complex care.	✔	✔	✔
Work with communities to develop safe access, including transportation options, for GBV survivors to obtain health services.	✔	✔	✔
Ensure that a consistent GBV focal point is present in health sector meetings and activities, and that a health sector focal point participates in GBV meetings.		✔	✔
Provide support to health-care actors to train and support medical and non-medical personnel on the needs of GBV survivors and the importance of promoting survivor-centred, compassionate care that is appropriate to the survivor's age, gender and developmental stage.	✔	✔	✔
Strengthen the capacity of community health providers, traditional birth attendants and other community-based health actors who are important entry points for referrals and basic support.	✔	✔	✔
Work with health actors to ensure follow-up and referral of cases.	✔	✔	✔
Work with health providers and community leaders to inform the community about the urgency of, and the procedures for, referring survivors of sexual violence if safe to do so.	✔	✔	✔
Disseminate information and engage communities on the health consequences of intimate partner violence and child marriage, which often increase in emergencies, if safe to do so.	✔	✔	✔
Re-establish comprehensive reproductive health-care services and strengthen national health systems after the immediate emergency onset and during transition phases.		✔	✔

In order to facilitate care, survivors must have safe and easy access to health facilities. Many survivors will not disclose violence to a health care (or any other) provider due to feelings of shame, fear of blame, social stigma, rejection from partners/families and other possible repercussions.[128] Health-care providers need training and ongoing support to provide effective care for women and girls who are subjected to violence. Survivors may be discouraged from disclosing or asking for help for GBV-related health problems if service providers do not demonstrate survivor-centred attitudes and are not properly trained, equipped, skilled and knowledgeable on how to discuss and address GBV. To enhance survivors' access to services, it is important that:

- Female staff are present;
- The health provider asks the right questions in a non-judgmental way;
- The health facility has private spaces for consultation, protocols for provision of health care to survivors, essential medicines and supplies, and confidential mechanisms for documentation and referrals;
- Communication materials in the facility describe clearly the types of services that are available; and
- The provider makes clear that any disclosure of GBV will be met with respect, sympathy and confidentiality.

In some contexts, survivors are required to report to the police before accessing health care, which is against best practice. It is strongly recommended that GBV and health-care actors coordinate with the police to ensure survivors can access health care first and then choose whether to report GBV incidents to the police. Mandatory reporting procedures that require survivors to first report to the police delay or obstruct survivors from seeking potentially life-saving medical care. Health-care services are the first priority and must be provided regardless of the reporting circumstances.[129] GBV Standing Operating Procedures and referral pathways among health, police and GBV programme actors must uphold a survivor's right to choose where and when to report, and facilitate timely access to health care.

Health-care providers have the responsibility to provide care and refer survivors to case management

Mandatory reporting

Health-care providers need to be aware of the laws and obligations on reporting sexual violence and intimate partner violence to the police or authorities. Although mandatory reporting is often intended to protect survivors (particularly children), in some cases it may conflict with the GBV Guiding Principles (see Standard 1). Furthermore, in the case of adults, mandatory reporting impinges on their autonomy and ability to make their own decisions. It also raises safety concerns as women may experience retaliation, fear losing custody of their children or face legal consequences (for example, in countries where extramarital sex is illegal).

In countries where same-sex relationships are criminalized, people with diverse sexual orientations and gender identities may be hesitant to seek health services if mandatory reporting is required. Health-care providers need to understand their legal obligations (if any) and professional codes of practice to ensure that survivors are fully informed about their choices and limitations of confidentiality where this is the case. By ensuring survivors are aware of mandatory reporting requirements, health-care providers can help survivors make informed decisions about what to disclose during a health visit.

Source: WHO, UNFPA and UNHCR 2019.

services (see Standard 6: Case Management) where available. Health-care programmes that are safe, sensitive, confidential, accessible (e.g., free or low cost, easy to reach, non-judgmental) can facilitate immediate and life-saving care for survivors, and initiate a process of recovery that results in physical and mental health benefits for individual survivors, and wide-ranging benefits for families, communities and societies.[130] Health-care providers should also make referrals to other agencies providing psychosocial support, legal, shelter or other services.[131] If confidentiality, respect and safety are not upheld, survivors may be exposed to heightened risk of additional harm or violence from partners, family and/or community members.

During the acute phase of an emergency, the prevention and management of sexual violence is considered a life-saving activity that prevents illness, trauma, disability and death, and is among the core components of the Minimum Initial Service Package (MISP).[132] The MISP is an international standard of care that should be implemented at the onset of every emergency and is part of the Sphere Sexual Reproductive Health and HIV Standards.[133] This package ensures that basic health-care needs are met and helps to mitigate the negative long-term effects of violence on survivors through a coordinated series of priority actions designed to prevent morbidity and mortality, particularly among women and girls. The MISP meets CERF life-saving criteria, making these funds available for health-care programmes[134] and preparedness planning (see Guidance Note 2).

Minimum Initial Service Package (MISP)

- Ensure health sector/cluster identifies an organization to lead the implementation of the MISP;
- Prevent sexual violence and respond to the needs of survivors;
- Prevent the transmission of and reduce morbidity and mortality due to HIV and other sexually transmitted infections;
- Prevent excess maternal and newborn morbidity and mortality;
- Prevent unintended pregnancies; and
- Plan for comprehensive sexual and reproductive health services, integrated into primary health care as soon as possible. Work with health sector/cluster partners to address the six health system blocks.

Source: IAWG on Reproductive Health in Crises 2011.

Access to health-care services for rape and intimate partner violence survivors has been identified as a major gap in humanitarian response; there is a critical need to ensure that established protocols for the clinical management of rape and intimate partner violence are implemented.[135] Health service delivery systems should be equipped to provide clinical management of rape, intimate partner violence and the consequences of other forms of GBV (see Guidance Note 1). This includes first-line support/psychological first aid, the provision of emergency contraception, HIV post-exposure prophylaxis, treatment of sexually transmitted infections, Hepatitis B immunization, identification and care of survivors of intimate partner violence (including assessing the risk of continued and more serious violence, treatment of injuries and other physical care needs), and assessment and management of mental health conditions such as depression, suicidal thoughts or attempts, and post-traumatic stress disorder.

Health-care providers should also be able to address the health needs of survivors of child marriage (e.g., high-risk pregnancy, health effects of forced sexual activity) and complications related to female genital mutilation/cutting (e.g., pain, bleeding, urinary and vaginal infections, menstrual problems, childbirth complications, etc.).

Health-care programmes that are safe, sensitive, confidential, and accessible can facilitate immediate and life-saving care for survivors, and initiate a process of recovery.

It is essential to inform communities about the benefits of and locations for health care once services are established, and of the urgency of some aspects of post-rape care, such as emergency contraception and HIV prophylaxis, which are effective only within a short time period and should be provided as close to the incident as possible. The availability of post-exposure prophylaxis (PEP) within 72 hours of the onset of an emergency is mandatory. Supplies should be prepositioned so that women and girls can receive PEP within 72 hours of potential exposure.

The key actions in this standard are relevant for GBV programme staff, who should work closely with health-care actors to support the establishment of health services and conduct related advocacy. The *IASC GBV Guidelines* and *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings* outline actions that apply throughout the programme cycle to organizations implementing health programmes, including primary health care, and specify the importance of appointing GBV focal points from the health sector to participate in GBV coordination.

Indicators

- All health facilities have trained staff, sufficient supplies and equipment for clinical management of rape survivor services based on national or international protocols.[136]
- MISP implemented within two weeks of crisis onset.
- Health-care actors integrated in (emergency) GBV standard operating procedures and included in the referral pathway.
- All GBV survivors[137] state they accessed health care in a way that felt safe and respectful of their dignity in a survivor-centered manner.[138]
- All eligible survivors of rape receive post-exposure prophylaxis within 72 hours of an incident or from exposure, and emergency contraception within 120 hours of an incident or from exposure.

It is not the health-care provider's responsibility to determine whether a person has been raped because that is a legal determination. The health-care provider's responsibility is to provide appropriate care, record the details of the incident, conduct and document a physical examination, and, with the client's consent, collect and preserve any forensic evidence that might be needed in a subsequent legal action.

It is not the health-care provider's responsibility to determine whether a woman or girl is a virgin. The WHO and Inter-agency Working Group on Reproductive Health state that virginity testing has no scientific basis, is a violation of women's and girls' human rights, and can be detrimental to their physical, psychological and social well-being.

Virginity testing is performed with the belief that a specific appearance of the female genitalia can demonstrate whether or not sexual intercourse has occurred. Exposing women and girls to unnecessary genital examinations can have a wide range of physical, psychological and social consequences. Given that these examinations are medically unnecessary, it is unethical for physicians or health professionals to perform them.

Source: WHO 2014; IRC 2018k.

Guidance notes

1. Clinical management of rape survivors[139]

Survivors of sexual assault, including survivors of rape, require an immediate medical response to manage injuries, and administer medication to prevent or treat sexually transmitted infections and prevent unwanted pregnancies. Treatment within 72 hours is preferable, particularly to administer post-exposure prophylaxis for HIV and other sexually transmitted infections, and pregnancy prevention care (up to 120 hours). Survivors may present much later than 72 hours and require other treatment.

If a woman or adolescent girl seeks services later than the 72/120 hour windows for preventive care, health-care providers should still provide first-line support, Hepatitis B immunization, tests for pregnancy and sexually transmitted infections including HIV (test only if a referral is available for HIV counselling, testing and treatment), and mental health assessment and referrals if needed. Providers should offer, or provide referrals for, safe abortion care, to the fullest extent of the law. Clinical care for rape survivors must be available from the onset of an emergency, and health-care staff should be trained in the clinical management of rape, including performing and documenting a physical exam, providing treatment, and referring to other services (e.g., case management and psychosocial support) according to the survivor's wishes. Health-care staff should also be trained in survivor-centred care and the GBV Guiding Principles (see Standard 1: GBV Guiding Principles), including informed consent, confidentiality, respect and non-discrimination. Female health staff should be present where possible. Community health officers and/or other support providers trained on GBV should accompany female survivors to the clinic or hospital based on the survivor's wishes.[140]

2. Minimum Initial Service Package

All individuals, including those living in humanitarian settings, have the right to the highest standard of care for sexual and reproductive health.[141] To exercise this right, affected populations must have access to the Minimum Initial Service Package (MISP) from the onset of an emergency to save lives and prevent morbidity.[142] The transition to comprehensive sexual and reproductive health-care information and services should occur as soon as feasible.

The MISP is a set of internationally accepted minimum actions for treatment and care that must be implemented in a coordinated manner by appropriately trained staff at the beginning of a crisis. It is important that medical treatment is part of a package of holistic, survivor-centred care, and administered by trained health professionals.[143] Pre-assessment of sexual violence, HIV and other sexual and reproductive health issues is not required to implement the MISP.[144] The priority life-saving activities of the MISP are integrated into the Sphere Sexual Reproductive Health and HIV Standards,[145] recognizing that women and girls suffer from unnecessary and excess death and disability when basic and priority reproductive health services are not established for weeks or months into an emergency.[146]

3. Specialized services to address survivors' specific needs

Pregnant women survivors

It is important to differentiate between sexual violence against a pregnant woman and pregnancy resulting from rape. Women and adolescent girls who experience sexual violence while pregnant may face a higher risk of complications such as miscarriage, pregnancy-induced hypertension, premature delivery and infections, including hepatitis and HIV. The health service provider should ensure that the medical drugs that are prescribed for the clinical management of rape have no side effects (or contraindications) for the pregnancy.[147] Women and girls who are at risk of pregnancy resulting from rape should be offered emergency contraception and, as required, safe abortion services to the full extent of the law, and post-abortion care. Additionally, risks of physical, sexual or emotional intimate partner violence may increase during pregnancy and result in greater health complications.

All health-care staff should:

- Offer first-line support/psychological first aid and basic psychosocial support to all survivors of intimate partner and sexual violence. This support may be sufficient for those experiencing transient signs of psychological stress. In an emergency setting where a health-care provider may only see a survivor once, this type of support may be the most important help to give.
- Assess for mental health problems if symptoms are severe enough to affect daily functioning and do not diminish over time. If possible, link survivor to a social worker (see Standard 5: Psychosocial Support and Standard 8: Women's and Girls' Safe Spaces) or mental health counsellor to provide appropriate care.
- Make regular follow-up appointments for monitoring and further support at two weeks, one month and three months after the event, if possible.

Source: WHO, UNFPA and UNHCR 2019.

Adolescent girl survivors

Adolescent girls are especially vulnerable to GBV during a crisis. They experience elevated risks of sexual violence, exploitation and child marriage, but are often not specifically considered for provision of sexual and reproductive health care. Given their age, the risks of early pregnancy, lack of decision-making power and limited access to information and services – including health care – special attention must be given to removing barriers and facilitating their access to services. For example, parents should be informed of the potential long-term sexual and reproductive health implications of denying contraception and medical treatment to adolescent girl survivors of gender-based violence, and should be aware of the life-threatening health consequences of child marriage and early pregnancy. It is important to ensure that female health service providers are available to provide counselling and treatment to adolescent girl survivors that is age-appropriate, accessible, non-judgmental and non-discriminatory. Health systems should be supported to tailor protocols for service provision to adolescent girls.[148]

Adequate health services are not only vital to ensuring life-saving care for women and girls, but they are also essential for a society to overcome the devastation of a humanitarian emergency.

Male survivors of sexual violence

Men and boys also experience rape and other forms of sexual violence, but this is not always acknowledged or well understood. Sexual violence inflicted on men can be used as a tactic of war to disempower, dominate and undermine traditional concepts of masculinity. Entrenched social, cultural and religious norms, including taboos around sexual orientation and masculinity, may stigmatize male survivors, evoke feelings of shame, and prevent men and adolescent boys from reporting incidents or seeking services. Sexual violence can cause significant and long-lasting impacts on the physical, mental and sexual health and well-being of male survivors and their families. It is important that multisectoral services including health care, psychosocial services, safety and security mechanisms, and legal assistance are available to all survivors. Male survivors have specific needs regarding treatment and care that should be addressed by health-care providers, who must be trained to identify indications of sexual violence in men and boys, and offer care that is survivor-centred, non-stigmatizing and non-discriminatory.[149]

Child survivors of sexual abuse

Children are more vulnerable than adults to abuse, due to their age, size and limited participation in decision-making. In emergencies, systems that protect children, including family and community structures, often break down. Children may be separated from their families, placing them at even greater risk. Specific measures should be implemented to protect girls and boys from the risk of child sexual abuse at home, school and in the community.

Health-care service providers, teachers, parents, caregivers and others should be aware of the signs and symptoms of child sexual abuse, as girls and boys will often remain silent. Services should be provided in a non-discriminatory manner, with the informed assent and/or consent of the child or of their caregiver. Confidentiality may be limited by the mandatory requirement to report all cases of child abuse in accordance with local protocols. The best interests of the child and their immediate care and safety should be the primary consideration in all decisions.[150] Since child survivors and non-offending family members have specific needs, they require a tailored response and specialized services. Children should be interviewed and treated in an environment where they feel safe, using child-friendly communication techniques. They should participate in decisions that affect their lives, as appropriate to their age and maturity. Although children are resilient, they vary in how they are affected by abuse; their care needs and recovery and healing plans should build on their skills, capacities and life situations, drawing upon non-offending family and community support networks.[151]

If confidentiality, respect and safety are not upheld, survivors may be exposed to heightened risk of additional harm or violence from partners, family and/or community members.

Tools and Resources

International Rescue Committee (IRC) (2018). *Myths Surrounding Virginity: A Guide for Service Providers.* New York. http://ccsas.iawg.net/sdm_downloads/myths-surrounding-virginity-guide-service-providers/.

IRC and University of California Los Angeles (UCLA) (2014). Competent, Compassionate, and Confidential Clinical Care for Sexual Assault Survivors (CCSAS) Multimedia Learning Tool. Available from: *www.iawg.net/ccsas.*

Jhpiego and the U.S. Centers for Disease Control and Prevention (2018). Gender-based Violence (GBV) Quality Assurance Tool. Available from: http://resources.jhpiego.org/resources/GBV-QA-tool.

Inter-Agency Working Group on Reproductive Health in Crises (IAWG) (2018). *2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.* Available from: http://iawg.net/iafm/

_____ (2019). *MISP Calculator.* Available from: http://iawg.net/resource/misp-rh-kit-calculators/.

World Health Organization (WHO) (2017a). *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers.* https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/.

_____(2017b). *Responding to children and adolescents who have been sexually abused: WHO clinical guidelines.* Geneva. http://ccsas.iawg.net/wp-content/uploads/2017/12/9789241550147-eng.pdf.

United Nations High Commissioner for Refugees (UNHCR) (2012). *Working with Men and Boy Survivors of Sexual and Gender-based Violence in Forced Displacement.* Geneva. http://www.refworld.org/pdfid/5006aa262.pdf.

WHO, UNFPA and UNHCR (2019). *Clinical Management of Rape and Intimate Partner Violence Survivors.*

STANDARD

5 Psychosocial Support

Women and girls safely access quality, survivor-centred psychosocial support focused on healing, empowerment and recovery.

Mental health and psychosocial support programming falls across the health and protection sectors. It describes support that aims to protect or promote psychosocial well-being and mental health.

This Minimum Standard focuses on psychosocial support only, as it relates to GBV directly and can be provided without specialized mental health-care services. Specialized or clinical mental health care is addressed in Standard 4: Health Care for GBV Survivors.

Other services and activities related to psychosocial support services include GBV case management (see Standard 6: GBV Case Management), women's and girls' safe space activities (see Standard 8: Women's and Girls' Safe Spaces), and building community support and risk mitigation (see Standard 9: Safety and Risk Mitigation).

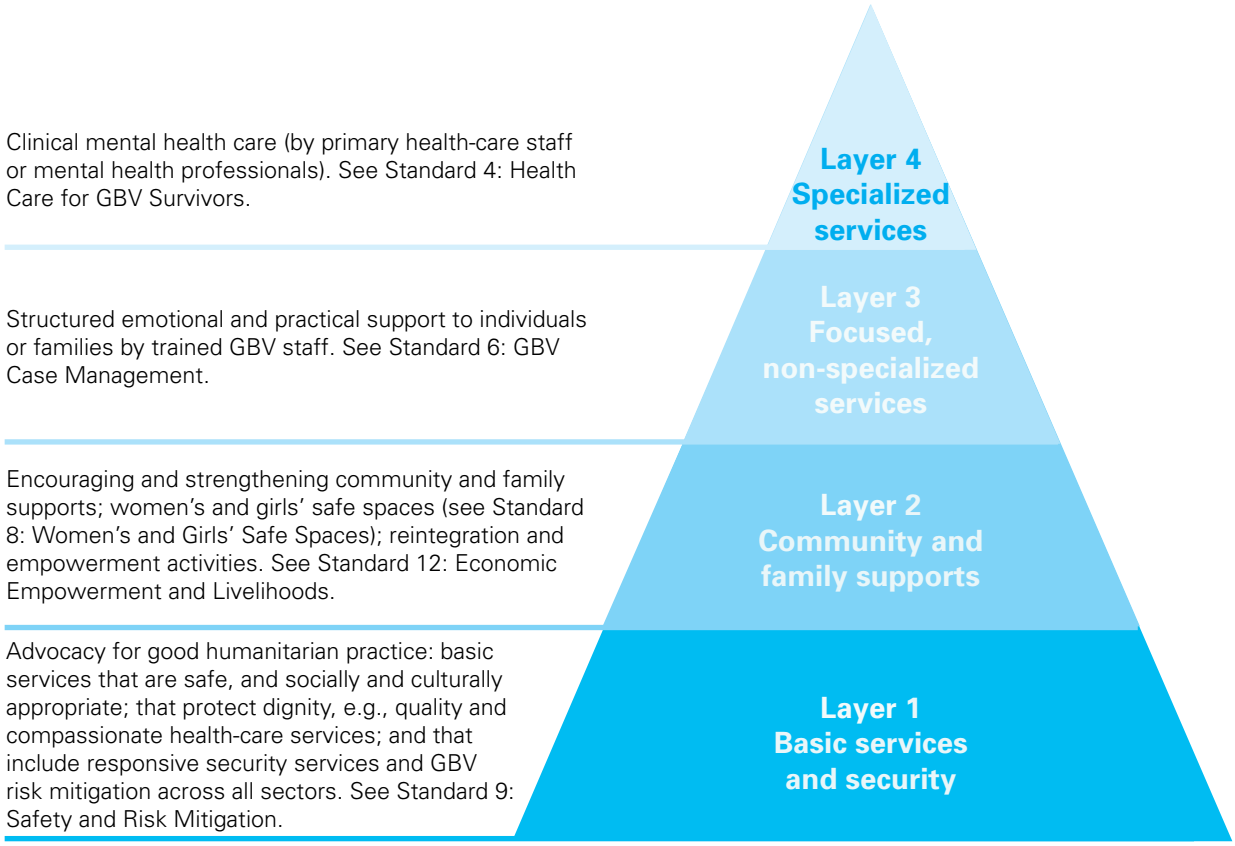
The impact of violence varies from person to person. Many survivors of GBV experience long-lasting psychological and social effects due to the silence and stigma surrounding GBV, a lack of family and community support and appropriate response services, internalized shame, and a lack of power and resources to escape continued perpetration of GBV. Psychosocial support is therefore a critical emergency intervention. It should be a central component of both short- and long-term GBV-specialized programming.[152]

Quality psychosocial support services are survivor-centred, age-appropriate, build individual and community resilience, and support positive coping mechanisms.[153] They should include opportunities for social networking and solidarity-building among women and girls. As a critical intervention that contributes to survivors' safety, healing and recovery, psychosocial support interventions can range from basic support by first responders, such as psychological first aid to survivors and families, to more focused case management support, including psychological interventions provided by non-mental health specialists. It is important that psychosocial support for women and girls is informed by an understanding of their experiences of violence and discrimination.

KEY ACTIONS Psychosocial Support

	Preparedness	Response	Recovery
Assess and strengthen existing psychosocial services, mechanisms and capacities where possible.	✔	✔	
Provide individual and group psychosocial support services that are safe and accessible for women and adolescent girls, welcome and integrate women and girls who experience discrimination, and address barriers to access while not exclusively targeting GBV survivors.	✔	✔	✔
Ensure GBV programming provides women and girl survivors with access to context-appropriate individual and/or group psychosocial support services adapted to their ages and needs.	✔	✔	✔
Recruit and train GBV response workers with strong interpersonal skills, belief in gender equality, empathy, and knowledge of the local language(s) and culture(s).	✔	✔	✔
Ensure that all psychosocial support services focused on women and girls promote a sense of safety, calm, self-efficacy, community solidarity and support, connectedness and hope.[154]	✔	✔	✔
Establish or strengthen existing safe spaces for women and girls to provide psychosocial support activities (see Standard 8: Women's and Girls' Safe Spaces).	✔	✔	✔
Link with child protection actors to understand available psychosocial support activities for young and adolescent girl and boy survivors of sexual abuse, offer child survivors and caregivers information on services, and refer as appropriate.	✔	✔	✔
Ensure information about psychosocial support services is shared with and reaches diverse women and girls through targeted outreach.	✔	✔	✔
Train GBV response workers on the root causes, consequences and impacts of GBV, survivor-centred principles and skills, and the capacity to support survivors (whether or not survivors disclose).	✔	✔	✔
Consider and address obstacles to women's and girls' access to psychosocial support services, including emotional distress and fear, documentation, discrimination, safety and security issues, proximity, cost, privacy, language and cultural issues.[155]	✔	✔	✔
Identify and promote community-based support, self-help and resilience strategies, including working with women and girls to establish support groups and networks that promote healing and recovery.	✔	✔	✔
Provide skills and knowledge-building opportunities for women and girls to improve their psychosocial well-being, e.g., social and emotional learning, financial skills, numeracy and literacy, etc. (see Standard 8: Women's and Girls' Safe Spaces), including by linking survivors to livelihood activities and additional services[156] (see Standard 12: Economic Empowerment and Livelihoods).	✔	✔	✔
Train GBV response workers to recognize signs that women and girls may benefit from GBV case management or specialized mental health care (see Standard 4: Health Care for GBV Survivors).	✔	✔	✔
Ensure that the minority of GBV survivors who require specialized mental health support are referred to mental health services where available.	✔	✔	✔
Integrate psychosocial support services in the referral pathway, including confidential referrals and links with health-care providers for clinical services/mental health care and other services as needed.	✔	✔	✔
Advocate for all front-line workers (including, for example, registration, health posts, community outreach teams, etc.) to be trained in psychological first aid.	✔	✔	✔

FIGURE 2. The IASC Intervention Pyramid for Mental Health and Psychosocial Support in Emergencies



Source: IASC 2007.

Layer 1: Basic Services and Security

GBV-specific interventions at this layer focus on providing protection and services that meet the specific needs of GBV survivors and other women and girls at increased risk of violence, including:

- Ensuring that all service delivery is survivor-centred and aimed at meeting basic needs.
- Ensuring that humanitarian action aimed at meeting basic needs does not increase harm, e.g., by increasing risk of sexual exploitation and abuse.
- Preventive security and protection actions to identify and address environmental and situational GBV protection threats (see Standard 9: Safety and Risk Mitigation).

The term "psychosocial" highlights the interaction between the psychological aspects of human beings and their environment or social surroundings. Psychological aspects are related to people's functioning, e.g., beliefs, thoughts, emotions and behaviours. Social surroundings concern a person's relationships, family and community networks, cultural traditions and economic status, ability to participate in public affairs and decision-making, as well as daily activities such as school or work. The term "psychosocial" is used in place of "psychological" to recognize that a person's mental well-being is consistently influenced by both her psychological makeup and also social factors.

Source: GBVIMS Steering Committee 2017, pp. 9-10.

Layer 2: Community and Family Supports

GBV survivors and women and girls at increased risk of violence are able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports. This includes:

- Community awareness-raising and education to help communities understand and reduce stigma attached to GBV, and promotion of community acceptance of and support to survivors.
- Community self-help and resilience strategies to support survivors and those at increased risk of GBV, e.g., through supporting women's and girls' safe spaces.
- Strengthening survivor-centred traditional support and coping mechanisms.
- Supporting resumption of educational and livelihood activities.

Layer 3: Focused, Non-Specialized Services

This level focuses on GBV survivors who come forward for help and require individual or group support. Survivor-centred multisectoral responses deliver appropriate, accessible and high-quality services and assistance to support coping and recovery for individuals and groups of survivors. This includes:

- Case management for holistic and coordinated individualized service delivery and assistance (see Standard 6: GBV Case Management).
- Group-based psychosocial support sessions with women and girls, including GBV survivors, but not exclusively focused on survivors, and including group psychosocial sessions focused on promoting connectedness, peer relationships, self- and community efficacy, calming and relaxation (see Standard 8: Women's and Girls' Safe Spaces).
- Culturally appropriate counselling that provides information and emotional support.
- Livelihood and other social or economic reintegration interventions.

Layer 4: Specialized Services

This layer focuses on the additional support required for the small percentage of survivors whose suffering, despite the three layers of support outlined above, is intolerable, and who may have significant difficulties in basic daily functioning.

- Psychological or psychiatric evaluation, treatment and care by trained professionals.
- Specialized psychological interventions to individual survivors who exhibit signs of distress that are so severe they cannot be addressed at lower layers.
- Continuity of access to services (e.g., case management, women's and girls' safe spaces).

See Guidance Note 1 for additional information on the IASC Intervention Pyramid.

Survivors of GBV can present a wide range of reactions, symptoms and difficulties. It is important to keep in mind that a survivor's reaction is usually a temporary and natural response to an abnormal event.[157] The effects of GBV depend on individual, family, economic, socio-cultural and environmental factors, including but not limited to intersecting inequalities that further increase risks to women and girls; their relationship to the perpetrator, and personal and social coping and support mechanisms; the nature and context of the violence; and the level of social stigma or family and community support and acceptance. Protective factors that may minimize psychological impact include the ability to exercise control and choice in responding to the violence; having access to material support and resources to meet needs; and receiving psychosocial and emotional support.[158] Most women recover with basic psychosocial support, although some may experience severe and enduring symptoms that require specialized support. GBV staff should allow the survivor to determine what she wishes to share, and whether she would like further psychosocial and/or mental health and support.

Sexual violence can cause significant and long-lasting impacts on the mental health and psychosocial well-being of adult male survivors who should be supported to access survivor-centred care through trained health, mental health and psychosocial support programming, and community-based groups (see Standard 4: Health Care for GBV Survivors). Psychosocial group support activities should not focus exclusively on male survivors. GBV referral pathways should support men and adolescent boys to access mental health and psychosocial support care through health facilities and to join relevant community support groups and life skills programmes, according to the survivors' wishes.

Since stigmas surrounding mental health and psychosocial difficulties often present barriers to seeking care, GBV programme actors should work with local staff and leaders to identify terms that may exacerbate stigma or carry negative connotation in local cultures, and confirm acceptable and relevant terms.

Indicators

- Context-specific psychosocial support services focused on the needs of women and girls established within two weeks of the onset of a crisis.
- Percentage of GBV staff trained to provide quality, age-appropriate, focused psychosocial support services to women and girls.
- Percentage of women and girls (disaggregated by age) who accessed focused psychosocial support services indicating satisfaction with services.
- Percentage of women and girls who report that the focused psychosocial support services they accessed were delivered in accordance with their needs and preferences (disaggregated by individual and group-based support, gender and age).

Guidance notes

1. Mental health and psychosocial support: the IASC Intervention Pyramid

Women and girls in emergencies are affected in different ways and require different kinds of psychosocial support (See Figure 2, the IASC Intervention Pyramid). Most women and girls will benefit from basic services, safety and security. Community and family structures can promote protection and well-being. Women and girls also may benefit from focused person-to-person services, such as counselling, case management, and emotional and practical support provided by trained community or social workers. A smaller proportion of the population who experience specific mental health issues may require specialized mental health services delivered by mental health professionals, such as a psychologist or psychiatrist, in a manner that is appropriate to the local social and cultural context.[159]

The IASC Intervention Pyramid illustrates the need for multilayered psychosocial and mental health support in emergencies, and the proportion of people who will need or benefit from different services. It does not illustrate a hierarchy of different types of support. All layers of services in the pyramid are important and, ideally, implemented concurrently.

Creating accessible safe, female-only spaces for women and girls, where female GBV survivors can go to receive services and support, or seek immediate safety if they are at risk of GBV, is an effective psychosocial support intervention that promotes safety, healing and recovery.

See Standard 8: Women's and Girls' Safe Spaces.

GBV programmes mainly work in the centre of the pyramid – Layers 2 and 3 – by strengthening family and community supports and also providing focused support for survivors of GBV. Often the first line of focused services (Layer 3) will be through community-based organizations and trained GBV support workers.[160] Timely and strong support from families, friends and trained GBV support workers – Layers 2 and 3 – are likely to reduce the likelihood that a survivor will develop a condition requiring treatment.

Some survivors may experience persistent symptoms and emotional distress, however. If a survivor continues to experience problems with mood, thoughts or behaviour, and is unable to function in her daily life, she may have more severe health problems. It is important that service providers are able to recognize when a survivor requires more specialized mental health services, and can help her obtain such care. All GBV programme staff should be familiar with the services available to survivors in their area of operation, and able to make safe and confidential referrals based on informed

Signs that a survivor may need specialized mental health support:

- If a survivor does not show signs of improved coping or recovery, or shows deterioration.
- If a survivor is not functioning and not able to care for self or children.
- If a survivor is believed or known to have a mental health condition.
- If a survivor talks of suicide or indicates she may be a risk to herself or others.
- If a survivor requests specialized mental health services.

See Standard 4: Health Care for GBV Survivors.

consent. Clinical treatment for mental health disorders requires specialized services delivered by qualified mental health professionals. Although it may be challenging to identify providers for specialized services, programmes should not attempt specialized mental health care without proper qualifications.

GBV programmes do not often provide basic services (Layer 1), but they may play a role in training other service providers and sectors in basic GBV prevention and response, the GBV Guiding Principles, etc. to ensure high-quality and compassionate care among service providers.

All psychosocial support providers must understand the consequences of GBV and be able to provide compassionate support to survivors whether or not survivors disclose. In emergencies, as health is often an entry point for other services, GBV programme actors can support health-care providers to offer emotional support; understand the potential psychological, social and medical impacts of GBV; and refer survivors to appropriate services in a safe and timely manner (see Standard 4: Health Care for GBV Survivors).

2. Individual and group psychosocial support

Psychosocial support for survivors is best provided through community-based interventions that strengthen local capacities and pay attention to the multiple needs (e.g., security, livelihoods) of women and girls.

Group psychosocial support takes place at both Layers 2 (community and family support) and 3 (focused, non-specialized support) of the IASC Intervention Pyramid (see Figure 2). A large portion of group psychosocial support in GBV programmes occurs at Layer 2. For example, drop-in recreation, skills-building or information-sharing groups provide common activities for women and girls to enjoy in a safe environment.

At Layer 3, group psychosocial support can provide GBV survivors with avenues leading to reintegration in the community and strengthen interpersonal connections among group members. Structured Layer 3 groups include multiple meetings over the course of several weeks with the same group of women. They should be guided by a specific curriculum[161], and may include activities like sewing, beading and financial literacy. These groups often include a set of topics that guide the group from week to week. They focus on common emotional responses to events, understanding reactions, challenges in recovery and coping mechanisms to overcome challenges. Facilitators need additional training and supervision to implement structured group activities.

GBV programme actors should be cautious in ensuring GBV survivors are safely integrated into group psychosocial support activities. Activities should never target only survivors, and should not focus on experiences of GBV unless survivors choose to speak freely about their experiences. Without compromising confidentiality, service providers can invite survivors of GBV to join supportive groups focused on accomplishing a shared goal or learning a new skill. If these groups are organized at women's centres or safe spaces run by GBV programmes, it should be conveyed that survivors are always welcome and accepted in these activities, and all participants can agree to maintain confidentiality, if and when survivors choose to freely talk about their experiences. All staff/volunteers facilitating any type of psychosocial group should be prepared for survivors to share their experiences and able to assist both the survivor and other

group members to ensure that negative emotions associated with either sharing or hearing the experience are addressed.

When grounded in the survivor-centred approach outlined in this resource, GBV case management can be considered a psychosocial support intervention that falls under the third level of the pyramid. Case management is also an important method for helping survivors access other mental health and psychosocial services, programmes and resources in their community that are part of the other layers of the pyramid. The consistent relationship between a survivor and caseworker is a psychosocial support intervention; case management also includes skill-building on the consequences and dynamics of GBV, relaxation strategies and ongoing safety planning (see Standard 6: GBV Case Management). It is important to remember that not all survivors will want or need case management services. When appropriate, response workers trained on GBV can provide psychosocial support or connect a survivor to psychosocial services without leading a survivor through the entire case management process.

Tools and Resources

GBV Area of Responsibility and International Medical Corps (IMC). 2018. Managing Gender-based Violence Programmes in Emergencies Training Course: Facilitation Manual.

Health and Human Rights Info (2014). *Mental Health and Gender-based Violence: Helping Survivors of Sexual Violence in Conflict – A Training Manual.* Rev. ed. Oslo. https://www.hhri.org/wp-content/uploads/2019/01/HHRI_EN_GBV.pdf.

Inter-Agency Standing Committee (IASC) (2015). Pocket Guide. *How to support survivors of gender-based violence when a GBV actor is not available in your area.* https://gbvguidelines.org/en/pocketguide/

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IASC Global Protection Cluster Working Group and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2010). *Mental Health and Psychosocial Support in Emergency Settings: What Should Protection Programme Managers Know?* Geneva: IASC. https://interagencystandingcommittee.org/system/files/legacy_files/MHPSS%20Protection%20Actors.pdf.

IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings (2012). *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide.* http://www.who.int/mental_health/publications/IASC_reference_group_psychosocial_support_assessment_guide.pdf.

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STANDARD

6 GBV Case Management

GBV survivors access appropriate, quality case management services including coordinated care and support to navigate available services.

Case management is a collaborative process that engages a range of service providers to meet a survivor's immediate needs and support long-term recovery. Effective GBV case management ensures informed consent and confidentiality, respects the survivor's wishes, and provides inclusive services and support without discrimination (see Standard 1: GBV Guiding Principles).[162] GBV case management is responsive to the unique needs of each survivor. It is important that survivors are provided with comprehensive information so they can make informed choices, including choices about using multisectoral GBV response services (health, psychosocial, legal, security) and the possible consequences of accessing those services (e.g., mandatory reporting).[163]

GBV case management involves a trained psychosocial support or social services actor: (1) taking responsibility for ensuring that survivors are informed of all the options available to them and referring them to relevant services based on consent; (2) identifying and following up on issues that a survivor (and her family, if relevant) is facing in a coordinated way; and (3) providing the survivor with emotional support throughout the process. GBV case management has become the primary entry point for GBV survivors to receive crisis and longer term psychosocial support because of the lack of more established health and social support service providers in humanitarian settings.[164]

Case Management Steps

1. Introduction and engagement
2. Assessment
3. Case action planning
4. Implement the case action plan
5. Follow-up
6. Case closure

Source: GBVIMS Steering Committee 2017.

The case management process is not linear and, in emergencies, it is often difficult to complete all case management steps. Survivors' immediate needs and choices should be prioritized always, including their safety and security, and access to health care and psychosocial support.[165] The caseworker works closely with the survivor to assess their immediate risks and needs, and prepare a safety plan. In addition, the caseworker should

KEY ACTIONS GBV Case Management

	Preparedness	Response	Recovery
Conduct service mapping to identify existing services and gaps, and develop a plan to address critical capacity gaps with other actors (e.g., health and child protection) and community members.	✔	✔	✔
Engage health, psychosocial, child protection, protection, legal, livelihood and other relevant and available service providers to support referral of survivors by caseworkers (see Standard 7: Referral Systems).	✔	✔	✔
Recruit and hire sufficient GBV caseworkers to allow for a caseworker-to-survivor ratio of 1 to 15 active cases and no more than 1 to 20, and a supervisor-to-caseworker ratio of 1 to 5 and no larger than 1 to 8.[166]	✔	✔	✔
Train GBV caseworkers to implement the steps of case management, in a survivor-centred way and respecting the GBV Guiding Principles.[167]	✔	✔	✔
Recruit a team of GBV caseworkers and train them on qualities, knowledge and skills required to provide quality GBV case management services to address different forms of GBV.	✔	✔	✔
Build the capacity of GBV staff/volunteers on the GBV Guiding Principles and provide information to all those working on GBV on how to safely refer survivors to case management services.	✔	✔	✔
With women and girls, identify safe location(s) to provide GBV case management services. Consider utilizing safe spaces for women and girls to provide non-stigmatizing access points to GBV case management as well as mobile options (see Standard 8: Women's and Girls' Safe Spaces).	✔	✔	✔
Develop protocols for GBV case coordination to coordinate services among all service providers.[168]	✔	✔	✔
Engage with child protection and protection caseworkers in joint trainings, coordination and mapping of response services, and establish joint referral pathways and standard operating procedures that provide clear criteria for offering specialized support to adolescent girls and boys.	✔	✔	✔
Disseminate information and engage the community around the availability and utility of case management services, if safe to do so.	✔	✔	✔
Tailor case management services to ensure appropriate access and support for all women and girls.	✔	✔	✔
Work with health, child protection, disability and other protection actors and community groups to ensure men and boys have access to case management following sexual assault through appropriate entry points.[169]	✔	✔	✔
Deliver GBV case management services according to international standards, including safe and ethical data collection (see Standard 14: Collection and Use of Survivor Data).	✔	✔	✔
Draft written policies that outline organizational GBV case management protocols to help staff understand what is expected of them within their day-to-day work, including but not limited to, limits on contact hours with survivors, case archives, protocols for high-risk cases, etc.	✔	✔	✔
Understand context-specific mandatory reporting procedures, community-based reporting mechanisms and investigation processes to support clients, including with cases of sexual exploitation and abuse.	✔	✔	✔
Work with organizations and sectors to reduce barriers to service access and delivery (see Standard 2: Women's and Girls' Participation and Empowerment).	✔	✔	✔
Ensure regular supervision is provided to GBV caseworkers by supervisors trained in supervision and case management, to support their work, and assess their attitudes and behaviour towards survivors (see Standard 3: Staff Care and Support).[170]	✔	✔	✔
Monitor the quality of care and case management services through client feedback surveys, case file audits and ongoing supervision of GBV caseworkers.	✔	✔	✔

Male Survivors of Sexual Violence

GBV programmes are oriented around the rights and protection needs of women and girls. Male survivors of sexual violence may seek support from GBV caseworkers. The *Interagency GBV Case Management Guidelines* provides guidance on caring for male survivors, and *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings* provides guidance specific to boys.

GBV programme actors should understand that additional services may be required to meet the needs of male survivors of sexual violence, including men and boys with disabilities, diverse sexual orientations and gender identities, and young and adolescent boys, particularly those who are unaccompanied, separated, engaged in child labour or in detention.

Most services developed for women and girls will not be appropriate for male survivors. Further, providing support for male survivors through such services will make them less safe and accessible for women and girls. Male survivors of sexual violence require diversified entry points to services and staff with specialized skills. Alternative entry points for men and boys include general psychosocial support services, protection services, health facilities, community centres, disability support centres, LGBTI centres, and, for young and adolescent boys, child and youth protection centres and services.

For more information, see GBVIMS Steering Committee 2017, pp. 135-137.

connect the survivor to health care and/or other prioritized services if she so wishes.[171] Even in an acute emergency, GBV caseworkers must first establish safe referral pathways and assess the quality of services before offering information and referrals.[172]

GBV programme actors should invest in quality GBV case management as a priority action in GBV responses. All actors, and caseworkers in particular, must have strong interpersonal skills and the capacity to apply a survivor-centred approach to support, guide, listen, assess, plan and follow up on services for survivors.[173]

Case management discussions should be held in a quiet, private setting where the survivor feels safe. Meeting in a survivor's home is discouraged because of the lack of confidentiality and risks to the survivor, caseworker and community.[174] Survivors should not be actively "identified" in their homes or any other forum (e.g., through information dissemination activities). Confidential, non-stigmatizing access to GBV case management services can be provided to women and girls, for example, through safe spaces that offer a range of activities (see Standard 8: Women's and Girls' Safe Spaces). Female GBV caseworkers are essential across all GBV service providers; the majority of survivors prefer female caseworkers as the majority of perpetrators of GBV are male. Female GBV caseworkers can also work within integrated health/reproductive health settings to facilitate timely access to both clinical care and case management support.

The caseworker works with the survivor to develop a comprehensive plan that identifies what the survivor needs and how her needs will be met. Caseworkers must be familiar with the range of quality multisectoral services available, and engage regularly with other agencies to ensure a coordinated process of referral, service delivery and follow-up.[175] The consistent communication (including active listening) and emotional support provided in a trusting and ethical relationship is the basis of good case management and is also a form of psychosocial support (see Standard 5: Psychosocial Support). It is critical that caseworkers are supported with structured and regular supervision.[176] As required, and with the survivor's informed consent, caseworkers can act as advocates on behalf of survivors (e.g., to follow up on survivors' access to other services).[177]

Caseworkers should never mediate between a survivor and a perpetrator, even if a survivor requests this type of intervention, because meditation is unlikely to stop violence in the long term, and has the potential to escalate violence and cause more harm to the survivor. It is a great risk to the survivor, caseworkers and organization.[178] Organizations should have clear guidelines on how to respond to requests for mediation in a survivor-centred manner.

Child Survivors of Sexual Abuse

In cases of sexual abuse involving children, the best interests of the child need to be considered. The "best interests of the child" principle recognizes that every child is unique and will be affected differently by sexual violence. All decisions and actions affecting the child should reflect what is best for the safety, well-being and development of that particular child.

See Guidance Note 2 for further discussion.

Accessing case management services is **voluntary**; not all survivors will want or need case management services. Staff should not identify or seek out survivors in any setting.

In addition, in some settings, trained caseworkers may not be available, and actors receiving a disclosure from a GBV survivor may be from other humanitarian sectors (water and sanitation, nutrition, shelter, etc.). The roles of these actors are critical in responding to the immediate needs of a survivor but must be limited to providing psychological first aid and links to GBV services.[179]

The quality of care and support that GBV survivors receive, including the way they are treated by the people they turn to for help, affects their safety, well-being and recovery. It also influences whether other survivors feel comfortable coming forward for help. Qualified staff and systems in organizations providing GBV case management services are essential to establishing and maintaining quality, survivor-centred care.[180]

In GBV case management, confidentiality is maintained through strict information-sharing practices that rely on principles of sharing only what is absolutely necessary to those involved in the survivor's care, and always with her consent. It is also necessary to protect written data about a survivor or a case through safe data collection and storage practices (see Standard 14: Collection and Use of Survivor Data).[181]

Indicators

- Percentage of GBV caseworkers who, after training, meet 80 per cent of supervision criteria for attitudes, knowledge and skills required to provide quality GBV case management services.[182]
- Percentage of GBV caseworkers with active cases at or below the 1 to 20 maximum ratio.
- Percentage of GBV supervisors supporting caseworkers at or below the 1 to 8 maximum ratio.
- Percentage of survivors (disaggregated by sex and age) who completed a feedback survey who are satisfied with the case management services.[183]

Guidance notes

1. Common services that GBV survivors have the right to receive

GBV survivors often need various types of care and support to help them recover and heal and to be safe from further violence:

- **Medical treatment and health care** to address the immediate and long-term physical and mental health effects of GBV, including but not limited to initial examination and treatment, follow-up medical care, and health-related legal services, such as preparation of documentation (see Standard 4: Health Care for GBV Survivors).
- **Psychosocial care and support** to assist with healing and recovery from emotional, psychological and social effects, including but not limited to crisis care, longer term emotional and practical support, and information and advocacy (see Standard 5: Psychosocial Support).
- **Options for safety and protection** for survivors and their families who are at risk of further violence, and who wish to be protected through safe shelters, police or community security, and relocation.
- **Legal (informal and formal) and law enforcement services** that can promote or help survivors to claim their legal rights and protections, including but not limited to legal aid services (see Standard 10: Justice and Legal Aid).
- **Education, economic/assistance and livelihood opportunities** to support survivors and their families to live independently and in safety and with dignity, including but not limited to referral pathways for existing livelihood and education programmes, and targeted economic interventions that can mitigate risks of GBV, and foster healing and empowerment (see Standard 12: Economic Empowerment and Livelihoods).
- **Other protection services, including durable solutions for displaced populations.** Documentation and entitlement services (e.g., separate ration cards) as well as planning for durable solutions, including resettlement, local integration and voluntary repatriation, can contribute significantly to a survivor's safety. [184]

2. Mandatory reporting

Many countries have laws that require service providers to report to police or other government authorities any acts that are believed to be criminal offences. In such situations, legal requirements override the survivor's permission. Survivors (and caregivers) should be made aware of these legal requirements as part of the informed consent process. In humanitarian settings, all organizations are mandated to have protocols in place for responding to sexual exploitation and abuse by humanitarian workers. Organizations need to be clear on the inter-agency protocol and inform the survivor as to whom the case would be reported, what information would be shared, and what the expectations would be regarding the survivor's involvement.[185] Caseworkers are generally mandated to report to a supervisor if a client has suicidal ideation.[186]

All response actors need to **understand the laws and obligations on mandatory reporting** as they relate to GBV cases, and the specific requirements for children. Although mandatory reporting is often intended to protect survivors (particularly children), following mandatory reporting procedures in some situations conflicts with the GBV Guiding Principles, including safety, confidentiality and respect for self-determination. It can also result in actions that are not in the best interests of the survivor. For example, mandatory reporting of cases of sexual violence or intimate partner violence to the police can put the survivor at great risk of harm from the perpetrator, family members or community members. Every organization must decide how it is going to handle mandatory reporting when doing so is not in the best interests of the survivor.

Survivors must be informed immediately upon reporting an incident when mandatory reporting procedures are in place.[187] Do not "promise" confidentiality as it is not acceptable to make promises to survivors that you might not be able to keep. **Instead, from the very beginning, be clear what confidentiality means and what the limits are in your context.**

3. Caring for child survivors of sexual abuse

Child protection and GBV caseworkers should work together closely to ensure that young and adolescent girls and boys who are sexually assaulted receive appropriate gender- and age-sensitive case management support. They should both implement the *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings,* and invest in joint trainings and ongoing mentoring and supervision to increase the quality of case management support to child survivors.[188] In contexts with both child protection and GBV programme actors providing case management services, it is recommended that service-level coordination agreements are established between organizations.[189] When both child protection and GBV response services are equipped to meet the needs of child survivors of sexual abuse, then young and adolescent girls and boys benefit from increased access to age- and gender-sensitive case management support services. Engaging in joint coordination and mapping of response services, joint referral pathways, and clear criteria for offering specialized support to young and adolescent girls and boys are key actions for child protection and GBV response actors.

Children have the right to participate in decisions affecting them, appropriate to their level of maturity. Children's ability to form and express their opinions develops with age, and adults should give the views of adolescents greater weight than those of a younger child.[190]
A child's best interests are central to good care. Best interest considerations for children are focused on securing their physical and emotional safety and well-being throughout their care and treatment. Service providers must evaluate the positive and negative consequences of actions with the participation of the child and her caregivers as appropriate. The least harmful course of action is always preferred. All actions should ensure that children's rights to safety and ongoing development are never compromised.[191]

Older adolescents, ages 15 years and above, are generally considered mature enough to make decisions. They are often allowed to make decisions about their own care and treatment, especially for sexual and reproductive health-care services. They can give their informed consent or assent in accordance with local laws and with the best interests of the child.[192]

Tools and Resources

Gender-based Violence Information Management System (GBVIMS) Steering Committee (2017). *Interagency Gender-based Violence Case Management Guidelines: Providing Care and Case Management Service to Gender-based Violence Survivors in Humanitarian Settings.* https://gbvresponders.org/response/gbv-case-management/.

International Rescue Committee (2018). *GBV Response Services Mapping Tool (English and French).* Available from: https://gbvresponders.org/emergency-response-preparedness/emergency-response-assessment/.

_____ (2018f). *GBV Case Management Outcome Monitoring Toolkit.* Available from GBV Responders' Network*:* https://gbvresponders.org/wp-content/uploads/2018/11/GBV-Case-Management-Outcome-Monitoring-Toolkit_FINAL.docx.

International Rescue Committee and UNICEF (2012). *Caring for Child Survivors of Sexual Abuse Guidelines (2012) and training toolkit (English, French, Arabic).* Available from: https://gbvresponders.org/response/caring-child-survivors/.

United Nations High Commissioner for Refugees (2008). *Guidelines on Assessing and Determining the Best Interests of the Child.* https://www.refworld.org/docid/5c18d7254.html. Accessed on 26 May 2019.

United Nations Population Fund (2015). *Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies.* New York. https://www.unfpa.org/featured-publication/gbvie-standards.

STANDARD

7 Referral Systems

Referral systems are in place to connect GBV survivors to appropriate, quality, multisectoral services in a timely, safe and confidential manner.

In emergency settings, GBV survivors must be able to access life-saving services quickly and safely. At a minimum, this requires: (1) a network of qualified multisectoral service providers; and (2) an established referral pathway or system[193] that supports survivors' timely, safe and confidential access to services.[194]

A **referral pathway** is a flexible mechanism that safely links survivors to services such as health, psychosocial support, case management, safety/security, and justice and legal aid.[195] A functional referral system of survivor-centred, multisectoral service providers supports survivors' health, healing and empowerment. Referral systems must prioritize survivor safety and confidentiality, and respect survivors' choices (see Standard 1: GBV Guiding Principles); this means recognizing that even with services in place, survivors may still choose not to access certain types of care.

Referral systems:

- Coordinate service delivery;
- Improve safe and timely access to quality services for survivors of GBV;
- Prioritize survivor safety and confidentiality, and respect survivors' choices; and
- Ensure that survivors are active participants in defining their needs and deciding what response and support options best meet those needs.

During an acute emergency, the first step is to establish a **minimum referral pathway**[196] at the local level, as it may take time to gather the information required to establish a full referral system and standard operating procedures (see Guidance Note 2).[197] An initial referral pathway should include health, psychosocial support,

In all emergency contexts – particularly in the acute phase, where sexual violence and intimate partner violence are prevalent – **health** is the priority service.

KEY ACTIONS Referral Systems

	Preparedness	Response	Recovery
Conduct or update a rapid mapping and quality assessment of GBV response services to determine inclusion in the referral pathway to meet survivors' urgent needs, including health, case management, psychosocial support, safety/security and legal aid/justice systems.	✔	✔	
Establish a functional and context-appropriate referral pathway that builds on existing GBV services and community-based structures.	✔	✔	✔
Identify and address barriers to GBV survivors' access to services (e.g., transport, knowledge of services, language, literacy, disability, age, etc.) through meaningful consultation with diverse groups of women and girls.	✔	✔	✔
Build on initial mapping of services to develop standard operating procedures among all service providers to ensure the referral pathway promotes the safety and dignity of survivors and is updated regularly. In addition to priority services (e.g., health, psychosocial support), include services that support longer term recovery and reintegration (e.g., livelihood, education).	✔	✔	✔
Engage child protection actors to map support services for young and adolescent girl and boy survivors, and establish age- and gender-appropriate referral pathways agreed between child protection and GBV programme actors.	✔	✔	✔
Establish systems to ensure survivor information is not accessible to those outside of the service provision relationship during the referral process (see Standard 14: Collection and Use of Survivor Data).	✔	✔	✔
Design and disseminate referral pathway information campaigns that are accessible and understandable for all groups of women and girls (e.g., referral cards/flyers in the local language using pictures/diagrams).	✔	✔	✔
Reassess and update the referral pathway every six months at a minimum, including service providers' contact information.	✔	✔	✔
Ensure women, girls, men and boys are informed of GBV services and referral pathways as soon as possible by engaging community leaders and "gatekeepers" to promote awareness of the referral pathway.	✔	✔	✔
Disseminate information on the referral pathway among service providers and GBV focal points across agencies. Provide other sectors with information about the referral pathway and GBV guiding principles.	✔	✔	✔
Include the identification of focal persons and alternates for each member agency in the GBV referral system.	✔	✔	✔
Establish regular meetings to discuss common challenges among service providers to improve timely referrals.	✔	✔	✔
Regularly engage women and girls to monitor their understanding of the access points in the referral pathway and identify any harmful unintended consequences (e.g., breaches in confidentiality, safety, respect and non-discrimination; see Standard 1: GBV Guiding Principles).	✔	✔	✔
Conduct periodic rapid assessments to determine survivor needs and access to services to promote safe and timely access.	✔	✔	✔
Continuously address challenges that prevent the referral system from functioning (e.g., barriers for survivors in accessing services, challenges for coordinated service provision and case management).		✔	✔

case management and safety/security. Establishing a referral system is the task of coordination mechanisms such as the GBV working group or GBV subcluster; however, in the absence of a coordination body, GBV programme actors should conduct their own mapping and assessment to inform and establish a referral system, including by engaging with all service providers in the local setting. Referral systems should be updated on a regular basis and reflect any changes in service providers.

Service mapping should assess:

- What services existed prior to the emergency?
- What services are still functioning?
- Are these services safe, accessible and adequately staffed?
- Are minimum standards of service delivery being met or is further capacity strengthening required?

Service providers should guide individual survivors through the referral system as the survivor accesses services; this approach ensures that survivors can obtain multiple services without having to retell their stories. Referral systems should be established based on a coordinated mapping and/or assessment of available services and capacity in each location. This includes understanding the capacity of each actor that may be included in the referral system. The quality of services should be documented and monitored over time to ensure they are functional and meet minimum standards of care in line with GBV Guiding Principles (see Standard 1: GBV Guiding Principles). For example, the assessment of health services should determine if there is a confidential space to treat survivors, and if staff have been trained on clinical care for GBV survivors (see Standard 4: Health Care for GBV Survivors). GBV programme actors should conduct the assessment directly or in collaboration with other relevant service providers.

Indicators

- Referral pathway in place and regularly updated, and service mapping and standard operating procedures established.
- Capacity of service providers is assessed to improve quality of service delivery and strengthen referral system.
- Percentage of clients who report satisfaction with service providers to which they are referred.
- Standard GBV consent and intake forms are adapted and utilized by service providers within the GBV information management system, if available.
- Survivors who report are referred to health, psychosocial, case management, legal or any other service based on their needs and informed consent within the recommended timeframe.

Guidance notes

1. Referral systems and GBV Guiding Principles

Service providers within a referral system must adhere to the GBV Guiding Principles (see Standard 1: GBV Guiding Principles) and a survivor-centred approach. This means service providers share information and options with survivors so they can make informed decisions, and providers only act with survivors' explicit **informed consent**. A service provider should never try to convince or coerce a survivor into reporting her case or accessing specific services.

When is a referral complete?

A referral is complete once a survivor has received the service to which she was referred. In other words, only referring a survivor to another service provider does not constitute a "referral". For example, if a GBV caseworker refers a survivor to receive health care for her injuries, that referral is complete only once the survivor has been treated by the health-care provider.

Prioritizing survivor **safety** and security includes ensuring hard-to-reach populations have safe access to services, integrating GBV activities into other services and locations (e.g., health centres), and using simple activities as a discreet entry point for GBV-specific activities (e.g., organizing generic activities for women and girls that allow survivors to access case management services and psychosocial activities). To maintain **confidentiality,** service providers must ensure that individual information is shared only with the consent of the survivor and in support of her access to services. The number of people informed of the case must be kept to concerned people only, and all service providers must provide a safe and confidential space for survivors to receive services. Service providers should develop and sign a data protection policy.

> *A functional referral system of survivor-centred, multisectoral service providers supports survivors' health, healing and empowerment.*

GBV Standard Operating Procedures

Standard operating procedures (SOPs) are specific procedures and agreements among organizations in a particular context that outline a plan of action, and the roles and responsibilities of each actor in the prevention of and response to GBV. In addition to coordinating response programming, SOPs should reinforce the GBV Guiding Principles and standards for ethical, safe, and coordinated multisectoral service delivery.

The SOP development process is an intervention in itself because it must engage all relevant actors, and involves collaboration, interorganizational and cross-sectoral exchange, community participation and negotiation, thereby increasing all participants' understanding of how to prevent and respond to GBV. Agreed and documented SOPs for GBV prevention and response actions are considered a good practice. Any plan of action for the GBV humanitarian response should include a plan for developing SOPs.

In addition to inter-agency SOPs, individual organizations should establish internal policy and procedural guidance with regard to their GBV activities and programmes.

Source: IASC Sub-Working Group on Gender and Humanitarian Action 2008, pp. 2-3.

2. Elements of a functional referral system

A functional GBV referral system is accessible and safe for survivors, and includes the following elements:[198]

- At least one service provider for health, psychosocial support, case management, safety and security, and, as appropriate and feasible, legal aid and other support, in a given geographical area.
- Referral pathways identify all available services and are documented, disseminated and regularly assessed and updated, in a format that can be easily understood (e.g., through pictures/diagrams).
- Services are delivered in a manner consistent with the GBV Guiding Principles.
- All service providers understand where to refer survivors for additional services, and how to do so safely, confidentially and ethically.
- All service providers have a mechanism for following up on referrals to ensure referrals have been completed. For instance, a return slip or checklist should be used by referring service providers to indicate the status of services received by the GBV survivor.
- All service providers demonstrate a coordinated approach to case management, including confidential information-sharing and participation in regular case management meetings to ensure survivors have access to multisectoral services (see Standard 6: GBV Case Management).
- GBV data collection among all service providers, including standardized intake and referral forms, is safe and ethical (see Standard 14: Collection and Use of Survivor Data).
- All service providers prioritize the response to GBV survivors.

3. Community engagement and awareness-raising

The objectives of community outreach and awareness-raising in emergencies are to increase timely and safe access to services and mitigate risks of GBV.[199] Community engagement and information-sharing during the emergency response phase are not about shifting community norms or preventing violence more broadly (see Standard 13: Transforming Systems and Social Norms).

STOP! Do No Harm.

All awareness-raising on GBV must include information on how survivors can access support. In order to respect the principle of "do no harm", it is generally not recommended to conduct community awareness-raising activities on GBV in locations where response services have not yet been established.

In the emergency phase, community engagement messages and activities should focus on:

- Access to services, especially life-saving and time-sensitive health services, because survivors need to know where to find help.
- Activities that can help reduce women's and girls' risk of GBV, especially sexual violence.

Community engagement and outreach methods may vary based on the context; some ideas include loudspeakers; dissemination of information, education, communication materials (e.g., posters, pamphlets); meetings or small-group discussions; sharing information at distributions of materials or food; social media and websites (e.g., www.refugee.info).

Safety is an essential element to consider in designing community outreach and awareness-raising messages and methods. It is important to assess how certain messages may be viewed by different members of the community or armed groups, and what this may mean for staff and women and girls.[200] The means of sharing information with communities must also be weighed; e.g., in many emergency situations, men will not allow women to meet together or mobilize.[201] In some cases, it may be safer to adapt messaging to speak with small groups of women rather than conduct large community-level awareness-raising campaigns. Engaging with women and girls is important for guiding community engagement efforts, including towards ensuring that no additional risks are created (see Standard 2: Women's and Girls' Participation and Empowerment).

Key attributes of effective community outreach messages include:

- **Clarity**: Keep the wording and meaning of the message simple.
- **Easy to read/hear/understand**: Images should be clear and culturally appropriate using common words.

An initial referral pathway should include health, psychosocial support, case management and safety/security.

- **Action-oriented**: Consider how the messages conveyed help the community, women and girls, and GBV survivors know what to do to help themselves.
- **Specific**: Include instructive details.
- **Positive**: Illustrate positive action and attitudes; do not patronize, shame or depict people in negative ways.[202]

Additional considerations for community engagement include:

- Designing messages to reach the most people possible; for example, taking into account the overall literacy rate.
- Messages should be as inclusive as possible by ensuring that different groups of women and girls – including all age groups, relevant ethnicities, those with different disabilities, etc. – are reflected in community outreach images.
- Images of violence against women and girls should not be used in community outreach messaging as this can normalize the violence and be a harmful trigger for survivors.

When deciding when and how to share information, keep in mind the barriers that women and girls may face in accessing information. It is important to use various channels and consider how women and girls can best access information.

Tools and Resources

Gender-based Violence Information Management System (GBVIMS) Steering Committee (2017). *Interagency Gender-based Violence Case Management Guidelines: Providing Care and Case Management Service to Gender-based Violence Survivors in Humanitarian Settings.* https://gbvresponders.org/response/gbv-case-management/.

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STANDARD 8 Women's and Girls' Safe Spaces

Women and girls only safe spaces are available, accessible and provide quality services, information and activities that promote healing, well-being and empowerment.

Creating safe spaces for women and girls is a critical part of GBV programming. A women's and girls' safe space (WGSS) is an intervention that GBV programme actors in humanitarian programming have employed for decades as an entry point for women and girls to report protection concerns, express their needs, receive services, engage in empowerment activities and connect with the community.[203]

A WGSS is "a structured place where women and girls' physical and emotional safety is respected and where women and girls are supported through processes of empowerment to seek, share, and obtain information, access services, express themselves, enhance psychosocial wellbeing, and more fully realize their rights".[204]

The five standard objectives of a WGSS

- Provide a vital entry point for female survivors of GBV to safely access information, specialized services, and referrals to health, protection and other services;
- Serve as a place where women and girls can access information, resources and support to reduce the risk of violence;
- Facilitate women's and girls' access to knowledge, skills and services;
- Support women's and girls' psychosocial well-being, and create social networks to reduce isolation or seclusion, and enhance integration into community life; and
- Generate conditions for women's and girls' empowerment.

IRC and International Medical Corps 2019.

A "safe space" is also a women-and-girls-only space; this is important because public spaces in most cultures are inhabited largely by men.[205] Safe spaces provide a critical space where women and girls can be free from harm and harassment, and access opportunities to exercise their rights, and promote their own safety and decision-making. Safe spaces may also be a venue for livelihood activities, sexual and reproductive health information, and access to justice services.[206] (See Guidance Note 1 for a description of different names for, and types of, WGSS.)

KEY ACTIONS Women's and Girls' Safe Spaces

	Preparedness	Response	Recovery
Conduct an assessment with women and adolescent girls prior to establishing the WGSS to gather basic information on the feasibility of establishing and supporting it, and about their needs, preferences and constraints related to access to, and participation in, safe space programming.[207] • Map informal meeting places and networks with women and girls to identify an existing or new location to establish a safe space, and validate with a wider participatory assessment. • Engage with women's groups and civil society to identify existing WGSS. • Partner with local women's organizations to establish WGSS in new areas hosting displaced women and girls.	✔	✔	✔
Consult regularly with women, girls and other community members to understand key security risks in the community, and types of community support systems that existed for women and girls before the crisis.	✔	✔	✔
Engage regularly with women, girls, men and boys from the affected community to explain WGSS activities, facilitate community acceptance and address barriers to women's and girls' attendance.	✔	✔	✔
Coordinate with child protection partners to determine the most appropriate model for facilitating adolescent girls' access to safe spaces.		✔	
Ensure the WGSS is safe, accessible, and has adequate water and sanitation facilities, including by considering the surrounding area, lighting and potential threats. Provide childcare to facilitate participation by mothers.	✔	✔	✔
Establish and train staff on available GBV response services and the referral system to support access to multisectoral services.			
Develop mobile teams and/or outreach activities for those who cannot reach the WGSS.	✔	✔	✔
Train all staff on WGSS principles and concepts.	✔	✔	✔
Hire at least three female staff[208] and female community volunteers to operate the safe space. Train WGSS female staff and volunteers on GBV Guiding Principles and other relevant principles, policies and procedures, including a code of conduct.	✔	✔	✔
Establish advisory groups to support women's and girls' leadership and accountability, and WGSS sustainability.		✔	✔
Train the WGSS advisory groups to facilitate activities and progressively assume responsibilities for the WGSS.		✔	✔
Provide partner organizations and women and girls attending the WGSS with ongoing educational opportunities.		✔	✔
Properly secure case files (if case management is provided through the WGSS), documentation of services and client data kept at the WGSS (see Standard 14: Collection and Use of Survivor Data).	✔	✔	✔
Provide regular staff supervision, self-care activities and safety monitoring, and adapt programming as needed.	✔	✔	✔
Organize and distribute dignity kits through the WGSS (see Standard 11: Dignity Kits, Cash and Voucher Assistance).		✔	
Assess potential partnerships and collaborations to complement safe space programming with other services such as livelihoods or education programmes.	✔	✔	✔
Develop an exit strategy in consultation with women, adolescent girls, and female and male community leaders to minimize harm if the safe space needs to close.[209]		✔	✔

Although specific WGSS interventions may include different services and activities, all should work towards the five standard objectives. Individual empowerment and psychosocial support services are generally present in all WGSS, but other components may not be (e.g., some WGSS do not deliver case management services). In some situations, formal women's centres, in public facilities or operated by local organizations, may be the most easily accessible and appropriate means to provide services. Safe spaces can also be informal and held within community or educational spaces, and linked to women's networks.[210]

Approaches to WGSS space development should be based on the context, risk analysis, and consultation with women, girls and their communities. The safe space modality can be adapted to a variety of humanitarian contexts through diverse delivery models and implementation approaches (see Guidance Note 1). The sustainability of safe spaces should be considered from the start of the intervention.

The WGSS staffing structure depends on multiple factors, including the implementation approach, available resources, number of regular members, and type and number of activities offered.[211] Throughout implementation, WGSS should develop strategies and mechanisms to strengthen members' capacities to co-facilitate and co-organize activities in the WGSS, and assume progressive responsibilities for oversight of the space.[212]

Indicators

- Number and percentage of women and girls consulted to inform WGSS development, disaggregated by age, disability, etc.
- Number of women and girls using WGSS to meet their needs (e.g., attending one cycle of recreational/psychosocial sessions).
- Percentage of trained WGSS personnel who exhibit sufficient knowledge and skills in implementing the GBV Guiding Principles and WGSS guidelines.

Guidance notes

1. Women's and girls' safe space approaches

WGSS are adaptable to best respond to the needs and safety of women and girls across diverse communities and contexts. The choice of approach should ensure the safe space's relevance and effectiveness. WGSS delivery models include:

A **static WGSS** consists of women and girls coming to an easily reached fixed space established in a central location that is open during standard service hours each day. The static delivery model is the primary model used in humanitarian settings. It is appropriate and effective in most contexts, including:

- Formal camps or informal settlements where the area of coverage for service provision is clearly delineated, the number of displaced women and girls residing in the location is generally available, and all are considered in need.
- Urban or rural settings with a relatively defined area of coverage.

A **mobile WGSS** consists of safe space teams moving to locations where women and girls are displaced, residing or in transit so they cannot access a static WGSS. Contexts where mobile WGSS models have been appropriate and effective include:

- **Acute displacement contexts**. A mobile team may be deployed as part of a GBV rapid response team. The space in this context is considered temporary, but women and girls should still be consulted in the planning and implementation of the WGSS.
- **Protracted displacement contexts** in hard-to-reach locations, or responses with a geographically dispersed or random displacement pattern.

This resource on the Minimum Standards uses the term "women's and girls' safe space" to refer to women-and-girls-only spaces that adhere to WGSS objectives and principles. The terms women-friendly space and adolescent girls' safe spaces also refer to WGSS.[213]

The model for **adolescent girls' safe spaces** includes three core elements: a safe place, friends and mentorship.[214] Because of the specific risks adolescent girls experience in crises, creating a safe space specifically for them is an important protective measure and provides access to psychosocial support. Within GBV programming, it is generally recommended that adolescent girls' safe spaces be established within the wider WGSS – rather than as a stand-alone intervention – as a way to link directly with broader GBV prevention and response activities. Activities for adolescent girls in safe spaces should be segmented by age and consider the specific needs of the population.[215] It is important to engage female and male parents/guardians and the wider community in conversations around safe space protection and empowerment activities specific to adolescent girls' participation.

Adolescent Girls

In addition to being at high risk for GBV, including rising rates of child marriage, adolescent girls often experience difficulties accessing humanitarian programming across various sectors. This risk also exists with safe spaces programming, particularly in situations where GBV interventions target adult women and child protection interventions focus on younger children. To avoid excluding adolescent girls, it is crucial for GBV programme actors to coordinate with child protection actors to determine the most appropriate way to make safe spaces programming accessible to adolescent girls. Options may include, but are not limited to, organizing dedicated activities/timeslots for adolescent girls within WGSS or offering activities for adolescent girls as part of child-friendly space programming.

Although women and girls may find safety and support in other types of spaces, the following are **not** generally considered WGSS:

- **One-stop centres:** A one-stop centre provides integrated services for survivors of GBV so they are not required to travel to multiple sites. These spaces may be attached to a hospital or service site, and provide a range of services including health, psychosocial and legal. A one-stop centre is often available to both male and female survivors, and may not be led

by women and girls. It can be considered a WGSS if it meets all principles and standard objectives of WGSS. Where one-stop centres are implemented, additional WGSS are necessary to provide broader protection and empowerment activities to women and girls across the affected community.

- **Safe houses and shelters:** Safe houses/shelters are places that provide immediate security, temporary refuge, and support to survivors who are escaping violent or abusive situations. This service is made available to women and girl survivors of GBV who are in imminent danger. Ideally, a safe shelter or house is accredited and staffed by professionals. Admission is contingent on specific criteria and strict standard operating procedures. It is rarely possible for safe houses and shelters to be operated safely within a camp setting due to the need for their location to be confidential.
- **Women's spaces in reception areas and health facilities**: Women-and-girls-only safe spaces in reception areas of refugee camps or health facilities differ from WGSS. The former is a specific sex-segregated section of the reception area or service provider. The primary objective of such areas is to minimize the risks of violence and harassment for single, separated or unaccompanied women and girls while undergoing the camp registration processes. These areas can also be used to provide information regarding the services available to women and girls.
- **Child-friendly spaces**: Child-friendly spaces are used widely in emergency situations as a first response to the needs of girls and boys, and as a forum for working with affected communities.[216] They are established in response to children's immediate rights for protection, psychosocial well-being and non-formal education. WGSS and child-friendly spaces share common elements, and both may cater to adolescent girls if a sufficient investment is made by GBV programme and child protection actors to equip staff with age- and gender-appropriate capacities. Barriers to adolescent girls' safe participation in mixed spaces need to be addressed appropriately, and, at minimum, a separate space for them within a child-friendly space is recommended.
- **Protection desks** (also called protection integrated centres, community development centres, community centres): Community centres are safe, public places where all community members can meet for social events, recreation, education and livelihood programmes, and other purposes. WGSS may coordinate with community centres for cross-referrals and information-sharing.

2. Guiding considerations for establishing women's and girls' safe spaces

The following principles should guide each phase of establishing and managing a WGSS:

1. **Empowerment:** Each woman and girl has the capacity to shape her own life, and create and contribute to wider social change. Women and girls are included in WGSS planning, implementation, and monitoring and evaluation (see Standard 2: Women's and Girls' Participation and Empowerment).[217]

2. **Solidarity:** The safe space environment enables women and girls to understand their individual experiences within the broader power inequalities in which they live. The WGSS provides opportunities to connect with individuals and groups by encouraging sharing, mentoring and cooperation. These supportive relationships increase self-esteem, positive coping mechanisms and social assets central to women's, girls' and survivors' emotional safety and healing.
3. **Accountability:** Women and girls can openly share their experiences and challenges, and be assured of confidentiality and support. All aspects of the WGSS location, design and programming prioritize the safety and confidentiality of women and girls. Each of these components ensures the integrity of a WGSS as a place where women and girls feel physically and emotionally safe.[218]
4. **Inclusion:** All women and girls are respected and welcomed in a safe space. Staff and volunteers are trained extensively on the principles of inclusion and non-discrimination.[219] All women and girls are:
   - Included in the WGSS design and provided opportunities as staff or volunteers.
   - Supported to engage in the range of services and activities delivered in the WGSS.
   - Engaged actively through tailored outreach strategies to mitigate identified access barriers that hinder their equal participation.
5. **Partnership:** The WGSS should serve to link women and girls to services through strong referral networks. Partnerships with local civil society, particularly women's civil society organizations and/or networks, are central to the WGSS approach and also strategic for sustainability.[220] Partnership with local entities should be considered from the assessment phase and implemented while establishing the WGSS.[221]

3. WGSS activities

All activities and services should be determined in consultation with women and girls so that the activities are responsive to their needs and experiences, are context and age appropriate, and consider the types of activities that women and girls participated in before their displacement.[222] Childcare services should be made available to increase access to WGSS for women and adolescent girls with young children. These services can be provided by either volunteer or incentive-based staff working at the safe space. At a minimum, toys should be made available for children.

The four general categories of activities for women and girls in WGSS include:

1. Service delivery, including referrals

All safe spaces connect survivors to information about their rights, options to report GBV, and care in a safe and confidential manner. WGSS can also provide discrete access to services specifically for women and girls, including case management and sexual and reproductive health care, if available on site and delivered through trained staff.

2. Psychosocial support and recreational activities

All WGSS activities should be based on women's and girls' priorities, and customized according to their specific needs.[223] Age-appropriate support group sessions consist of recreational activities such as informal and formal life skills (see Standard 5: Psychosocial Support). These activities support development of adaptive and positive behaviours that support women and adolescent girls in dealing with the demands and challenges of everyday life. Certain core psychosocial empowerment activities may require leadership by trained psychosocial staff, whereas recreational activities may be led directly by women and girls from the community.

3. Skills development and livelihood activities

Skills-based classes, formal vocational trainings, and individual or communal income-generation activities facilitate women's meaningful participation in public life, including through job training that will support women to access the labour market.[224] Informal skills-based classes can be implemented directly to support women to generate assets safely. Livelihood interventions comprising formal vocational trainings and income generation schemes require specialized technical expertise and coordination with livelihood actors (see Standard 12: Economic Empowerment and Livelihoods).

4. Information and awareness-raising

The WGSS may be a forum to enhance women's access to information and resources. For example, other sectors are frequently invited to provide information on a range of issues, including water and sanitation or nutrition (provided the integrity of the centre as a space designed for women and girls is not compromised).

4. WGSS staffing roles and capacity development

The WGSS staffing structure depends on multiple factors, including needs, population size and the scope of programme interventions. Staff should consist of volunteers, staff provided with incentives and paid staff, reflecting the diversity of the population. WGSS staff should be trained so that they are able to perform their duties safely, effectively and ethically. They should be selected carefully and trained on GBV core concepts and Guiding Principles, the referral pathway, communication skills and how to organize group activities; caseworkers require thorough training and supervision (see Standard 6: GBV Case Management).[225] All staff should sign a code of conduct that includes provisions on protection from sexual exploitation and abuse.

Clear guidelines should ensure the space remains female-only. In some contexts, only guards (if necessary) to secure the physical space and assets and one outreach worker should be male. The latter can engage with camp leadership structures, police, and men and boys.[226]

Tools and Resources

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STANDARD 9

Safety and Risk Mitigation

GBV actors advocate for and support the integration of GBV risk mitigation and survivor support across humanitarian sectors.

This Minimum Standard highlights GBV-specialized actors' advocacy and technical support roles in supporting the integration of GBV risk mitigation efforts across humanitarian sectors, in compliance with the *IASC GBV Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery.*

All humanitarian sectors and actors are responsible for promoting women's and girls' safety, and reducing their risk of GBV. Reducing risk by implementing GBV prevention and mitigation strategies across all areas of humanitarian response, from the pre-emergency to the recovery stages, is necessary for maximizing protection and saving lives.[227] The *IASC GBV Guidelines* state clearly and prominently: "All humanitarian actors must be aware of the risks of GBV and – acting collectively to ensure a comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation."[228] Protecting women and girls from GBV stems from all national and international actors' essential **duty to protect** those affected by crisis.[229]

> All humanitarian personnel must assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening issue; and take actions . . . regardless of the presence or absence of concrete "evidence".
>
> Source: IASC 2015a, p. 2.

In emergencies, women and girls face a wide range of GBV risks that increase during displacement and conflict, including sexual exploitation and abuse perpetrated by male humanitarian actors. Humanitarian agencies may unintentionally increase these risks without properly identifying and addressing the needs of women and girls, and the potential obstacles they may face in accessing services safely.[230] Humanitarian actors can both mitigate risks in advance (e.g., through code of conduct training) and quickly address many of these once they arise. Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations. Inaction and/or poorly designed programmes can cause further harm.[231]

KEY ACTIONS Safety and Risk Mitigation

	Preparedness	Response	Recovery
Conduct regular assessments and listening sessions with women and girls, considering age and diversity, to identify: (1) barriers to accessing humanitarian aid and services; (2) risks of GBV, including sexual exploitation and abuse; and (3) risk mitigation strategies.		✔	✔
Participate in multisectoral initial rapid assessments by joining assessment teams, contributing to the development of tools and questions, etc. to ensure attention to GBV, and reinforce ethical data collection practices.	✔	✔	✔
Conduct regular safety audits to identify GBV risks in the environment, including with other actors and sectors when possible. Where appropriate, conduct joint analyses and circulate findings among community members and relevant humanitarian sectors.	✔	✔	✔
Facilitate fora where women and girls can meet to develop and implement advocacy strategies to hold humanitarian actors accountable to deliver equitable and safe access to aid and services.	✔	✔	✔
Use GBV assessment and safety audit findings, including those conducted by other sectors, to advocate with community leaders, government and humanitarian actors to mitigate the risks of GBV, and improve safety and security for women and girls.	✔	✔	✔
Advocate with clusters/sectors for the inclusion of contextualized and relevant *IASC GBV Guidelines* Thematic Area Guidance and essential actions.	✔	✔	✔
Encourage uptake of recommendations contained in the *IASC GBV Guidelines* among all humanitarian actors. Provide technical support for actors to meet their responsibilities.	✔	✔	✔
Coordinate with other GBV programme actors to facilitate trainings with effective follow-up coaching and action plans for all sector actors on GBV Guiding Principles, GBV referral pathways, and how to engage with survivors respectfully and supportively.	✔	✔	✔
As part of the local GBV coordination mechanism, facilitate training of trainers for sector coordination leads to roll out the *IASC GBV Guidelines* within their own sector, and provide guidance to other sectors on using the guidelines.		✔	✔
Take advantage of opportunities for joint programming/sector initiatives to prevent, mitigate and/or respond to GBV.	✔	✔	✔
Support establishment of community-based strategies to safely monitor and address GBV-related risks in affected communities, and include zero tolerance of sexual exploitation and abuse and incident reporting information in community GBV outreach messaging, along with other actors (see Standard 7: Referral Systems).	✔	✔	✔
Advocate with other protection actors and PSEA focal points for senior leaders in all agencies to establish PSEA inter-agency networks, focal points, and clear referral and reporting procedures.	✔	✔	✔
Work with the PSEA coordinator and/or the PSEA in-country network to integrate the sexual exploitation and abuse complaints process into the existing referral pathway.	✔	✔	✔
Support the development, endorsement of and adherence to codes of conduct forbidding all forms of sexual exploitation and abuse, and ensure reporting and complaint mechanisms are survivor-centred.	✔	✔	✔
Integrate risk reduction into GBV emergency preparedness strategies.	✔		

Humanitarian agencies are required to "minimize the harm they may inadvertently be doing by being present and providing assistance". The *IASC GBV Guidelines* provide practical recommendations, by sector, on how to reduce risks across the humanitarian response.

Risk mitigation focuses on reducing the risks of GBV, including sexual exploitation and abuse, that women and girls face in the emergency and post-emergency contexts, and protecting those who have already experienced violence from further harm.[232] Although it may be challenging to prevent violence from occurring in emergencies, it is possible to put measures in place to reduce the risks that women and girls face. GBV programme actors have a role in advocating that other humanitarian actors, authorities and community members take action to proactively address risks.

Prevention and Mitigation of GBV

***Prevention* generally refers to action to stop GBV from first occurring** (e.g., scaling up activities that promote gender equality or working with communities to address practices that contribute to GBV). See Standard 13: Transforming Systems and Social Norms.

***Mitigation* refers to reducing the risk of exposure to GBV** (e.g., ensuring that reports of "hot spots" are immediately addressed through risk reduction strategies, or that sufficient lighting and security patrols are in place from the onset of establishing displacement camps).

All sectors of humanitarian response should undertake essential prevention and mitigation activities.

Source: IASC 2015a, p. 1.

The overall response benefits from GBV programme actors and other protection actors collectively addressing identified risks and barriers to safe and equitable provision of humanitarian aid. GBV risk analyses can be a part of and/or complement protection monitoring and mainstreaming activities, as well as analysis by actors addressing disabilities, the rights of people with diverse sexual orientations and gender identities, child protection, older age inclusion, etc.

In addition, protection from sexual exploitation and abuse (PSEA) is the responsibility of entire organizations, including management, operations, human resources and programme sections. In terms of programming, all sectors have a critical role to play in designing and implementing interventions in a way that minimizes risks of sexual exploitation and abuse, and helps connect survivors of this and other forms of GBV to appropriate care and services.

In order for GBV integration to be effective within a given sector, the process must be owned and driven by the sector itself. As with PSEA, GBV integration is never the sole responsibility of GBV specialists, but rather the responsibility of each sector and its personnel. Given their technical expertise, however, GBV specialists have an important role to play in **supporting other sectors** to integrate GBV risk mitigation into their work.[233] Various sectors and clusters have shown strong leadership in addressing GBV risks, including by publishing their own global standards.[234]

In support of GBV integration in other sectors, GBV specialists play an advisory role[235] in:

- Supporting humanitarian actors to contextualize and apply the *IASC GBV Guidelines*;
- Providing accurate and accessible information on available GBV services and referral processes;

- Facilitating support to non-GBV sectors and actors to safely and ethically analyse the GBV risks in their environment, using available information and data from an age, gender and diversity perspective; and
- Providing technical inputs to other sectors' coordination and programming actions on GBV risk mitigation. This encompasses how to consult safely with affected communities, especially women and girls, on barriers to accessing services as well as safety concerns they may have, including sexual exploitation and abuse perpetrated by humanitarian actors.[236] All GBV programme actors should know how to refer survivors to existing complaint mechanisms based on informed consent.[237]

GBV staff are not expected to have specialized knowledge of each humanitarian sector. Efforts to integrate GBV risk reduction strategies into different sectoral responses should be led by sector actors to ensure that any recommendations from GBV-specialized actors are relevant and feasible within the sectoral response.

Source: IASC 2015a, p. 43.

Programmes that are not planned in consultation with women and girls, nor implemented or monitored with their participation, often increase the risks they face.[238] **Women and girls are the best source of information about these risks.** It is necessary to engage proactively with women and girls of different ages and backgrounds, including those with disabilities and others (see Introduction), about risk factors without increasing their risk or overburdening them. Feedback systems should be in place so that women and girls can easily and confidentiality report concerns, including sexual exploitation and abuse, or give feedback on the quality of services they access.[239] Women and girls, along with other community members, should be supported to plan and implement risk reduction strategies.

Community outreach and awareness-raising in emergencies may increase timely and safe access to services and mitigate risks of GBV.[240] In the emergency phase, community engagement messages and activities should focus on:

- Access to services, especially life-saving and time-sensitive health services, because survivors need to know where to find help.
- Activities that can help reduce women's and girls' risk of GBV, especially sexual violence.

Indicators

- Percentage of active clusters/sectors with a GBV focal point.
- All Humanitarian Response Plans and Refugee Response Plans include GBV risk mitigation interventions.
- Number of safety audits conducted and tracked.
- Percentage of community members surveyed who report increased knowledge of GBV risks and how to seek services/support.
- Humanitarian organizations and service providers have in place community-based feedback and complaint mechanisms that can respond to sexual exploitation and abuse, including complaint referral forms.

Guidance notes

1. Categories of risk to women and girls and mitigation strategies

Women and girls can face risks of GBV across every aspect of their lives. Humanitarian actors have the responsibility to pursue actions to mitigate these risks within their areas of operation.[241] In many cases, humanitarian agencies can reduce women's and girls' exposure to risk, especially sexual exploitation and abuse, by providing assistance to meet their basic needs. The following table highlights possible risks and mitigation approaches; the strategies must be led by the relevant sector, with technical support from GBV specialists if needed and community involvement (see Standard 2: Women's and Girls' Participation and Empowerment). GBV-specialized actors must be aware of risks to women and girls to inform advocacy with the sectors responsible for mitigating these risks.

Key categories of risk include, but are not limited to:[242]

Risk category	Potential risks	Potential risk-mitigation strategies
Living space and physical camp/ site layout	• Lack of lighting in public spaces • Communal shelter with multiple families/individuals living together and lack of privacy • Living areas are close to stream and/or bush • Latrines are far from living areas and close to bush/stream areas • Latrines are made of plastic, do not have locks, and are not separated for men and women • Water points are in isolated or distant locations • Girls have to pass through bush areas and market to get to school	• Strong coordination among organizations and active involvement of communities, especially women and girls, to ensure security-focused and gender-sensitive shelter arrangements during an emergency • Frequent safety audits and joint analyses with responsible sectors, and concrete follow-up on findings • Consultations with girls and women about the physical placement and design of water points • Lighting of sanitation facilities and water collection routes • Sex-separated latrines and showers • Shelters, latrines and showers installed with lockable doors • Placement and delivery of services, including those specific to GBV, guided by discussions and risk assessments with women and girls • Firewood/water patrols or collection groups

Risk category	Potential risks	Potential risk-mitigation strategies
Unmet needs	• Lack of firewood means women and girls need to travel long distances through unsafe locations • Lack of bathing facilities means individuals bathe in the stream, also related to hygiene concerns • Insufficient water points mean women and girls have to wait for long periods to collect water and are at greater risk of physical assault • Lack of menstrual hygiene materials leads women and girls to hide away from settlements during menstruation, making them vulnerable to assault and denying them access to education, services and participation in public life • Lack of non-food items that can lead to exploitation in exchange for necessities	• Special consideration should be given to ensure that risks associated with fuel collection and other activities that involve movement in insecure or volatile areas are identified and properly addressed • Identification of alternative sources of energy from the onset of an emergency • Dignity kit assembly and distribution based on discussions with women and girls • Ration cards assigned to female heads of households • Distribution of fuel or fuel-efficient stoves • Cash and voucher assistance (see Standard 11: Dignity Kits, Cash and Voucher Assistance) • Codes of conduct, training and accountability mechanisms for staff about sexual exploitation and abuse
Service delivery	• Distribution and health staff are all male and have not been properly trained • Distance to and location of service delivery • Limited police presence at night or lack of police presence, including female police, in sections of settlement • Service delivery offices located near identified risks	• Ensure the presence of trained female staff in distributions and among service provision personnel • Special protocols for women and girls at increased risk of GBV, including those with disabilities, girl-headed households, older women, pregnant/lactating women, single mothers, etc. • Codes of conduct for distribution staff that are explicit about sexual exploitation; confidential reporting systems with enforcement mechanisms • Monitor design and implementation of activities to ensure they do no harm • Ensure quality services and referral systems to avoid re-traumatization
Information and participation	• Lack of consultation leads to latrines being located far from settlement, insufficient water points, and lack of bathing facilities and menstrual hygiene materials • Lack of consultation on ration type and amount leads to women and girls engaging in risky behaviour to supplement meals • Lack of information about which services are provided for free causes women and girls to be vulnerable to sexual exploitation and abuse by service providers	• Women and adolescent girls consulted and involved in dialogue and decision-making (see Standard 2: Women's and Girls' Participation and Empowerment) • Work with community leaders to promote women's and girls' participation in decision-making • Trainings and capacity-building of female and male community leaders and camp committees • Women's groups and leaders involved in the community outreach process • Community meetings with security sector personnel • Establishment of confidential, accessible reporting mechanisms

2. Assessing and monitoring risks to women and girls

Several tools[243] are available to assess protection risks to women and girls, all of which can be used as part of GBV-specific assessments and in collaboration with sector specialists (see also Standard 16: Assessment, Monitoring and Evaluation). Some of these include:

Conducting joint assessments between GBV programme actors and other sectors is effective and a good practice.

a. **Safety audit:** A safety audit can be part of a situational assessment and analysis. It is an observational tool that helps to identify observable risks and gaps in the camp or site environment. It entails walking through the environment, if appropriate, and comparing conditions against a set of pre-selected indicators. It can be used on a regular basis (daily, weekly, etc.) so changes and new risks can be identified and risk mitigation efforts tracked.

b. **Focus group discussion:** These can focus on key topics, including safety and basic needs. Focus group discussions involve small groups of people (about 10 to 12) from similar backgrounds (e.g., gender, age, ethnicity) and help develop a general sense of the community's perception of key areas of concern. Focus group discussions are not appropriate for personal accounts of GBV, but may be used to explore the concerns of a particular group related to security and protection.

c. **Community mapping:** A community map is an excellent tool for collecting qualitative data, especially in cultures with a strong visual tradition. During a GBV-specific assessment, this approach can be incorporated into focus group discussions as a means of better assessing the community's knowledge of services available to women and girls (e.g., number, location, and quality of health and psychosocial care), challenges women and girls may face in accessing services (e.g., privacy, distance, safety), and the community's perception of areas that present risks to women and girls (e.g., public or remote areas where sexual assault, harassment or exploitation are likely to take place).

During the acute emergency phase, risk factors are continually evolving; therefore, it is important to monitor risks on a regular basis, often with a combination of tools that go beyond an initial assessment. At the beginning of an emergency response, when the situation is constantly fluctuating, it may be necessary to monitor risks every week or two weeks, but as the situation becomes more stable, monitoring once a month might be sufficient.

3. Protection from sexual exploitation and abuse

GBV risk mitigation across all programmatic sectors also contributes to PSEA efforts more broadly. PSEA is an agency-wide responsibility requiring action from management, operations, human resources, programme sections and others. All sectors have a critical role to play in designing and implementing their interventions in ways that minimize risks of sexual exploitation and abuse, and help connect survivors of this and other forms of GBV to appropriate care. The *IASC GBV Guidelines* provide practical recommendations, by sector, on how to achieve these aims. Although PSEA is an accountability issue to be addressed by each agency, it also involves the entire humanitarian response through inter-agency structures charged with promoting and addressing PSEA collectively.[244]

As outlined in the UN Secretary-General's Bulletin for Protection from Sexual Exploitation and Abuse,[245] sexual exploitation and abuse violates universally recognized international legal norms

and standards, and is prohibited conduct for humanitarian aid personnel. It harms those whom humanitarian actors are mandated to protect. The Bulletin stipulates that reporting of sexual exploitation and abuse is mandatory for all United Nations staff. All reporting must be confidential and be made through the in-country PSEA focal point, who is assigned by the Head of Mission within each UN country team/humanitarian country team. Managers and human resource staff are responsible for ensuring that all UN staff are trained on PSEA, mechanisms are in place for reporting, and that staff understand their individual responsibilities to report any suspected incidents and have signed a code of conduct. Although GBV programme staff can play a role in advocating for PSEA measures, implementation of internal measures and the coordination of inter-agency processes to address sexual exploitation and abuse are outside the purview of the GBV subcluster or working group. They are the responsibility of the UN country team-assigned PSEA focal points (see Standard 15: GBV Coordination). This is important to ensure the independence, integrity and confidentiality of mandatory reporting mechanisms and investigation processes.[246]

GBV response service providers should be aware of community-based reporting mechanisms and investigation processes to ensure informed consent when supporting survivors of sexual abuse and exploitation (see Standard 6: Case Management).

Tools and Resources

GBV Area of Responsibility, 2019. Handbook for Coordinating GBV Interventions in Humanitarian Settings. https://gbvaor.net/.

International Rescue Committee (IRC) (2018a). "Community Mapping Guidance Note," in *Emergency Assessments Tools.* Available from GBV Responders' Network: https://gbvresponders.org/wp-content/uploads/2014/03/Community-Mapping-Guidance-Note-2012-ENG.doc.

_____ (2018e). "Safety Audit Tool," in *Emergency Assessments Tools.* Available from GBV Responders' Network: https://gbvresponders.org/wp-content/uploads/2014/03/Safety-Audit-Tool-Updated-2013-ENG.doc.

Inter-Agency Standing Committee (IASC) (2016). *Best Practice Guide on Establishing Inter-agency Community-based Complaint Mechanisms.* https://interagencystandingcommittee.org/system/files/best_practice_guide_inter_agency_community_based_complaint_mechanisms_1.pdf.

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IASC Task Team on Accountability to Affected Populations and Protection from Sexual Exploitation and Abuse (2018). *IASC Plan for Accelerating PSEA in Humanitarian Response.* https://interagencystandingcommittee.org/system/files/iasc_plan_for_accelerating_psea_in_humanitarian_response.pdf.

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STANDARD

10 Justice and Legal Aid

Legal and justice sectors support GBV survivors to access safe and survivor-centred legal services that protect their rights and promote their access to justice.

Access to justice for GBV survivors is part of the multisectoral response to GBV and also a crucial aspect of GBV prevention; the justice sector has a powerful role to play to end violence against women and girls.[247] Legal protection, with its foundations in access to justice and security, is essential to conflict prevention, mitigation, recovery, and saving the lives of women and girls in humanitarian crises.[248] Access to justice is fundamental to the protection of women's rights and makes possible the realization of all other[249] rights for women and girls, including the rights to live free from violence, discrimination and inequality.[250] Ensuring that perpetrators are brought to justice has rule-of-law implications beyond the individual survivor and perpetrator.[251]

> In many displacement situations, particularly in camp settings, refugee life is governed by a complex justice system comprising multiple sources of law. This could include laws applicable in the country of asylum and in the country of origin. There may also be a variety of mechanisms, both formal and informal, to enforce laws and rules.
>
> Source: UNHCR 2016, p. 9.

In times of crisis and transition, GBV programme actors may play an active advocacy, coordination and/or capacity-strengthening role with justice sector actors to support survivors' access to justice, promote accountability for crimes committed and support long-term rebuilding of communities. GBV programme actors can work with partners to coordinate, advocate and facilitate GBV survivors' access to justice and legal aid services that are provided by actors with expertise in this area.[252] It is critical to invest in preparedness efforts to strengthen women's and girls' access to justice as part of broader women's rights efforts, as systems often fail to protect women and girls from violence, discrimination and inequality.

Women generally face barriers in their efforts to seek justice. These include limited resources, mobility and decision-making power as well as fear of stigma and reprisals, cultural perceptions of men as the only rights-bearers, and male guardianship laws, where a woman is required to have a male guardian – a father, brother, husband or even a son – make a range of critical decisions on her behalf.[253]

KEY ACTIONS Justice and Legal Aid

	Preparedness	Response	Recovery
Listen to and address women's and girls' concerns related to justice, including physical access, financial access and other factors linked to social norms and gender dynamics.[254] An assessment should identify survivors' barriers to making choices (e.g., mandatory reporting in health clinics) in the context of access to justice, and include questions related to different types of violence (e.g., intimate partner violence, sexual assault, trafficking, female genital mutilation/cutting).[255]	✔	✔	✔
Advocate for a survivor-centred approach to justice that prioritizes the rights, needs, dignity and choices of the survivor, including the survivor's choice whether to access legal and/or justice services.	✔	✔	✔
Support the development of GBV standard operating procedures and referral mechanisms to respond to GBV cases using a survivor-centred approach, and include police, legal aid and other justice actors in the development and implementation of the procedures in line with IASC guidance (see Standard 15: GBV Coordination).	✔	✔	✔
Work with local women's rights actors to assess the capacity of the formal justice sector to safely and ethically respond to incidents of GBV (e.g., accessibility of free/low-cost legal aid services, how judicial processes provide protection to GBV survivors and witnesses) to provide accurate information to survivors.	✔	✔	✔
Engage with women and girls and women's rights experts to assess the capacity of the formal and informal justice sectors to safely and ethically respond to incidents of GBV.[256]	✔	✔	✔
Promote the availability of local legal aid organizations, staffed by personnel trained on the GBV Guiding Principles, to support survivors and promote their rights.[257]	✔	✔	✔
Sensitize actors in the justice system on their obligation to investigate a complaint of GBV safely and while respecting the dignity of the survivor.	✔	✔	✔
Advocate to reform policies that require mandatory reporting to police before a survivor may receive health care or other services.	✔	✔	✔
Integrate legal aid services and appropriately trained justice actors into the general GBV referral system. Make information on rights, remedies and support available to the affected population.	✔	✔	✔
Sensitize communities on existing laws and policies that uphold women's and girls' rights and protections from GBV, and ensure survivors' access to care.	✔	✔	✔
Support the inclusion of female police officers and other personnel or police units who are specially trained to respond to GBV.	✔	✔	✔
Enhance the capacity of security institutions/personnel to prevent and respond to GBV (e.g., support employment of women in the security sector, work with GBV specialists to train security personnel on GBV, advocate for implementation of codes of conduct, support secure environments in which GBV can be reported to police).[258]	✔	✔	✔
Provide assistance to reform procedures and laws so that they are sensitive to the needs and safety of women and girls and are in line with the GBV Guiding Principles.	✔		✔
With the help of other stakeholders (e.g., legal/justice institutions, governments, NGOs and international NGOs), raise awareness about women's and girls' legal rights, including the right to due process.[259]	✔	✔	✔
Partner with local women's groups to positively engage community leaders who enforce customary or informal legal systems that do not respect women's rights.	✔	✔	✔
Partner with women, peace and security actors, women's movements and human rights actors to promote the equal participation of women as decision makers within informal justice systems, and champion reform of customary law to uphold women's rights and protections.		✔	✔

GBV-specialized programming should prioritize the establishment and strengthening of GBV response services to meet survivors' health, psychosocial and safety/security needs in the acute emergency phase. Once these services are of adequate quality, the response should include legal aid and access to justice services.

In some contexts, the legal and security system may hinder access to health and other services. In these contexts, GBV programme actors should set up referral points and access to GBV response services through focal points on health, women's and girls' safe spaces, and psychosocial and community support, rather than through the police or formal or informal justice systems.

Women and girl survivors of GBV face even greater barriers in accessing justice, including but not limited to a lack of locally available police or courts; lack of trust in the legal system, low awareness of laws and rights, the high cost of legal representation, corruption, delays in gathering evidence by police or health providers or poor documentation of evidence, gaps in the legal framework, impunity for perpetrators, and lack of sensitivity or active bias from justice actors.[260, 261] Reporting instances of GBV may carry stigma that can include fear of retribution by the perpetrator and/or his family, fear of being ostracized by one's own family, or fear of being blamed for the attack.[262] Health-care providers in humanitarian contexts may not be trained or resourced to provide appropriate clinical care, including gathering and preserving appropriate forensic evidence (see Standard 4: Health Care for GBV Survivors). Health-care providers may also worry about testifying in court, and fear reprisals from perpetrators and their families. Access to protection for male survivors of sexual violence can be inhibited by legal frameworks that criminalize sexual relations between people of the same sex or that do not include male survivors in the definition of rape.

In humanitarian contexts, barriers to effective legal protection for women and girls are even greater, including limits on access to justice and legal support due to displaced women's and girls' lack of legal status, overstretched and underresourced host legal systems, lack of interpreters for displaced populations, lack of accessible legal advice and poor legal infrastructure. Survivors may be hesitant to report due to lack of awareness of their specific rights, concerns about their legal status in a foreign country, economic and social dependence on husbands or other male family members, and stigma and cultural beliefs around violence against women by the community and legal service providers.[263]

In many contexts, justice systems do not serve survivors' needs and may perpetuate further harm.[264] Legal aid for GBV survivors is typically underfunded, understaffed and of poor quality. Often the issue is systemic, with no GBV protocols in place, and weak, non-existent or unimplemented and ignored legislation.[265] Therefore, for various reasons, some survivors may seek legal justice while others may not.

GBV survivors must be able to make informed decisions that enable them to gain more control over their lives. This process of empowerment incorporates access to legal information and legal aid.[266] Women's equal rights to divorce, including child custody and equitable distribution of household assets, inheritance, land, property and education facilitate women's equal power and choice in spousal relationships, reducing male control and increasing women's ability to leave abusive relationships.

Legal services should be part of a safe, non-stigmatizing, multisectoral response to GBV. They should be staffed by trained personnel, accessible to GBV survivors and integrated into the general GBV referral system. The provision of free or low-cost legal aid, advice and representation in judicial and quasi-judicial processes is crucial in guaranteeing that justice systems are economically accessible to women.[267] Survivors should not accrue any legal or other costs related to transportation, accommodation, meals for the perpetrator, etc. to access legal services.[268] Costs should be covered by the State or legal aid service provider[269] or provided through cash support through GBV case management services (see Standard 6: GBV Case Management and Standard 11: Dignity Kits, Cash and Voucher Assistance).

Justice mechanisms should:

- Allow and support each survivor to determine what constitutes justice in her particular situation;
- Protect her safety and recovery by allowing for *in camera* testifying;
- Be non-discriminatory, fair and transparent; and
- Respond to the survivor's decisions and the unique local context.

Source: UNFPA 2015a, p. 41.

In humanitarian settings, informal justice mechanism are often utilized by communities to settle what are perceived as "private" matters. GBV incidents may also be addressed through negotiated settlements between families or through judgments by religious and community leaders. Due to the lack of functional and available formal legal systems, some humanitarian actors work to improve customary and informal processes and courts, yet the safety and rights of survivors are rarely upheld by these (see Guidance Note 3).

Indicators

- Proportion of GBV programme participants who report that the legal support they accessed was delivered in accordance with their needs and preferences.
- Number of security personnel, disaggregated by sex, trained on how to safely respond to incidents of GBV according to established protocols that adhere to GBV Guiding Principles.[270]
- Number of judicial institutions and law enforcement bodies supported to reduce barriers to women's access to justice.

Guidance notes

1. Access to justice

Access to justice for women and girls for acts of GBV requires that States implement a range of measures. These measures include, where necessary, amending domestic law to ensure that acts of violence against women and girls are properly defined as crimes, and ensuring appropriate procedures for investigations, prosecutions, and access to effective remedies and

reparation.[271] Access to justice for individual women is often assumed to reside in a criminal justice response to the perpetrator; however, women may identify other ideas to obtain justice for the harm they have experienced, including but not limited to access to livelihood opportunities, dignity, the ability to seek safety through effective protection orders, physical and psychosocial recovery through good quality and accessible health-care services, and/or the opportunity to seek a divorce and a new life free from the violence of a spouse. Often these forms of justice must be in place before a woman feels able to embark on the process of seeking justice through criminal law procedures.[272] Because "justice" may mean different things to different survivors, it is crucial that GBV programme actors listen to those who are seeking it, respect their wishes and respond to their needs.

Improving access to justice therefore entails much more than providing legal support and physical access: It is also about making sure that law enforcement and justice actors, as well as the relevant laws and frameworks, protect and respect the rights of survivors. This includes addressing harmful attitudes and practices by members of the judiciary that undermine laws and procedures. Community awareness about the rights of survivors and options for pursuing legal redress is also crucial.[273]

The dangers of mediating GBV cases

Mediation is a process to address a variety of interpersonal conflicts, and is often initiated by community leaders or family members as a means to resolve a problem. Mediation is not recommended as an intervention to address GBV, including intimate partner or domestic violence.

Mediation is focused on maintaining family or community cohesion, which may perpetuate discrimination and put women and girls at risk of losing individual rights in favour of preserving harmony within a social group. Especially in circumstances of intimate and domestic violence, which is rarely an isolated event, mediation may inadvertently condone a perpetrator's behaviour or imply easy solutions to complex problems with deep social and cultural roots.

Mediation can be extremely problematic and dangerous in cases of violence against women and girls because it assumes that both parties have equal negotiating power. Yet violence against women and girls involves unequal power relationships between the parties based on acts of assault, violent intimidation, and/or controlling, abusive or humiliating behaviour.

Mediation often denies the survivor's control of the process, and may expose her to intimidation and re-victimization, inhibit her access to services and put her at direct risk of further abuse.

For these reasons, although considered common practice in some cultures and communities, mediation may violate the survivor-centred approach and breach the GBV Guiding Principles. Although mediation for GBV cases continues to be used in many parts of the world, it is not recommended as an intervention.

Caseworkers should never mediate between a survivor and a perpetrator, even if a survivor requests this type of intervention. This poses a great risk to the survivor, caseworkers and the organization. Organizations should have clear guidelines on how to respond to requests for mediation in a survivor-centred manner (see Standard 6: GBV Case Management).

Source: UNFPA 2015a, p. 44; Thomas et al. 2011, pp. 23-24.

2. Legal aid

Access to legal aid is fundamental to safeguarding fair, equal and meaningful access to justice. Legal aid plays a crucial role in enabling people to navigate the justice system, make informed decisions and obtain justice remedies.[274] Legal aid helps people to assert their rights and contest discrimination, and contributes to enhancing people's trust in the justice system and the legitimacy of the State. Legal aid can also ensure that people have access to information about their rights, entitlements and obligations.[275]

Legal aid for GBV survivors needs to be targeted and specialized. Legal aid service providers should be trained to uphold the GBV Guiding Principles and provide survivor-centred support to women and girls. Depending on the context, this includes specific protection measures for survivors of intimate partner violence, psychosocial and economic support, the availability of female paralegals and lawyers to make survivors feel at ease, and a general understanding by legal service providers of the sensitivities and security risks involved in a GBV case.[276]

3. Informal justice and alternative dispute mechanisms

Informal justice mechanisms may pose many risks to women and girl GBV survivors, but are often the only system accessible to them. Informal justice mechanisms, in particular, often reflect customary or prevailing community attitudes towards women and girl survivors of violence that present risks to survivors' safety and allow gaps in accountability among male perpetrators.[277] These processes can perpetuate discrimination against women and girls, and pressure them to give up their individual rights so as to preserve harmony within a social group.[278] In situations of intimate partner violence or other forms of so-called "private" violence, for example, both the perpetrator and the survivor may be perceived as equally at fault, and both called upon to moderate their behaviour to resolve the issue.[279] Negotiation, conciliation, mediation (see 'The dangers of mediating GBV cases', above), and restorative justice mechanisms can all be detrimental in GBV cases because of power imbalances and safety risks for women who must meet with perpetrators directly.

GBV-specialized actors should be aware of the risks to GBV survivors that are inherent to informal justice mechanisms. They should clearly communicate those risks to survivors while being non-judgmental and honouring survivors' wishes for a justice outcome.

There are a number of strategies for working with informal justice mechanisms to minimize risks to women and girls, including:

- Working with women's rights or women's legal organizations to develop and strengthen informal justice mechanisms that respond to the needs of survivors;
- Engaging constructively with traditional leaders who are often "custodians of culture", and have the authority to positively influence a change in customs and traditions to reinforce women's rights;
- Taking measures to enhance women's participation and leadership in community or informal justice mechanisms;
- Strengthening the relationship or building positive links between formal and informal justice mechanisms; and

- Including an outlet for judicial review for women or others who feel that traditional justice mechanisms have discriminated against them.

In emergency contexts, without a functioning formal legal system, informal or traditional legal systems and mediation may be identified as the main source of redress.[280] The safety and well-being of women and their children must be prioritized in situations where these avenues are used to address civil and family law issues, and where a male perpetrator continues to pose a threat.[281]

4. Security

Respecting and upholding the rights of women and girls should be central to all security efforts. As part of a survivor-centred approach, security personnel should respect women's confidentiality and decisions regarding the GBV incident, including where the survivor decides not to immediately (or ever) pursue a case against the perpetrator(s) or be involved in a case. Focusing on the survivor also requires that security personnel and policies reflect an awareness of the immediate and ongoing threats facing women and girls who have experienced violence.[282] Certain forms of violence require particular safety measures (e.g., facilitating access to safe houses or shelters for those at risk of so-called "honour-based" crimes).[283]

Law enforcement personnel often lack the knowledge and capacity to respond adequately to survivors. They may also share the societal values that condone violence against women and girls, leading to survivor-blaming or discriminatory attitudes and decisions. Thus, in addition to establishing clear responses to violence against women and girls, and specialized support services for survivors, it is crucial to support ongoing training and awareness-raising interventions for security personnel at all levels.[284] For police, training should focus on clear protocols for responding to reports of violence, emphasizing women's legal right to protection.[285]

Tools and Resources

International Commission of Jurists (2016). *Women's Access to Justice for Gender-Based Violence: A Practitioners' Guide.* Practitioners' Guide No. 12. Geneva. https://www.icj.org/wp-content/uploads/2016/03/Universal-Womens-accesss-to-justice-Publications-Practitioners-Guide-Series-2016-ENG.pdf.

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United Nations High Commissioner for Refugees (UNHCR) (2016). *SGBV Prevention and Response: Training Package*. October 2016. https://www.unhcr.org/publications/manuals/583577ed4/sgbv-prevention-response-training-package.html.

UN Women, UNFPA, WHO, UNDP and UNODC (2015). *Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines*. https://www.unfpa.org/essential-services-package-women-and-girls-subject-violence.

War Child Canada (2016). *A Guide to Sexual and Gender-based Violence (SGBV) Legal Protection in Acute Emergencies*. https://warchild.ca/wp-content/uploads/2018/03/GuideToSGBVLegalProtectionInAcuteEmergencies.pdf.

STANDARD 11 Dignity Kits, Cash and Voucher Assistance

Women and girls receive dignity kits, and/or cash and voucher assistance to reduce GBV risk, and promote safety and dignity.

In times of crisis, women and girls often struggle to meet essential material needs. They lack items that enhance their safety, facilitate basic hygiene, enable access to humanitarian services, and promote their mobility and presence in public spaces. Women and girls need basic items to interact comfortably in public and maintain personal hygiene, particularly menstrual hygiene. Without access to culturally appropriate clothing and hygiene products, women and adolescent girls are at greater risk of GBV, their health is compromised, their mobility is restricted, and they may become increasingly isolated.[286]

Cash and voucher assistance (CVA) refers to all programmes where **cash transfers** or **vouchers** for goods or services are provided directly to recipients. In the context of humanitarian assistance, the term is used to refer to the provision of cash transfers or vouchers to individuals and household or community recipients only (not to governments or other State actors).

The terms "**cash**" or "**cash assistance"** refer specifically to cash transfers (and do not include vouchers).

Source: The Cash Learning Partnership 2017, pp. 1-2.

For these reasons, humanitarian actors often distribute dignity kits that typically contain menstrual hygiene materials, soap, underwear and information on available GBV services, including where and how to access those services.[287] Dignity kits may also include items that may help mitigate GBV risks such as radios, whistles and lights. Research on dignity kits has found that their value is more than material; women have said that the experience of receiving a kit in a time of need was in itself beneficial and made them feel as though they had not been forgotten.[288]

By providing essential supplies in dignity kits, humanitarian actors can help enable women and girls to use their limited resources to purchase other critical items, such as food.[289] Therefore, dignity kits allow women and girls to meet their own needs while also meeting the needs of their families,[290] and maintaining their dignity during humanitarian crises. Preserving dignity is essential to maintaining self-esteem and confidence, which are critical to protection and coping in stressful humanitarian situations.[291]

KEY ACTIONS — Dignity Kits, Cash and Voucher Assistance

	Preparedness	Response	Recovery
DIGNITY KITS			
Preposition basic supplies to ensure immediate distribution at the onset of an emergency.	✔		
Consult with women and girls to inform dignity kit content selection, including identifying the menstrual hygiene management practices women and girls prefer.	✔	✔	✔
Include locally relevant items in dignity kits when available that may mitigate GBV risks and improve safety.	✔	✔	✔
Identify items that may be produced by women locally to provide psychosocial support and/or an income-generating activity. Organize local women and/or women's organizations or networks to assemble the dignity kits and support distribution.	✔	✔	✔
Use assessment information related to women and girls most at risk of GBV to guide distribution of dignity kits (see Guidance Note 1).[292]		✔	✔
Assess the context and security risks to determine the best channels for dignity kit distribution.		✔	✔
Coordinate effective distribution of kits by: • Determining, in partnership with women and girls in the affected community, the best timing, location and process of distribution so as to decrease the risk of GBV; • Providing information prior to distribution (i.e., what, when, where, how) so women and adolescent girls are aware that the dignity kits will be available, and able to safely and comfortably collect or receive them; and • Partnering with local organizations and networks.		✔	✔
Provide stipends to women from the affected community to distribute the dignity kits; they should be able to explain the dignity kit contents using local language and terminology, share information on local health services, explain how to dispose of menstrual hygiene materials with the least environmental impact, and provide other critical information (e.g., awareness-raising on rights and hygiene issues, additional services).		✔	✔
Require all dignity kit assembly and distribution staff to sign a code of conduct.		✔	✔
Use dignity kit distributions to provide women and girls with information on GBV services, and link survivors with response services and safe space activities if these services are available and of adequate quality.		✔	✔
Conduct post-distribution monitoring to assess satisfaction with distributed items and determine whether any additional risks were created as a result of distribution.		✔	✔
CASH AND VOUCHER ASSISTANCE			
Assess the feasibility of safe CVA with women and girls, including a GBV risk and benefit analysis, and facilitate identification of GBV risks and potential mitigation strategies.	✔	✔	✔
Support the monitoring of any risks posed by cash distribution and/or unintended harmful consequences, such as an increase in intimate partner violence, or the inability to use and control cash distributed (see Standard 9: Safety and Risk Mitigation).	✔	✔	✔
Advocate for CVA that minimizes GBV risk and collaborate with cash actors, where relevant, to ensure GBV mainstreaming within CVA.[293]	✔	✔	✔
Develop partnerships with cash actors to integrate CVA within GBV case management services to meet clients' protection needs as safe and appropriate.[294]	✔	✔	✔
Develop a referral pathway or standard operating procedures, including an information-sharing protocol, between GBV and cash actors (see Guidance Note 3).	✔	✔	✔
Coordinate with appointed cash focal point(s) to adjust CVA approaches as needed (e.g., the delivery mechanism or the amount, duration or frequency of the transfer), to maximize protection benefits and minimize protection risks.[295]	✔	✔	✔

In addition to dignity kits, there is evidence that cash and voucher assistance (CVA), when utilized as part of a broader protection intervention, may help address a range of commodity-based needs, particularly in urban settings where markets and banking systems are in place. CVA is also a modality other sectors use to meet women's and girls' needs. It refers to all initiatives through which cash transfers or vouchers for goods or services are provided directly to individual, household or community recipients.

The direct provision of cash to be spent in local markets can shift demand for goods and services towards the needs of recipients.[296] Cash and vouchers may also be useful in rural areas and camps where markets grow as more people settle in the area. New technologies, such as money transfers through mobile phones or ATM cards, can facilitate the dispersal of assistance in insecure contexts.[297]

Cash also can be lifesaving; for example, it can help a survivor meet the costs (e.g., rent, temporary shelter, transportation, food, clothing, etc.) associated with fleeing an abusive relationship. The flexibility of cash transfers can enable a timely response to meet urgent needs.[298] When a GBV survivor discloses an imminent risk of violence, cash can support risk mitigation and the prevention of violence.[299] As such, cash can be both a risk mitigation modality and a component of survivor-centred GBV case management services in humanitarian settings. In situations where core GBV response services (e.g., health or legal services) have associated costs and/or are not available free of charge, cash transfers can facilitate access and support recovery.

Further learning and guidance are required on the protection outcomes of cash for women and girls. Some research has suggested that women within households who received cash experienced negative protection outcomes and increases in violence. PSEA risks must also be mitigated through the design of CVA interventions. These concerns underscore the need for humanitarian actors to consult with women and girls regarding appropriate risk mitigation measures[300] before choosing to deliver cash or vouchers rather than providing material assistance.[301] The ways in which cash and voucher assistance can facilitate access and reduce risks is contextual, and a participatory assessment is critical before implementation.

Indicators

Dignity kits

- Percentage of women and adolescent girls who received dignity kits, disaggregated by age.
- Percentage of women and adolescent girls who indicate they are satisfied with the items provided in the dignity kits they received, disaggregated by age.

Cash and voucher assistance

- Assessment of women's and girls' specific needs conducted to inform CVA.
- Inter-agency, interdepartment protocol and/or information-sharing protocol for CVA developed and operationalized.
- Number of women and girls who receive cash and/or voucher assistance.

Guidance notes

1. Dignity kit content and distribution

Assessment and determination of contents

Dignity kit content must be based on the inputs and preferences of women and girls in the community, and include context-specific items, such headscarves, without which women cannot appear in public.[302] In addition, it is important to assess which items may be available in the marketplace. Whenever possible, questions should be integrated into other assessments (e.g., sexual and reproductive health, GBV) to minimize duplication and avoid overburdening women and girls. To identify relevant, appropriate content for dignity kits, organizations should consider the following basic parameters: relevance of the items, cultural sensitivity, context, environment, quantity, frequency of distribution and price.[303]

> Dignity kits may be procured and distributed by water, sanitation and hygiene; health; or shelter, settlement and recovery actors. GBV programme actors should coordinate with other sectors to ensure dignity kits are responsive to the needs of women and girls, maximize the distribution potential of all items, and avoid gaps or unnecessary duplication of efforts.
>
> Source: IASC 2015a, p. 292.

Although standard dignity kits may be pre-positioned to be ready for distribution as soon as a crisis hits, further engagement with affected populations, including monitoring the initial distribution, is necessary to determine the most useful and culturally appropriate items to include in subsequent distributions, and to identify safety risks and/or other unanticipated consequences related to the distribution.[304] The following questions may be helpful in planning consultations with women and girls in relation to dignity kits.

- What are the basic hygiene products that you need to stay clean and healthy?
- Do you have what you need for washing your body? (If not, what would be useful?)
- Do you have what you need for washing clothes? (If not, what would be useful?)
- What kinds of items would help you to move around more freely and spend time outside your shelter?
- Do you need any specific clothing items to conduct your daily tasks?
- Are there items that you need to help you stay safe or access information, aid and services?
- Is there any other item you need for your daily life here (in the camp/shelter/etc.)?
- What items do you miss from home that would provide comfort if you had them?
- What types of menstrual hygiene materials do you usually use during menstruation? If the answer to the question on types of sanitary materials is reusable cloth, also ask: Do you have safe access to water to wash the cloth?
- In what type of bag/package should the dignity kit be provided?[305]

Dignity kits: "Worth more than their contents"

The distribution of kits is an opportunity to meet and speak with women and girls, to provide necessary information and to better understand their concerns. Therefore, dignity kit distribution should not be a stand-alone activity, but accompanied by explanations of the items and their disposal, and by discussions regarding safety, information on services, and awareness-raising on rights and hygiene issues. The exception to this is when dignity kit distribution is undertaken as an acute emergency response activity (e.g., in the first three days of the emergency). In general, dignity kit provision should serve as an entry point for broader GBV programming and response services.[306]

Dignity kit interventions should adhere to the following standards:

- Responsive to the specific needs of women and girls in the affected community;
- Procured and assembled locally (if possible);
- Content selected in consultation with women and girls;
- Customized to meet the hygiene needs of affected populations, i.e., including culturally appropriate and context-specific items; and
- Distribution coordinated with other humanitarian organizations.

Source: Gender-based Violence Sub-Cluster Turkey (Cross-border Operations in Syria) 2015, p. 8.

Dignity kits can be used in the context of GBV programming in a number of ways, including:

- As an entry point to begin working with women to identify the GBV risks in the community;
- To raise awareness and encourage communities to engage in discussions on important topics such as preventing and responding to GBV;
- To share information on where women can access GBV services;
- To reach women at risk, including GBV survivors, and pregnant and lactating women, and to ensure women know where and how to access available services; and
- As an income-generating activity for women and girls affected by crisis. In addition to important economic support, bringing affected women together for kit assembly presents opportunities for awareness-raising sessions and/or other group activities.[307]

Targeting

When identifying target groups to receive dignity kits, GBV and other humanitarian actors should consider the following criteria:

- Immediate/acute needs, paying particular attention to underserved communities and women and adolescent girls at increased risk of GBV due to barriers to participation and access (see Introduction). For example, older women may not need menstrual hygiene materials but could benefit from other items to improve safety and mobility. Adolescent girls face high risks of sexual exploitation and abuse when they are unable to meet their basic needs.
- Programmatic opportunities to provide sexual and reproductive health and GBV information, referrals and services.
- Geographical location: identify a specific area, taking into account the number of affected people and presence of partners to help with distribution.
- Coordination with partner agencies and national authorities (as feasible) on the content and distribution of dignity kits.
- Specific individual criteria such as age, reproductive health status or other criteria as needed in the local context.[308]

2. Dignity kit distribution and safety for women and girls

When organizing distribution, it is critical to discuss with women and girls potential safety and security risks, specifically GBV-related risks, and devise strategies to address these (e.g., designating a location separate from other distributions for dignity kit distribution). There are a number of ways in which organizations distributing dignity kits can ensure that distribution is safe and appropriate, and that the kits go to targeted women and girls. These include:

- Involving women and adolescent girls in the process of selecting the distribution points and dates;
- Providing information prior to the distribution (i.e., what, when, where, how) so women and girls can plan to collect their dignity kit safely and discreetly;
- Organizing the distribution in an appropriate place and at an appropriate time so that women and girls do not miss other distributions;
- Involving female staff and hiring female community members if appropriate;
- Avoiding locations that are a long distance from shelters as this may increase GBV risks;
- Auditing dignity kit distribution as part of safety audits, if trained staff are available;
- Selecting a security focal point for the distribution; and
- Ensuring that distribution personnel know the available referral pathways and services so that they can provide information and assist GBV survivors if necessary.[309]

Ensure all the people distributing the dignity kits have signed a code of conduct, are aware of the risk of sexual exploitation and abuse, and are knowledgeable and competent in handling disclosures of GBV, including sexual exploitation and abuse.[310]

3. Cash and voucher assistance

The use of CVA across sectors can support individual risk mitigation, both as part of response services and for prevention purposes. For example, in non-camp settings, the use of cash-for-rent or voucher assistance may reduce risks of GBV associated with lack of appropriate shelter. As part of a broader prevention programme, targeted cash transfers to families where poor children are at risk of commercial sexual exploitation, or where families may seek to place girls in child marriages, may keep girls in school. In the context of response, cash may be utilized as part of survivor care and assistance, and integrated in case management and livelihoods support (see Standard 12: Economic Empowerment and Livelihoods). For example, CVA can be given to purchase items, support rent or medical bills, or facilitate access to services (e.g., transportation costs).

Although evidence and guidelines on CVA are still emerging, risk analysis is a clear, necessary step towards utilizing it. Since CVA can potentially create and increase existing risks, it is important to assess potential risks, benefits, mitigation strategies and the feasibility of different assistance approaches based on the context. Information on how to best use the resources distributed should accompany CVA.

In situations when core GBV response services (e.g., health or legal services) have associated costs and are not available free of charge, cash transfers can facilitate access. Specifically,

GBV case management should assess any financial needs that a survivor might have (e.g., that may hinder service access) and refer the client for cash assistance. Coordination between cash and GBV programme actors is essential to prioritizing clients and developing systems and procedures that effectively meet the specific needs of diverse populations, including women and girls at increased risk of GBV, while preserving confidentiality and safety.

Cash works best when it complements rather than replaces other types of assistance. It should be viewed as one modality of GBV response services and wider prevention and empowerment efforts. GBV programme actors in humanitarian settings must establish clear internal or inter-agency protocols to outline the roles and responsibilities of cash and GBV programme actors to ensure the availability of quality services and timely, confidential and accessible care for survivors.[311]

Case Study: Jordan

Cash transfers have the potential to respond to the disadvantages, discrimination and abuse faced by women and children. According to reports, 55 per cent of female-headed households among Syrian refugees did not have an income. In order to cope, families resorted to engaging their girls in child marriages, sending their children to work, and forced and/or coerced transactional sex. The risk of intimate partner violence and other forms of domestic violence also increased as economic pressures caused frustrations and feelings of helplessness among household members. A 2012 survey conducted by the IRC reported that cash transfers through prepaid ATM cards were the most appropriate means of support because they provided refugees with an increased sense of independence and dignity.

Adapted from IRC 2012a. Source: IASC 2015a, p. 293.

As part of the project set up, GBV case management and cash actor protocols should be based in local infrastructures and systems, which determine the constraints or flexibility of cash transfers. This preparatory step ensures that clients receive referrals to services that are accessible, timely and do not cause further harm.[312]

Tools and Resources

CARE USA (2019). *Cash & Voucher Assistance and Gender-Based Violence Compendium: Practical Guidance for Humanitarian Practitioners: A Companion Guide to the IASC GBV Guidelines.* http://www.cashlearning.org/downloads/user-submitted-resources/2019/05/1557937891.CVA_GBV%20guidelines_compendium.FINAL.pdf.

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Global Protection Cluster (n.d.). *Protection and Cash and Voucher Assistance.* Available from: http://www.cashlearning.org/sector-specific-cash-transfer-programming/protection-1.

The Cash Learning Partnership (2018). *Cash-based Assistance (CBA) Programme Quality Toolbox.* http://pqtoolbox.cashlearning.org/.

United Nations High Commissioner for Refugees (UNHCR) (2015). *Guide for Protection in Cash-based Interventions.* http://www.cashlearning.org/downloads/erc-guide-for-protection-in-cash-based-interventions-web.pdf.

_____(2015b). *Protection Risks and Benefits Analysis Tool.* http://www.cashlearning.org/downloads/erc-protection-risks-and-benefits-analysis-tool-web.pdf.

Women's Refugee Commission, International Rescue Committee and Mercy Corps (2018a). "Assessing and Mitigating Risks of Gender-Based Violence in Cash-based Interventions Through Story: A Focus Group Discussion and Interview Guide," Toolkit: Section 1 in *Toolkit for Optimizing Cash-based Interventions for Protection from Gender-based Violence.* https://www.womensrefugeecommission.org/issues/livelihoods/research-and-resources/document/download/1551.

_____ (2018b). "Post-distribution Monitoring (PDM) Module: Adapting CBIs to Mitigate GBV Risks," Toolkit: Section I in *Toolkit for Optimizing Cash-based Interventions for Protection from Gender-based Violence.* https://www.womensrefugeecommission.org/issues/livelihoods/research-and-resources/document/download/1550.

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STANDARD 12 Economic Empowerment and Livelihoods

Women and adolescent girls access economic support as part of a multisectoral response.

Supporting women's and adolescent girls' access to and control over economic resources can be an effective means to enhance resilience, reduce vulnerability, mitigate the risk of GBV in emergencies, and help ensure that the needs of women, girls and their families are met.[313] Access to education, vocational training and skills development can promote self-sufficiency, empowerment and resilience. Economic empowerment programmes also can help shift negative gender and social norms that confine women to the domestic sphere, build women's agency and participation in public life, and enhance the economic, physical and psychological well-being of individuals, families and communities.[314]

The term "livelihoods" refers to the capabilities, assets and strategies that people use to make a living. Livelihood programming encompasses a variety of activities, including but not limited to asset restoration (e.g., livestock and tools, access and/or tenure over land), training and placement programmes, building in-camp economies, income-generating activities, and village savings and loans associations.[315]

Participation in well-planned, targeted livelihood interventions can lead to an increase in women's and girls' access to resources, opportunities and decision-making power, and can, over time, also contribute to changing social, cultural and gender norms. In addition to helping to meet immediate basic needs, livelihood interventions can improve the future prospects of women and adolescent girls, and change the way the community treats them when their contribution to economic security is recognized.[316] In some settings, it may be necessary to overcome legal barriers to work; for example, in many contexts, refugees may not have proper documentation, the right to work or freedom of movement.

Investing in economic empowerment and livelihood programmes for women immediately after an emergency reduces their vulnerability to GBV, including sexual exploitation and abuse. The earlier women's economic empowerment and livelihood programmes can stem the depletion of critical assets and savings, the more resilient the crisis-affected population can be, shortening recovery time.[317]

KEY ACTIONS Economic Empowerment and Livelihoods

	Preparedness	Response	Recovery
Conduct a gender analysis to identify: (1) potential harm/risks that may arise from the participation of women and older adolescent girls (ages 15 to 19, as appropriate) in economic activities, as well as measures to mitigate those risks; (2) potential barriers women and adolescent girls might face in accessing and participating in economic recovery and/or livelihoods interventions; and (3) household power dynamics around asset management, financial decision-making, and control and use of income.[318]	✔	✔	✔
Map livelihood and reintegration support programmes that target women and older adolescent girls, and include relevant livelihood services/initiatives in GBV standard operating procedures and referral systems.	✔	✔	✔
Support gender- and risk-sensitive livelihood needs assessments and market analyses.	✔	✔	✔
Support livelihood programmes to incorporate relevant GBV prevention and risk mitigation strategies into policies, standards and guidelines.	✔	✔	✔
Promote women and older adolescent girls within the affected population as staff and leaders in livelihood programming.	✔	✔	✔
Support information-sharing and coordination between livelihoods and GBV subclusters/working groups, including by identifying joint actions to target livelihood programmes to marginalized women and girls.	✔	✔	✔
Work with livelihood partners to identify safe and unsafe areas within the local environment for livelihood activities, and plan the location/timing of income-generating activities based on safety, considering access to fuel, water and other key resources.[319]	✔	✔	✔
Support livelihood partners to assess the impact of livelihood strategies on the population.[320]	✔	✔	✔

In the context of economic empowerment and livelihoods, women, adolescent girls and other at-risk groups face particular obstacles related to gender and/or cultural norms, including those that may inhibit women from working outside the home, or relegate them to work that offers lower income than traditionally male jobs.[321] Stigma and discrimination also may exclude women from economic opportunities. Female heads of households may be unable to work outside of the home if they do not have access to adequate childcare or family members limit their participation. A lack of safe livelihoods opportunities for women not only increases economic dependence on men, but can also increase risks of violence.[322] At the same time, women and girls earning an income may be seen as a threat to existing power structures, which could lead to violence from family and/or community members.[323]

Introducing livelihood programmes in humanitarian contexts without taking gender and cultural norms into account can create a backlash and heighten the risk of violence against women and girls. Engaging the community, including male household members, to support women's participation in livelihoods programming is an important step to mitigate risk. Further, if not well planned, livelihood interventions can add to women's and girls' domestic responsibilities and workload, leading to increased stress and pressure.

To avoid having to trade protection for economic security, livelihood programmes, like all interventions, must be designed to be gender- and risk-sensitive.[324] Women and adolescent girls should not be excluded from economic activities because of potential risks, but rather engaged directly in designing programmes that address and mitigate these risks. It is important to apply a "do no harm" approach to reduce the possibility that livelihood programmes further exacerbate protection risks for women and adolescent girls, or isolate or further stigmatize GBV survivors.[325]

Livelihood programming for women and older adolescent girls should **not**:

- Reinforce women's traditional roles;
- Add burdens by increasing workloads;
- Fuel conflict and violence within the household or community by changing gender norms and/or shifting the balance of control over assets between men and women; or
- Heighten women's and girls' risk of experiencing violence.[326]

GBV survivors should not be the sole participants of a specific livelihood programme, as this can increase stigma and compromise confidentiality, safety and security. One approach is to work with communities to identify the women and adolescent girls who are most at risk of violence. Programmes can target these groups and/or individuals in a way that does not segregate or expose survivors.[327]

GBV-specialized actors are not responsible for direct provision of economic empowerment and livelihood support. They should consider, however, how to work best with livelihood programmes and/or other partners to establish linkages and ensure that GBV survivors can access livelihood support as part of a comprehensive multisectoral approach to addressing GBV. As a response measure, livelihood and economic empowerment programmes can be entry points for GBV survivors to receive information and access services, and may also provide an outlet for emotional support and healing activities.[328]

Indicators

- Economic empowerment and livelihood programmes are integrated into GBV standard operating procedures, and included in the referral system and service mapping.
- Percentage of women and older adolescent girls who report sole or joint involvement in household decision-making.
- Percentage change from baseline in women's and girls' access to and control over financial resources following participation in economic empowerment or livelihood programmes.
- Percentage change in net income of the female participants of livelihood programmes.
- Number of projects to support the economic empowerment of women and older adolescent girls through targeted livelihood and employment interventions funded in Humanitarian Response Plans.[329]

Guidance notes

1. Livelihood programming in emergencies

Understanding the context for programme design

The design of economic empowerment programmes for women and older adolescent girls must be based on a thorough understanding of the emergency context, and social, cultural and gender norms within the community.[330] Programmes that include built-in protective mechanisms to monitor and address potential risk factors can help to reduce the exposure of women and older adolescent girls to violence and exploitation, while empowering them with skills training, and social and financial capital.

Programmes can:

- Provide women, older adolescent girls and other at-risk groups with safe avenues for generating income;
- Enhance their knowledge and skills base for microenterprises, financial management, natural resource management and leadership;
- Empower and foster their independence, which may increase their ability to leave exploitative situations;
- Enhance the economic, physical and psychological well-being of individuals, families and communities;
- Create and raise awareness about GBV, gender norms and power imbalances in the family and community in a sensitive way; and
- Improve the management of natural resources thereby supporting sustainable livelihoods.[331]

Empowering women socailly and economically through the EA$E intervention

The IRC's Women's Protection and Empowerment programme works to empower women socially and economically through the EA$E (Economic and Social Empowerment) intervention. EA$E seeks to promote safer gender dynamics in the household by increasing women's decision-making in the home. It does this through three components of empowerment: (1) access to financial services through village savings and loan associations, (2) discussion group series and (3) business skills training.

Preliminary research has shown that adding space for gender dialogues – in addition to economic programmes for women – can be helpful in reducing intimate partner violence. The EA$E programme facilitates a discussion series for women village savings and loan members and their male spouses that focuses on household finances and joint economic decision-making, while also incorporating deeper issues of power imbalance, women's value in the home and alternatives to violence. At the same time, participants are able to address these topics in a non-threatening way by making improvements in household well-being and shared decision-making – rather than intimate partner violence – the main focus of the discussions. Initial measures in the pilot programme in Burundi showed that integrating the discussion series along with economic empowerment led to a decrease in intimate partner violence and acceptance of violence; it also increased women's involvement in decision-making and the use of negotiation skills between spouses.

Source: IASC 2015a, p. 233.

Understanding and identifying safe, market-based opportunities for women and older adolescent girls

Economic empowerment programmes must be informed by a gender-sensitive market assessment that identifies safe and viable work opportunities for women and older adolescent girls. Knowledge and skills-building activities should be adapted based on updated market information to support sustainable and profitable livelihoods.

Addressing unpaid work across livelihood programming

Livelihood programmes must consider the barriers that women and older adolescent girls often face due to unpaid work in their households and communities, which results in time poverty and no time or space for self-care. At a minimum, programmes should be adapted to accommodate women's schedules and responsibilities by consulting them on the best timing, duration and location for services; offering transportation or stipends when appropriate; and providing adequate childcare either on site or near service locations. For a more transformative approach, programmes should engage key stakeholders, including community leaders and policymakers, private sector employers and male household members, in discussions around unpaid work and harmful gender norms, towards encouraging more equitable policies and behaviours.

Mitigating negative consequences

Livelihood interventions must consider risks to women and older adolescent girls before, during and after the programme in order to mitigate potential harm to participants.[332] Moreover, as emergencies are characterized by an increase in insecurity, sexual violence, and sexual exploitation and abuse, humanitarian practitioners can unintentionally contribute to increased exposure to these dangers due to poor livelihood response planning.[333] From the very early days of an emergency, it is critical to understand gender dynamics, assess GBV risks and take measures to reduce vulnerability to violence for women, girls, boys and men.[334] GBV programme actors should actively monitor both positive and negative unintended consequences of programming; for example, by visiting a small number of programme participants every few months to ask about any unexpected outcomes of their participation in the programme or any other feedback they would like to share.

Changes in established social and gender norms can pose the risk of increasing the incidence of some forms of GBV. For example, intimate partner and domestic violence can increase if partners or family members feel threatened by or resentful of women's economic independence – especially in humanitarian settings where male family members may not be able to meet their traditional responsibilities as "breadwinners". Increased access to and availability of assets may also enhance women's and girls' risk of sexual violence, sexual abuse and exploitation, and other forms of violence (e.g., theft). In settings involving internally displaced people/refugees, livelihood initiatives that target these populations exclusively can increase tension with receptor/host communities.[335]

Emergency income generation projects should be integrated into longer-term transition programmes and donor funding strategies to help build women's sustained economic empowerment, strengthen community resilience and mitigate protection risks from the onset of the emergency through early recovery, development and durable solutions.[336]

Tools and Resources

Child Protection in Crisis Network, Women's Refugee Commission and UNICEF (2014). *Empowered and Safe: Economic Strengthening for Girls in Emergencies.* https://www.womensrefugeecommission.org/images/zdocs/Econ-Strength-for-Girls-Empowered-and-Safe.pdf .

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International Center for Research on Women (ICRW) (2011). *Understanding and Measuring Women's Economic Empowerment: Definition, Framework and Indicators.* https://www.icrw.org/wp-content/uploads/2016/10/Understanding-measuring-womens-economic-empowerment.pdf.

STANDARD 13 Transforming Systems and Social Norms

GBV programming addresses harmful social norms and systemic gender inequality in a manner that is accountable to women and girls.

Although crises can exacerbate pre-existing gender inequalities and lead to increased risks, exclusion and discrimination, they also provide opportunities for social change. Research shows that women, girls, boys and men have the ability to question traditional gender norms in emergency situations.[337] There may be shifts in conventional roles, attitudes, beliefs and practices, or new opportunities to discuss subjects that were previously proscribed.[338] Space may open to build positive social and cultural norms that challenge GBV and a culture of impunity for perpetrators.

What is a social norm?

A **social norm** is a shared belief about what behaviour is typical, normal, appropriate and expected in a group. Social norms are generally maintained by social approval and/or disapproval.

Source: Heise and Manji 2016, pp. 1-2.

Transforming norms and systems that perpetuate gender inequality can have a tangible impact on women's and girls' health, safety and security. It is possible to promote their participation and create opportunities for increased decision-making from the start of the emergency (see Standard 2: Women's and Girls' Participation and Empowerment). Humanitarian actors should proactively seek opportunities to facilitate and model equality to encourage social norms and systems that will protect women and girls and support their access to services, including GBV response services.[339]

Emergency contexts can provide opportunities for change that can enhance gender equality and strengthen national systems throughout recovery and rebuilding. Given the increasingly protracted nature of humanitarian crises, promoting positive gender and social norms from the start of the emergency response provides a basis for continued efforts throughout the crisis and sets a foundation for longer-term interventions, acknowledging that changes to attitudes, beliefs and practices may take time. Transformative programming must be undertaken carefully and requires gauging community acceptance before engaging in conversations on deeply rooted issues.

KEY ACTIONS Transforming Systems and Social Norms

	Preparedness	Response	Recovery
Ensure essential services for health and psychosocial support, at minimum, are functional before beginning more transformative social norms and systems change activities.	✔	✔	✔
To appropriately contextualize and target GBV prevention programming, conduct a gender and power analysis of local systems and norms to identify how they sustain gender inequality and GBV (see Standard 16: Assessment, Monitoring and Evaluation).	✔		✔
Ensure staff and volunteers working on prevention programming are aware of how to safely refer GBV survivors who disclose GBV during community outreach activities and wish to access support services.	✔	✔	✔
Invest in female and male staff and volunteer attitudes, knowledge and behaviour change[340] before starting programming with the community on GBV prevention and gender equality.	✔	✔	✔
Train and mentor community activists (women, adolescent girls, adolescent boys and men) in social norm change strategies using tested approaches.[341]	✔		✔
Build the skills of staff and community activists engaged in GBV prevention work.	✔	✔	✔
Equip male community activists and staff with skills to support women's voice and leadership and to act as allies for GBV prevention programming.	✔		✔
Facilitate women's and girls' leadership in prevention programming and ensure prevention programming is safe and responsive to the needs of women and girls.	✔	✔	✔
Engage women and adolescent girls in transformative life skills/education sessions to change internalized harmful gender norms, increase understanding of GBV causes and consequences, and strengthen solidarity and support among survivors.	✔		✔
Mobilize community members (women, adolescent girls, adolescent boys and men) committed to gender equality, inclusive of marginalized groups within the affected community, who are motivated to act as community activists.	✔	✔	✔
Engage female and male community leaders, religious institutions and other opinion leaders to support social change and GBV prevention activities, and ensure their accountability to women and girls.	✔	✔	✔
Work with local women's movements and women's rights activists to understand gaps in legal protections against GBV, and participate in joint action to promote systemic change to achieve women's and girls' equal rights under the law.	✔	✔	✔
Use social and behaviour change communication strategies (see Guidance Note 3) to enhance the effectiveness and sustainability of service delivery, and build individual and community-level acceptance of positive gender and social norms.		✔	✔
Establish accountability mechanisms to ensure prevention programming is led and guided by women's and girls' interests and needs (see Standard 16: Assessing, Monitoring and Evaluation), including by facilitating regular listening sessions with women and girls from the community to seek feedback on the harmful and helpful effects of GBV prevention programme activities (see also Standard 2: Women's and Girls' Participation and Empowerment).	✔	✔	✔
Identify partners and develop strategies to engage men and boys in efforts to prevent and respond to GBV, and to transform harmful social norms that perpetuate gender inequality in ways that are accountable to, and led by, women and girls.	✔	✔	✔
Monitor the changes in social norms and utilize data to inform targeted, responsive GBV prevention programming.[342]		✔	✔
Enhance the capacity of national authorities, as well as local organizations, to enact and enforce laws, policies and protocols that promote gender equality and address GBV.	✔	✔	✔
Advocate for peacebuilding and post-conflict State-building actors to apply a gender lens throughout the analysis of a conflict, and the planning and implementation of peacebuilding and State-building initiatives.[343]		✔	✔

GBV is rooted in unequal power relationships between women and men that are replicated across different levels of society, from individual expectations and attitudes to social norms, policies and legal frameworks and systems (see Introduction). The root causes of GBV relate to the "attitudes, beliefs, norms and structures that promote and/or condone gender-based discrimination and unequal power"[344] Often, discriminatory social and gender norms make up the underlying causes of exclusion, violations and denial of rights. Therefore, promoting positive social norms can prevent GBV by challenging the norms that support violence and a culture of impunity. It can also improve the response to GBV by reducing victim blaming and the social stigma that survivors experience, and promoting help-seeking behaviours. Furthermore, changing gender and social norms even within an emergency context can promote shared control of resources and decision-making. Programming that does not work in this manner can do harm by reinforcing harmful stereotypes or compounding risks to women and girls.[345]

GBV programming that promotes transformational change is based on understanding GBV to be the result of gender inequality. Gender inequality is compounded by a number of contributing factors. Intersecting factors of oppression, such as age, race, class, gender identity and sexual orientation, and disability further harm and disempower women and girls. Therefore, GBV prevention requires working along a spectrum, ranging from immediate risk mitigation in the acute emergency (see Standard 9: Safety and Risk Mitigation) to longer term social norms and systemic change.

While community outreach and awareness-raising are necessary to increase timely and safe access to services and mitigate risks of GBV,[346] awareness-raising is not insufficient to affect social norms change. To transform harmful social norms, GBV programming must: (1) shift social expectations, not just individual attitudes; (2) publicize the changes; and (3) catalyse and reinforce new norms and behaviours.[347] GBV prevention approaches recognize the importance of increasing women's agency, widening women's spaces to act, and engaging with and transforming the systems that maintain inequality (see also Standard 2: Women's and Girls' Participation and Empowerment).

Although it is important to understand the social and cultural context in an emergency setting, culture should also be viewed as dynamic, subject to many influences over time, and therefore subject to change. Moreover, many aspects of culture are highly contested within the culture itself; some segments of society may be keen to change a cultural practice while others, particularly those who benefit from it, may fight hard to maintain it. Therefore, GBV programme actors should not assume cultural consensus but identify allies and opinion leaders who can promote positive shifts to prevent GBV.[348]

GBV programming should promote and support women's and girls' inclusion in leadership positions from the start of an emergency response, while understanding that interventions related to social norms and systemic change should be implemented when basic GBV response services are functional.

Indicators

- Programmes focused on male engagement include explicit mechanisms for accountability to women and girls.
- All programmes focused on male engagement include commitment to the principle of perpetrator accountability, and clear protocols and mechanisms for responding to disclosures of perpetration of GBV by programme participants.
- Percentage of women, men, girls and boys who report that they disagree or strongly disagree with locally relevant harmful social norms (e.g., victim-blaming attitudes, discriminatory attitudes towards survivors).
- Percentage of community members targeted (disaggregated by sex and age) with social and behaviour change communication strategies that demonstrate increased knowledge of GBV and harmful traditional practices.
- Culturally and locally appropriate key messages, and information, education and communication materials developed to accompany information on GBV services and social norms.

Guidance notes

1. GBV prevention work

Prevention and empowerment programming aims mainly to address the root causes of GBV. The preventative value of response services (e.g., health, psychosocial support, case management) is essential for designing an effective GBV prevention approach with realistic objectives and sufficient resources. GBV prevention approaches can be described in four categories:

1. **Risk mitigation**: Risk mitigation aims to reduce the risk of exposure to GBV through all aspects of service provision. For example, effective safety planning can aim to reduce exposure by providing more lights in camps, appropriate space for living conditions, sex-segregated and lockable bathrooms, fuel-efficient stoves, firewood patrols, etc. Risk mitigation focuses primarily on addressing "contributing factors" to GBV that might expose women and girls to increased risk of violence. It is important that these activities do not reinforce inequitable practices or promote victim-blaming attitudes by considering women and girls as responsible for their own safety; for example, by suggesting a "dress code" for young women to mitigate the risk of sexual violence (see Standard 9: Safety and Risk Mitigation).

2. **Primary prevention or "tackling the root cause":** Primary prevention includes strategies that focus on preventing GBV before it occurs by tackling its root cause – gender inequality. These approaches focus on behaviour modification and attitudinal change, and require long-term resources. Long-term social norms change is possible in the protracted and recovery stages of humanitarian crises and should be embedded in efforts to build national systems after a crisis. A GBV prevention strategy is incomplete

and unsafe unless it includes specific measures and resources to support women and girls, including survivors, to recover and build support and solidarity. Primary prevention also includes holding perpetrators to account through legal and justice systems (see Standard 10: Justice and Legal Aid) and enhancing women's and girls' agency through economic, political and social empowerment (see Standard 2: Women's Participation and Empowerment and Standard 12: Economic Empowerment and Livelihoods).

3. **Secondary prevention**: Secondary prevention includes strategies that focus on response for survivors and consequences for perpetrators. This includes addressing the consequences of various forms of violence, mitigating the harm this violence can cause, and taking steps to prevent the violence from happening again. Health care for GBV survivors, case management, and psychosocial support are examples of secondary prevention.

4. **Tertiary prevention**: Tertiary prevention includes actions that focus on the long-term impact of violence when untreated, such as community reintegration and acceptance, addressing trauma, and the long-term medical and psychosocial needs a survivor may have.

2. Accountability to women and girls

All stages of programming to address harmful social norms and systemic gender inequality should support the meaningful participation of women and girls (see Standard 2: Women's and Girls' Participation and Empowerment). Furthermore, accountability to women and girls at every level of male involvement efforts is critical to ethical and effective GBV programming, and to securing women's and girls' full and equal rights.

Within the context of male engagement efforts, accountability means:

- Promoting and ensuring women's and girls' leadership in work on GBV;
- Listening to the demands and advice of diverse women and girls when undertaking male engagement efforts;
- Recognizing the existing gender hierarchy, and striving to transform a system of inequality from which men benefit;
- Working at both individual and structural levels to change personal behaviour while transforming patriarchal systems;
- Ensuring that male involvement efforts demonstrably empower women and girls and honour women's leadership; and
- Examining funding decisions to ensure that gender hierarchies are not inadvertently reproduced.[349]

Rigid gender norms about the appropriate attitudes and behaviours of men and women across the world are related to men's and boys' use of "power over" women and girls, and gender inequality more generally. Engaging men and boys requires transformation at both the individual

and systemic levels. Programming that is accountable to women and girls supports men's and boys' critical reflection on the power and privileges they enjoy, and helps them to give up their "privileges" to dismantle patriarchy. GBV prevention programming can also provide opportunities for men and boys to benefit from transformed gender roles and norms that open up new opportunities for positive masculinities, such as increased communication and sharing with female partners, participation in fatherhood, emotional expression, or less restricted sexual and gender identities.

The primary outcome of GBV prevention programming remains the improved safety and equality of women and girls. Without accountability, GBV programme actors will not know if interventions endanger women and girls or make them safer. Approaches that fail to centre on women and girls may reproduce the dynamics of patriarchy, where women and girls are not agents of their own well-being, and men's concerns and priorities overshadow those of women and girls. Such approaches may regress rather than enhance women's status and agency.[350]

3. Social and behaviour change communication

Social and behaviour change communication uses media messaging, community mobilization and interpersonal communication to influence the knowledge, attitudes and practices of individuals, families and communities.[351] It is particularly important during emergencies as a vehicle for enhancing the effectiveness and sustainability of service delivery, and building individual and community-level acceptance of positive gender and social norms.[352]

Most social change strategies must target factors operating at multiple levels,[353] including:

- **Individual** factors: attitudes, agency, factual beliefs, self-efficacy;
- **Social** factors: social norms and networks;
- **Material** realities: access to resources, poverty, existing infrastructure, and
- **Structural** forces: laws, political ideologies, policy framework and globalization.

In GBV programming, social and behaviour change communication campaigns aim to share relevant and action-oriented information to influence individual, group, institutional and community behaviours and practices around gender, rights and equality. GBV-related campaigns during emergencies support the creation of an environment in which positive gender and social norms can flourish, and have a positive impact on GBV prevention and response. Social and behaviour change communication interventions may reduce stigma and encourage use of services, for example. Since there are often cultural, political and religious barriers to behaviour change, it is important to engage the community in programme design, implementation and evaluation. Key stakeholders to be included at all stages comprise women, girls, boys and men, community leaders and gatekeepers, and police and judiciary. Community ownership of interventions ensures long-term impact and motivation for change.[354]

Tools and Resources

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International Rescue Committee (2013). "Part 1: Introductory Guide," in *Preventing Violence Against Women and Girls: Engaging Men Through Accountable Practice (EMAP) – A Transformative Individual Behaviour Change Intervention for Conflict-Affected Communities.* https://gbvresponders.org/wp-content/uploads/2014/07/IRC-EMAP-Introductory-Guide-High-Res.pdf.

Raising Voices (2009). "Basic Monitoring Tools: Outcome Tracking Tool Module," in *Monitoring and Evaluation Series, Staff Skill Building Library*. Kampala. http://www.raisingvoices.org/wp-content/uploads/2013/03/downloads/Activism/SBL/BasicMonitoringToolsOutcomeTrackingTool.pdf

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THE INTER-AGENCY

MINIMUM STANDARDS

for Gender-Based Violence in Emergencies Programming

Process Standards

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STANDARD 14

Collection and Use of Survivor Data

Survivor data are managed with survivors' full informed consent for the purpose of improving service delivery, and are collected, stored, analysed and shared safely and ethically.

This Minimum Standard focuses on survivor data. Survivor data comprise only one type of data on GBV. Other types of information include qualitative and quantitative data from GBV needs assessments, programme monitoring and other sources.

GBV **survivor data** refer to:

- Personal or identifiable data about an individual survivor accessing the service that are required to deliver quality GBV response services.
- The details of the GBV incident: e.g., type of violence, location of the incident, relationship of the survivor to the perpetrator, etc.
- Case management data: information about the support provided to an individual survivor through the GBV case management process (see Standard 6: GBV Case Management).

Any type of survivor data should be collected **in the framework of service provision and only when reported directly by the survivor** or their caregiver in the presence of the survivor if appropriate (e.g., age, maturity, level of cognitive development). For example, seeking out or recording identifiable information about survivors solely for the purpose of protection or human rights monitoring does not align with safe and ethical practices.

Minimum Requirements for GBV Survivor Data Management

- Services (e.g., health or psychosocial support) must be available to GBV survivors if data are to be gathered from them.
- Survivor/incident data must be collected in a way that limits identification, and, if shared for analytical/reporting purposes, must be non-identifiable.
- Survivor/incident data can only be shared with the informed consent of the client.
- Identifiable case information (i.e., referral forms or, in situations of a case transfer, relevant portions of the case file) are only shared within the context of a referral and with the consent of the survivor.
- Client data must be protected at all times and only shared with those who are authorized.
- Before data are shared, an agreement must be established in collaboration with service providers to determine how data will be shared, protected, used and for what purpose.

Source: GBVIMS Steering Committee n.d., p. 2.

KEY ACTIONS — Collection and Use of Survivor Data

	Preparedness	Response	Recovery
Identify a safe and ethical information management system in line with globally recognized standards[355] on survivor data management, and dedicate financial and human resources to ensure safe and ethical data collection, analysis and use. If GBV service providers are considering rolling out the Gender-based Violence Information Management System (GBVIMS) or Primero/GBVIMS+, contact the GBVIMS Steering Committee to determine suitability and eligibility.[356, 357]	✔	✔	✔
Procure all items necessary for safe and ethical storage of survivor and incident data, including but not limited to a lockable cabinet, encrypted computer, etc.	✔	✔	✔
Ensure that a data evacuation plan is in place allocating roles and responsibilities in case of emergency.	✔	✔	✔
Train relevant staff (e.g., GBV caseworkers) on safe and ethical data collection, storage, analysis and sharing, including coding systems and safe filling.[358]	✔	✔	✔
Regularly assess the quality and effectiveness of GBV data management systems, and evaluate the need to strengthen them to adhere to global safety and security standards.[359]	✔	✔	✔
Develop internal protocols to determine how individual-level identifiable data (for referrals) and aggregate-level non-identifiable data (for reporting) will be shared within your organization and with others.	✔	✔	✔
Develop an information-sharing protocol to share aggregate-level, non-identifiable data for compilation to inform programming, advocacy and reporting (see Guidance Note 2).	✔	✔	✔
Produce regular analytical reports to inform programming and advocacy in a collaborative manner if a signatory to an information-sharing protocol.	✔	✔	✔
Develop policies and train the media and communications team on using available GBV programming data in a safe and ethical way.	✔	✔	✔
Train communications, media staff and external media on reporting on GBV in emergencies, the survivor-centred approach, and how and why to ensure safe and ethical reporting on GBV issues.	✔	✔	✔

The actual magnitude of GBV is difficult to measure in both stable and emergency settings. However, it is crucial to understand that GBV happens everywhere and is underreported worldwide for many reasons, including fear of stigma or retaliation, limited availability or accessibility of trusted service providers, impunity for perpetrators, and lack of awareness of the benefits of seeking care. As such, **all humanitarian personnel must assume GBV is occurring and threatening affected populations**, treat it as a serious and life-threatening problem, and take actions regardless of the presence or absence of concrete "evidence".[360]

The five general activities involved in managing survivor data include the following:

1. **Data collection** is the process by which survivor data are gathered or obtained. When GBV survivors seek services from an organization, an important aspect of that organization's work is to collect relevant, accurate information regarding the survivor

and the incident in order to provide a response that meets survivors' needs and offers them appropriate services. **The primary concern of service providers should be the immediate well-being of survivors**; in other words, service provision comes first. The primary purpose of data collection is to support the quality of service delivery by serving as a source of record-keeping for caseworkers with multiple cases, and for supervisors to assess the quality of care, check progress and ensure the continuity of services. Data collection, therefore, is a secondary priority that plays a supporting role to service provision.

2. Survivors have the right to know what data are being collected and what will be done with them. Data should only be collected with survivors' **informed consent.** Service providers must always assess whether the benefits of data collection outweigh the risks.

For organizations providing GBV response services, quality, anonymized statistical data on reported incidents that are disaggregated by sex and age (at minimum) helps in tracking trends in cases reported to them, and analysing whether adaptations are needed to improve service provision.

However, there are many limitations in interpreting survivor data in isolation from other data. In order to obtain a more representative understanding of the GBV situation in a given context, other sources of information must be included in the analysis.

It is not recommended to report GBV case numbers, as these can be easily misinterpreted, and doing so can compromise confidentiality, particularly in situations where numbers of cases or service providers are low. Moreover, this information is not useful and can be misleading as it undermines the extent to which GBV is happening. Trend data, like that generated by GBVIMS (see Guidance Note 2), allows for more informed decision-making based on patterns over time. It is also more helpful to inform decision-making on programming and advocacy than raw numbers, which are not reliable for the reasons outlined above.

3. Safe **data storage** means that all data must be stored safely and confidentially, whether in paper or electronic form. The sensitive nature of survivor data and the potential harm that can result from misuse make it necessary for service providers to store data in a manner that maximizes protection for the survivor, the community and those collecting the data.[3361]

4. **Data analysis** allows organizations to understand the data collected, extract meaning from it and draw informed conclusions to strengthen GBV programming. Properly analysing quality GBV data can help to: (1) understand the trends and patterns of reported incidents; (2) make informed decisions regarding interventions; (3) plan for future action; and (4) improve the overall effectiveness of GBV service provision and programming at-large.

5. **Data sharing** occurs when survivor data are shared with or accessed by a different source than the one that collected it. There are two types of data sharing: (1) identifiable individual-level data that are shared by GBV programme actors for referrals to other services (see Standard 7: Referral Systems); and (2) non-identifiable, aggregate-level data that are shared for producing compiled reports to inform programming and advocacy.

At the individual level, identifiable information on survivors may be shared with their informed consent for referrals among service providers. Forms and protocols should be in place at the organization and inter-agency level (i.e., GBV subcluster/working group standard operating procedures) to ensure that referrals are made safely and confidentially.

Non-identifiable, aggregate-level data should be compiled from multiple service providers into a report analysed at the inter-agency level. Data-sharing at this level should only happen if data-gathering organizations are using the same information management system and have an information-sharing protocol in place with rules on how data should be shared.[362] Because multiple providers often operate in the same area and provide services to the same client population, the ability to produce high-quality GBV data that can be safely shared and analysed at the inter-agency level is a critical step towards understanding trends in reported cases and ensuring a coordinated response.[363]

Individual, non-identifiable data: Data about an individual survivor that cannot be used to identify the survivor.

Aggregate-level data: Combined data about many incidents that do not identify any individual.

Foundational to these Minimum Standards is the requirement that all partners respect the information-sharing protocol. This means partners never share identifiable, individualized data outside of the context of referrals and without informed consent, or any data that could compromise the survivor's confidentiality or create safety risks for their communities. GBV programme actors should not be pressured to share data outside of the information-sharing protocol or other interagency protocols, as these protocols are in place to protect survivors' safety and confidentiality, and promote survivors' and the wider community's trust in service

Prevalence data represent the rate and frequency of GBV in a given population. In general, it is not possible to obtain GBV prevalence data in humanitarian settings.

Incidence data do not capture all GBV incidents in an area but only those where survivors chose to report cases and had access to GBV service providers.

Any type of survivor data should only be collected in the framework of service provision and only when reported directly by the survivor or their caregiver in the presence of the survivor. It is not appropriate, for example, to seek out or record identifiable information about survivors solely for the purpose of protection or human rights monitoring.

providers. Partnership agreements between donors and implementing partners do not extend to data about individual survivors or incidents regardless of contractual agreements for reporting other types of information to donors. Sharing this information outside of a consent-based referral or case transfer is a violation of confidentiality.

Indicators

- Percentage of GBV staff with the knowledge and skills to implement safe and ethical practices related to survivor data and internal procedures on data sharing.
- Percentage of organizations that adhere to the GBVIMS Data Protection Checklist.[364]
- Percentage of service provider organizations with internal procedures to regulate how individual-level identifiable data (for referrals) and non-identifiable aggregate-level data can be shared safely and confidentiality.
- GBV information management systems in place, including an inter-agency information-sharing protocol.

Guidance notes

1. The Gender-Based Violence Information Management System and Other Systems[365]

GBVIMS and Primero/GBVIMS+ are inter-agency and globally endorsed incident monitoring and case management information systems. They exemplify global standards in GBV survivor data management and are a best practice for both individual organizations and inter-agency use. In line with the WHO's *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies,*[366] the GBVIMS was designed from a service-provision perspective to provide:

> GBV survivor data are sensitive. The management of GBV data is complex and requires that systems and safeguards be in place to ensure data security and the safety of everyone involved. Revealing someone's identity can have serious repercussions for the survivor (including putting her safety at risk), the community and even the organization (such as other survivors' loss of trust in the organization). Collecting GBV data means one has the responsibility to protect it.
>
> Source: GBVIMS Steering Committee 2010b, p. 21.

- A simple and efficient process for GBV service providers to collect, store, analyse and share their incident data.
- A standardized approach to data collection for GBV service providers.
- A confidential, safe, and ethical approach to sharing anonymous incident data on reported cases of GBV.

GBVIMS data should not be confused with prevalence data as GBVIMS data only represent cases reported by survivors who chose to disclose their experiences to a GBV service provider who uses the system. For example, if GBVIMS data show a decrease in the number of reported cases of GBV against children, this would not necessarily mean that there are fewer child survivors, but might indicate that few service providers focus on providing services to children.

The GBVIMS helps to reduce risks of unsafe and unethical data collection practices and overcollection of data. Developed specifically for organizations providing services to GBV survivors in a context of humanitarian response, GBVIMS is aimed at improving the coordination and provision of those services and meets the standards required by the GBV Guiding Principles. The system enables humanitarian actors who are responding to GBV to safely collect, store and analyse reported GBV incident data, and facilitates the safe and ethical sharing of aggregate-level GBV incident data. The intention of the system is to assist the GBV community to better understand the GBV cases being reported by enabling service providers to generate high-quality GBV incident data across their programmes more easily, analyse that data properly, and share it safely with other agencies for broader trends analysis and improved GBV coordination.

The GBVIMS is not appropriate for all GBV programme actors; partners who are not providing GBV services should not use it.[367] Some GBV service providers may choose to use other information management systems or develop their own. It is essential to ensure that these other systems adhere to this Minimum Standard and the GBVIMS principles, including role-based access to databases containing individual survivor data that is limited to direct service providers.

2. Information-sharing protocol

The sensitivity of GBV information requires that clear guidelines and information-sharing agreements are in place to ensure that safe and ethical data-sharing can take place among organizations. These agreements, referred to as information-sharing protocols, aim at sharing aggregate-level non-identifiable data. Inter-agency data-sharing agreements must take into account: (1) what information is being shared, (2) how it will be used, and (3) at what levels (e.g., within one's organization only, among all signatories to the protocol, external to protocol signatories, geographic levels of sharing). In order to develop such agreements, organizations collecting survivor data should agree on using the same information management system.

The information-sharing protocol outlines rules and guiding principles on procedures for sharing non-identifiable data on reported cases of GBV. Signatories to these protocols are limited to organizations gathering data and agencies supporting the implementation of the information management system (including compilation, analysis and reporting). All organizations and agencies that are part of an information-sharing protocol agree to uphold basic principles of confidentiality (e.g., no information is shared that could be used to identify the survivor, the alleged perpetrator, the family or the community of the survivor), and informed consent (survivors' control over their data must be respected at all times). It is inappropriate to ask for or share a survivor's data unless, in addition to service provision, proper and agreed protocols are in place, and unless informed consent conversations with a survivor make clear how her data will be used, by whom, and for what purposes.

3. National GBV data systems

Governments can be engaged in GBV survivor data management whenever safe, appropriate and feasible, as they are key partners in the implementation of GBV prevention and response programming. Government participation can increase understanding of and support for the system, while also promoting good practices around GBV data collection regardless of the role the GBVIMS ultimately has within a national data collection system on GBV. Involving governments in the rollout of a GBV information system may provide an opportunity for establishing a sustainable system that takes into account the safe and ethical data collection standards promoted by the GBVIMS.

Government engagement needs to be measured against their role (if any) in a conflict, the role they want to play in terms of the information system, and a determination of the alignment of their standards and goals for data management. Capacity-strengthening efforts can help ensure data collection happens in the framework of quality service provision to GBV survivors.

4. Reporting and communications on GBV

Media can play an important role in advocacy and communications on GBV issues. Media reporting on sexual violence and other forms of GBV in emergency contexts facilitates advocacy with decision makers and communities, and supports fundraising for comprehensive GBV programmes. The media can support efforts to raise awareness on a particular issue, ensure that women's voices and protection concerns are heard, inform the community and the public about how to access GBV response services, and promote positive gender and social norms.[368] Media reports on GBV in emergencies that fail to comply with basic ethical and safety principles can put GBV survivors, and their families, communities and those who are helping them at risk.[369]

GBV programme actors have the responsibility to respect and uphold the survivor-centred approach. When it comes to engaging with media, GBV programme actors should support survivors to make informed decisions based on risk analysis and, to the extent possible, prevent non-consent-based access to survivors by media or communications actors. If survivors express the desire to speak to the media on their own accord, GBV specialists can assess the environment and consider advising if and how survivors could engage.[370]

The caseworker or service provider should conduct a careful review of the risks of a survivor publicly disclosing her experience of violence, and put in place risk mitigation measures in consultation with the survivor. Media can put survivors and those supporting them at risk, reinforce harmful social norms, and contribute to negative stereotyping of survivors and victim blaming. There may be a power differential between reporter and survivor; the survivor may feel pressured to consent to speak, even if she does not feel comfortable. Agencies and organizations that provide direct support to survivors are not responsible for "finding" survivors for journalists or communications actors to interview.

Due to the potential repercussions on the safety, security and psychological well-being of the survivor, facilitating individual interviews between journalists and GBV survivors is

not recommended.[371] Equally, effective stories may be produced by speaking to local or international organizations working with GBV survivors.[372]

When communications staff within organizations or journalists wish to speak to survivors, it is important that they are trained to cover GBV with respect for the safety and confidentiality of survivors.[373] Reporting on GBV issues should follow best practice guidelines[374] to ensure ethical and safe interviews where survivors are treated with dignity and respect. Journalists or communications staff have a duty to protect potentially vulnerable sources and ensure confidentiality of the survivors. Survivors should be fully aware of all potential risks. Journalists must obtain "informed consent", i.e., consent with full knowledge of the consequences of the interview, appearing in the media or the survivor's name identified publicly.

It is unethical to photograph GBV survivors without their explicit consent. Photography inside service areas should only be taken with advance consent from the women and girls who use those spaces, and with full consideration of possible unintended negative consequences, such as undue attention from the community or stigmatization of women who use the centre currently or in the future. Survivors' faces should not be shown directly.

Tools and Resources

Gender-based Violence Information Management System (GBVIMS) Steering Committee (2016). *Data Protection Protocol.* http://www.gbvims.com/?s=data+protection+protocol .

_____ (2012). *Guidance Note: GBVIMS Do's and Don'ts*. http://www.gbvims.com/wp/wp-content/uploads/GBVIMS-Guidance-Note-Dos-and-Donts-Final.pdf.

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Global Protection Cluster (2013). *Media Guidelines for Reporting on Gender-Based Violence in Humanitarian Contexts*. Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Media-Guidelines-25July2013.pdf.

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STANDARD 15

GBV Coordination

Coordination results in timely, concrete action to mitigate risks, and prevent and respond to GBV.

Good coordination promotes a common understanding of GBV issues among key humanitarian actors, upholds the GBV Minimum Standards, monitors adherence to the GBV Guiding Principles, facilitates information-sharing and best practice, and promotes timely action to prevent and respond to GBV.[375] The protection and safety of women and girls in emergencies can be achieved only through collective and sustained action[376] because GBV is addressed best when multiple sectors and organizations work together to create and implement unified prevention, response and risk mitigation strategies.[377]

GBV Coordination Groups

In some contexts, formal "cluster" systems are active. A formally activated cluster is accountable to the Humanitarian Coordinator through the cluster lead agency, national authorities and the affected population. Clusters are groups of humanitarian actors in each of the main sectors of humanitarian action; they may be referred to as "working groups" even in settings where a Humanitarian Coordinator is present. In 2015, the IASC issued the IASC Reference Module for Cluster Coordination at Country Level, explaining the functions and roles a cluster must play to contribute effectively to a response.

Formal coordination mechanisms within the cluster system are important and should be kept informed of assessments, activities and response plans so that they can understand and coordinate gaps in programming. In some cases, the cluster approach may coexist with other forms of national or international coordination, and its application must take into account the specific needs of a country and the context.

In refugee contexts, UNHCR provides coordination and leadership structured around sectors and working groups based on its Refugee Coordination Model. Depending on the context and capacity, other agencies may co-lead the GBV subworking group in coordination with UNHCR (see below for further information on UNHCR's mandate).

Source: IASC Sub-working Group on the Cluster Approach and the Global Cluster Coordinators' Group 2015, p. 4.

KEY ACTIONS GBV Coordination

	Preparedness	Response	Recovery
GBV SUBCLUSTER/SECTOR LEAD COORDINATION AGENCY			
Deploy a GBV coordinator within 72 hours of a humanitarian system-wide scale-up activation.	✔	✔	
Resource and recruit dedicated GBV coordinators to co-lead GBV coordination mechanisms with appropriate GBV-specialized information management and programming expertise.	✔	✔	
GBV SUBCLUSTER/SECTOR COORDINATION TEAM TOGETHER WITH SUBCLUSTER/ SECTOR MEMBERS			
Map existing stakeholders, networks, groups and organizations to identify service delivery agencies and other actors who address GBV; consult with these entities about establishing new, or supporting current, emergency GBV coordination mechanisms.	✔	✔	
Develop and endorse a clear subcluster/sector terms of reference, and review and update it on an annual basis.	✔	✔	✔
Facilitate GBV coordination meetings in an accessible and accountable manner to support meaningful participation of diverse GBV programme actors, including local and national organizations and government entities.	✔	✔	✔
Ensure all members of the subcluster/sector know who can deliver which GBV response services in which of the crisis locations to ensure coverage of services and avoid duplication of service delivery (e.g., completing a who, what, where (3/4W) matrix).	✔	✔	✔
Lead the development of GBV standard operating procedures that are aligned with international standards and include PSEA victim assistance protocols, and update at least every six months.[378]	✔	✔	✔
Establish and regularly update a referral pathway to promote survivors' access to services with relevant partners (see Standard 7: Referral Systems).	✔	✔	✔
Establish and produce regularly updated information products (3/4W dashboards, briefing notes, etc.) and maintain a functional dissemination platform for the subcluster (e.g., www.humanitarianresponse.info).	✔	✔	✔
Lead, contribute to and/or disseminate GBV-specific and multisectoral assessments and analyses. Review, contribute to and mainstream GBV in other needs assessment mechanisms. Provide evidence-based needs analysis on the GBV situation (e.g., secondary data review, gap analysis) to help inform the Humanitarian Needs Overview or Refugee Needs Assessment, Humanitarian Response Plan or Refugee Response Plan, and other planning and advocacy efforts.[379]	✔	✔	✔
Lead the development of a GBV subcluster/sector strategy and workplan.	✔	✔	✔
Clarify funding requirements and raise funds to enable implementation of response plans.	✔	✔	✔
Establish monitoring measures that assess GBV subcluster/working group functioning, performance and accountability to GBV survivors, and girls and women in particular.	✔	✔	✔
Establish regular and systematic monitoring of the GBV response to measure and report against Humanitarian Response Plan indicators, e.g., 3/4W reporting, dashboard.	✔	✔	✔
Develop a contingency plan for GBV humanitarian response.	✔		
Lead the transition of GBV subcluster coordination to government leadership and women-led organizations when appropriate.		✔	✔
Participate in the protection cluster/sector and intercluster/sector working groups (and other groups as necessary) to contribute key information and messages, and undertake advocacy on behalf of the GBV subcluster/sector.	✔	✔	✔

KEY ACTIONS GBV Coordination (continued)

	Preparedness	Response	Recovery
Establish linkages with other key sectors/working groups, e.g., protection, child protection, health, livelihoods, mental health and psychosocial support, etc.	✔	✔	✔
Support the PSEA network to map and design systems to integrate community-based complaint mechanisms for PSEA into existing GBV referral systems.	✔	✔	✔
Promote use of and adherence to international standards for GBV prevention and response programming, including the IASC GBV Guidelines.	✔	✔	✔
GBV SUBCLUSTER/SECTOR MEMBERS			
Engage regularly with women and girls to monitor their understanding of access points in the referral pathway and any harmful unintended consequences (e.g., breaches in the GBV Guiding Principles of confidentiality, safety, respect and non-discrimination).	✔	✔	✔
Participate actively in interagency, multisectoral GBV coordination mechanisms.	✔	✔	✔
Support the functioning of the referral pathway to promote survivors' access to services.	✔	✔	✔
Support the establishment of, and participate in a system for, safe and ethical management of reported GBV incident data.	✔	✔	✔
Contribute to capacity-strengthening activities to build knowledge about the humanitarian response to GBV, including the GBV Guiding Principles, by providing technical expertise to relevant actors, including local organizations, women's groups and government, on preventing and responding to GBV.	✔	✔	✔
Regularly update and share information on context-specific GBV risks, and regularly report to the GBV coordination mechanism on service coverage and priorities for action.	✔	✔	✔
Provide other clusters and sectors with information on risk mitigation actions as set out in the IASC GBV Guidelines.	✔	✔	✔

The primary goals of GBV coordination are to:

- Ensure accessible, safe, quality services are prioritized and available to survivors through strategic planning;
- Promote appropriate attention to prevention of GBV across sectors and actors in line with the *IASC GBV Guidelines*; and
- Secure sufficient funding to support GBV-specialized programming.

Coordination systems help plan interventions and strategies, manage information, mobilize resources, uphold accountability, fill gaps and avoid duplication.[380] Coordination is also important in ensuring capacity gaps are addressed, including by supporting governments on preparedness and contingency planning. Since governments hold the primary responsibility for the well-being of their citizens, including internally displaced people, coordination systems should engage national authorities.[381] These systems also offer space to raise critical issues – for example, if organizations are not responding to the needs of women and girls, if geographic coverage is insufficient, or if there are service delivery or other gaps that need to be filled.[382]

GBV coordination can, and should, happen at all levels – from formal to informal, local to regional, and national to international. Even where formal coordination bodies do not exist, "coordination" itself can still happen – organizations or agencies in the same area can meet bilaterally or convene meetings. Effective coordination with health and child protection actors to ensure the provision of clinical care to GBV survivors and collaborative support to young and adolescent girl and boy survivors of sexual abuse is particularly important (see Standard 6: GBV Case Management).

An efficient and effective coordination forum requires active engagement and commitment among all GBV programme actors. Most of the Key Actions above are relevant to all organizations that are active in a particular context and have a duty to ensure their actions are coordinated with those of other actors. A few Key Actions relate specifically to the GBV coordination lead(s) – the organizations or government departments that are mandated or have agreed to lead the coordination function. This distinction aims to enhance clarity around accountability.

Indicators

- All multisectoral assessments include questions relevant to GBV service provision (e.g., understanding existing community resources and capacities, gaps in service provision, preferences of women and girls for locations and types of services), while avoiding questions regarding GBV incidents or prevalence.
- Referral system in place and regularly updated, and service mapping and GBV SOPs established.
- GBV subcluster/sector strategy developed and workplan in place.
- All Humanitarian Response Plans and Refugee Response Plans include: (1) GBV risk mitigation, (2) GBV-specialized programming, including response services, and (3) protection from sexual exploitation and abuse.[383, 384]

Guidance notes

1. Core functions of a GBV subcluster/sector or working group

The **six core functions** of a GBV subcluster/sector or working group are:

1. To support service delivery by:

- Providing a platform that ensures service delivery is driven by the Humanitarian/Refugee Response Plan and strategic priorities.
- Developing mechanisms to eliminate duplication of service delivery.

2. To inform the Humanitarian Coordinator/Humanitarian Country Team/Refugee Coordinator's strategic decision-making by:

- Preparing needs assessments and analysis of gaps to inform priority-setting.
- Identifying and finding solutions for (emerging) gaps, obstacles, duplication and cross-cutting issues.
- Formulating priorities on the basis of analysis.

3. To plan and implement the subcluster/sector strategy by:

- Developing a GBV sectoral plan, objectives and indicators that directly support realization of the overall response's strategic objectives.
- Applying and adhering to common standards and guidelines.
- Clarifying funding requirements, helping to set priorities, and agreeing on subcluster/sector contributions to the Humanitarian Coordinator/Humanitarian Country Team/Refugee Coordinator's overall humanitarian funding proposals.

4. To monitor and evaluate performance by:

- Monitoring and reporting on activities and needs.
- Measuring progress against the subcluster/sector strategy and agreed results.
- Recommending corrective action where necessary.

5. To build national capacity in preparedness and contingency planning.

6. To support robust advocacy by:

- Identifying concerns, and contributing key information and messages to the Humanitarian Coordinator and Humanitarian Country Team messaging and action.
- Undertaking advocacy on behalf of the cluster/sector, cluster/sector members and affected people.[385]

In refugee settings, the core functions listed above can be applied to the GBV subcluster/sector working group in coordination with the refugee protection working group.

Protecting Asylum Seekers, Refugees, Stateless People and Returnees

UNHCR is accountable for ensuring the international protection of refugees and seeking durable solutions; it is mandated to lead and coordinate international action on these issues worldwide. UNHCR supports States in fulfilling their obligations to protect asylum seekers, refugees and returnees.

Although UNHCR's mandate for, and accountability to, these groups is non-transferable, it collaborates with governments and develops partnerships with other agencies and national and international NGOs. As protection is the priority purpose of any given response, UNHCR establishes the Refugee Protection Working Group and leads with the relevant host government entity where feasible.

Where populations of concern in the same geographical area include both refugees and internally displaced persons, the High Commissioner for Refugees and the Emergency Relief Coordinator decide on the use of sector and cluster capacities.

Source: UNHCR 2013b.

2. GBV coordination membership

A range of actors are involved in GBV coordination at the national and subnational levels, including but not limited to international and national NGOs, civil society organizations and government actors. All actors engaged in GBV coordination have a responsibility to be familiar with the GBV Guiding Principles and key forms of GBV in emergencies in order to: (1) understand and anticipate the risks for, and effects of, GBV in the affected population, and (2) educate the humanitarian community about its responsibility to address GBV.[386] The ability to articulate clearly the need for GBV prevention and response is important to all aspects of GBV coordination.

It is critical that GBV coordination fora include a range of GBV programme actors. **The involvement and participation of local actors is a core principle for humanitarian action** and essential for assessing whether humanitarian assistance and protection are timely, relevant and accountable to women, girls and other community members. Local organizations not only bring significant expertise in the local context, but also may reflect the critical voices and perspectives of women and girls.

Regardless of which coordination arrangements are established at the beginning of an emergency, it is very important to work with and build upon existing GBV-related networks and partners. In all contexts, any pre-existing inter-agency coordination forum for addressing GBV should be considered a potential mechanism for coordinating emergency response and ongoing humanitarian action on GBV.

3. The GBV Area of Responsibility

At the global level, GBV coordination is led by the GBV Area of Responsibility within the Global Protection Cluster.[387] The GBV Area of Responsibility aims to develop effective and inclusive protection mechanisms that promote a coherent, comprehensive and coordinated approach to GBV at the field level, including prevention, care, support and recovery for survivors, and perpetrator accountability. UNFPA is the IASC-mandated global lead. At the country level, UNFPA co-chairs and manages, with an NGO or government co-lead, an inter-agency forum (GBV subcluster or working group) that supports information-sharing and joint action to address GBV risks and programming gaps. Although UN staff chair and coordinate a subcluster, coordinators under the cluster approach are responsible for representing the interests of all members of the cluster, including local NGOs and other civil society partners. A coordinator must ensure the integrity of the GBV response as a whole and should not coordinate from the perspective of her or his host agency alone.[388]

In some settings, government authorities co-lead GBV coordination, while in others, an international NGO with GBV expertise or civil society actors co-lead. Under the IASC Transformative Agenda, the lead agency is encouraged to consider developing a clearly defined sharing of cluster leadership by NGOs, including women-led organizations, where feasible.[389] In refugee contexts, UNHCR provides coordination and leadership structured around sectors and working groups based on its Refugee Coordination Model.

Co-leading the GBV subcluster and/or working group means working in partnership with national and local authorities and humanitarian actors to lead GBV coordination mechanisms, help establish and strengthen national systems, and ensure accessible, confidential and appropriate services for survivors.[390] Where UNFPA is not operational or able to assume leadership at the national or subnational levels, another UN entity, an international or national NGO, or the government will lead GBV coordination. At a minimum, GBV coordination bodies must ensure that all other actors with a role in GBV prevention, mitigation and response are familiar with basic standards for practice – in particular, the GBV Guiding Principles (see Standard 1); standards pertaining to ethics, safety and survivors' rights; and respective responsibilities as GBV programme actors and as outlined in the *IASC GBV Guidelines*.

GBV Coordination and Protection from Sexual Exploitation and Abuse

The Humanitarian Coordinator (HC)/Resident Coordinator (RC) is responsible for leading PSEA efforts, including via establishment of an in-country PSEA network. Both the HC/RC and the country team are responsible for preventing and responding to sexual exploitation and abuse perpetrated by the humanitarian community against the affected population.

Under the leadership of the HC/RC, the PSEA network is responsible for creating an action plan with links to existing survivor support. It should provide guidance and resources, including on reporting and accountability mechanisms, and have a dedicated PSEA coordinator. The coordinator should be distinct from the coordinator of the GBV subcluster/working group, which intersects with the PSEA network primarily on survivor support. It is highly recommended that the GBV coordination group be represented in the PSEA network to provide technical guidance and represent GBV service providers affected by the network's strategic decisions on survivor assistance.

A GBV coordination group should play two primary roles regarding PSEA: (1) support field implementation of PSEA victim assistance protocols, and (2) support prevention of PSEA. The GBV subcluster/sector should ensure that all members understand and adopt PSEA policies. It should share the IASC core principles, and discuss ways to promote best practices and the highest standards of PSEA policy and the Code of Conduct among its members. If organizations in the subcluster/sector do not have PSEA policies, the subcluster/sector should support them in developing these, such as by providing a sample code of conduct to adapt and adopt. These activities should occur in coordination with the inter-agency PSEA network, where it is present.

The *IASC Best Practice Guide Inter-Agency Community-Based Complaints Mechanisms (CBCM): Protection against Sexual Exploitation and Abuse* (2016) states: "The CBCM is responsible for ensuring that GBV sub-cluster coordinators are apprised of local reporting procedures and processes for SEA allegations in order to facilitate case referrals" (p. 30). **Although GBV coordinators provide technical guidance, the ultimate responsibility lies with the PSEA network to ensure that the CBCM respects the GBV Guiding Principles, including the right to safety, confidentiality and the well-being of survivors.**

The links between the PSEA network and the GBV coordination group should be clarified at the field level to enhance both groups' work and provide comprehensive assistance to survivors of sexual exploitation and abuse and GBV.

Source: GBV Area of Responsibility 2019, pp. 33-34

GBV subclusters/working groups play an important role in providing technical support to other humanitarian sectors, helping them better understand the nature of GBV in the context or advising them on how to implement essential sectoral actions to mitigate the risk of GBV. Coordination is an integral strategy for implementing essential actions in line with the *IASC GBV Guidelines*. Although GBV coordination mechanisms do many things to facilitate a multisectoral GBV response – by drawing together partners, developing and overseeing a coordinated action plan, and providing expert technical guidance to other sectors/clusters – accountability for addressing GBV is shared across all key sectors/clusters engaged in humanitarian response.[391]

Coordination leaders are responsible for setting the standard for ethical, safe and effective programming. All activities of the GBV coordination body should reflect basic humanitarian and GBV Guiding Principles. The personal biases or attitudes of coordination partners must not compromise the GBV Guiding Principles, and all partners must take a unified approach in implementing programming.

Tools and Resources

Global Protection Cluster (GPC) Gender-based Violence Area of Responsibility (GBV AoR) (2019). *Handbook for Coordinating GBV Interventions in Humanitarian Settings*. http://gbvaor.net/handbook-coordinating-gender-based-violence-emergencies-now/.

Inter-Agency Standing Committee (IASC) (2017). *IASC Gender Policy Accountability Framework*. https://interagencystandingcommittee.org/system/files/iasc_accountability_framework_with_adjusted_self_assessment_0.pdf.

_____ (2016). *Best Practice Guide on Establishing Inter-agency Community-based Complaint Mechanisms*. https://interagencystandingcommittee.org/system/files/best_practice_guide_inter_agency_community_based_complaint_mechanisms_1.pdf.

_____ (2015). *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*. https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf.

IASC Sub-Working Group on the Cluster Approach and the Global Cluster Coordinators' Group (2015). *IASC Reference Module on Cluster Coordination at Country Level*. https://www.humanitarianresponse.info/en/coordination/clusters/document/iasc-reference-module-cluster-coordination-country-level-0.

The Sphere Project (2011). "Core Standard 2: Coordination and Collaboration" in *Sphere Handbook*. Geneva. The Sphere Handbook (2018). https://www.spherestandards.org/handbook-2018/.

United Nations Population Fund (UNFPA) (2015). *Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies*. https://www.unfpa.org/featured-publication/gbvie-standards.

STANDARD 16 Assessment, Monitoring and Evaluation

Information collected ethically and safely is used to improve the quality of GBV programmes and accountability to women and girls.

Quality assessments, risk analyses, and monitoring and evaluation should inform programmatic interventions and learning to improve the GBV response and prevention programming. Ethically collected data on the nature and scope of GBV ensure that programme development and implementation, advocacy and resource mobilization are based on the needs and solutions identified by the affected population.[392] When information is collected through community-based, participatory approaches, it improves the impact and outcomes of humanitarian interventions. Moreover, data collection activities are opportunities to make space for members of the affected population who would not typically be heard, such as women and girls.[393]

> GBV happens everywhere. Waiting for, or seeking, population-based data on the true magnitude of GBV is not a priority in emergencies due to safety and ethical challenges in collecting such data.
>
> **All humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions . . . regardless of the presence or absence of concrete "evidence"**.
>
> Source: IASC 2015a, p. 2.

In emergencies, GBV-specialized agencies must ensure that services are available **before** pursuing GBV-focused information-gathering activities, and that persons tasked with collecting data on GBV are trained in the survivor-centred approach (see Standard 1: GBV Guiding Principles) and able to advise survivors on available services and provide referrals (see Standard 7: Referral Systems).[394]

GBV is underreported in all settings; recorded cases represent only a small fraction of the overall incident total. **A lack of available data should not be interpreted to mean that GBV is not a major issue. The absence of quantitative data may be viewed as an indication of survivors' barriers to accessing services**.[395] Further, having services in place often ensures that service-based data can be used to guide and inform programming.[396] Routine collection of data on reported incidents will start when basic services are available, and before information-

KEY ACTIONS — Assessment, Monitoring and Evaluation

	Preparedness	Response	Recovery
Before collecting new data, review and analyse existing secondary data (e.g., household surveys, aggregated service data, legal framework, academic and media reports, etc.), to inform decision-making.	✔	✔	✔
Assess GBV information gaps/needs, and weigh the risks, costs and benefits of data collection and analysis (see Guidance Note 3).	✔	✔	✔
Undertake mapping on GBV response services (e.g., existing quality and scale of multisectoral services, national legal and policy frameworks) to inform GBV-specialized programming priorities and coordination with child protection, health and other key response actors.	✔	✔	✔
Identify the best methods for reaching women, girls, boys and men in separate groups for routine data collection and targeted participatory assessments.	✔	✔	✔
Select members of a data-gathering team carefully, and ensure they receive relevant and sufficient specialized training and ongoing support. Give careful consideration to the composition of the data collection team (sex, age, language, etc.).[397] A majority female data-gathering team is recommended to facilitate the participation of women and girls. Assess the team for supportive attitudes and values towards marginalized women and girls and GBV survivors.	✔	✔	✔
Work with and through community structures and groups such as religious groups, youth groups, health facilities, community-based organizations and local NGOs to gather data; use multifunctional teams, including local partners, to make initial contact when the affected population might be scattered in an urban or remote area.	✔	✔	✔
Train the data collection team on participatory approaches, GBV Guiding Principles (see Standard 1) and WHO ethical considerations for GBV data collection,[398] and monitor the level of survivor-centred, gender-equitable attitudes of the team throughout training and implementation.	✔	✔	✔
Make specific efforts to reach marginalized groups of women and girls, and partner with child protection and disability actors to hold age and disability responsive consultations.	✔	✔	✔
Map informal meeting places and networks through which a wider assessment can be conducted.		✔	✔
Conduct risk analyses and generate solutions with women and girls to address identified risks (see Standard 9: Safety and Risk Mitigation and Standard 2: Women's and Girls' Participation and Empowerment).		✔	✔
Ensure that initial assessment reports – which can influence funding priorities for the entire response – include non-identifying information on the types of GBV occurring, risks, assessment of the quality and scale of existing multisectoral services, barriers to women's and girls' access to services, and clear recommendations informed by women and girls based on these findings.	✔	✔	
Establish mechanisms, protocols and methods to ensure women and girls provide inputs throughout all phases of the data-gathering cycle.	✔	✔	✔
Establish routine monitoring and evaluation systems that address the inputs, outputs and outcomes of GBV-specialized programming.	✔	✔	✔
Collaborate with women and girls, women's organizations, CSOs and other local actors to share recommendations and learning in a manner that does not cause harm.		✔	✔
Communicate systematically with affected populations using appropriate feedback and communication mechanisms.[399]	✔	✔	✔

sharing protocols are established or more formal systems like the emergency GBVIMS are functional (see Standard 14: Collection and Use of Survivor Data).

GBV data collection in humanitarian settings involves many challenges and risks, including:[400]

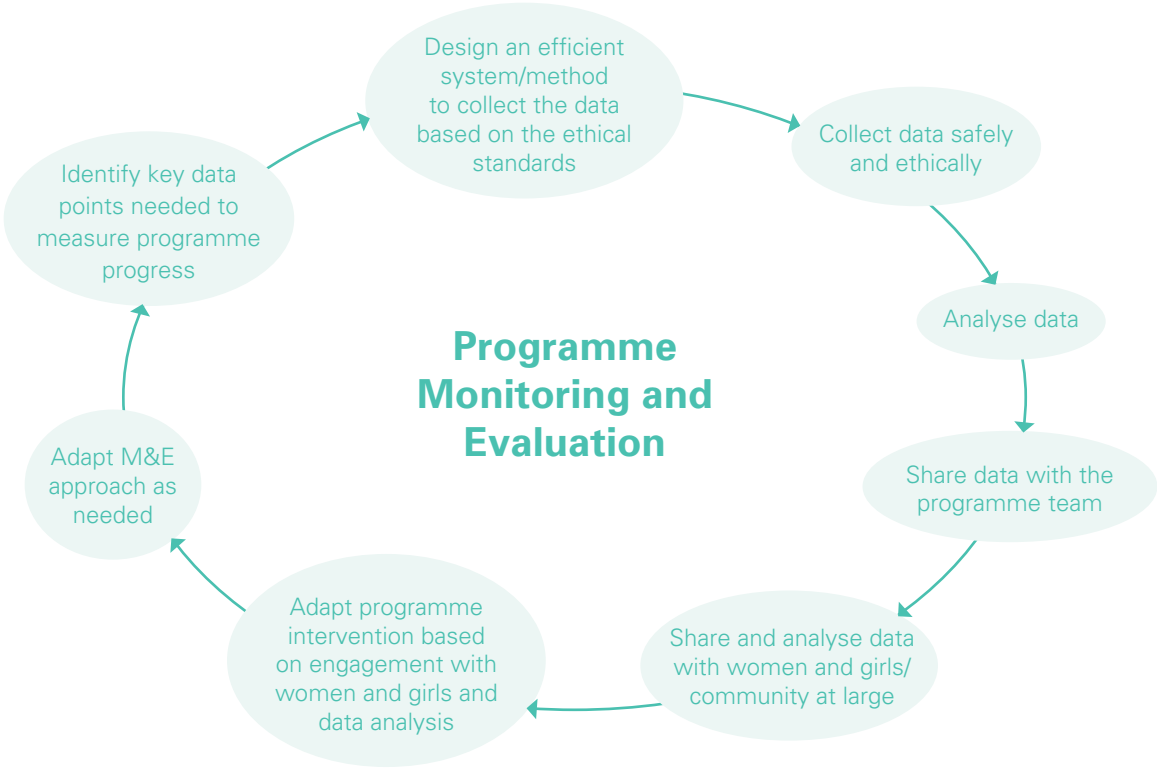
- Potential to cause harm to beneficiaries, including in creating safety risks for survivors and other women and girls;
- Shortage of qualified, female enumerators/data collectors;
- Stigma faced by survivors who report GBV incidents;
- Insecurity, including the risk of retaliation by perpetrators and/or the community;
- Impunity of perpetrators;
- Lack of harmonized GBV-related data collection tools and data collection methods;
- Lack of or weak data-protection mechanisms to ensure the safety, security, confidentiality and anonymity of case information;
- Lack of service infrastructure;
- Lack of effective and quality case management services for GBV survivors;
- Limitations on the mobility of typically marginalized segments of the female population (e.g., older women and adolescent girls or women and girls with disabilities);
- Restricted humanitarian access to the affected population, especially women and girls;
- Limited time to establish trust and rapport with affected populations; and
- Difficulty in establishing adequate interview settings that ensure basic privacy.

Methods of data collection and information-gathering should be both quantitative and qualitative to provide a more comprehensive understanding of the nature and scope of GBV. Quantitative methods typically include surveys, questionnaires and statistics. Qualitative methods comprise interviews, focus group discussions and safety audits or observations. Qualitative methods can provide contextual information on risks faced by women and girls, perpetration of different types of GBV, harmful consequences for survivors, and shifts in social and gender norms as a result of the humanitarian crisis.[401] Primary and secondary data also should be included; e.g., demographic and social and economic indicators, legal and judicial frameworks, academic and other reports, etc.

Efforts must be made to safely engage marginalized groups of women and girls to ensure their participation in data collection (see Standard 2: Women's and Girls' Participation and Empowerment). In acute emergencies, the primary focus of information-gathering should be assessing service availability and quality, and determining risks of GBV and barriers to accessing services (see Guidance Note 1).

Research can play an important role in understanding how violence affects women's and girls' lives, and what works to best address and prevent it, especially when research is led by women's organizations using feminist-informed approaches.[402] During the acute emergency stage, research is not prioritized because the focus is on life-saving services; however, existing research, particularly by local researchers, can and should be used to inform and contextualize interventions.

Programme monitoring and evaluation (M&E) refers to activities designed to understand how a programme has been implemented and what it has achieved. Monitoring is the systematic and continuous process of collecting, analysing and using information to track a programme's progress towards reaching its objectives and to guide management decisions.[403] Evaluation builds on monitoring data to understand how activities met programme objectives. It focuses on comparing the expected and achieved programme accomplishments. M&E can help practitioners conceptualize their programme goals and strategies, facilitate the development of logic models (e.g., causal pathways and logical frameworks), and clarify how a programme expects to create change.[404]



Indicators

- All staff involved in data collection are trained on the *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* and on participatory approaches.
- WHO ethical and safety recommendations are met in all routine data collection (as measured against an agreed checklist).
- Women make up 70 per cent of GBV-related assessment teams.
- At least one post-assessment participatory consultation with women and girls to share results and strategize on improvements to interventions is included in every assessment plan and budget.

Guidance notes

1. Assessments

GBV assessments seek to identify and improve GBV programme actors' understanding of the nature and scope of violence against women and girls, protective and risk factors for violence (e.g., age, minority status, disability), gaps in the quality and scale of available multisectoral services, and whether GBV programme actors have the appropriate level of resources and capacity to respond.[405] **Assessments do not aim to identify individual or groups of survivors or whether GBV is happening**.

STOP! Do No Harm.

GBV survivors should not be sought out or targeted as a specific group during assessments.

An assessment is not required before implementing GBV prevention and response programming in the acute phase of a humanitarian response. As stated above, all humanitarian actors should assume GBV is happening to women and girls, and prioritize appropriate response services and prevention and risk mitigation actions. A credible and thoughtful assessment is a highly valuable tool for internal and external advocacy efforts, and can increase funding and action to address GBV in emergencies. Good assessments produce good interventions. Participatory assessments, when conducted safely and ethically, may also have the effect of opening up a safe space for affected populations to talk about GBV, and may lead some survivors to disclose an incident of violence.[406] Basic response services should be in place prior to the assessment, and the assessment team should be briefed on how to respond to reports of GBV or other protection issues arising during the course of the assessment, including by providing information to survivors on how to access care. The assessment may be an intervention itself.[407]

The purpose of assessments is to determine how women and girls are at risk for GBV, which interventions will best address the identified problems (e.g., barriers to accessing services), and whether GBV programme actors have the appropriate level of resources and capacity to respond. It is never to establish whether or not GBV is occurring.

Source: IRC 2017b, p. 28.

2. Accountability in action: participatory approaches

Participatory approaches refer to data collection and analysis activities that aim to involve and empower local communities, and ensure that the results can be used by and for the affected community. In all methods employed to collect data, it is essential that the participation of all relevant community groups is promoted and facilitated, with a specific focus on including women and girls. Community participation in data collection should be encouraged with caution in situations where this poses potential security risks or increases the risk of GBV.[408] Also, as a routine practice, all GBV incident data and information collected should be disaggregated by sex and age, as well as by disability status, ethnicity, sexual orientation and other pertinent variables as relevant and safe to collect in the context.[409]

GBV assessments are important in the preparedness and initial emergency response phases, and throughout the response, serving a number of purposes:

- Ensure programmes across all sectors are based on an accurate understanding of the distinct protection risks faced by women and girls, and the needs of affected women, girls, boys and men;
- Facilitate the design of more appropriate responses, such as by ensuring that services are culturally relevant and gender-responsive, and that protection considerations, including GBV, are factored into the design of programmes;
- Help to target GBV interventions to ensure programmes effectively reach marginalized women and girls;
- Highlight opportunities, resources and strengths within the affected community, including by harnessing the capacity of women and girls to actively participate in preparedness and early recovery, and identify and participate in solutions to improve their own protection; and
- Facilitate a smoother transition from preparedness to humanitarian assistance to recovery and development.

Source: UNFPA 2015a, p. 64.

During acute emergencies, it may be difficult to employ fully participatory approaches; however, even during the acute emergency phase, it may be possible to incorporate some participatory approaches into data collection activities. As the situation stabilizes, opportunities will expand to engage meaningfully with the local community and more fully employ participatory approaches in data collection activities.[410]

Key **participatory principles** to be followed throughout the design, implementation and analysis processes include:

- **Facilitate local ownership and actively engage with local groups throughout the design, data collection and analysis processes**.
- **Work with local researchers**. Whenever possible, it is important to conduct research through, or engage with, researchers based in the country where data collection is taking place.
- **Ensure meaningful engagement with the community throughout data collection** to increase accountability to the affected population, provide transparency and build trust. Women and girls can act as researchers, with appropriate considerations, to collect and analyse data on their own lives and communities.
- **Work with the community to understand and analyse data**. Whenever possible, work directly with members of the community, particularly women and girls and women's groups, to analyse and contextualize the collected data. Bring back the results of data collection activities to the affected communities in locally meaningful and understandable ways.[411]

The GBVIMS System

Although the GBVIMS is not an M&E system, it is valuable from an M&E perspective because it collects common data on reported GBV cases, and institutes safe and ethical data-sharing mechanisms. Aggregated, non-identifiable data from the GBVIMS help support service providers and the wider GBV sector to track the number of survivors accessing services as well as key trends in case reporting (see Standard 14: Collection and Use of Survivor Data).

The GBVIMS is not necessary for implementing GBV response programming. It is unethical to use the GBVIMS without established GBV services. The GBVIMS is not appropriate to every setting or context, e.g., where quality GBV services are not available or where service providers or coordinating agencies are not committed to establishing and sustaining the system. It is not feasible to set up the GBVIMS during the acute emergency phase.

Source: The Global Women's Institute 2017, p. 28.

3. Ethical considerations for GBV research, evaluation and learning activities

Collecting data on any subject with vulnerable populations must be undertaken with care. All information collected must be used to design and improve interventions or to advocate for improved action for women and girls; collecting information that will not be used is unethical and wasteful.[412]

The WHO[413] outlines eight general principles for assessing, monitoring and researching violence against women and girls that are the starting point for any learning activity that includes GBV components:

Given the highly sensitive and potentially life-threatening nature of GBV, any type of qualitative or quantitative assessment or survey must follow robust ethical and safety considerations, accepted international standards and "do no harm" principles. A failure to do so places women and girls, GBV survivors and staff at risk.

1. **Analyse risks and benefits**: Before collecting any data, it is important to consider both: (1) potential risks that respondents and data collectors may experience, and (2) potential benefits to the affected community and the wider humanitarian community. It is critical that the benefits outweigh the risks.[414]

2. **Methodology**: Data collection activities must be safe and survivor-centered, methodologically sound and not time intensive.[415]

3. **Referral services**: Basic care and support to survivors must be available locally before commencing any activity that may involve individuals disclosing information about their experiences of violence.[416]

4. **Safety**: The safety and security of all those involved in information gathering is a primary concern and should be monitored continuously. Safety and security conditions should be regularly incorporated into the security protocol.[417]

5. **Confidentiality**: The confidentiality of individuals who participate in any data-collection activity must be protected at all times. Data should be collected anonymously where possible.

6. **Informed consent**: Anyone participating in data-gathering activities must give informed consent. Before collecting data, all participants need to be informed of the purpose of the exercise, the risks they may face, and the benefits (including any monetary or in-kind compensation) they can expect to receive due to their participation.

7. **Information gathering team**: The data-gathering team must include women. All members must be selected carefully and receive relevant and sufficient specialized training and ongoing support.

> International standards note that collecting prevalence data on GBV in emergencies "is not advisable due to methodological and contextual challenges related to undertaking population-based research on GBV in emergency settings (e.g., security concerns for survivors and researchers, lack of available or accessible response services, etc.)".
>
> See the IASC GBV Guidelines, p. 7.

8. **Children**: Additional safeguards must be established if children (i.e., those under 18 years old) participate in information-gathering.[418]

4. Learning through research

In addition to routine programme monitoring and evaluation, general research studies refer to data collected through systematized methods that aim to help the wider humanitarian community improve its understanding of a topic (e.g., the types of GBV most common in a community, the consequences commonly experienced by GBV survivors). Research can involve activities that are not associated explicitly with measuring programme performance.[419] Impact evaluations measure the effect of the programme within the target population, including determining whether or not to attribute change explicitly to the programme's influence.[420]

Extremely vulnerable populations are often subjected to many data collection activities (e.g., assessments, surveys, interviews, focus group discussions). Therefore, it is necessary to ask if the data collection activity would improve the lives of women and girls, and whether the overall research objective is something that is necessary to know (e.g., to improve programming, advocate for further funding for GBV programmes, design new programmes).[421]

Tools and Resources

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Funded by European Commission's Civil Protection and Humanitarian Aid Operations Department

This initiative was implemented with the financial assistance of the European Union. The views expressed herein should not be taken, in any way, to reflect the official opinion of the European Union, and the European Commission is not responsible for any use that may be made of the information it contains.

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