

Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action:

*Reducing Risk, Promoting Resilience,
and Aiding Recovery*



The Gender-based Violence Area of Responsibility (GBV AoR) is a global level forum for coordination on GBV in humanitarian settings. The group brings together NGOs, UN agencies, academics and others under the shared objective of ensuring more predictable, accountable and effective prevention of and response to GBV in settings affected by emergencies. In the humanitarian system, the GBV AoR constitutes an “area of responsibility” within the Global Protection Cluster.

<http://gbvaor.net>

Camp Coordination and
Camp Management



Child
Protection



Education



Food Security
and Agriculture



Health



Housing, Land
and Property



Humanitarian
Mine Action



Livelihoods



Nutrition



Protection



Shelter, Settlement
and Recovery



Water and
Sanitation



Support Sectors



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Foreword



Acronyms



Acronyms (continued)



PART ONE: INTRODUCTION



1. About these Guidelines

Purpose of these Guidelines

The purpose of these Guidelines is to assist humanitarian actors and communities affected by armed conflict, natural disasters, and other humanitarian emergencies to *coordinate, plan, implement, monitor and evaluate essential actions for the prevention and mitigation of gender-based violence (GBV) across all sectors of humanitarian response.*

As detailed below, GBV is a widespread international public health and human rights issue. During a humanitarian crisis, many factors can exacerbate GBV-related risks. These include—but are not limited to—increased militarization, lack of community and State protections, displacement, scarcity of essential resources, disruption of community services, changing cultural and gender norms, disrupted relationships, and weakened infrastructure.

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“Prevention” and “Mitigation” of GBV

Throughout these Guidelines, there is a distinction made between “**prevention**” and “**mitigation**” of GBV. While there will inevitably be overlap between these two areas, **prevention** generally refers to taking action to stop GBV from first occurring (e.g. *scaling up activities that promote gender equality; working with communities, particularly men and boys, to address practices that contribute to GBV; etc.*). **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; ensuring sufficient lighting and security patrols are in place from the onset of establishing displacement camps; etc.*). Some sectors, such as health, may undertake activities related to survivor care and assistance. For these sectors, there are recommendations related to specialized response programming. Even so, the overarching focus of these Guidelines is on essential prevention and mitigation activities that should be undertaken within and across all sectors of humanitarian response.

All national and international actors responding to an emergency have a duty to protect those affected by the crisis; this includes protecting them from GBV. *In order to save lives and maximise protection, essential actions must be undertaken in a coordinated manner from the earliest stages of emergency preparedness.* These actions, described in **Part Three: Thematic Area Guidance**, are necessary in every humanitarian crisis and are focused on three overarching and interlinked goals:

1. To **reduce risk** of GBV by implementing GBV prevention and mitigation strategies from pre-emergency through to recovery stages of humanitarian response;
2. To **promote resilience** by strengthening national and community-based systems that prevent and mitigate GBV, and by enabling survivors¹ and those at risk of GBV to access care and support; and
3. To **aid recovery** of communities and societies by supporting local and national capacity to create lasting solutions to the problem of GBV.

¹ A survivor is a person who has experienced gender-based violence. The terms “victim” and “survivor” can be used interchangeably. “Victim” is a term often used in the legal and medical sectors, while the term “survivor” is generally preferred in the psychological and social support sectors because it implies resiliency. These Guidelines employ the term “survivor” in order to reinforce the concept of resiliency.



How these Guidelines are Organized

Part One introduces these Guidelines, presents an overview of GBV, provides an explanation for why GBV is a protection concern for all humanitarian actors and outlines recommendations for ensuring implementation of the Guidelines.

Part Two provides a background to the “**thematic areas**” in **Part Three** and summarizes the structure of each thematic area. It also introduces the guiding principles and approaches that are the foundation for all planning and implementation of GBV-related programming. This section should be read by all sector actors in conjunction with their relevant thematic area section.

Part Three constitutes the bulk of these Guidelines. It provides specific guidance, organized into thirteen thematic area sections. Each section focuses on a different sector of humanitarian response.²

Although the guidance is organized in terms of discrete areas of humanitarian operation, *all humanitarian actors must avoid “siloeed” interventions*. The importance of cross-sectoral coordination is highlighted in each section and guidance is provided for sector actors regarding cross-sectoral linkages. It is also recommended that sector actors review the content of all thematic area sections, not just those that apply to their area of operation.

The Guidelines draw from many tools, standards, background materials and other resources developed by UN, I/NGO and academic sources. In each thematic area there is a list of resources specific to that area, and additional GBV-related resources are provided in **Annex 1**.



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Assume GBV is Taking Place

The actions outlined in these Guidelines are relevant from the earliest stages of humanitarian intervention and in any emergency setting, regardless of whether the prevalence or incidence of various forms of GBV is “known” and verified. It is important to remember that **GBV is happening everywhere. It is under-reported worldwide**, due to fears 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. Waiting for or seeking population-based data on the true magnitude of GBV should not be a priority in an emergency due to safety and ethical challenges in collecting such data. With this in mind, **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 based on sector recommendations in these Guidelines**, regardless of the presence or absence of concrete “evidence”.

² The different thematic area sections have been identified based on areas of humanitarian operation within the global cluster system. However, these Guidelines generally use the word “sector” rather than “cluster” in an effort to be relevant to both cluster and non-cluster contexts. Where specific reference is made to work only conducted in clusterized settings, the word cluster is used. For more information about the cluster system, see <http://www.humanitarianresponse.info/clusters/page/what-cluster-approach>



Target Audience

These Guidelines are designed for national and international humanitarian actors operating in settings affected by armed conflict, natural disasters, and other humanitarian emergencies, as well as in host countries and/or communities that receive people displaced by emergencies. The principal audience is programmers—agencies and individuals who can use the information to incorporate GBV prevention and mitigation strategies into the design, implementation, monitoring and evaluation of their sector-specific interventions. However, it is critical that humanitarian leadership—including governments, humanitarian coordinators, sector coordinators and donors—also use these Guidelines as a reference and advocacy tool. These Guidelines can assist humanitarian leadership to facilitate inter-agency planning and coordination; ensure sufficient resource allocation; and work to reform national, local and agency policies and national laws that may directly or indirectly contribute to GBV. These Guidelines can further serve those working in development contexts—particularly contexts affected by cyclical disasters—in planning and preparing for humanitarian action that includes efforts to prevent and mitigate GBV.

The Guidelines are primarily targeted to non-GBV specialists—that is, agencies and individuals who work in humanitarian response sectors other than GBV and do not have specific expertise in GBV prevention and response programming, but can nevertheless undertake activities that significantly reduce the risk of GBV for affected populations.³

For some thematic areas of the Guidelines—such as health, education, protection and child protection—certain recommendations require GBV expertise to implement. In these sectoral areas, programming will often extend beyond basic prevention and mitigation activities to more specialized response activities: for instance, providing medical care to sexual assault survivors, providing counseling services to GBV survivors, or building the capacity of police to respectfully interview survivors and undertake investigations. *Technical support should be sought from GBV experts when undertaking any of these specialized GBV response activities.*



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GBV Specialists, GBV-Specialized Agencies, and the Importance of Focused GBV Programming

Throughout these Guidelines, there are references to “GBV specialists” and “GBV-specialized agencies.” A GBV specialist is someone who has received GBV-specific professional training and/or has considerable experience working on GBV programming. A GBV-specialized agency is one which undertakes targeted programmes for the prevention of and response to GBV. **It is expected that GBV specialists, agencies and inter-agency mechanisms will use this document to assist non-GBV specialists in undertaking prevention and mitigation (and, for some sectors, response) activities within and across their areas of operation.** The Guidelines include recommendations (outlined under “Coordination” in each thematic area) about how GBV specialists can be mobilized for technical support. However, the Guidelines do not have a section detailing responsibilities for GBV specialists who design and manage focused (also sometimes referred to as “vertical”) GBV programmes. That does not imply that focused GBV projects are unimportant, or that cross-sectoral GBV mainstreaming should seek to replace specialized GBV programmes. In fact, **it is essential that GBV specialists are in place from the earliest stages of emergency preparedness to plan, implement and coordinate GBV specialized interventions, and that those interventions be sustained and expanded throughout all stages of humanitarian response.** For general resources related to specialized GBV programming, see **Annex 1**.

³ Affected populations include all those who are adversely affected by an armed conflict, natural disaster, or other humanitarian emergency, including those displaced (both internally and across borders) who may still be on the move or have settled into camps, urban areas or rural areas.



These Guidelines emphasize the importance of active involvement of **all members** of affected communities; this includes the leadership and meaningful participation of women and girls—alongside men and boys—in all preparedness, design, implementation, and monitoring and evaluation activities.



2. Overview of Gender-based Violence

Defining GBV

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

Acts of GBV violate a number of universal human rights protected by international instruments and conventions (see "The Obligation to Address GBV in Humanitarian Action" below). Many—but not all—forms of GBV are criminal acts in national laws and policies; this differs from country to country, and the practical implementation of laws and policies can vary widely.

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. The UN Declaration on the Elimination of Violence Against Women (DEVAW, 1993) 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." DEVAW emphasizes that the 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." Gender discrimination is not only a cause of many forms of violence against women and girls but also contributes to the widespread acceptance and invisibility of such violence—so that perpetrators are not held accountable and survivors are discouraged from speaking out and accessing support.

The term gender-based violence is also increasingly used by some actors to highlight the gendered dimensions of certain forms of violence against men and boys—particularly some forms of sexual violence committed with the explicit purpose of reinforcing norms of masculinity (e.g. sexual violence committed in armed conflict aimed at emasculating the enemy). This violence against males is based on socially constructed ideas of what it means to be a man and exercise male power. It is used by men (and in rare cases by women) to cause harm to other males. As with violence against women and girls, this violence is often underreported due to issues of stigma for the survivor—in this case associated with norms of masculinity (e.g. norms that discourage male survivors from acknowledging vulnerability, or suggest that a male survivor is somehow weak for having been assaulted). Sexual assault against males



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Informed Consent

When considering whether an act is perpetrated "against a person's will," it is important to consider the issue of consent. **Informed consent is voluntarily and freely given** based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action. In order to give informed consent, the individual concerned must have all relevant facts at the time consent is given and be able to evaluate and understand the consequences of an action. They also must be aware of and have the power to exercise their right to refuse to engage in an action and/or to not be coerced (i.e. being persuaded based on force or threats). **Children are generally considered unable to provide informed consent** because they do not have the ability and/or experience to anticipate the implications of an action, and they may not understand or be empowered to exercise their right to refuse. There are also instances where consent might not be possible due to cognitive impairments and/or physical, sensory, or developmental disabilities.



may also go unreported in situations where such reporting could result in life-threatening repercussions against the survivor and/or his family members. Many countries do not explicitly recognize sexual violence against men in their laws and/or have laws which criminalize survivors of such violence.

The term gender-based violence is also used to describe violence perpetrated against lesbian, gay, bisexual, transgender and intersex (LGBTI) persons that is, according to OHCHR, “driven by a desire to punish those seen as defying gender norms” (OHCHR, 2011). The acronym “LGBTI” encompasses a wide range of identities that share an experience of falling outside of societal norms due to their sexual orientation and/or gender identity. (See **Annex 2** for a review of terms.) OHCHR further recognizes that “lesbians and transgender women are at particular risk because of gender inequality and power relations within families and wider society.” Homophobia and transphobia not only contribute to this violence but also significantly undermine LGBTI survivors’ ability to access support (most acutely in settings where sexual orientation and gender identity are policed by the State).



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Women, Girls, and 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 relations. GBV against women and girls occurs in the context of this imbalance. While humanitarian actors must analyze different gendered vulnerabilities that may put men, women, boys and girls at heightened risk of violence and ensure care and support for all survivors, **special attention should be given to females due to their documented greater vulnerabilities to GBV, the over-arching discrimination they experience, and their lack of safe and equitable access to humanitarian assistance.** Humanitarian actors have an obligation to promote gender equality through humanitarian action in line with the IASC “Gender Equality Policy Statement” (2008). They also have an obligation to support, through targeted action, women’s and girls’ protection, participation and empowerment as articulated in the Women, Peace and Security thematic agenda outlined in UN Security Council Resolutions (see **Annex 6**). While supporting the need for protection of all populations affected by humanitarian crises, these Guidelines recognize the heightened vulnerability of women and girls to GBV and provide targeted guidance to address these vulnerabilities—including through strategies that promote gender equality.

Nature and Scope of GBV in Humanitarian Settings

A great deal of attention has centered on monitoring, documenting, and addressing sexual violence in conflict—for instance the use of rape or other forms of sexual violence as a weapon of war. Because of its immediate and potentially life-threatening health consequences, coupled with the feasibility of preventing these consequences through medical care, addressing sexual violence is a priority in humanitarian settings. At the same time, there is a growing recognition that affected populations can experience multiple forms of GBV during conflict and natural disasters, during displacement, and during and following return. In particular, intimate partner violence is increasingly recognized as a critical GBV concern in humanitarian settings. These additional forms of violence—including intimate partner violence and other forms of domestic violence, forced and/or coerced prostitution, child and/or forced marriage, female genital mutilation/cutting, female infanticide, and trafficking for sexual exploitation and/or forced /domestic labor—must be considered in GBV prevention and mitigation efforts according to the trends in violence and the needs identified in a given setting. (See **Annex 3** for a list of types of GBV and associated definitions.)



Obtaining prevalence and/or incidence data on GBV in emergencies is not advisable due to the methodological and contextual challenges related to researching GBV in emergency settings (e.g. security concerns for survivors and researchers; lack of available or accessible response services; etc.). The majority of information about the nature and scope of GBV in humanitarian contexts is derived from qualitative research, anecdotal reports, humanitarian monitoring tools and service delivery statistics. This data suggest that many forms of GBV are significantly aggravated during humanitarian emergencies, as illustrated in the statistics provided below. (See **Annex 4** for additional statistics.)

- In DRC during 2013, UNICEF coordinated with partners to provide services to 12,247 GBV survivors; 3,827—or approximately 30%—were children, of which 3,748 were girls and 79 were boys (UNICEF DRC, 2013).
- In Pakistan following the 2011 floods, 52% of surveyed communities reported that privacy and safety of women and girls was a key concern. In a 2012 Protection rapid assessment with conflict-affected IDPs, interviewed communities reported that a number of women and girls were facing aggravated domestic violence, forced marriage, early marriages and exchange marriages, in addition to other cases of gender-based violence (de la Puente, 2014).
- In Afghanistan, a household survey (2008) showed 87.2% of women reported one form of violence in their life time and 62% had experienced multiple forms of violence (de la Puente, 2014).
- In Liberia, a survey of 1,666 adults found that 32.6% of male combatants (118 of 367) experienced sexual violence while 16.5% (57 of 360) were forced to be sexual servants (Johnson et al, 2008). Seventy-four percent of a sample of 388 Liberian refugee women living in camps in Sierra Leone reported being sexually abused prior to being displaced. Fifty-five percent experienced sexual violence during displacement (IRIN, 2006; IRIN, 2008).
- Of 64 women with disabilities interviewed in post-conflict Northern Uganda, one third reported experiencing some form of GBV and several had children as a result of rape (HRW, 2010).
- In a 2011 assessment, Somali adolescent girls in the Dadaab refugee complex in Kenya explained that they are in many ways “under attack” from violence that includes verbal and physical harassment; sexual exploitation and abuse in relation to meeting their basic needs; and rape, including in public and by multiple perpetrators. Girls reported feeling particularly vulnerable to violence while accessing scarce services and resources, such as at water points or while collecting firewood outside the camps (UNHCR, 2011).
- In Mali, daughters of displaced families from the North (where female genital mutilation/cutting [FGM/C] is not traditionally practiced) were living amongst host communities in the South (where FGM/C is common). Many of these girls were ostracized for not having

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Women and Natural Disasters

In many situations, women and girls are disproportionately affected by natural disasters. As primary caregivers who often have greater responsibilities related to household work, agriculture and food production, women may have less access to resources for recovery. They may also be required to take on new household responsibilities (for example when primary income earners have been killed or injured, or need to leave their families to find employment). If law and order break down, or social support and safety systems (such as the extended family or village groups) fail, women and girls are also at greater risk of GBV and discrimination.

(Adapted from “**Global Protection Cluster. n.d.** “Natural Disaster Reference Sheet: Women and Girls”, draft, <http://www.globalprotectioncluster.org/en/tools-and-guidance/protection-cluster-coordination-toolbox.html>)



undergone FGM/C; this led families from the North to feel pressured to perform FGM/C on their daughters (Plan Mali, April 2013).

- Domestic violence was widely reported to have increased in the aftermath of the 2004 Indian Ocean Tsunami. One NGO reported a three-fold increase in cases brought to them (UNFPA, 2011). Studies from the United States, Canada, New Zealand and Australia also suggest a significant increase in intimate partner violence related to natural disasters (Sety, 2012).
- Research undertaken by the Human Rights Documentation Unit and the Burmese Women's Union in 2000 concluded that an estimated 40,000 Burmese women are trafficked each year into Thailand's factories and brothels and as domestic workers (IRIN, 2006).
- The GBV Information Management System (IMS), initiated in Colombia in 2011 to improve survivor access to care, has collected GBV incident data from 7 municipalities. As of mid-2014, 3,499 females (92.6% of whom were 18 years or older) and 437 males (91.8% of whom were 18 years or older) were recorded in the GBVIMS, of which over 3,000 received assistance (GBVIMS Colombia, 2014).



ESSENTIAL TO KNOW

Protection from Sexual Exploitation and Abuse (PSEA)

As highlighted in the Secretary-General's Bulletin on Special measures for protection from sexual exploitation and sexual abuse (ST/SGB/2003/13, <http://www.refworld.org/docid/451bb6764.html>), PSEA relates to certain responsibilities of international humanitarian, development and peacekeeping actors. These responsibilities include preventing incidents of sexual exploitation and abuse **committed by UN, NGO, and inter-governmental organization (IGO) personnel against the affected population**; setting up confidential reporting mechanisms; and taking safe and ethical action as quickly as possible when incidents do occur. PSEA is an important aspect of preventing GBV and PSEA efforts should therefore link to GBV expertise and programming—especially to ensure survivors' rights and other guiding principles are respected.

These responsibilities are at the determination of the Humanitarian Coordinator/Resident Coordinator and individual agencies. As such, detailed guidance on PSEA is outside the authority of these Guidelines. The Guidelines nevertheless wholly support the mandate of the Secretary General's Bulletin and provide several recommendations on incorporating PSEA strategies into agency policies and community outreach. Detailed guidance is available on the IASC AAP/PSEA Task Force website: www.pseataskforce.org

Impact of GBV on Individuals and Communities

GBV seriously impacts survivors' immediate sexual, physical and psychological health, and contributes to greater risk of future health problems. Possible sexual health effects include unwanted pregnancies, complications from unsafe abortions, female sexual arousal disorder or male impotence, and sexually transmitted infections, including HIV. Possible physical health effects of GBV include injuries that can cause both acute and chronic illness, impacting neurological, gastrointestinal, muscular, urinary, and reproductive systems. These effects can render the survivor unable to complete otherwise manageable physical and mental labour. Possible mental health problems include depression, anxiety, harmful alcohol and drug use, post-traumatic stress disorder and suicidality.⁴

⁴ For more information on the health effects of GBV on women, see WHO. 1997. *Violence Against Women: Health Consequences*, <http://www.who.int/gender/violence/v8.pdf>. For more information on health effects of sexual violence against men, see UNHCR. 2012. *Need to Know Guidance Note on Sexual Violence against Men and Boys in Forced Displacement*, <http://www.refworld.org/pdfid/5006aa262.pdf>.



Survivors of GBV may suffer further because of the stigma associated with GBV. Community and family ostracism may place them at greater social and economic disadvantage. The physical and psychological consequences of GBV can inhibit a survivor's functioning and well-being—not only personally but in relationships with family members. The impact of GBV can further extend to relationships in the community, such as the relationship between the survivor's family and the community, or the community's attitudes towards children born as a result of rape. LGBTI persons can face problems in convincing security forces that sexual violence against them was non-consensual; in addition, some male victims may face the risk of being counter-prosecuted under sodomy laws if they report sexual violence perpetrated against them by a man.

GBV can affect child survival and development by raising infant mortality rates, lowering birth weights, contributing to malnutrition and affecting school participation. It can further result in specific disabilities for children: injuries can cause physical impairments; deprivation of proper nutrition or stimulus can cause developmental delay; and consequences of abuse can lead to long-term mental health problems.

Many of these effects are hard to link directly to GBV because they are not always easily recognizable by health and other providers as evidence of GBV. This can contribute to mistaken assumptions that GBV is not a problem. However, failure to appreciate the full extent and hidden nature of GBV—as well as failure to address its impact on individuals, families and communities—can limit societies' ability to heal from humanitarian emergencies.

Contributing Factors to and Causes of GBV

Integrating GBV prevention and mitigation into humanitarian interventions requires anticipating, contextualizing and addressing factors that may contribute to GBV. Examples of these factors at the societal, community, and individual/family levels are provided below. These levels are loosely based on the ecological model developed by Heise (1998). The examples are illustrative; actual risk factors will vary according to the setting, population, and type of GBV. Even so, these examples underscore the importance of addressing GBV through broad-based interventions that target a variety of different risks.

Conditions related to humanitarian emergencies may exacerbate the risk of many forms of GBV. 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 during times of stability. Linking GBV to its roots in **gender discrimination and gender inequality** necessitates not only working to meet the immediate needs of the affected populations, but also implementing strategies—as early as possible in any humanitarian action—that promote long-term social and cultural change toward gender equality. Such strategies include ensuring leadership and active engagement of women and girls, along with men and boys, in community-based groups related to the humanitarian area/sector; conducting advocacy to promote the rights of all affected populations; and enlisting females as programme staff, including in positions of leadership.



Contributing Factors to GBV	
Society-level Contributing Factors	<ul style="list-style-type: none"> • Porous/unmonitored borders; lack of awareness of risks of being trafficked • Lack of adherence to rules of combat and International Humanitarian Law • Hyper-masculinity; promotion of and rewards for violent male norms/behavior • Combat strategies (e.g. torture or rape as a weapon of war) • Absence of security and/or early warning mechanisms • Impunity, including lack of legal framework and/or criminalization of forms of GBV, or lack of awareness that different forms of GBV are criminal • Lack of inclusion of sex crimes committed during a humanitarian emergency into large-scale survivors' reparations and support programmes (including for children born of rape) • Economic, social and gender inequalities • Lack of meaningful and active participation of women in leadership, peacebuilding processes, and security sector reform • Lack of prioritization on prosecuting sex crimes; insufficient emphasis on increasing access to recovery services; and lack of foresight on the long-term ramifications for children born as a result of rape, specifically related to stigma and their resulting marginalization • Failure to address factors that contribute to violence such as long-term internment or loss of skills, livelihoods, independence, and/or male roles
Community-level Contributing Factors	<ul style="list-style-type: none"> • Poor camp/shelter/WASH facility design and infrastructure (including for persons with disabilities, older persons and other at-risk groups) • Lack of access to education for females, especially secondary education for adolescent girls • Lack of safe shelters for women, girls and other at-risk groups • Lack of training, vetting, and supervision for humanitarian staff • Lack of economic alternatives for affected populations, especially for women, girls and other at-risk groups • Breakdown in community protective mechanisms and lack of community protections/ sanctions relating to GBV • Lack of reporting mechanisms for survivors and those at risk of GBV, as well as for sexual exploitation and abuse committed by humanitarian personnel • Lack of accessible and trusted multi-sectoral services for survivors (health, security, legal/justice, mental health and psychosocial support) • Absence/underrepresentation of female staff in key service provider positions (healthcare, detention facilities, police, justice, etc.) • Inadequate housing, land and property rights for women, girls, children born of rape and other at-risk groups • Presence of demobilized soldiers with norms of violence • Hostile host communities • "Blaming the victim" or other harmful attitudes against survivors of GBV • Lack of confidentiality for GBV survivors • Community-wide acceptance of violence • Lack of child protection mechanisms • Lack of psychosocial support as part of disarmament, demobilization and reintegration (DDR) programming
Individual/Family-level Contributing Factors	<ul style="list-style-type: none"> • Lack of basic survival needs/supplies for individuals and families or lack of safe access to these survival needs/supplies (e.g food, water, shelter, cooking fuel, hygiene supplies, etc.) • Inequitable distribution of family resources • Lack of resources for parents to provide for children and older persons (economic resources, ability to protect, etc.), particularly for woman and child heads of households • Lack of knowledge/awareness of acceptable standards of conduct by humanitarian staff, and that humanitarian assistance is free • Harmful alcohol/drug use • Age, gender, education, disability • Family history of violence • Witnessing GBV





ESSENTIAL TO KNOW

Risks for a Growing Number of Refugees Living in Urban and Other Non-Camp Settings

A growing number and proportion of the world's refugees are found in urban areas. As of 2009, UNHCR statistics suggested that almost half of the world's 10.5 million refugees reside in cities and towns, compared to one-third who live in camps. As well as increasing in size, the world's urban refugee population is also changing in composition. In the past, a significant proportion of the urban refugees registered with UNHCR in developing and middle-income countries were young men. Today, however, large numbers of refugee women, children and older people are found in urban and other non-camp areas, particularly in those countries where there are no camps. They are often confronted with a range of protection risks, including the threat of arrest and detention, *refoulement*, harassment, exploitation, discrimination, inadequate and overcrowded shelter, HIV, human smuggling and trafficking, and other forms of violence. The recommendations within these Guidelines are relevant to humanitarian actors providing assistance to displaced populations living in urban and other non-camp settings, as well as those living in camps.

(Adapted from **UNHCR**. 2009. "Policy on Refugee Protection and Solutions in Urban Areas", <http://www.unhcr.org/4ab356ab6.html>)

Key Considerations for At-risk Groups

In any emergency, there are groups of individuals more vulnerable to harm than other members of the population. This is often because they hold less power in society, are more dependent on others for survival, are less visible to relief workers, or are otherwise marginalized. These Guidelines use the term "at-risk groups" to describe these individuals.

When sources of vulnerability—such as age, disability, sexual orientation, religion, ethnicity, etc.—intersect with gender-based discrimination, the likelihood of women's and girls' exposure to GBV can escalate. For example, adolescent girls who are forced into child marriage—a form of GBV itself—may be at greater risk of intimate partner violence than adult females. In the case of men and boys, gender norms related to masculinity can increase their exposure to violence. For example, men and boys in detention who are viewed by inmates as particularly weak (or "feminine") may be subjected to sexual harassment, assault and rape. In some settings, some groups of males may not be protected from violence because they are assumed to not be at risk by virtue of the privileges they enjoyed during peacetime.

Not all of the at-risk groups listed below will always be at heightened risk of *gender-based* violence. Even so, they will very often be at heightened risk of harm in humanitarian settings. Whenever possible, efforts to address GBV should be alert to and promote the protection rights and needs of these groups. Targeted work with specific at-risk groups should be in collaboration with agencies that have expertise in addressing their needs. With due consideration for safety, ethics, and feasibility, the particular experiences, perspectives and knowledge of at-risk groups should be solicited to inform work throughout all phases of the programme cycle. Specifically, humanitarian actors should:

- Be mindful of the protection rights and needs of these at-risk groups and how these may vary within and across different humanitarian settings;
- Consider the potential intersection of their specific vulnerabilities to GBV; and
- Plan interventions that strive to reduce their exposure to GBV and other forms of violence.



Key Considerations for At-risk Groups		
At-risk groups	Examples of violence to which these groups might be exposed	Factors that contribute to increased risk of violence
Adolescent girls	<ul style="list-style-type: none"> • Sexual assault • Sexual exploitation and abuse • Child and/or forced marriage • Female genital mutilation/cutting (FGM/C) • Lack of access to education 	<ul style="list-style-type: none"> • Age, gender and restricted social status • Increased domestic responsibilities which keep girls isolated in the home • Erosion of normal community structures of support and protection • Lack of access to understandable information about health, rights and services (including reproductive health) • Being discouraged or prevented from attending school • Early pregnancies and motherhood • Engagement in unsafe livelihoods activities • Loss of family members, especially immediate caretakers • Dependence on exploitative or unhealthy relationships for basic needs
Elderly women	<ul style="list-style-type: none"> • Sexual assault • Sexual exploitation and abuse • Exploitation and abuse by caregivers • Denial of rights to housing and property 	<ul style="list-style-type: none"> • Age, gender, and restricted social status • Weakened physical status, physical or sensory disabilities, and chronic diseases • Isolation and higher risk of poverty • Limited mobility • Neglected health and nutritional needs • Lack of access to understandable information about rights and services
Woman and child heads of households	<ul style="list-style-type: none"> • Sexual assault • Sexual exploitation and abuse • Child and/or forced marriage (including wife inheritance) • Denial of rights to housing and property 	<ul style="list-style-type: none"> • Age, gender, and restricted social status • Increased domestic responsibilities that keep them isolated in the home • Erosion of normal community structures of support and protection • Dependence on exploitative or unhealthy relationships for basic needs • Engagement in unsafe livelihoods activities
Girls and women who bear children of rape, and their children born of rape	<ul style="list-style-type: none"> • Sexual assault • Sexual exploitation and abuse • Intimate partner violence and other forms of domestic violence • Lack of access to education • Social discrimination 	<ul style="list-style-type: none"> • Age, gender • Social stigma and isolation • Exclusion or expulsion from their homes, families and communities • Poverty, malnutrition, and reproductive health problems • Lack of access to medical care • High levels of impunity for crimes against them • Dependence on exploitative or unhealthy relationships for basic needs • Engagement in unsafe livelihoods activities
Indigenous women, girls, men and boys, and ethnic and religious minorities	<ul style="list-style-type: none"> • Social discrimination and oppression • Ethnic cleansing as a tactic of war • Lack of access to education • Lack of access to services • Theft of land 	<ul style="list-style-type: none"> • Social stigma and isolation • Poverty, malnutrition, and reproductive health problems • Lack of protection under the law and high levels of impunity for crimes against them • Lack of opportunities and marginalization based on their national, religious, linguistic or cultural group • Barriers to participating in their communities and earning livelihoods
Lesbian, gay, bisexual, transgender and intersex (LGBTI) persons	<ul style="list-style-type: none"> • Discrimination • Sexual assault • Sexual exploitation and abuse • Domestic violence (e.g. violence against LGBTI children by their caretakers) • Denial of services • Harassment/sexual harassment • Rape expressly used to punish lesbians for their sexual orientation 	<ul style="list-style-type: none"> • Discrimination based on sexual orientation and/or gender identity • High levels of impunity for crimes against them • Restricted social status • Transgender persons not legally or publicly recognized as their identified gender • Same-sex relationships not legally or socially recognized, and denied services other families might be offered • Exclusion from housing, livelihoods opportunities, and access to health care and other services • Exclusion of transgender persons from sex-segregated shelters, bathrooms, and health facilities • Social isolation/rejection from family or community, which can result in homelessness • Engagement in unsafe livelihoods activities

(continued)



Key Considerations for At-risk Groups (continued)

At-risk groups	Examples of violence to which these groups might be exposed	Factors that contribute to increased risk of violence
Separated or unaccompanied girls, boys and orphans, including children associated with armed forces/ groups	<ul style="list-style-type: none"> • Sexual assault • Sexual exploitation and abuse • Child and/or forced marriage • Forced labour • Lack of access to education • Domestic violence 	<ul style="list-style-type: none"> • Age, gender, and restricted social status • Neglected health and nutritional needs • Engagement in unsafe livelihoods activities • Dependence on exploitative or unhealthy relationships for basic needs • Early pregnancies and motherhood • Social stigma, isolation, and rejection by communities as a result of association with armed forces/groups • Active engagement in combat operations • Premature parental responsibility for siblings
Women and men involved in forced and/ or coerced prostitution, and child victims of sexual exploitation	<ul style="list-style-type: none"> • Coercion, discrimination • Sexual assault • Physical violence • Sexual exploitation and abuse • Lack of access to education 	<ul style="list-style-type: none"> • Dependence on exploitative or unhealthy relationships for basic needs • Lack of access to reproductive health information and services • Early pregnancies and motherhood • Isolation and a lack of social support/peer networks • Social stigma, isolation, and rejection by communities • Harassment and abuse from law enforcement • Lack of protection under the law and/or laws that criminalise sex workers
Women, girls, men and boys in detention	<ul style="list-style-type: none"> • Sexual assault as punishment or torture • Physical violence • Lack of access to education • Lack of access to health, mental health and psychosocial support, including psychological first aid 	<ul style="list-style-type: none"> • Poor hygiene and lack of sanitation • Overcrowding of detention facilities • Failure to separate men, women, families, and unaccompanied minors • Obstacles and disincentives to reporting incidents of violence (especially sexual violence) • Fear of speaking out against authorities • Possible trauma from violence and abuse suffered before detention
Women, girls, men and boys living with HIV	<ul style="list-style-type: none"> • Sexual harassment and abuse • Discrimination • Verbal abuse • Lack of access to education • Loss of livelihood • Prevented from having contact with their children 	<ul style="list-style-type: none"> • Exclusion, isolation and higher risk of poverty • Loss of land, property and belongings • Reduced work capacity • Stress, depression, and/or suicide • Family disintegration and breakdown • Poor physical and emotional health • Harmful use of alcohol and/or drugs
Women, girls, men and boys with disabilities	<ul style="list-style-type: none"> • Discrimination • Sexual assault • Sexual exploitation and abuse • Intimate partner violence and other forms of domestic violence • Lack of access to education • Denial of access to housing, property and livestock 	<ul style="list-style-type: none"> • Limited mobility, hearing and vision resulting in greater reliance on assistance and care from others • Isolation and a lack of social support/peer networks • Exclusion from obtaining information and receiving guidance, due to physical, technological and communication barriers • Exclusion from accessing washing facilities, latrines, or distribution sites due to poor accessibility in design • Physical, communication and attitudinal barriers in reporting violence • Barriers to participating in their communities and earning livelihoods • Lack of access to medical care and rehabilitation services • High levels of impunity for crimes against them • Lack of access to reproductive health information and services



3. The Obligation to Address Gender-based Violence in Humanitarian Work

"Protection of all persons affected and at risk must inform humanitarian decision making and response, including engagement with States and non-State parties to conflict. It must be central to our preparedness efforts, as part of immediate and life-saving activities, and throughout the duration of humanitarian response and beyond. In practical terms, this means identifying who is at risk, how and why at the very outset of a crisis and thereafter, taking into account the specific vulnerabilities that underlie these risks, including those experienced by men, women, girls and boys, and groups such as internally displaced persons, older persons, persons with disabilities, and persons belonging to sexual and other minorities."

(Inter-Agency Standing Committee Principals' statement on the Centrality of Protection in Humanitarian Action, endorsed December 2013 as part of a number of measures that will be adapted by the IASC to ensure more effective protection of people in humanitarian crises.⁵ Available at <http://www.globalprotectioncluster.org/en/tools-and-guidance/guidance-from-inter-agency-standing-committee.html>)

The primary responsibility to ensure that people are protected from violence rests with States. In situations of armed conflict, both State and non-State parties to the conflict have obligations in this regard under international humanitarian law. This includes refraining from causing harm to civilian populations and ensuring that people affected by violence get the care they need. When States or parties to conflict are unable and unwilling to meet their obligations, humanitarian actors play an important role in supporting measures to prevent and respond to violence. No single organization, agency or entity working in an emergency has the complete set of knowledge, skills, resources and authority to prevent GBV or respond to the needs of GBV survivors alone. Thus, collective effort is paramount: **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.**

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 also unintentionally cause further harm, as illustrated in the examples below. Lack of action or ineffective action contribute to a poor foundation for supporting the resilience, health, and well-being of survivors, and create barriers to reconstructing affected communities' lives and livelihoods. In some instances, inaction can serve to perpetuate the cycle of violence: some survivors may later become perpetrators if their medical, psychological and protection needs are not met. In the worst case, inaction can indirectly or inadvertently result in loss of lives.

⁵ The Centrality Statement further recognises the role of the protection cluster to support protection strategies, including mainstreaming protection throughout all sectors. To support the realisation of this, the Global Protection Cluster has committed to providing support and tools to other clusters, both at the global and field level, to help strengthen their capacity for protection mainstreaming. For more information see the **Global Protection Cluster. 2014. Protection Mainstreaming Training Package**, <http://www.globalprotectioncluster.org/en/areas-of-responsibility/protection-mainstreaming.html>

Humanitarian Areas of Operation	Examples of Harm to Affected Populations by NOT Addressing GBV Issues
Camp Coordination and Camp Management (CCCM)	When the rights and needs of single women and other at-risk groups are not addressed during site planning, these persons may be placed in isolated and/or unprotected areas, in turn exposing them to sexual harassment and violence.
Child Protection	Child-friendly spaces that are set up in isolated locations or do not hire female staff can increase exposure of children, particularly girls, to violence. If staff has not received appropriate training they may not recognize the risks of GBV and other forms of violence against girls and boys, or take steps to ensure child survivors have access to care and support services. Children may face increased risk of sexual exploitation and abuse by humanitarian workers if staff working in child-friendly spaces has not been properly vetted.
Education	Education programming that does not take into account the particular rights, needs and vulnerabilities of students can increase their risk of exploitation by teachers, school dropout and child and/or forced marriage. Schools that are located far from homes may prevent children, particularly girls, from attending, and/or increase their risk of sexual harassment or assault during long commutes.
Food Security and Agriculture	Where access to food is inadequate, women and girls—who are most often tasked with finding fuel and food—may venture to unprotected areas where they are at heightened risk of sexual abuse, including forced and/or coerced prostitution.
Health	Health care providers who are not trained or prepared to receive child and adult survivors of GBV with non-judgmental attitudes create a barrier to life-saving services.
Housing, Land and Property (HLP)	Adhering to traditional norms and practices in HLP programming—such as widow inheritance, male-to-male inheritance, or land tenure being granted to males in the household—may increase women's vulnerability to unsafe livelihoods activities (e.g. forced and/or coerced prostitution), as well as intimate partner violence and other forms of domestic violence.
Livelihoods	Targeting women and adolescent girls in livelihoods programming without attention to the risks associated with shifting gender roles may increase their exposure to violence by intimate partners and/or males in the community.
Humanitarian Mine Action	Women and girls directly injured in a blast may be less likely than their male counterparts to receive support for their physical rehabilitation and socio-economic reintegration. Their disability may in turn increase their risk of intimate partner violence and other forms of domestic violence.
Nutrition	Failure to incorporate GBV into nutrition programmes can result in poor families trying to ensure the nutritional needs of their daughters are met through child and/or forced marriages, or sacrificing female children's nutrition in order to meet the needs of male children. Mothers weakened by poor nutritional status might also be less able to protect their children from GBV and other forms of violence.
Protection	Protection monitoring activities that do not consider the key ethical considerations related to collecting data on GBV can put survivors at risk of stigmatization and retaliation if exposed.
Shelter, Settlement and Recovery (SS&R)	When programmes do not address the rights and needs of those who do not have the skills or the physical strength to collect building materials or undertake construction, these persons may be compelled to exchange sex or other favors for shelter materials and/or construction assistance. In addition, if SS&R actors—particularly in camp settings—lack protocols for developing new shelters for those needing to shift from existing shelters, women and girls may be prevented from leaving violent domestic situations.
Water, Sanitation and Hygiene (WASH)	Failing to establish safe access to water points and accessible, sex-segregated latrines and bathing facilities may expose women, girls and other at-risk groups to sexual assault.



The responsibility of humanitarian actors to address GBV is supported by a framework that includes key elements highlighted in the diagram below. (See **Annex 6** for additional details of elements of the framework.)



It is important that those working in settings affected by humanitarian emergencies understand the framework's key components and act in accordance with it. They must also use it to guide others—States, communities and individuals—to meet their obligations to promote and protect human rights.

International and national law: GBV violates principles that are covered by international humanitarian law, international and domestic criminal law, and human rights and refugee law at the international, regional, and national levels. These principles include the protection of civilians even in situations of armed conflict and occupation, and their rights to life, equality, security, equal protection under the law, and freedom from torture and other cruel, inhumane or degrading treatment.

United Nations Security Council resolutions: Protection of Civilians (POC) lies at the center of international humanitarian law and also forms a core component of international human rights, refugee, and international criminal law. Since 1999, the UN Security Council (SC), with its UN Charter mandate to maintain or restore international peace and security, has become increasingly concerned with POC—with the Secretary-General regularly including it in his country reports to the SC and the SC providing it as a common part of peacekeeping mission mandates in its resolutions. Through this work on POC, the **SC has recognized the centrality of women, peace and security by adopting a series of thematic resolutions on the issue.** Of these, three resolutions (1325, 1889 and 2212) address women, peace and security broadly (e.g. women's specific experiences of conflict and their contributions to conflict prevention, peacekeeping, conflict resolution and peacebuilding). The others (1820, 1888, 1960 and 2106) also reinforce women's participation, but focus more specifically on conflict-related sexual violence. UN Security Council Resolution 2016 is the first to explicitly refer to men and boys as survivors of sexual

violence. The UN Security Council's agenda also includes Children and Armed Conflict (CAAC) through which it established, in 2005, a monitoring and reporting mechanism (MRM) on six grave violations against in armed conflict, including rape and sexual violence against children. For more details on the UN Security Council resolutions, see **Annex 6**.

Humanitarian principles: The humanitarian community has created global principles on which to improve accountability, quality and performance in the actions they take. These principles have an impact on every type of GBV-related intervention. They act as an ethical and operational guide for humanitarian actors on how to behave in an armed conflict, natural disaster or other humanitarian emergency.

UN agencies are guided by four humanitarian principles enshrined in two General Assembly resolutions: GA resolution 46/182 (1991) and GA resolution 58/114 (2004). These humanitarian principles include humanity, neutrality, impartiality and independence.

Humanity	Neutrality	Impartiality	Independence
Human suffering must be addressed whenever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.	Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.	Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions.	Humanitarian action must be autonomous from the political, economic, military or other objectives that any actors may hold with regard to areas where humanitarian action is being implemented.

(Excerpted from OCHA. 2012. "OCHA Message: Humanitarian Principles", <https://ochanet.unocha.org>)

Many humanitarian organizations have further committed to these principles by developing codes of conduct, and by observing the "do no harm" principle and the principles of the Sphere Humanitarian Charter. The principles in this Charter recognize the following rights of all people affected by armed conflict, natural disasters and other humanitarian emergencies:

- The right to life with dignity
- The right to receive humanitarian assistance, including protection from violence
- The right to protection and security⁶

Humanitarian standards and guidelines: Various standards and guidelines that reinforce the humanitarian responsibility to address GBV in emergencies have been developed and broadly endorsed by humanitarian actors. Many of these key standards are identified in **Annex 6**.



ESSENTIAL TO KNOW

What the Sphere Handbook Says:

Guidance Note 13: Women and girls can be at particular risk of gender-based violence.

When contributing to the protection of these groups, humanitarian agencies should particularly consider measures that reduce possible risks, including trafficking, forced prostitution, rape or domestic violence. They should also implement standards and instruments that prevent and eradicate the practice of sexual exploitation and abuse. This unacceptable practice may involve affected people with specific vulnerabilities, such as isolated or disabled women who are forced to trade sex for the provision of humanitarian assistance.

(Sphere Project. 2011. *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*, <http://www.spheredproject.org/resources/downloadpublications/?search=1&keywords=&language=English&category=22>)

⁶ For more information, see "The Humanitarian Charter," available at <http://www.spheredhandbook.org/en/the-humanitarian-charter/>



4. Ensuring Implementation of the Guidelines: Responsibilities of Key Actors

The leadership and actions taken by key humanitarian decision-makers in-country have significant influence on the extent to which GBV is recognized as a life-saving priority across all areas of humanitarian response. Positive and proactive leadership also facilitates uptake and implementation of the GBV Guidelines by each humanitarian sector. The table below highlights **essential actions for ensuring implementation of these Guidelines** to be undertaken at pre-emergency/preparedness and emergency/stabilized stages of humanitarian intervention by: **1) Government; 2) Humanitarian Coordinators; 3) Humanitarian Country Teams/Inter-Cluster Working Groups; 4) Cluster/Sector Lead Agencies; 5) Cluster/Sector Coordinators; and 6) GBV Coordination Mechanisms.** The actions are further organized in terms of the programme cycle in order to link with the overall structure of each thematic area of these Guidelines. For more information about the programme cycle, see **Part Two: Background to Thematic Area Guidance**.

Essential Actions undertaken by Key Actors	Stage of Emergency	
	Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage
1. GOVERNMENT		
Element 1: Assessment, Analysis and Strategic Planning		
Identify GBV Guidelines champions in key ministries who will catalyse processes to ensure that GBV prevention, mitigation and response is addressed as an immediate life-saving priority across all clusters/sectors of humanitarian action	✓	✓
Make available any existing data on affected populations' risks of and exposure to GBV for inclusion in response strategies and to inform initial assessments (in line with safe and ethical practice for the collection and dissemination of GBV data)	✓	✓
Support the work of GBV specialists (national and international) to undertake mapping on GBV (e.g. nature and scope; risk and vulnerability factors; national legal framework; cluster/sector capacities to prevent, mitigate and respond to GBV)	✓	✓
Ensure design and implementation of safe and ethical data collection, storage and sharing	✓	✓
Element 2: Resource Mobilization		
Advocate with donors on the importance of providing resources for life-saving GBV interventions from the start of the response—including for targeted GBV programmes, sectoral prevention and mitigation interventions and inter- and intra-cluster/sector coordination	✓	✓
Lead on ensuring that initial assessment reports—which can influence funding priorities for the entire response—include anonymized data on GBV incidents, risks, existing services, etc.	✓	✓
Ensure that different cluster/sector programming policies and plans integrate GBV concerns and include strategies for on-going budgeting of GBV-related activities	✓	✓
Element 3: Implementation		
► Programming		
As part of leadership and coordination of pre-emergency contingency planning:		
▪ Highlight ubiquity of GBV and the importance of making GBV prevention, mitigation and response a priority for humanitarian emergencies	✓	✓
▪ Ensure that GBV is always included in regular planning cycles for emergency response		
▪ Highlight to all ministries, government agencies, and national NGOs the importance of integrating GBV prevention, mitigation and—for some clusters/sectors—response into their programming (without waiting for 'evidence' that GBV is occurring)		

(continued)



Essential Actions undertaken by Key Actors	Stage of Emergency	
	Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage
1. GOVERNMENT (continued)		
► Programming		
Ensure key decision makers are aware of the importance of implementing GBV Guidelines' recommendations to fulfil humanitarian principles and international humanitarian and human rights law ⁷	✓	✓
Promote participatory processes that engage women, girls and other at-risk groups in planning, design, implementation and M&E of humanitarian action	✓	✓
Promote GBV Guidelines trainings and orientation for all government staff working on humanitarian response. Support staff in attending GBV Guidelines orientations/trainings and in implementing the recommendations when they return to the office	✓	✓
► Policies		
Ensure that the humanitarian response respects, protects and fulfils the rights of affected populations in accordance with domestic, regional and international instruments on preventing, mitigating and responding to GBV	✓	✓
Ensure that national and local government policies and strategic guidance reflect good practice on GBV prevention, mitigation and response in line with GBV Guidelines' recommendations	✓	
Ensure national and local legal frameworks reinforce the government responsibility to protect and promote the rights of citizens to be free from GBV	✓	✓
► Communications and Information Sharing		
Appoint focal points within relevant government bodies to drive and monitor awareness of how the GBV Guidelines can be used to strengthen GBV prevention, mitigation and response throughout humanitarian action	✓	✓
Use all opportunities to promote awareness of the GBV Guidelines' recommendations for all clusters/sectors. Reference the GBV Guidelines in relevant meetings and initiatives of all government bodies with national and international humanitarian actors	✓	✓
Integrate training on the GBV Guidelines into staff training packages and orientations	✓	✓
Ensure that there are national protocols which support GBV experts to safely and ethically manage GBV data (collection, storage, sharing and dissemination)	✓	✓
As part of regular information-sharing within and across government systems, proactively identify and share good practice and lessons learned in GBV prevention, mitigation and response in internal and external communications (including social media) and at public events	✓	✓
Element 4: Coordination with Other Humanitarian Sectors		
Introduce and promote the GBV Guidelines and related tools in national and local inter-sectoral emergency preparedness meetings to ensure all decision makers are aware of and have access to guidance relevant to their clusters/sectors and geographic areas	✓	
Ensure all clusters/sectors are working together to implement GBV prevention, mitigation and response programming across all areas of humanitarian response	✓	✓
Element 5: Monitoring & Evaluation		
Identify at least one relevant indicator from each thematic area section of the GBV Guidelines to include in local and/or national reports	✓	✓
Require regular monitoring reports on actions and results taken to prevent and mitigate GBV as part of the response and use this data in all regular reporting on implementation of national policies, plans and strategies	✓	✓
Include GBV as a standing agenda item in government reporting meetings	✓	✓
Integrate indicators from GBV Guidelines in assessments and evaluations	✓	✓

(continued)

⁷ See "The Obligation to Address Gender-based Violence in Humanitarian Work", above



Essential Actions undertaken by Key Actors		Stage of Emergency	
2. HUMANITARIAN COORDINATORS (HC)		Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage
Element 1: Assessment, Analysis and Strategic Planning			
Take the lead in ensuring that GBV prevention, mitigation and—for some clusters/sectors—response is addressed as an immediate life-saving priority in humanitarian action (whether or not data on GBV is available)		✓	✓
In initial HCT/ICWG discussions on cross-cutting issues, highlight responsibility of all clusters/sectors to integrate GBV risk reduction in their strategies and proposals		✓	✓
Request GBV specialists as part of the overall protection assessment capacity, e.g. within the UN Disaster Assessment and Coordination (UNDAC) and other assessment teams deploying to the emergency		✓	✓
<ul style="list-style-type: none"> Lead on ensuring that appropriate GBV-related questions are included in initial rapid multi-cluster/sector assessments (with input from GBV specialists on questions and data collection methods) Ensure that GBV is addressed specifically in assessment reports and the overall Protection Strategy 			
Support the work of GBV specialists (national and international) to:		✓	
<ul style="list-style-type: none"> Undertake mapping on GBV (e.g. nature and scope; risk and vulnerability factors; national legal framework; cluster/sector capacities to prevent, mitigate and respond to GBV) Ensure design and implementation of safe and ethical data collection, storage and sharing 			
In Preliminary Scenarios of emergencies, ensure that any available data on affected populations' risks of and exposure to GBV is included (in line with safe and ethical practice for the collection and dissemination of GBV data)		✓	✓
Element 2: Resource Mobilization			
Ensure that CERF/Flash and other funding mechanisms address GBV as a life-saving criterion from the start of any emergency. Promote inclusion of GBV Guidelines' recommendations in the earliest drafts of CERF and Flash Appeals by all clusters/sectors			✓
Advocate with donors on the importance of providing resources for life-saving GBV interventions from the start of the response—including for targeted GBV programmes, cluster/sector interventions, and inter- and intra-cluster/sector coordination		✓	✓
Lead on ensuring that initial assessment reports—which can influence funding priorities for the entire response—include anonymized data on GBV incidents, risks, existing services, etc.		✓	✓
Advocate with government to ensure that different cluster/sector programming policies and plans integrate GBV concerns and include strategies for on-going budgeting for GBV activities			✓
Element 3: Implementation			
► Programming			
Promote participatory processes that engage women, girls and other at-risk groups in planning, design, implementation and M&E of humanitarian action		✓	✓
Highlight the importance of all clusters/sectors integrating GBV prevention, mitigation and—for some clusters/sectors—response into their programming (without waiting for 'evidence' that GBV is occurring)		✓	
Ensure that the government is aware of the GBV Guidelines and has access to copies of both the comprehensive Guidelines and the shorter Thematic Area Guidance (TAGs)		✓	✓
Promote GBV Guidelines trainings and orientation for humanitarian stakeholders (e.g. HCT/ICWG, cluster/sector lead agencies and coordinators, cluster/sector programmers, national counterparts)		✓	✓
Support inclusion of GBV issues regularly on the HCT/ICWG agendas, with on-going reports from GBV experts and different cluster/sector coordinators on how the GBV Guidelines' recommendations are being integrated into cluster/sector programming, and with what results		✓	✓

(continued)



Essential Actions undertaken by Key Actors	Stage of Emergency	
	Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage
2. HUMANITARIAN COORDINATORS (HC) (continued)		
Policies		
Support the revision and adoption of national and local laws and policies (including customary laws and policies) that promote the empowerment of women, girls and other at-risk groups and assist government to fulfil their responsibility to protect the rights of citizens to be free from GBV	✓	✓
Advocate for inclusion of GBV risk-reduction strategies into national and local policies and plans and allocate funding for sustainability of these actions	✓	✓
Ensure a ‘no tolerance’ policy related to sexual exploitation and abuse committed by humanitarian actors, in line with the Secretary-General’s bulletin (ST/SGB/2003/13)	✓	✓
Communications and Information Sharing		
Advocate for addressing specific GBV risks in all fora and meetings with national and international stakeholders	✓	✓
Ensure regular reporting on GBV in communications and reports to stakeholders (donors, HCT/ICWG, the Emergency Relief Coordinator [ERC], regular emergency funding reports, reports on the Strategic Response Plan, etc.), in-country and globally	✓	✓
Element 4: Coordination with Other Humanitarian Sectors		
Introduce and promote the GBV Guidelines in inter-agency preparedness meetings to ensure that all decision makers are aware of the relevant guidance for their clusters/sectors/agencies, as well as the importance of implementing GBV Guidelines’ recommendations to meet humanitarian principles and international humanitarian and human rights law ⁸	✓	
Ensure that a GBV coordination mechanism is activated to support integration of GBV across all areas of humanitarian response (as well as to support specialized GBV programming by GBV partners)	✓	✓
As part of leadership and coordination of pre-emergency contingency plans, highlight ubiquity of GBV and the importance of making GBV prevention, mitigation and response priority protection issues for humanitarian emergencies	✓	
Element 5: Monitoring & Evaluation		
Identify at least one relevant indicator from each thematic-area section of the GBV Guidelines to include in country annual reports	✓	✓
Require regular monitoring updates during HCT/ICWG meetings on actions taken to prevent, mitigate and respond to GBV	✓	✓
Include GBV in regular monitoring against the different accountability frameworks	✓	✓
3. HUMANITARIAN COUNTRY TEAM/INTER-CLUSTER WORKING GROUP (HCT/ICWG)		
Element 1: Assessment, Analysis and Strategic Planning		
Highlight GBV as an immediate life-saving priority in inter-cluster/sector meetings	✓	✓
Ensure that all assessments, monitoring and other data collection mechanisms include GBV related questions as well as the disaggregation of data by sex, age and other vulnerability factors	✓	✓
Consult GBV specialists when designing assessments—initial and on-going—to ensure that data is collected in line with safe and ethical practice	✓	
Element 2: Resource Mobilization		
Ensure that programming to prevent, mitigate and—or some clusters/sectors—respond to GBV is reflected in all cluster/sector and multi-cluster/sector response funding proposals for the Flash Appeal, the CERF, and other funding mechanisms	✓	✓
Ensure that reference to/use of relevant GBV Guidelines’ recommendations is one criteria for successful funding proposals in OCHA guidance for resource mobilization	✓	✓
Coordinate the pre-positioning of age-, gender-, and culturally sensitive GBV-related supplies where necessary and appropriate	✓	

(continued)

⁸ See “The Obligation to Address Gender-based Violence in Humanitarian Work”, above

Essential Actions undertaken by Key Actors		Stage of Emergency	
3. HUMANITARIAN COUNTRY TEAM/INTER-CLUSTER WORKING GROUP (HCT/ICWG) (continued)		Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage
Element 3: Implementation			
<p>► Programming</p> <p>Ensure there are hard copies of the GBV Guidelines (comprehensive and TAG) available in the office and that weblinks to the GBV Guidelines are publicized</p> <p>Regularly discuss on-going and emerging GBV risks and risk-reduction responses in inter-cluster/sector meetings, highlighting opportunities for joint cluster/sector approaches to prevent, mitigate and respond to GBV</p> <p>As part of regular information sharing, proactive identify and share good practice and lessons learned in GBV prevention, mitigation and response in HCT/ICWG meetings and in other fora</p>			
► Policies			
<p>Incorporate GBV prevention and mitigation strategies into cluster/sector policies, standards and guidelines from the earliest stages of the emergency</p> <p>Put in place necessary actions to protect women, girls, boys and men from all forms of sexual exploitation and abuse by all agency staff and partners, and lead advocacy for all international and national agencies/organizations to do the same</p>			
<p>► Communications and Information Sharing</p> <p>Familiarize agency staff and partners with GBV Guidelines, championing uptake of recommendations among all humanitarian partners</p> <p>Attend GBV Guidelines orientations/trainings and release staff from all agencies to also attend and to implement the recommendations when they return to the office</p> <p>Include regular reporting on GBV in all communications with and reports to internal and external stakeholders</p> <p>For HCT/ICWG:</p> <ul style="list-style-type: none"> • Ensure all communication and advocacy materials capture the different needs, capacities and voices of women, girls, and other at-risk groups with respect to GBV risks, prevention, mitigation and response (in line with safe and ethical data collection, storage and sharing) • Support GBV experts to safely and ethically manage GBV data (collection, storage, sharing and dissemination) <p>For OCHA:</p> <ul style="list-style-type: none"> • Include regular reporting on GBV trends as well as prevention, mitigation and response actions in sitreps and other emergency reports (e.g. include paragraph on GBV within the broader protection section of the first situation report) 			
Element 4: Coordination with Other Humanitarian Sectors			
<p>For HCT/ICWG:</p> <ul style="list-style-type: none"> • As part of HCT/ICWG responsibility to ensure a coherent response to emergencies (and in the light of the fact that GBV programming is designated as a life-saving intervention), be pro-active in ensuring links between clusters/sectors for safe access to services for GBV survivors (e.g. connecting other clusters/sector with the GBV coordination mechanism as well as the Health Cluster/Sector) at all stages of the response, including early recovery <p>For OCHA:</p> <ul style="list-style-type: none"> • As the leader of inter-cluster coordination, ensure that GBV issues are a regular part of HCT/ICWG discussions/communications and that the GBV coordination mechanism gets a seat in the ICWG 			
Element 5: Monitoring & Evaluation			
<p>Include regular reporting in inter-cluster/sector meetings about strategies that have been integrated into programming to prevent, mitigate and respond to GBV and the results of integrating strategies</p> <p>Include evaluation questions relating to GBV prevention, mitigation and—for some clusters/sectors—response in inter-agency Real Time Evaluations, and other evaluation Terms of References</p>			

(continued)



Essential Actions undertaken by Key Actors	Stage of Emergency	
	Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage
4. CLUSTER/SECTOR LEAD AGENCIES (CLA)		
Element 1: Assessment, Analysis and Strategic Planning		
Ensure Heads of Agencies—particularly of UNCHR (as global protection lead) and UNICEF and UNFPA (as global GBV co-leads)—refer to the GBV Guidelines in HCT/ICWG meetings and other fora to raise awareness and engagement among peers	✓	✓
Element 2: Resource Mobilization		
Leading by example, include relevant GBV Guidelines' recommendations in funding proposals	✓	✓
Element 3: Implementation		
▶ Programming		
Ensure that GBV Guidelines' recommendations are integrated into programme responses across all humanitarian sectors addressed by the CLA	✓	✓
Employ and retain women and other at-risk groups as staff members	✓	✓
Pre-position age-, gender-, and culturally-sensitive GBV-related supplies where necessary and appropriate	✓	
▶ Policies		
Develop and implement agency policies, standards/guidelines, response plans and proposals to ensure that GBV prevention, mitigation and (as appropriate) response is integrated in all aspects and across all CLA programmes (e.g. recruitment and HR policies, procurement policies as well as programming response) and into global cluster policies	✓	✓
▶ Communications and Information Sharing		
In the field, ensure there are sufficient copies of the GBV Guidelines for CLA programming staff and cluster/sector partners	✓	✓
Ensure that CLA programme staff and managers are aware of, have been trained in, and use the GBV Guidelines	✓	✓
From the start of the response through its duration, include regular reporting on GBV trends and prevention, mitigation and—for some clusters/sectors--response actions in internal and external reports, with reports of progress made	✓	✓
Element 4: Coordination with Other Humanitarian Sectors		
Engage with the GBV coordination mechanism's CLAs and the Protection Cluster/Sector as resources for the implementation of the GBV Guidelines across all sectors	✓	✓
Proactively support cross-cluster/sector, multi-agency approaches to addressing GBV prevention, mitigation and response in the HCT/ICWG and other inter-cluster/sector fora	✓	✓
Element 5: Monitoring & Evaluation		
Include relevant indicators from the GBV Guidelines in CLA monitoring frameworks for all sectors and monitor and report on them regularly	✓	✓
Include evaluation questions relating to GBV prevention, mitigation and—for some clusters/sectors—response into agency evaluations	✓	✓

5. CLUSTER/SECTOR COORDINATORS

Element 1: Assessment, Analysis and Strategic Planning

Introduce the GBV Guidelines in the first days of the response in cluster/sector meetings (sharing information about the various communication media through which partners can access them, such as print, internet, phone apps, etc.)	✓	
Work with GBV specialists to develop GBV assessment questions and to advise on appropriate methods of data collection for cluster/sector-specific assessments	✓	✓
Include relevant GBV Guidelines' recommendations in cluster/sector guidance for conducting the 3/4/5Ws	✓	✓

(continued)



Essential Actions undertaken by Key Actors	Stage of Emergency	
	Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage
5. CLUSTER/SECTOR COORDINATORS (continued)		
Element 2: Resource Mobilization		
Use information collected on GBV risk factors and other GBV-related issues when drafting GBV-related elements of cluster/sector-specific proposals. Draw on GBV Guidelines' recommendations (contextualized for the particular setting) to inform funding proposals	✓	✓
Submit joint proposals of cluster/sector partners to ensure that GBV has been adequately addressed in the cluster/sector programming response	✓	✓
Work with national cluster/sector counterparts at different levels of government to ensure that different cluster/sector programming policies and plans include strategies for on-going budgeting for GBV activities	✓	✓
Element 3: Implementation		
▶ Programming		
Promote the employment and retention of women and other at-risk groups as members of staff, and advocate for their active participation and leadership in all cluster/sector-related community activities	✓	✓
Work with the GBV coordination mechanism to contextualize the GBV Guidelines for the setting and for each cluster/sector	✓	✓
Advocate for cluster/sector partners to reference GBV Guidelines to inform their programming responses:	✓	✓
• Attend training on the GBV Guidelines and support cluster/sector membership to attend		
• Promote guiding principles for working with GBV survivors into all responses		
• Plan and implement programmes in an inclusive way so that women, girls and other at-risk groups contribute to programme design and implementation		
In line with the GBV Guidelines, develop cluster/sector strategies which specifically note GBV risks and how cluster/sector programmes can address these	✓	✓
Take advantage of GBV specialists to enhance cluster/sector programming interventions	✓	✓
▶ Policies		
Support the revision and adoption of national and local laws and policies (including customary laws and policies) relevant to the cluster/sector that promote and protect the rights of women, girls and other at-risk groups	✓	✓
Develop and implement cluster/sector work plans with clear milestones that include GBV-related inter-agency actions	✓	✓
Incorporate relevant GBV prevention and mitigation strategies into cluster/sector policies, standards and guidelines (drawing, as necessary, upon GBV specialists or cluster/sector staff who have attended GBV Guidelines trainings) and circulate them widely (e.g. standards for equal employment of men and women; procedures to share information on GBV incidents; cluster/sector procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse)	✓	✓
▶ Communications and Information Sharing		
Share experience of integrating GBV Guidelines' recommendations into different cluster/sector responses and how this has contributed to an effective response	✓	✓
Share cluster/sector strategies which address GBV risks with global clusters and in inter-cluster/sector meetings	✓	✓

(continued)



Essential Actions undertaken by Key Actors	Stage of Emergency	
	Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage
5. CLUSTER/SECTOR COORDINATORS (continued)		
Element 4: Coordination with Other Humanitarian Sectors		
For all cluster/sector coordinators:	✓	✓
<ul style="list-style-type: none"> Raise awareness of the GBV Guidelines--particularly cluster/sector specific guidance--within cluster/sector working group meetings Use relevant GBV Guidelines' recommendations to inform cluster/sector contingency planning and response scenario development Refer to GBV Guidelines in meetings with national counterparts to ensure that they are aware of, and use, the GBV Guidelines for emergency preparedness and trainings Designate a focal point to participate in or engage with the with GBV coordination mechanism and act as a communication channel for each cluster/sector on GBV-related issues Liaise with the GBV coordination mechanism for updated referral information on where survivors who report an experience of GBV can receive safe, confidential and appropriate care 		
For the Protection Cluster/Sector coordinator:	✓	✓
<ul style="list-style-type: none"> Be a strong ally in implementing the GBV Guidelines in humanitarian action, supporting the GBV coordination mechanism in its leadership of the implementation process and modelling good practice by incorporating GBV Guidelines' recommendations into protection work 		
Element 5: Monitoring & Evaluation		
Integrate relevant, contextualized indicators from GBV Guidelines into regular cluster/sector monitoring activities and share reports with GBV coordination mechanisms, HCT/ICWG and other stakeholders		✓
Develop monitoring systems which allow the cluster/sector to track their own GBV-related activities (e.g. including GBV-related activities in the 3/4/5Ws)		✓
Advocate for the inclusion of questions on the extent to which GBV has been prevented, mitigated, and (if relevant) responded to in all cluster/sector assessments and evaluations		✓
6. GBV COORDINATION MECHANISM⁹		
Element 1: Assessment, Analysis and Strategic Planning		
As far as possible, ensure GBV specialists from the GBV coordination mechanism—and, where relevant, other GBV surge capacity—are available to support the HC, OCHA and clusters/sectors to develop and contextualize GBV components of assessments (multi-sectoral and sector specific)	✓	✓
Share any existing data (on the nature and scope of GBV, high-risk groups, vulnerability factors, etc.) to inform assessments, Preliminary Scenario Definitions, and funding proposals <ul style="list-style-type: none"> Ensure that data is collected and shared according to safety and ethical standards Raise awareness that lack of data doesn't mean lack of incidence of GBV, and that provision of services often results in increased levels of reporting 	✓	✓
Element 2: Resource Mobilization		
Engage and build relationships with donors around use of the GBV Guidelines as part of their funding criteria	✓	✓
<ul style="list-style-type: none"> Share any relevant GBV data with donor representatives and advocate that GBV Guidelines' recommendations inform their funding decisions Where appropriate, advocate for funding to GBV-specialized programming proposals and themes 		
Develop joint proposals with clusters/sectors, drawing on the GBV Guidelines' recommendations and ensuring comprehensive and coordinated action	✓	✓

(continued)

⁹ The responsibilities listed here are specific to the implementation of these Guidelines. For more comprehensive information about the roles and activities of the GBV coordination mechanism, see: **GBV AoR. 2015. Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings**, www.gbaor.net



Essential Actions undertaken by Key Actors		Stage of Emergency	
6. GBV COORDINATION MECHANISM (continued)		Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage
Element 3: Implementation			
<p>► Programming</p> <p>Lead cross-cluster/sector contextualization of the GBV Guidelines in order to promote context-specific understanding of GBV risks and priorities for action</p> <p>Identify local GBV specialists who can be tapped to provide surge capacity to clusters/sectors to integrate the GBV Guidelines' recommendations throughout all stages of the response</p> <p>Foster coordination on joint programming responses across clusters/sectors to ensure a comprehensive, coordinated response to GBV</p>			
► Policies			
Act as expert advisors to any cluster/sector, agency, or national government body developing policies to prevent, mitigate and—for some clusters/sectors—respond to GBV as part of humanitarian action		✓	✓
Act as expert advisors on the review and reform of national and local legal frameworks related to GBV prevention and response		✓	✓
<p>► Communications and Information Sharing</p> <p>Inform contingency planning and response activities:</p> <ul style="list-style-type: none"> Collate existing data on GBV for the setting (nature and scope; risk and vulnerability factors; national legal framework; cluster/sector capacities to prevent, mitigate and respond to GBV) and share with all clusters/ sectors and key decision makers Compile information on global and national cluster/sector standards and practices related to GBV risk reduction (identifying those which are in place as well as gaps) and share with the RC/HC, the head of OCHA and the HCT/ICWG <p>Lead on raising awareness of the GBV Guidelines in-country:</p> <ul style="list-style-type: none"> Use all opportunities to introduce the GBV Guidelines Present the GBV Guidelines to all cluster/sector working groups Identify potential GBV Guidelines champions at all levels of decision makers and programmers, and start working with them on different mechanisms to catalyse GBV Guidelines' uptake Proactively engage with government actors <p>Form strategic partnerships and networks to conduct advocacy for improved programming that meets the responsibilities set out in the GBV Guidelines (with due caution to the safety and security risks for humanitarian actors, survivors, and those at risk of GBV who speak publicly about the problem of GBV)</p> <p>Lead on providing training on the GBV Guidelines:</p> <ul style="list-style-type: none"> Hold orientations with key humanitarian decision makers (e.g. RC/HC, HCT/ICWG members, OCHA Head of Office, key government partners, cluster/sector coordinators, donors, etc.) Conduct trainings with different clusters/sectors on the GBV Guidelines and with women's and human rights groups <p>Develop a cross-cluster/sector information sharing protocol to ensure safe, ethical, survivor-centred GBV data collection, storage and sharing and dissemination</p> <p>Collect and keep updated information on local GBV response capacities and referral pathways and share this proactively with all clusters/sectors and key decision makers so that they can refer any survivors to the appropriate channels of support/response</p> <p>Develop basic GBV messages with all clusters/sectors and disseminate during community outreach and awareness-raising</p> <p>Be aware of the work of other clusters/sectors in incorporating GBV Guidelines' recommendations and share any related reports with the wider GBV community</p> <p>Systematically input into OCHA reporting on integration of GBV Guidelines' recommendations across the response (and, where available, the results in terms of effective programming)</p>		✓	

(continued)



Essential Actions undertaken by Key Actors

6. GBV COORDINATION MECHANISM (continued)

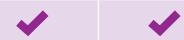
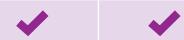
Element 4: Coordination with Other Humanitarian Sectors

Identify GBV focal points to proactively engage with all clusters/sectors, attending their meetings and providing input on how to integrate GBV Guidelines' recommendations

Stage of Emergency	
Pre-Emergency/ Preparedness	Emergency/ Stabilized Stage



Provide on-going support to cluster/sector staff on meeting their responsibilities outlined in the GBV Guidelines



Element 5: Monitoring & Evaluation

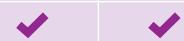
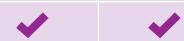
Share baseline data on GBV with other clusters/sectors (primary or secondary data which was collected prior to or at the start of an emergency) to inform programming



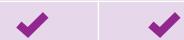
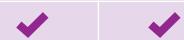
Conduct regular monitoring of GBV Guidelines' implementation during the response and regularly share results in inter-cluster/sector fora and meetings with donors, national government, and other key stakeholders



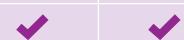
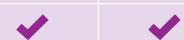
Advocate for and support the inclusion of GBV Guidelines' indicators in other cluster/sector monitoring frameworks and evaluations



Advocate for protection-related response evaluations that assess GBV-specific elements



Plan for and conduct periodic reviews/evaluations of GBV Guidelines implementation and effectiveness



Additional Citations

United Nations General Assembly. December 1993.
Declaration on the Elimination of Violence against Women, A/RES/48/104, <http://www.un.org/documents/ga/res/48/a48r104.htm>

Office of the High Commissioner for Human Rights (OHCHR). 2011. *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity*, A/HRC/19/41, http://www.ohchr.org/documents/issues/discrimination/a.hrc.19.41_english.pdf

Inter-Agency Standing Committee (IASC). 2008. "Policy Statement Gender Equality in Humanitarian Action", http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.humanitarianinfo.org%2Fiasc%2Fdownloaddoc.aspx%3FdocID%3D4497%26type%3Dpdf&ei=5SdqVLC2DlfealnagpgD&usg=AFQjCNH2wrkJYIPkUx_fcyBVCzYj9pGglQ&bvm=bv.79142246,d.d2s

Heise, L. 1998. "Violence Against Women: an integrated, ecological framework", *Violence Against Women*. 1998 Jun;4(3):262-90. <http://www.ncbi.nlm.nih.gov/pubmed/12296014>



PART TWO: BACKGROUND TO THEMATIC AREA GUIDANCE



1. Content Overview of Thematic Areas

This section provides an overview of the guidance detailed in each of the thirteen thematic area sections that follow. Sector actors should read it in conjunction with their relevant thematic area. The information below:

- ▶ Describes the summary **fold-out table** of essential actions presented at the beginning of each thematic area, designed as a quick reference tool for sector actors.
- ▶ Introduces the **programme cycle**, which is the framework for all the recommendations within each thematic area.
- ▶ Reviews the **guiding principles** for addressing GBV and summarizes how to apply these principles through **four inter-linked approaches**: the rights-based approach, survivor-centered approach, community-based approach and systems approach.

Summary Fold-out Table of Essential Actions

Each thematic area section includes a summary fold-out table for use as a quick reference tool. The fold-out table links key recommendations made in the body of each thematic area with guidance on when the recommendations should be applied across four stages of emergency: *Pre-emergency/preparedness* (before the emergency and during ongoing preparedness planning), *Emergency* (when the emergency strikes)¹, *Stabilized Stage* (when immediate emergency needs have been addressed), and *Recovery to Development* (when the focus is on facilitating returns of displaced populations, rebuilding systems and structures, and transitioning to development). In practice, the separation between different stages is not always clear; most emergencies do not follow a uniformly linear progression, and stages may overlap and/or revert. The stages are therefore only indicative.



ESSENTIAL TO KNOW

Emergency Preparedness and Contingency Planning

“Experience confirms that effective humanitarian response at the onset of a crisis is heavily influenced by the level of preparedness and planning of responding agencies/organizations, as well as the capacities and resources available to them.”

In the summary fold-out table of each thematic area, the points listed under ‘pre-emergency/preparedness’ are not strictly limited to actions that can be taken before an emergency strikes. These points are also relevant to **ongoing preparedness planning**, the goal of which is to anticipate and solve problems in order to facilitate rapid response when a particular setting is struck by another emergency. In natural disasters, on-going preparedness is often referred to as contingency planning and is part of all stages of humanitarian response.

(Quote from IASC. 2007. *Inter-Agency Contingency Planning Guidelines for Humanitarian Assistance, Revised version*, p.7. <http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-products-products&productcatid=13>)

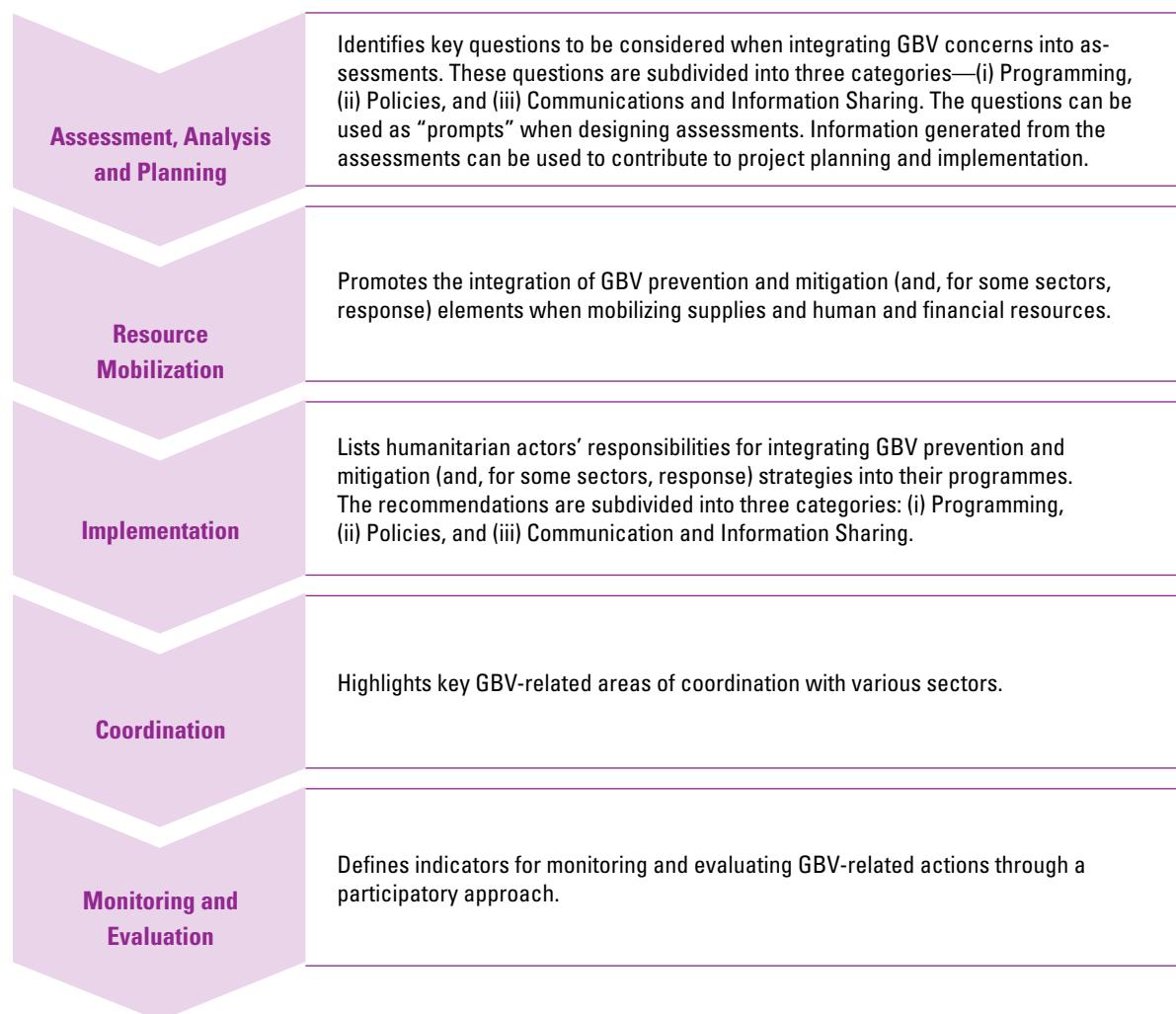
¹ Slow-onset emergencies such as drought may follow a different pattern from rapid-onset disasters. Even so, the risks of GBV and the humanitarian needs of affected populations remain the same. The recommendations in these Guidelines are applicable to all types of emergencies.



In each summary fold-out table, sector specific **minimum commitments**² appear in bold. These minimum commitments represent critical actions that sector actors can prioritize in the earliest stages of emergency when resources and time are limited. As soon as the acute emergency has subsided (anywhere from two weeks to several months, depending on the setting), additional essential actions outlined in the summary fold-out table—and elaborated in the body of the thematic area section—should be initiated and/or scaled up. Each recommendation should be adapted to the particular context, always taking into account the essential rights, expressed needs, and identified resources of target community.

Essential Actions Outlined According to the Programme Cycle Framework

Following the summary fold-out table, the thematic areas are organized according to five essential elements of a programme cycle. Each element of the programme cycle is designed to link with and support the other elements. *While coordination is presented as its own separate element, it should be considered and integrated throughout the entirety of the programme cycle.* The five elements³ are presented as follows:



² Note that the minimum commitments do not always come first under each programme cycle category of the summary table. This is because all of the actions are organized in chronological order according to an ideal model for programming. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date.

³ These elements of the programme cycle are an adaptation of the Humanitarian Programme Cycle (HPC). The HPC has been slightly adjusted within these Guidelines to simplify presentation of key information. The HPC is a core component of the Transformative Agenda, aimed at improving humanitarian actors’ ability to prepare for, manage and deliver assistance. For more information about the HPC, see <http://www.humanitarianresponse.info/programme-cycle/space>



Integrated throughout these stages is the concept of **early recovery** as a multidimensional process. Early recovery begins in the early days of a humanitarian response and should be considered systematically throughout. Employing an early recovery approach means:

"focusing on local ownership and strengthening capacities; basing interventions on a thorough understanding of the context to address root causes and vulnerabilities as well as immediate results of crisis; reducing risk, promoting equality and preventing discrimination through adherence to development principles that seek to build on humanitarian programmes and catalyse sustainable development opportunities. It aims to generate self-sustaining, nationally-owned, resilient processes for post-crisis recovery and to put in place preparedness measures to mitigate the impact of future crises."

(Global Cluster on Early Recovery. 2014. *Guidance Note on Inter-Cluster Early Recovery*, p. 7, publication pending)

In order to facilitate early recovery, GBV prevention and mitigation strategies should be integrated into programmes from the beginning of an emergency in ways that protect and empower women, girls and other at-risk groups. These strategies should also address underlying causes of GBV (i.e. gender inequality) and develop evidence-based programming and tailored assistance.

Element 1: Assessment, Analysis and Planning

In each thematic area, the programme cycle begins with a list of recommended GBV-related questions or "prompts." These prompts highlight areas for investigation that can be selectively incorporated into various assessments and routine monitoring undertaken by humanitarian actors. The questions link to the recommendations under "Implementation" in each thematic area and the three main types of responsibilities therein (see Element 3 below):

- Programming;
- Policies; and
- Communication and Information Sharing.



ESSENTIAL TO KNOW

Initiating Risk-Reduction Interventions Without Assessments

While assessments are an important foundation for programme design and implementation, they are not required in order to put in place some essential GBV prevention and mitigation (and, for some sectors, response) measures prior to or from the onset of an emergency. **Many risk reduction interventions can be introduced without conducting an assessment.** For example:

- The water, sanitation and hygiene (WASH) sector can ensure latrines have functional locks.
- Health sector actors can implement the *Minimum Initial Service Package (MISP) for Reproductive Health* at the onset of every emergency.
- Camp coordination and camp management (CCCM) actors can ensure lighting is installed in all communal areas of the site.



In addition to the “what to assess” question prompts within each thematic area, other key points should be considered when designing assessments:

Who to Assess	<ul style="list-style-type: none">• Key stakeholders and actors providing services in the community• GBV, gender and diversity specialists• Men and women of all ages and backgrounds of the affected community, paying particular attention to women, girls and other at-risk groups• Community leaders• Community-based organisations (i.e. organisations for women, adolescents/youth, persons with disabilities, older persons, etc.)• Representatives of humanitarian response sectors• Local and national governments• Members of receptor/host communities in IDP/refugee settings
When to Assess	<ul style="list-style-type: none">• At the outset of programme planning• At regular intervals for monitoring purposes (these intervals will vary by sector and should be determined by relevant sector guidance)• During on-going safety and security monitoring, depending on the sectors
How to Assess	<ul style="list-style-type: none">• Review available secondary data (existing assessments/studies/qualitative and quantitative information; IDP/refugee registration data; etc.)• Conduct regular consultations with key stakeholders, including relevant grass-roots organizations, civil societies, and government agencies• Carry out key informant interviews• Conduct focus group discussions with community members that are age-, gender-, and culturally-appropriate (e.g. participatory assessments held in consultation with men, women, girls and boys, separately when necessary)• Carry out site observation• Perform site safety mapping• Conduct analysis of national legal frameworks related to GBV and whether they provide protection to women, girls and other at-risk groups

When designing assessments, humanitarian actors should apply ethical and safety standards that are age-, gender-, and culturally-sensitive and prioritize the well-being of all those engaged in the assessment process. Wherever possible—and particularly when any component of the assessment involves communication with community stakeholders—**investigations should be designed and undertaken according to participatory processes** that engage the entire community, and most particularly women, girls, and other at-risk groups. This requires, as a first step, ensuring equal participation of women and men on assessment teams, as stipulated in the IASC Gender Handbook.⁴ Other important considerations are listed below.

⁴ An online survey conducted of humanitarian practitioners and decision-makers by Plan International found that the participation of women in assessment teams varies considerably, despite IASC standards. See *The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters*, <http://plan-international.org/girls/reports-and-publications/the-state-of-the-worlds-girls-2013.php>



DOs and DON'Ts for Conducting Assessments that Include GBV-related Components**DO's**

- Do consult GBV, gender and diversity specialists throughout the planning, design, analysis and interpretation of assessments that include GBV-related components.
- Do use local expertise where possible.
- Do strictly adhere to safety and ethical recommendations for researching GBV.
- Do consider cultural and religious sensitivities of communities.
- Do conduct all assessments in a participatory way by consulting women, girls, men and boys of all backgrounds, including persons with specific needs. The unique needs of at-risk groups should be fairly represented in assessments in order to tailor interventions.
- Do conduct inter-agency or multi-sectoral assessments promoting the use of common tools and methods and encourage transparency and dissemination of the findings.
- Do include GBV specialists on inter-agency and inter-sectoral teams.
- Do conduct ongoing assessments of GBV-related programming issues to monitor the progress of activities and identify gaps or GBV-related protection issues that arise unexpectedly. Adjust programmes as needed.
- Do ensure that an equal number of female and male assessors and translators are available to provide age-, gender-, and culturally-appropriate environments for those participating in assessments, particularly women and girls.
- Do conduct consultations in a secure setting where all individuals feel safe to contribute to discussions. Conduct separate women's groups and men's groups, or individual consultations when appropriate, to counter exclusion, prejudice, and stigma that may impede involvement.
- Do provide training for assessment team members on ethical and safety issues. Include information in the training about appropriate systems of care (i.e. referral pathways) that are available for GBV survivors, if necessary.
- Do provide information about how to report risk and/or where to access care—especially at health facilities—for anyone who may report risk of or exposure to GBV during the assessment process.
- Do include—when appropriate and there are no security risks—government officials, line ministries, and sub-ministries in assessment activities.

DON'Ts

- Don't share data that may be linked back to a group or an individual, including GBV survivors.
- Don't probe too deeply into culturally sensitive or taboo topics (e.g. gender equality, reproductive health, sexual norms and behaviors, etc.) unless relevant experts are part of the assessment team.
- Don't single out GBV survivors: speak with women, girls and other at-risk groups in general and not explicitly about their own experiences.
- Don't make assumptions about which groups are affected by GBV, and don't assume that reported data on GBV or trends in reports represent actual prevalence and trends in the extent of GBV.
- Don't collect information about specific incidents of GBV or prevalence rates without assistance from GBV specialists.

(Adapted from **GBV AoR. 2010. Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings (provisional edition)**; **CPWG. 2012. Minimum Standards for Child Protection in Humanitarian Action**; and **UN Action. 2008. Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries: Dos and Don'ts**)



The information collected during various assessments and routine monitoring will help to identify the relationship between GBV risks and sector-specific programming. The data can highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes, such as:

- ▶ Safety and security risks for particular groups within the affected population.
- ▶ Unequal access to services for women, girls and other at-risk groups.
- ▶ Global and national sector standards related to protection, rights, and GBV risk reduction that are not applied (or do not exist) and therefore increase GBV-related risks.
- ▶ Lack of participation by some groups in the planning, design, implementation, and monitoring and evaluation of programmes, and the need to consider age-, gender-, and culturally-appropriate ways of facilitating participation of all groups.
- ▶ The need to advocate for and support the deployment of GBV specialists for the sector.

Data can also be used to inform common response planning processes, which serve as the basis for resource mobilization in some contexts. As such, it is essential that GBV be adequately addressed and integrated into joint planning and strategic documents—such as the Humanitarian Program Cycle, the OCHA Minimum Preparedness Planning (MPP), the Multi-Cluster/Sector Rapid Assessment (MIRA), and Strategic Response Plans (SRPs).



ESSENTIAL TO KNOW

Investigating GBV-related Safety and Security Issues When Undertaking Assessments

It is the responsibility of all humanitarian actors to work within a protection framework and understand the safety and security risks that women, girls, men and boys face. Therefore it is extremely important that assessment and monitoring of general safety issues is an on-going feature of assistance. This includes exploring—through a variety of entry points and participatory processes—when, why, and how GBV-related safety issues might arise, particularly as the result of delivery or use of humanitarian services. However, **GBV survivors should not be sought out or targeted as a specific group during assessments. GBV-specific assessments — which includes investigating specific GBV incidents, interviewing survivors about their specific experiences, or conducting research on the prevalence of GBV in the population—should be conducted only in collaboration with GBV specialists and/or a GBV specialized partner or agency.** Training in gender, GBV and women's/human rights—and how these inform assessment practices—should be conducted with relevant staff in each humanitarian sector. To the extent possible, **assessments should be locally designed and led**, ideally by relevant local government actors and/or programme administrators and with the participation of the community. When non-GBV specialists receive specific reports of GBV during general assessment activities, they should share the information with GBV specialists according to safe and ethical standards that ensure confidentiality and, if requested by survivors, anonymity of survivors.

Element 2: Resource Mobilization

Resource mobilization most obviously refers to accessing funding in order to implement programming—either through specific donors or linked to coordinated humanitarian funding mechanisms. (For more information on funding mechanisms, see Annex 7.) These Guidelines aim to reduce the challenges of accessing GBV-related funds by outlining key GBV-related issues to be considered when drafting proposals.

In addition to the sector-specific funding points presented in each thematic area, humanitarian actors should consider the following general points:

! ESSENTIAL TO KNOW

Recognizing GBV Prevention and Response as Life-Saving

Addressing GBV is considered life-saving and meets multiple humanitarian donor guidelines and criteria, including the Central Emergency Response Fund (CERF). In spite of this, GBV prevention, mitigation and response are rarely prioritized from the outset of an emergency. Taking action to address GBV is more often linked to longer-term protection and stability initiatives; as a result, humanitarian actors operate with limited GBV-related resources in the early stages of an emergency (Hersh, 2014). This includes a lack of physical and human resources or technical capacity in the area of GBV, which can in turn result in limited allocation of GBV-related funding. These limitations are both a cause and an indicator of systemic weaknesses in emergency response, and may in some instances stem from the failure of initial rapid assessments to illustrate the need for GBV prevention and response interventions. (For more information about including GBV in various humanitarian strategic plans and funding mechanisms, see Annex 7.)

Components of a Proposal	GBV-related Points to Consider for Inclusion
HUMANITARIAN NEEDS OVERVIEW	<ul style="list-style-type: none"> Describe vulnerabilities of women, girls, and other at-risk groups in the particular setting Describe and analyse risks for specific forms of GBV (<i>e.g. sexual assault, forced and/or coerced prostitution, child and/or forced marriage, intimate partner violence and other forms of domestic violence</i>), rather than a broader reference to "GBV" Illustrate how those believed to be at risk of GBV have been identified and consulted on GBV-related priorities, needs and rights
PROJECT RATIONALE/ JUSTIFICATION	<ul style="list-style-type: none"> Explain the GBV-related risks that are linked to the sector's area of work Describe which groups are being targeted in this action and how the targeting is informed by vulnerability criteria and inclusion strategies Describe whether women, girls, and other at-risk groups are part of decision-making processes and what mechanisms have been put in place to empower them Explain how these efforts will link with and support other efforts to prevent and mitigate specific types of GBV in the affected community
PROJECT DESCRIPTION	<ul style="list-style-type: none"> Illustrate how activities are linked with those of other humanitarian actors/sectors Explain which activities may help in changing or improving the environment to prevent GBV (<i>e.g. by better monitoring and understanding the underlying causes and contributing factors of GBV</i>) Describe mechanisms that facilitate reporting of GBV, and ensure appropriate follow-up in a safe and ethical manner Describe relevant linkages with GBV specialists and GBV coordination mechanisms Consider how the project promotes and rebuilds community systems and structures that ensure the participation and safety of women, girls and other at-risk groups
MONITORING AND EVALUATION PLAN	<ul style="list-style-type: none"> Outline a monitoring and evaluation plan to track progress as well as any adverse effects of GBV-related activities on the affected population Illustrate how the monitoring and evaluation strategies include the participation of women, girls and other at-risk groups Include outcome level indicators from the Indicator Sheets in the thematic area of the Guidelines to measure programme impact on GBV-related risks Where relevant, describe a plan for adjusting the programme according to monitoring outcomes Disaggregate indicators by sex, age, disability and other relevant vulnerability factors





ESSENTIAL TO KNOW

The IASC Gender Marker

Despite universal acceptance that humanitarian assistance must meet the distinct needs of women, girls, boys and men to generate positive and sustainable outcomes, evaluations of humanitarian effectiveness show gender equality results are weak. The Gender Marker is a tool that codes, on a 0-2 scale, whether or not a humanitarian project is designed well enough to ensure that women/girls and men/boys will benefit equally from it or that it will advance gender equality in another way. If the project has the potential to contribute to gender equality, the marker predicts whether the results are likely to be limited or significant. Although the gender mainstreaming objectives of the Gender Marker differ in some ways from those of GBV prevention and response programming, in order to be effective, they **must both address issues of women's and girls' empowerment and gender equality and include men and boys as partners in prevention.**

(For links between the Gender Marker and GBV prevention and response projects, see **Annex 8**. For information on the Gender Marker, see <https://www.humanitarianresponse.info/topics/gender/page/iasc-gender-marker>. For information on trends in spending according to the Gender Marker, see **Global Humanitarian Assistance. 2014. Funding Gender in Emergencies: What are the Trends?** <http://www.globalhumanitarianassistance.org/report/funding-gender-emergencies-trends>)

Importantly, resource mobilization is not limited to soliciting funds. When planning for and implementing GBV prevention and response activities, sector actors should:

- ▶ Mobilize human resources by making sure that partners within the sector system:
 - Have been trained in and understand issues of gender, GBV, and women's/human rights.
 - Are empowered to integrate GBV risk reduction strategies into their work.
- ▶ Employ and retain women and other at-risk groups as staff, and ensure their active participation and leadership in all sector-related community activities.
- ▶ Preposition age-, gender-, and culturally-sensitive supplies where necessary and appropriate.
- ▶ Preposition accessible GBV-related community outreach material.
- ▶ Advocate with the donor community so that donors recognize GBV prevention, mitigation, and response interventions as lifesaving, and support the costs related to improving intra- and inter-sector capacity to address GBV.
- ▶ Ensure that government and humanitarian policies related to sector programming integrate GBV concerns and include strategies for on-going budgeting of activities.

Element 3: Implementation

The “Implementation” subsection of each thematic area section provides guidance for putting GBV-related risk reduction responsibilities into practice. The information is intended to:

- ▶ Describe a set of activities which, taken together, establish shared standards and improve the overall quality of GBV-related prevention and mitigation (and, for some sectors, response) strategies in humanitarian settings.
- ▶ Establish GBV-related responsibilities that should be undertaken by all actors within that particular sector, regardless of available data on GBV incidents.
- ▶ Maximize immediate protection of GBV survivors and persons at risk.
- ▶ Foster longer-term interventions that work toward the elimination of GBV.



Three main types of responsibilities—programming, policies, and communications and information sharing—correspond to and elaborate upon the suggested areas of inquiry outlined under the subsection “Assessment, Analysis and Planning.” Each targets a variety of sector actors.

1) Programming: Targets NGOs, community-based organizations (including the National Red Cross/Red Crescent Society), INGOs, UN agencies, and national and local governments to encourage them to:

- ▶ Support the involvement of women, girls and other at-risk groups within the affected population as programme staff and as leaders in governance mechanisms and community decision-making structures.
- ▶ Implement programmes that (1) reflect awareness of the particular GBV risks faced by women, girls and other at-risk groups, and (2) address their rights and needs related to safety and security.
- ▶ Integrate GBV prevention and mitigation (and, for some sectors, response) into activities.

! ESSENTIAL TO KNOW

Active Participation of Women, Girls and Other At-Risk Groups

Commitment 4 of the IASC Principles’ *Commitments on Accountability to Affected Populations* (CAAP) highlights the importance of enabling affected populations to play a decision-making role in processes that affect them. This is reflected in recommendations within these Guidelines that promote the active participation of women, girls and other at-risk groups in assessment processes and as staff and leaders in community-based structures. **Involving women, girls, and other at-risk groups in all aspects of programming is essential** to fulfilling the guiding principles and approaches discussed later in this section. However, such involvement — especially as leaders or managers — can be risky in some settings. Therefore the recommendations throughout these guidelines aimed at greater inclusion of women, girls and other at-risk groups (*e.g. striving for 50% representation of females in programme staff*) may need to be adjusted to the context. **Due caution must be exercised where their inclusion poses a potential security risk or increases their risk of GBV.** Approaches to their involvement should be carefully contextualized.

2) Policies: Targets programme planners, advocates, and national and local policy makers to encourage them to:

- ▶ Incorporate GBV prevention and mitigation strategies into programme policies, standards and guidelines from the earliest stages of the emergency.
- ▶ Support the integration of GBV risk-reduction strategies into national and local development policies and plans and allocate funding for sustainability.
- ▶ Support the revision and adoption of national and local laws and policies (including customary laws and policies) that promote and protect the rights of women, girls and other at-risk groups.

3) Communications and Information Sharing: Targets programme and community outreach staff to encourage them to:

- ▶ Work with GBV specialists in order to identify safe, confidential and appropriate systems of care (*i.e. referral pathways*) for GBV survivors; incorporate basic GBV messages into sector-specific community outreach and awareness-raising activities; and develop information-sharing standards that promote confidentiality and ensure anonymity of survivors. In the early stages of an emergency, services may be quite limited; referral pathways should be adjusted as services expand.



- Receive training on issues of gender, GBV, women's/human rights, and psychological first aid (e.g. how to engage supportively with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).



ESSENTIAL TO KNOW

Mental Health and Psychosocial Support: Providing Referrals and Psychological First Aid

The term “mental health and psychosocial support” (MHPSS) is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder (IASC, 2007). The experience of GBV can be a very distressing event for a survivor. Every survivor should have access to supportive listeners in their families and communities, as well as additional GBV-focused services should they choose to access them. Often the first line of focused services will be through community-based organizations, in which trained GBV support workers provide case management and resiliency-based mental health care. Some survivors—typically a relatively small number—may require more targeted mental health care from an expert experienced in addressing GBV-related mental health issues (e.g. when survivors are not improving according to a care plan, or when case workers have reason to believe a survivor may be at risk of hurting themselves or someone else).

As part of care and support for people affected by GBV, the humanitarian community plays a crucial role in ensuring survivors gain access to GBV-focused community-based care services and, as necessary and available, more targeted mental health care provided by GBV and trauma care experts. Survivors may also wish to access legal/justice support and police protection. **Providing information to survivors in an ethical, safe and confidential manner about their rights and options to report risk and access care is presented throughout these Guidelines as a cross-cutting responsibility.** Humanitarian actors should work with GBV specialists to identify systems of care (i.e. referral pathways) that can be mobilized if a survivor reports exposure to GBV. Some humanitarian sectors—such as health and education—should have GBV-specialist staff integrated into their operations.

For all humanitarian personnel who engage with affected populations, it is important not only to be able to offer survivors up-to-date information about access to services, but also know and apply the principles of psychological first aid. Even without specific training in GBV case management, non-GBV specialists can go a long way in assisting survivors by responding to their disclosures in a supportive, non-stigmatizing, *survivor-centered* manner. (For more information about the survivor-centered approach, see “Guiding Principles” below).

Psychological first aid describes a humane, supportive response to a fellow human being who is suffering and who may need support. Providing PFA responsibly means to:

1. Respect safety, dignity and rights.
2. Adapt what you do to take account of the person’s culture.
3. Be aware of other emergency response measures.
4. Look after yourself.

PREPARE

- Learn about the crisis event.
- Learn about available services and supports.
- Learn about safety and security concerns.

(continued)



ESSENTIAL TO KNOW (continued)

The three basic action principles of PFA presented below – look, listen and link – can help humanitarian actors with how they view and safely enter a crisis situation, approach affected people and understand their needs, and link them with practical support and information.

LOOK	<ul style="list-style-type: none">• Check for safety.• Check for people with obvious urgent basic needs.• Check for people with serious distress reactions.	
LISTEN	<ul style="list-style-type: none">• Approach people who may need support.• Ask about people's needs and concerns.• Listen to people, and help them to feel calm.	
LINK	<ul style="list-style-type: none">• Help people address basic needs and access services.• Help people cope with problems.• Give information.• Connect people with loved ones and social support.	

The following chart identifies **ethical do's and don'ts in providing PFA**. These are offered as guidance to avoid causing further harm to the person; provide the best care possible; and act only in their best interest. These ethical do's and don'ts reinforce a survivor-centered approach. In all cases, humanitarian actors should offer help in ways that are most appropriate and comfortable to the people they are supporting, given the cultural context. In any situation where a humanitarian actor feels unsure about how to respond to a survivor in a safe, ethical and confidential manner, he/she should contact a GBV specialist for guidance.

Do's

- Be honest and trustworthy.
- Respect people's right to make their own decisions.
- Be aware of and set aside your own biases and prejudices.
- Make it clear to affected people that even if they refuse help now, they can still access help in the future.
- Respect privacy and keep the person's story confidential, if this is appropriate.
- Behave appropriately by considering the person's culture, age and gender.

Dont's

- Don't exploit your relationship as a helper.
- Don't ask the person for any money or favor for helping them.
- Don't make false promises or give false information.
- Don't exaggerate your skills.
- Don't force help on people and don't be intrusive or pushy.
- Don't pressure people to tell you their story.
- Don't share the person's story with others.
- Don't judge the person for their actions or feelings.

(Adapted from: **World Health Organization (WHO), War Trauma Foundation and World Vision International. 2011. Psychological First Aid: Guide for Field Workers**, pp. 53-55, http://www.who.int/mental_health/publications/guide_field_workers/en/; and **WHO. 2012. Mental health and psychosocial support for conflict-related sexual violence: 10 myths**, http://www.who.int/reproductivehealth/publications/violence/rhr12_17/en/. For more information on providing first-line support see **WHO. 2014. Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook**. Field-testing version. WHO/RHR/14.26. Geneva: WHO. <http://www.who.int/reproductivehealth/publications/violence/vaw-clinicalhandbook/en/index.html>)

Element 4: Coordination

Given its complexities, GBV is best addressed when multiple sectors, organizations and disciplines work together to create and implement unified prevention and mitigation strategies. In an emergency context, actors leading humanitarian interventions (e.g. the Office for the Coordination of Humanitarian Affairs; the Resident Coordinator/Humanitarian Coordinator; the Deputy Special Representative of the Secretary-General/Resident Coordinator/Humanitarian Coordinator; UNHCR; etc.) can facilitate coordination that ensures GBV-related issues are prioritized and dealt with in a timely manner. (For more information see “Essential Actions for Implementation of the Guidelines” in **Part One: Introduction.**) Effective coordination can strengthen accountability, prevent a “siloed” effect, and ensure that agency-specific and intra-sectoral GBV action plans are in line with those of other sectors, reinforcing a cross-sectoral approach.



ESSENTIAL TO KNOW

Office for the Coordination of Humanitarian Affairs (OCHA) and GBV

OCHA is responsible for bringing together humanitarian actors to ensure a coherent response to internally displaced persons (IDP) emergencies by coordinating “effective and principled humanitarian action in partnership with national and international actors”.

Each thematic area of these Guidelines includes specific recommendations for coordination related to GBV prevention and mitigation (and, for some sectors, response). As the coordinating body for the entire humanitarian response in IDP settings, it is OCHA’s responsibility to promote and provide opportunities for this coordination to occur, for example by:

- Including GBV as an agenda item of Inter-Cluster Working Groups (ICWG) and Humanitarian Country Team (HCT) meetings.
- Highlighting clusters’ GBV prevention/risk mitigation efforts in OCHA publications.
- Encouraging partners to utilize a GBV lens for their data analysis and reporting (e.g. in inter-sectoral assessments, situation reports, etc.).
- Ensuring that the Information Management Network (IMN) includes GBV experts to facilitate analysis of service gaps for GBV survivors.
- Bringing GBV-related issues or concerns raised in sector-specific or multi-sectoral assessments to the attention of the GBV coordination mechanism for follow-up.
- Ensuring a minimum level of training across the entire humanitarian response (i.e. sector actors should be trained on these Guidelines in order to develop action plans for implementing programming recommendations).

(For more information on OCHA’s role in Coordination, see <http://www.unocha.org/what-we-do/coordination/overview>. For information on leadership and coordination mechanisms in settings with refugees, IDPs and other affected groups, see **UNHCR & OCHA. 2014. Joint UNHCR-OCHA Note on Mixed Situations: Coordination in Practice**, <http://www.unhcr.org/53679e679.pdf>)

Each thematic area provides guidance on key GBV-related areas for cross-sectoral coordination. This guidance targets NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies, national and local governments, and humanitarian coordination leadership—such as line ministries, humanitarian coordinators, sector coordinators and donors. Leaders of sector-specific coordination mechanisms should also undertake the following:

- ▶ Put in place mechanisms for regularly addressing GBV at sector coordination meetings, such as including GBV issues as a regular agenda item and soliciting the involvement of GBV specialists in relevant sector coordination activities.
- ▶ Coordinate and consult with gender specialists and, where appropriate, diversity specialists or networks (e.g. disability, LGBTI, older persons, etc.) to ensure specific issues of vulnerability—which may otherwise be overlooked—are adequately represented and addressed.



- ▶ Develop monitoring systems that allow sectors to track their own GBV-related activities (e.g. include GBV-related activities in the sector's 3/4/5W form used to map out actors, activities and geographic coverage).
- ▶ Submit joint proposals for funding to ensure that GBV has been adequately addressed in the sector programming response.
- ▶ Develop and implement sector work plans with clear milestones that include GBV-related inter-agency actions.
- ▶ Support the development and implementation of sector-wide policies, protocols and other tools that integrate GBV prevention and mitigation (and, for some sectors, response).
- ▶ Form strategic partnerships and networks to conduct advocacy for improved programming and to meet the responsibilities set out in these Guidelines (with due caution regarding the safety and security risks for humanitarian actors, survivors, and those at risk of GBV who speak publicly about the problem of GBV).

! ESSENTIAL TO KNOW

Accessing the Support of GBV Specialists

Sector coordinators and sector actors should identify and work with the chair (and co-chair) of the GBV coordination mechanism where one exists. They should also encourage a sector focal point to participate in GBV coordination meetings, and encourage the GBV chair/co-chair (or other GBV coordination group member) to participate in the sector coordination meetings. Whenever necessary, sector coordinators and sector actors should seek out the expertise of GBV specialists to assist with implementing the recommendations presented in these guidelines.

GBV specialists can ensure the integration of protection principles and GBV risk reduction strategies into ongoing humanitarian programming. These specialists can advise, assist and support coordination efforts through specific activities, such as:

- Conducting GBV-specific assessments.
- Ensuring appropriate services are in place for survivors.
- Developing referral systems and pathways.
- Providing case management for GBV survivors.
- Developing trainings for sector actors on gender, GBV and women's/human rights, and how to respectfully and supportively engage with survivors.

However, GBV experts neither can nor should have specialized knowledge of each 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 actors are relevant and feasible within the sectoral response.

In settings where the GBV coordination mechanism is not active, sector coordinators and sector actors should seek support from local actors with GBV-related expertise (e.g. social workers, women's groups, protection officers, child protection specialists, etc.) as well as the Global GBV AoR. (Relevant contacts are provided on the GBV AoR website, www.gbvaor.net)



! ESSENTIAL TO KNOW

Advocacy

Advocacy is the deliberate and strategic use of information – by individuals or groups of individuals – to bring about positive change at the local, national and international levels. By working with GBV specialists and a wide range of partners, humanitarian actors can help promote awareness of GBV and ensure safe, ethical and effective interventions. They can highlight specific GBV issues in a particular setting through the use of effective communication strategies and different types of products, platforms and channels, such as: press releases, publications, maps and media interviews; different web and social media platforms; multimedia products using video, photography and graphics; awareness-raising campaigns; and essential information channels for affected populations. All communication strategies must adhere to standards of confidentiality and data protection when using stories, images, or photographs of survivors for advocacy purposes.

(Adapted from **IRC. 2011. GBV Emergency Response and Preparedness Participant Handbook**, p. 93 . http://cpwg.net/resources/irc-2011-gbv_erp_participant_handbook_-_revised/)



Element 5: Monitoring and Evaluation

Monitoring and evaluation (M&E) is a critical tool for planning, budgeting resources, measuring performance and improving future humanitarian response. Continuous **routine monitoring** ensures that effective programmes are maintained and accountability to all stakeholders—especially affected populations—is improved. **Periodic evaluations** supplement monitoring

data by analyzing in greater depth the strengths and weakness of implemented activities, and by measuring improved outcomes in the knowledge, attitudes and behavior of affected populations and humanitarian workers. Implementing partners and donors can use the information gathered through M&E to share lessons learned among field colleagues and the wider humanitarian community. These Guidelines primarily focus on indicators that strengthen programme monitoring to avoid the collection of GBV incident data and more resource-intensive evaluations. (For general information on M&E, see resources available to guide real-time and final programme evaluations such as ALNAP's *Evaluating Humanitarian Action Guide*, <http://www.alnap.org/eha>. For GBV-specific resources on M&E, see **Annex 1**.)

Each thematic area includes a *non-exhaustive* set of indicators for monitoring and evaluating the recommended activities at each phase of the programme cycle. Most indicators have been designed so they can be incorporated into *existing* sectoral M&E tools and processes, in order to improve information collection and analysis without the need for additional data collection mechanisms. Humanitarian actors should select indicators and set appropriate targets prior to the start of an activity and adjust them to meet the needs of the target population as the project progresses. There are suggestions for collecting both quantitative data (through surveys and 3/4/5W matrices) and qualitative data (through focus group discussions, key informant interviews, and other qualitative methods). Qualitative information helps to gather greater depth on participants' perceptions of programmes. Some indicators require a mix of qualitative and quantitative data to better understand the quality and effectiveness of programmes.



ESSENTIAL TO KNOW

GBV Case Reporting

For a number of safety, ethical and practical reasons, these Guidelines do not recommend using the number of reported cases (either increase or decrease) as an indicator of success. As a general rule, GBV specialists or those trained on GBV research should undertake data collection on cases of GBV.



ESSENTIAL TO KNOW

Ethical Considerations

Though GBV-related data presents a complex set of challenges, the indicators in these Guidelines are designed so that the information can be safely and ethically collected and reported by humanitarian actors who do not have extensive GBV expertise. However, **it is the responsibility of all humanitarian actors to ensure safety, confidentiality, and informed consent when collecting or sharing data data**. See above, "Element 1: Assessment, Analysis and Planning" for further information.

It is crucial that the data not only be collected and reported, but also analyzed with the goal of identifying where modifications may be beneficial. In this regard, sometimes "failing" to meet a target can provide some of the most valuable opportunities for learning. For example, if a sector has aimed for 50% female participation in assessments but falls short of reaching that target, they may consider changing the time and/or location of the consultations, or speaking with the affected community to better understand the barriers to female participation. The knowledge gained through this process has the potential to strengthen sectors'



interventions even beyond the actions taken related to GBV. Therefore, indicators should be analyzed and reported by the relevant sector(s) using a ‘**GBV lens**’. This involves considering the ways in which all information—including information that may not seem ‘GBV-related’—could have implications for GBV prevention and mitigation (and, for some sectors, response).

Lastly, humanitarian actors should disaggregate indicators by sex, age, disability and other relevant vulnerability factors to improve the quality of the information they collect and to deliver programmes more equitably and efficiently. See “Key Considerations for At-Risk Groups” in **Part One: Introduction** for more information on vulnerability factors.



ESSENTIAL TO KNOW

Example of Conducting M&E and Data Analysis Using a ‘GBV Lens’

The education sector has designed a learning space for boys and girls from displaced communities. The success of the programme is monitored by collecting data on a suggested indicator from the GBV Guidelines and OCHA Humanitarian Indicator Registry: *Emergency affected boys and girls attending learning spaces/schools in affected areas*. The indicator is defined below:

$$\frac{\# \text{ of females attending learning spaces/schools in affected areas}}{\# \text{ of males attending learning spaces/schools in affected areas}}$$

The results are disaggregated by age group (5-13 and 14-18). Using a ‘GBV lens’ to report and act on the findings of this indicator would involve considering the underlying differences for boys and girls of different ages who are not attending learning spaces, and whether these differences might be related to GBV. For example, an early dropout rate of adolescent girls may result from early marriage, domestic responsibilities, or unsafe routes that discourage parents from sending their girls to school. Discovering a disparity in attendance between girls and boys can lead to further investigation about some of the GBV-related causes of those disparities.

2. Guiding Principles and Approaches for Addressing GBV

The following principles are inextricably linked to the overarching humanitarian responsibility to provide protection and assistance to those affected by a crisis. They serve as the foundation for all humanitarian actors when planning and implementing GBV-related programming. These principles state that:

- ▶ GBV encompasses a wide range of human rights violations.
- ▶ Preventing and mitigating GBV involves promoting gender equality and promoting beliefs and norms that foster respectful, non-violent gender norms.
- ▶ 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 prevention.



ESSENTIAL TO KNOW

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 extremely complex. Humanitarian actors can reinforce the “do no harm” principle in their GBV-related work through careful attention to the survivor-centered, human rights-based, community-based and systems approaches described below.



These principles can be put into practice by applying the four essential and interrelated approaches described below.

1. Human Rights-Based Approach

A human rights-based approach seeks to analyze the root causes of problems and to redress discriminatory practices that impede humanitarian intervention. This approach is often contrasted with the needs-based approach, in which interventions aim to address practical, short-term emergency needs through service delivery. Although a needs-based approach includes affected populations in the process, it often stops short of addressing policies and regulations that can contribute to sustainable systemic change.

By contrast, the human rights-based approach views affected populations as “rights-holders”, and recognizes that these rights can only be realized by supporting the long-term empowerment of affected populations through sustainable solutions. This approach seeks to attend to rights as well as needs, and how those needs are determined and addressed is informed by legal and moral obligations and accountability. Humanitarian actors, along with states (where they are functioning), are seen as “duty-bearers” who are bound by their obligations to encourage, empower and assist “rights-holders” in claiming their rights. A human rights-based approach requires those who undertake GBV-related programming to:

- ▶ Assess the capacity of rights-holders to claim their rights (identifying the immediate, underlying and structural causes for non-realization of rights) and to participate in the development of solutions that affect their lives in a sustainable way.
- ▶ Assess the capacities and limitations of duty-bearers to fulfill their obligations.
- ▶ Develop sustainable strategies for building capacities and overcoming these limitations of duty-bearers.
- ▶ Monitor and evaluate both outcomes and processes, guided by human rights standards and principles and using participatory approaches.
- ▶ Ensure programming is informed by the recommendations of international human rights bodies and mechanisms.

2. Survivor-Centered Approach

A survivor-centered approach means that the survivor’s rights, needs and wishes are prioritized when designing and developing GBV-related programming. The illustration below contrasts survivor’s rights (in the left column) with the negative impacts a survivor experiences when the survivor-centered approach is not employed.

To be treated with dignity and respect	VS.	Victim-blaming attitudes
To choose		Feeling powerless
To privacy and confidentiality		Shame and stigma
To non-discrimination		Discrimination on the basis of gender, ethnicity, etc
To information		Being told what to do

(Excerpted from **GBV AoR. 2010. GBV Coordination Handbook (provisional edition)**, p. 20, <http://gbvaor.net/tools-resources/>)



The survivor-centered approach can guide professionals—regardless of their role—in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which a GBV survivor's **rights** are respected, **safety** is ensured, and the survivor is treated with **dignity** and **respect**. The approach helps to promote a survivor's recovery and strengthen his/her ability to identify and express needs and wishes; it also reinforces his/her capacity to make decisions about possible interventions (adapted from IASC Gender SWG and GBV AoR, 2010).



ESSENTIAL TO KNOW

Key Elements of the Survivor-Centered Approach for Promoting Ethical and Safety Standards

- 1) Safety:** The safety and security of the survivor and others, such as her/his children and people who have assisted her/him, must be the number one priority for all actors. Individuals who disclose an incident of GBV or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them.
- 2) Confidentiality:** Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment.
- 3) Respect:** The survivor is the primary actor, and the role of helpers is to facilitate recovery and provide resources for problem-solving. All actions taken should be guided by respect for the choices, wishes, rights, and dignity of the survivor.
- 4) Non-discrimination:** Survivors of violence should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation, or any other characteristic.

(Adapted from UNFPA. 2012. "Module 2" in *Managing Gender-based Violence Programmes in Emergencies, E-Learning Companion Guide*. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/GBV%20E-Learning%20Companion%20Guide_ENGLISH.pdf)

3. Community-Based Approach

A community-based approach insists that affected populations should be leaders and key partners in developing strategies related to their assistance and protection. From the earliest stage of the emergency, all those affected should "participate in making decisions that affect their lives" and have "a right to information and transparency" from those providing assistance. The community-based approach:

- ▶ Allows for a process of direct consultation and dialogue with all members of communities, including women, girls and other at risk groups.
- ▶ Engages groups who are often overlooked as active and equal partners in the assessment, design, implementation, monitoring and evaluation of assistance.
- ▶ Ensures all members of the community will be better protected, their capacity to identify and sustain solutions strengthened, and humanitarian resources used more effectively (adapted from UNHCR, 2008).

4. Systems Approach

Using a systems approach means analyzing GBV-related issues across an entire organization, sector and/or humanitarian system to come up with a combination of solutions most relevant to the context. The systems approach can be applied to introduce systemic changes



that improve GBV prevention and mitigation (and, for some sectors, response) efforts—both in the short-term and in the long-term. Humanitarian actors can apply a systems approach in order to:

- ▶ Strengthen agency/organizational/sectoral commitment to gender equality and GBV-related programming.
- ▶ Improve humanitarian actors' knowledge, attitudes and skills related to gender equality and GBV through sensitization and training.
- ▶ Reach out to organizations to address underlying causes that affect sector capacity to prevent and mitigate GBV, such as gender imbalance in staffing.
- ▶ Strengthen safety and security for those at risk of GBV through the implementation of infrastructure improvements and the development of GBV-related policies.
- ▶ Ensure adequate monitoring and evaluation of GBV-related programming (adapted from USAID, 2006).



ESSENTIAL TO KNOW

Conducting Trainings

Throughout these Guidelines, it is recommended that sector actors **work with GBV specialists to prepare and provide trainings on gender, GBV, and women's/human rights**. These trainings should be provided for a variety of stakeholders, including humanitarian actors, government actors, and community members. Such trainings are essential not only for implementing effective GBV-related programming, but also for engaging with and influencing cultural norms that contribute to the perpetuation of GBV. Where GBV specialists are not available in-country, sector actors can liaise with the Global GBV Area of Responsibility (gbvaor.net) for support in preparing and providing trainings. Sector actors should also:

- Research relevant sector-specific training tools that have already been developed, prioritizing tools that have been developed in-country (e.g. local referral mechanisms, standard operating procedures, tip sheets, etc.).
- Consider the communication and literacy abilities of the target populations, and tailor the trainings accordingly.
- Ensure all trainings are conducted in local language(s) and that training tools are similarly translated.
- Ensure that non-national training facilitators work with national co-facilitators wherever possible.
- Balance awareness of cultural and religious sensitivities with maximizing protections for women, girls and other at-risk groups.
- Seek ways to provide ongoing monitoring and mentoring/technical support (in addition to training), to ensure sustainable knowledge transfer and improved expertise in GBV.

(For existing sector-specific training tools on GBV, see the “Resources” page in each thematic area. For a general list of GBV-specific training tools, see **Annex 1**.)

Additional Citations

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<http://www.unicefinemergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf>

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PART THREE: THEMATIC AREA GUIDANCE



CAMP COORDINATION AND CAMP MANAGEMENT



THIS SECTION APPLIES TO:

- Camp coordination and camp management (CCCM) coordination mechanisms
- Actors involved in camp administration (CA), camp coordination (CC) and camp management (CM): NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, older persons, etc.) related to CCCM
- Displaced populations
- Other CCCM stakeholders, including national and local governments, community leaders, and civil society groups

Why Addressing Gender-based Violence is a Critical Concern of the Camp Coordination and Camp Management Sector

Camp managers, coordinators and administrators all share the responsibility of ensuring the safety and security of affected populations during the entire life cycle of a site¹: from planning and set-up, to care and maintenance, and through to site closure and longer-term solutions for affected populations. Poorly planned camp coordination and camp management (CCCM) processes can heighten risks of GBV in many ways:

- ▶ **Registration procedures** which rely only on household registration may exclude some individuals from accessing resources, in turn increasing their risk of exploitation and abuse. Women may become dependent on male family members for access to food, assistance or

WHAT THE SPHERE HANDBOOK SAYS:

Standard 1: Strategic Planning

- ▶ Shelter and settlement strategies contribute to the security, safety, health and well-being of both displaced and non-displaced affected populations, and promote recovery and reconstruction where possible.

Guidance Note #7: Risk, Vulnerability and Hazard Assessments:

- ▶ Actual or potential security threats and the unique risks and vulnerabilities due to age, gender [including GBV], disability, social or economic status, the dependence of affected populations on natural environmental resources, and the relationships between affected populations and any host communities should be included in any such assessments.

(Sphere Project. 2011. *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*, <http://www.spheredproject.org/resources/download-publications/?search=1&keywords=&language=English&category=22>)

¹ The term “site” is used throughout this section to apply to a variety of camps and camp-like settings including planned camps, self-settled camps, reception and transit centers, collective centers and spontaneous settlements. Ideally, sites are selected and camps are planned before the controlled arrival of the displaced population. In most cases, however, the sector lead and camp management agencies will arrive on the scene—along with other actors—to find populations already settled and coping in whatever ways they can. The following guidance tries to capture this reality (though not all of it will apply to spontaneous settlements).



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery throughout

ASSESSMENT, ANALYSIS AND PLANNING

Promote the active participation of women, girls and other at-risk groups within the affected population in all CCCM assessment processes

Analyse the physical safety in and around sites as it relates to risks of GBV (e.g. adherence to Sphere standards; lighting; need for women-, adolescent- and safety of water and distribution sites and whether they accommodate the specific needs of women, girls and other at-risk groups; accessibility for persons with disabilities; etc.)

Assess the level of participation and leadership of women, adolescent girls and other at-risk groups in all aspects of site governance and CCCM programme and executive boards; etc.)

Analyse whether IDP/refugee registration and profiling are conducted in a manner that respects the rights and needs of women and other at-risk groups, and

Assess awareness of CCCM staff and stakeholders on basic issues related to gender, GBV, and women's/human rights (*including knowledge of where survivors reduction; etc.*)

Review existing/proposed community outreach material related to CCCM—specifically communicating with communities (CwC) and feedback mechanisms (*where to report risk and how to access care*)

RESOURCE MOBILIZATION

Identify and pre-position age-, gender-, and culturally-appropriate supplies for CCCM that can mitigate risk of GBV (e.g. lighting/torches, partitions where

Develop CCCM proposals that reflect awareness of GBV risks for the affected population and strategies for reducing these risks

Prepare and provide trainings for government, humanitarian workers and volunteers engaged in CCCM work on safe design and implementation of CCCM p

IMPLEMENTATION

► Programming

Involve women, adolescent girls and other at-risk groups as staff and leaders in site governance mechanisms and community decision-making structures that reduce risk or increases the risk of GBV)

Prioritize GBV risk reduction activities in camp planning and set-up (e.g. confidential and non-stigmatizing registration; safety of sleeping areas; use of partici

Prioritize GBV risk reduction and mitigation strategies during the care and maintenance phase of the camp lifecycle (e.g. undertake frequent and regular checks

Support the role of law enforcement and security patrols to prevent and respond to GBV in and around sites throughout the entire camp lifecycle (e.g. advocate options with the community; etc.)

Integrate GBV prevention and mitigation into camp closure (e.g. closely monitor GBV risks for returning/resettling/residual populations; work with GBV speciali

► Policies

Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of CCCM programmes (e.g. procedures for food and r sharing protected or confidential information about GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exp

Advocate for the integration of GBV risk-reduction strategies into national and local policies and plans related to CCCM, and allocate funding for sustainability personnel; develop camp closure and exit strategies that take GBV-related risks into consideration; etc.)

► Communications and Information Sharing

Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure CCCM staff has th

Ensure that CCCM programmes sharing information about reports of GBV within the CCCM sector or with partners in the larger humanitarian community a pose a security risk to individual survivors, their families or the broader community)

Incorporate GBV messages (*including prevention, where to report risk and how to access care*) into CCCM-related community outreach and awareness-raising a

COORDINATION

Ensure GBV risk reduction is a regular item on the agenda in all CCCM-related coordination mechanisms

Undertake coordination with other sectors address GBV risks and ensure protection for women, girls and other at-risk groups

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a CCCM focal point to regularly participate in GBV coordi

MONITORING AND EVALUATION

Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduc

Evaluate GBV risk reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making a

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for CCCM actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**.

at the Programme Cycle

	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
and child-friendly spaces; when, where, how and by whom security patrols are conducted; etc.)	✓	✓	✓	✓
(e.g. ratio of male/female CCCM staff; participation in site committees, governance bodies, etc.)	✓	✓	✓	✓
s well as of GBV survivors		✓	✓	✓
survivors can report risk and access care; linkages between CCCM programming and GBV risk	✓	✓	✓	✓
s—to ensure it includes basic information about GBV risk reduction (including prevention, etc.)	✓	✓	✓	✓
appropriate)	✓	✓		
programming that mitigates risks of GBV	✓	✓	✓	✓
Throughout the entire lifecycle of the camp (with due caution where this poses a potential security risk)	✓	✓	✓	✓
ons for privacy; designated areas for women-, adolescent- and child-friendly spaces; etc.)	✓	✓		
ks on site security; create complaint and feedback mechanisms for community; etc.)		✓	✓	✓
e for adequate numbers of properly trained personnel; work to identify the best safety patrol	✓	✓	✓	✓
sts to ensure continued delivery of services to GBV survivors who are exiting camps; etc.)		✓	✓	✓
non-food item distribution; housing policies for at-risk groups; procedures and protocols for protection and abuse; etc.)	✓	✓	✓	✓
(e.g. develop or strengthen policies related to the allocation of law enforcement and security		✓	✓	✓
The basic skills to provide them with information where they can obtain support	✓	✓	✓	✓
abide by safety and ethical standards (e.g. shared information does not reveal the identity of or	✓	✓	✓	✓
activities		✓	✓	✓
ation meetings	✓	✓	✓	✓
	✓	✓	✓	✓
	✓	✓	✓	✓
Induction activities throughout the programme cycle	✓	✓	✓	✓
nd ensure accountability		✓	✓	✓



ESSENTIAL TO KNOW

Defining “CCCM”

There are typically three distinct but interrelated areas of camp response. **Camp administration** refers to the functions carried out by governments and national (civilian) authorities that relate to the supervision and oversight of activities in camps and camp-like settings. **Camp coordination** refers to the creation of the humanitarian space necessary for the effective delivery of protection and assistance. **Camp management** refers to holistic responses that ensure the provision of assistance and protection to the displaced. These responses occur at the level of a single camp and entail coordinating protection and services; establishing governance and community participation; ensuring maintenance of camp infrastructure; collecting and sharing data; monitoring the standards of services; and identifying gaps in services. Various national authorities, humanitarian agencies, community volunteers and civil society stakeholders will be involved in camp responses.

(Adapted from NRC. 2008. *Camp Management Toolkit*, “Chapter 10: Prevention of and Response to Gender-Based Violence”, <http://www.globalccmcluster.org/tools-and-guidance/publications/campmanagement-toolkit>)

essential services—or have no access at all. Girls and boys who are not registered are at greater risk of separation from their families, as well as trafficking for sexual exploitation or forced/domestic labor and other forms of violence. Unregistered girls are more vulnerable to child marriage. Single women, women- and child-headed households, persons with disabilities and other at-risk groups² who arrive and register after a site has been established may be further marginalized by being placed on the outskirts of formal sites, potentially exposing them to sexual assault.

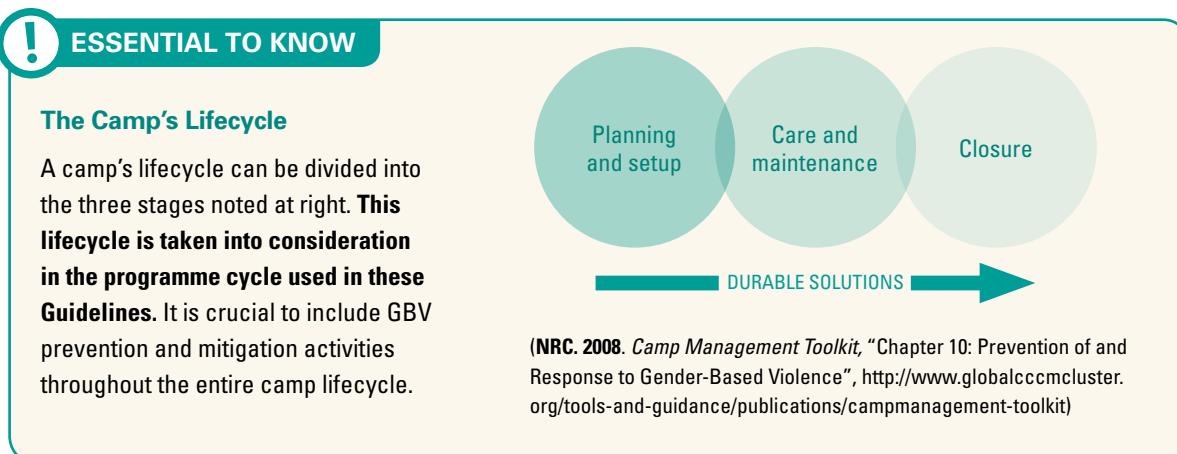
- ▶ Where **access to services such as food, shelter, and non-food items (NFIs)** is inadequate, women and girls are most often tasked with finding fuel and food outside of secure areas, which can expose them to assault and abduction. Distribution systems that do not take into consideration the needs of at-risk groups such as LGBTI persons can lead to their exclusion, in turn increasing their vulnerability to exploitation and other forms of violence.
- ▶ **Poorly lit and inaccessible areas, as well as ill-considered placement or design of site-related services** (such as shelter and sanitation facilities and food/cash/voucher distribution sites) can increase incidents of GBV.
- ▶ Risks of GBV can be compounded by **overcrowding and lack of privacy**. In multi-family tents and multi-household dwellings, lack of doors and partitions for sleeping and changing clothes can increase exposure to sexual harassment and assault. Tensions linked to overcrowding may lead to an escalation of intimate partner violence and other forms of domestic violence.
- ▶ As displacement continues, **scarcity of local land and natural resources** (such as food, water and fuel) may exacerbate community violence as well as problems such as child labor, forced labor and sexual exploitation. Women, girls and other at-risk groups may be abducted or coerced to leave sites, tricked by traffickers when seeking livelihood opportunities, or forced to trade sex or other favors for basic items and materials.

² For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



Well-designed camps and camp-like settings help to reduce exposure to GBV, improve quality of life, and ensure dignity of displaced populations. Camps should be designed to ensure delivery of and equitable access to services and protection. Proper identification of persons at risk, as well as effective management of information, space, and service provision (through data collection and monitoring systems such as registration and the Displacement Tracing Matrix) are also key to GBV prevention. By considering the natural resources of the area during camp set up and site selection, advocating for adequate and appropriate assistance, and developing livelihoods opportunities during the care and maintenance phase of camp life, CCCM actors can further mitigate the risk of GBV.

Camp management implies a holistic and cross-cutting response. Actions taken by the CCCM sector to prevent and mitigate GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. CCCM actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)



Addressing Gender-based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by CCCM actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with CCCM actors working in partnership with other sectors as well as with GBV specialists.

The information generated from these areas of inquiry should be analyzed to inform planning of CCCM programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.



KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in CCCM: local and national governments; site managers and coordinators; local police, security forces and peacekeepers responsible for providing protection to camp populations; civil societies; displaced populations; GBV, gender and diversity specialists
- Camp service providers: shelter, settlement and recovery; water, sanitation and hygiene; health; food assistance; protection; etc.
- Affected populations and communities
- In IDP/refugee settings, members of receptor/host communities
- In urban settings and locations where camps or camp-like situations are set up by communities: local and municipal authorities, civil society organisations, development actors, health administrators, school boards, private businesses, etc.

POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to CCCM PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female CCCM staff, including in positions of leadership?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are women and other at-risk groups actively involved in community-based camp governance structures (*e.g. community management structures, site committees, governing bodies, etc.*)? Are they in leadership roles when possible?
- c) Are the lead actors in CCCM response aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation strategies into their activities?

Physical Safety in and around Sites

- d) Is site and shelter selection made in consultation with representatives of the affected population, including women, girls and other at-risk groups? Have safety issues been considered when selecting site locations so that camps do not exacerbate GBV vulnerabilities (*e.g. proximity to borders that may increase risk of abduction and trafficking, particularly for women and girls*)?
- e) Have safety and privacy been considered at the camp planning and set-up stage (*e.g. through the provision of intrusion-resistant materials, doors and windows that lock, etc.*)? Are Sphere standards for space and density being met to avoid overcrowding?
- f) Is lighting sufficient throughout the site, particularly in areas at high risk of GBV?
- g) Is the construction or renovation of shelters and other infrastructure done according to standards of universal design and/or reasonable accommodation³ to ensure accessibility for all persons, including those with disabilities (*e.g. physical disabilities, injuries, visual or other sensory impairments, etc.*)?
- h) Are there any existing safe shelters that can provide immediate protection for GBV survivors and those at risk? If not, have safe shelters been considered at the camp planning and set-up stage?
- i) Have women-, adolescent- and child-friendly spaces been considered at the camp planning and set-up stage as a way of facilitating access to care and support for survivors and those at risk of GBV?
- j) Are persons working within the site clearly identified in a manner that local populations can understand (*e.g. with name tags/logos/t-shirts*) to help prevent sexual exploitation and abuse and /or facilitate reporting? Are there any security issues related to being identified as staff?
- k) Are safety audits of GBV risks regularly undertaken in and around the site (preferably multiple times of the day and night)?
 - Is there a system for follow-up on GBV issues and danger zones identified during the audits?
 - Are the findings shared with the appropriate GBV and protection partners, as well as other humanitarian actors?
- l) Do women, girls, and other at-risk groups face risks of harassment, sexual assault, kidnapping, or other forms of violence when accessing water, fuel or distribution sites?

(continued)

³ For more information regarding universal design and/or reasonable accommodation, see definitions in Annex 4.



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

- m) Do security personnel regularly patrol the site, including water and fuel collection areas?
- Are both women and men represented in the security patrols?
 - Do security patrol personnel receive GBV prevention and response training?

Registration and Profiling

- n) Are married women, single women, single men, and girls and boys without family members registered individually? Are individuals with different gender identities able to register in a safe and non-stigmatizing way?
- o) Do registration/greeting/transit centers have separate spaces for confidentially speaking with those who may be at particular risk of GBV or those who have disclosed violence?
- Are focal persons and/or GBV specialists available at registration/greeting/transit centers to expedite registration process for survivors and those at risk, and provide them with information on where to access care and support?

Areas related to CCCM POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of CCCM programmes?
- Are women, girls and other at-risk groups meaningfully engaged in the development of CCCM policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Has the camp management agency communicated these policies, standards and guidelines to women, girls, boys and men (separately when necessary)?
 - Is CCCM staff properly trained and equipped with the necessary skills to implement these policies?
- b) Do national and local CCCM policies and plans advocate for the integration of GBV-related risk reduction strategies? Is funding allocated for sustainability of these strategies?
- In situations of cyclical natural disasters, is there a policy provision for a GBV specialist to advise the government on CCCM-related GBV risk-reduction?
 - Are there policies about where and how to establish sites?
 - Are there policies or standards on the construction of women-, adolescent- and child-friendly spaces from the onset of an emergency?
 - Are there policies about the allocation of security/law enforcement personnel to camps and their training in GBV?
 - Do camp closure and exit strategies take GBV-related risks into consideration?

Areas related to CCCM COMMUNICATIONS and INFORMATION SHARING

- a) Has training been provided to CCCM staff and stakeholders on:
- Issues of gender, GBV, and women's/human rights?
 - How to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- b) Do CCCM-related community outreach activities—specifically communicating with communities (CwC) and feedback mechanisms—raise awareness within the community about general safety and GBV risk reduction?
- Does this awareness-raising include information on survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Is this information provided in age-, gender- and culturally appropriate ways?
 - Are males, particularly leaders in the community, engaged in these activities as agents of change?
- c) Are GBV-related messages (especially how to report risk and where to access care) placed in visible and accessible locations (*e.g. greeting/reception centers for new arrivals; evacuation centers; day care centers; schools; local government offices; health facilities; etc.*)?
- d) Are discussion forums on CCCM age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.*) so that participants feel safe to raise GBV issues?





KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for CCCM programming. Whether requesting pre-/emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**.

Two: Background to Thematic Area Guidance. Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under "Coordination" below.

A.

HUMANITARIAN NEEDS OVERVIEW

- ▶ Does the proposal articulate the GBV-related safety risks, protection needs and rights of the affected population as they relate to the site (*e.g. single women living on the perimeter of sites; collective centers without partitions; threats posed by armed groups or criminal activity in and around the site; attitudes of humanitarian staff that may contribute to discrimination against women, girls and other at-risk groups; etc.*)?
- ▶ Are risks for specific forms of GBV (*such as sexual assault, forced and/or coerced prostitution, child and/or forced marriage, intimate partner violence and other forms of domestic violence*) described and analysed, rather than a broader reference to "GBV"?

B.

PROJECT RATIONALE/JUSTIFICATION

- ▶ When drafting a proposal for emergency preparedness:
 - Is there a strategy for integrating GBV into preparedness trainings for site managers and coordinators?
 - Is there a strategy for preparing and providing trainings for government, CCCM staff and camp governance groups on the safe design and implementation of CCCM programming that mitigates the risk of GBV?
 - Is there a plan to ensure that site identification and negotiation takes into account GBV risks and prevention strategies?
 - Are additional costs required to ensure that construction and renovation of infrastructure adhere to standards of universal design and/or reasonable accommodation?
 - Are additional costs required to pre-position GBV risk-reduction supplies (*e.g. lighting; torches; partitions; intrusion-resistant materials; etc.*)?
 - Are additional costs required to ensure any GBV-related community outreach materials will be available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- ▶ When drafting a proposal for emergency response:
 - Is there a clear description of how camp management will prevent and mitigate GBV (*e.g. providing separate, confidential and non-stigmatizing registration areas for survivors and those at risk of GBV; establishing women-, adolescent- and child-friendly spaces; ensuring adequate lighting in high risk areas; conducting regular monitoring of sites; etc.*)?

(continued)

B.

PROJECT RATIONALE/ JUSTIFICATION (continued)

- Are additional costs required to ensure the safety and effective working environments for female staff in the CCCM sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
- ▶ When drafting a proposal for camp closure and durable solutions:
 - Is there an explanation of how the project will contribute to sustainable strategies that promote the safety and well-being of those at risk of GBV, and to long-term efforts to reduce specific types of GBV (*e.g. consultations with women, girls, men and boys prior to and during site closure and exit processes*)?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

C.

PROJECT DESCRIPTION

- ▶ Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for integrating GBV-related work?
- ▶ Do the proposed activities illustrate linkages with other humanitarian actors/sectors in order to maximize resources and work in strategic ways?
- ▶ Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as CCCM staff and in camp governance structures and camp committees?



KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some common GBV-related considerations when implementing CCCM interventions in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

Integrating GBV Risk Reduction into: CCCM PROGRAMMING

- 1. Involve, women, adolescent girls and other at-risk groups as staff and leaders in site governance mechanisms and community decision-making structures throughout the entire lifecycle of the camp (with due caution in situations where this poses a potential security risk or increases the risk of GBV).⁴**
 - ▶ Strive for 50% representation of females within CCCM programme staff. Provide them with formal and on-the-job training as well as targeted support to assume leadership and training positions.
 - ▶ Ensure women (and where appropriate, adolescent girls) are actively involved in CCCM committees and management groups. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.

⁴ Note: CCCM does not hire camp populations.



- ▶ Employ persons from at-risk groups in CCCM staff, leadership and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.
- ▶ Support women, adolescent girls and other at-risk groups in identifying and speaking out about factors that may increase the risk of GBV in sites (e.g. factors related to site management; security; shelter; availability of and access to resources such as food, fuel, water and sanitation; referral services; etc.). *Link with GBV specialists to ensure that this is done in a safe and ethical manner.*

2. Prioritize GBV risk-reduction activities in camp planning and set-up.

- ▶ Consider safety issues when selecting site locations so that camps do not exacerbate GBV vulnerabilities (e.g. proximity to national borders; competition for natural resources; etc.).
- ▶ Adhere to (and when possible, exceed) Sphere standards to reduce overcrowding, which can add to family stress and increase the risk of intimate partner violence and other forms of domestic violence.
- ▶ Improve safety and privacy in non-collective sleeping areas through the provision of intrusion-resistant materials, doors and windows that lock, and—where culturally appropriate—internal partitions.
- ▶ Where collective centers are the only option, put in place appropriate family and sex-segregated partitions (paying due attention to the rights and needs of LGBTI persons who may make up non-traditional family structures and/or be excluded from sex-segregated spaces).
- ▶ Ensure adequate lighting in all public and communal areas and in all areas deemed to be high risk for GBV. Camp management agencies should prioritize the installation of appropriate lighting in and around toilets, latrines and bathhouses.



ESSENTIAL TO KNOW

Camp Management Agency

Camp management operates at the level of a single camp. The Camp Management Agency, often present from the early phases of an emergency, responds to the changing needs of a dynamic camp environment. Due to its steady presence and leadership role in the camp, the Camp Management Agency shares a responsibility to ensure that conditions within the camp minimise the risk of GBV for all vulnerable populations, particularly women and girls. This means:

- Ensuring that the camp is designed and laid out in consultation with women, adolescent girls (where appropriate) and other at-risk groups.
- Consistently and meaningfully involving those at risk of GBV in all decisions—throughout the camp lifecycle—that effect the daily management of the camp and the delivery of assistance and services.
- Ensuring all Camp Management Agency staff are trained in GBV guiding principles and equipped to use tools such as observation-based safety audits and community mapping.
- Using these tools to regularly monitor safety concerns and ensure the security, dignity, and access to services and resources of all at-risk groups.

(Adapted from **NRC. 2008. Camp Management Toolkit**, "Chapter 10: Prevention of and Response to Gender-Based Violence", <http://www.globalccmcluster.org/tools-and-guidance/publications/campmanagement-toolkit>)



- ▶ Designate the use of women-, adolescent- and child-friendly spaces during camp planning and set up. Where safe shelters have been deemed appropriate, work with GBV and child protection specialists to designate and plan for their placement.
- ▶ Consider separate, confidential and non-stigmatizing spaces in registration, greeting and transit centers for engaging with those who may have been exposed to or are at risk of GBV. Ensure reception areas for new arrivals are equipped with a GBV specialist or with a focal point person who can provide referrals for immediate care of survivors (including those who disclose violence that occurred prior to flight or in transit and/or those encountering ongoing violence).
- ▶ Consider the natural resource base of the area during camp planning and site selection, as well as opportunities for sustainable livelihoods opportunities. This can help mitigate the depletion of natural resources such as food, water, land and fuel, which can in turn contribute to GBV.
- ▶ Consider—from the planning phase—durable solutions/exit strategies for camp closure that integrate GBV prevention and mitigation.



ESSENTIAL TO KNOW

Safe Shelters and Women-, Adolescent- and Child-Friendly Spaces

The term “**safe shelter**” is used throughout the Guidelines to refer to any physical space or network of spaces that exclusively or incidentally offers temporary safety to individuals fleeing harm. A variety of terms—such as “safe house” or “protection/safe haven”—are used to refer to shelters. When introducing safe shelters for affected populations:

- Consider whether safety is best achieved by making the safe shelter visible or keeping it concealed.
- Promote community buy-in, especially in camp settings.
- Ensure the security of both residents and staff.
- Provide support for both residents and staff.
- Explore and develop a diversity of shelter options.
- Identify and close safety gaps.
- Assess macro-level barriers to, and implications of, safe shelter in displacement settings.
- Evaluate programme impact.

(Adapted from **Seelinger, K.T., and Freccero, J. 2013. Safe Haven. Sheltering Displaced Persons from Sexual and Gender-Based Violence. Comparative Report.** Human Rights Center Sexual Violence Program, University of California, Berkeley, School of Law, <http://www.unhcr.org/51b6e1ff9.pdf>)

“**Women-friendly spaces**” are safe and non-stigmatizing locations where women may conduct a variety of activities, such as breastfeed their children, learn about nutrition, and discuss issues related to well-being (e.g. women’s rights, sexual and reproductive health, GBV, etc.). Ideally, these spaces also include counseling services (which may incorporate counseling for GBV survivors) to help women cope with their situation and prepare them for eventual return to their communities. Women-friendly spaces may also be a venue for livelihood activities.

“**Child-friendly spaces**” and “**Adolescent-friendly spaces**” are safe and nurturing environments in which children and/or adolescents can access free and structured play, recreation, leisure and learning activities.

(**Child Protection Working Group. 2012. Minimum Standards for Child Protection in Humanitarian Action.** <http://cpwg.net/minimum-standards/>. For additional information on child-friendly spaces see: **Global Protection Cluster, IASC Mental Health and Psychosocial Support Reference Group, Global Education Cluster, and International Network of Education in Emergencies. 2011. Guidelines for Child Friendly Spaces in Emergencies.** http://www.unicef.org/protection/Child_Friendly_Spaces_Guidelines_for_Field_Testing.pdf)





PROMISING PRACTICE

In June/July 2011, regular influxes of new refugees from Somalia began arriving in Dadaab in northeastern Kenya, overwhelming the four existing camps that had been housing refugees since 1991. Many newly arrived women and girls were living on the outskirts, distant from the protection of official camp borders and infrastructure and with limited access to aid. In the absence of key services such as latrines, women and children made frequent trips into the surrounding bush and were exposed to attacks from armed men. The number of GBV incidents reported to the International Rescue Committee (IRC) nearly tripled.

The IRC team worked with UNHCR to identify safe entry points for support for GBV survivors and at-risk groups. Female psychosocial officers and female refugee staff were placed within the reception center to identify those with particular vulnerabilities (such as female heads of households, unaccompanied minors, etc.). Once these persons were identified they were fast-tracked for registration and provided with immediate support, crisis counseling, and information on GBV and camp services. The female psychosocial officers and refugee staff were also available to accompany survivors to the hospital for clinical management of rape and other services as needed. In addition, women and girls were provided with dignity kits at the reception centers.

(Information provided by IRC's Women's Protection & Empowerment Team in Dadaab, Personal Communication, May 19, 2013)

3. Prioritize GBV risk reduction and mitigation strategies during the care and maintenance phase of the camp lifecycle.

- Regularly check on site security and the well-being of women, girls and other at-risk groups to ensure they are safe from assault, exploitation and harassment (e.g. through site observation; site safety mapping; consultations with women's groups/leaders; etc.). Ensure that camp/site management staff make regular visits—preferably multiple times of the day and night—to monitor:
 - Known danger zones in or near sites that may present GBV risks (e.g. distribution points; security check points; water and sanitation facilities; entertainment centers; site perimeters; collective centers; etc.).
 - Areas where at-risk persons or groups (e.g. women- or child-headed households; unaccompanied girls and boys; girls and boys in foster families; persons with mental health problems and physical disabilities; etc.) may be housed.



ESSENTIAL TO KNOW

LGBTI Persons

Camp design and safety should take into account the specific risks of violence faced by lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons. When possible, CCCM actors should **work with LGBTI specialists (including protection staff with expertise in this area)** to ensure that basic GBV-related rights and needs of LGBTI persons are addressed in CCCM programming. For instance:

- If the setting mandates ID or ration cards or any other kind of universal documentation, **allow people to self-identify their gender**, including the option not to identify as male or female in accordance with ICAO standards listing M, F, or X for gender/sex. (See http://www.icao.int/publications/Documents/9303_p1_v1_cons_en.pdf)
- **Provide separate spaces** in registration areas to allow people to disclose sensitive personal information in confidence, including information regarding sexual orientation and gender identity.
- **Ensure that registration staff is trained to assist LGBTI persons** and ask appropriate questions that enable them to safely disclose information regarding their sexual orientation or gender identity, particularly where it may relate to their security.

(Information provided by Duncan Breen, Human Rights First, Personal Communication, May 20, 2013)



- Women-, adolescent- and child-friendly spaces and other locations where activities are targeted to women, children and other at-risk groups.
- ▶ Share the findings of regular site checks, monitoring and data collection with relevant GBV and protection partners and other humanitarian actors, in compliance with agency data-sharing processes and according to GBV reporting and information sharing standards. Ensure that steps are taken to address any related security issues.
- ▶ Inform affected populations of their rights to assistance and protection. Create complaint mechanisms and promote feedback from the community that can be used to improve GBV-related site management issues, such as placement of and access to services.
- ▶ Ensure that CCCM staff working in camps and camp-like settings are properly identified (i.e. with a logo and name tag) and have signed the code of conduct.
- ▶ Advocate with other sectors for the application of vulnerability criteria in the delivery of all services.

4. Support the role of law enforcement and security patrols to prevent and respond to GBV in and around sites throughout the entire camp lifecycle.

- ▶ Advocate for adequate numbers of properly trained law enforcement and security personnel. Promote equal participation of women and men among security staff according to what is culturally and contextually appropriate.
- ▶ Work with protection partners and the community to identify the best options for enhancing security in the site (24 hours/day, 7 days/week)—including the formation of “community watch” teams of men and women to monitor and report risks of violence.
- ▶ Work with protection partners and GBV specialists to ensure law enforcement and security patrol personnel receive regular training on GBV prevention and response.
- ▶ In settings with peacekeeping missions, engage with peacekeepers to facilitate security patrols.



PROMISING PRACTICE

The Philippine National Police, Women and Children Protection Division is always asked to engage in the humanitarian response because of their role in providing referrals to GBV survivors. Female police officers—found to be approachable and trustworthy—are mobilized in disaster-stricken areas to make them visible in camps and to establish help desks for women and children. Due to their expertise they can act as resource persons to inform displaced populations and returnees about GBV-related laws and legal protections.

(Information provided by Mary Scheree Lynn Herrera, GBV Specialist in the Philippines, Personal Communication, September 1, 2013)

5. Integrate GBV prevention and mitigation into camp closure.

- ▶ Advocate for close monitoring of the returning/resettling/residual population with a particular focus on the safety of women, girls and other at-risk groups.
- ▶ Encourage GBV specialists to work with relevant government ministries and civil society organizations to ensure continued delivery of services to GBV survivors who are exiting camps. Wherever possible, identify referral systems for their care and support.
- ▶ Ensure that safe and ethical systems for the transfer of data—including confidential personal records of GBV survivors—are put in place by organizations and authorities involved in camp closure and return/resettlement/reintegration programmes (with due



consideration of the survivor's best interest and in keeping with the principles of GBV reporting and information sharing).

- Conduct communication campaigns to inform affected populations of camp closure processes to reduce the risks of GBV.



ESSENTIAL TO KNOW

Persons with Disabilities

Experience reveals that persons with disabilities are some of the most hidden, neglected and socially excluded of all displaced people. Due to attitudinal, physical and social barriers, as well as lack of preparation and planning, they are more likely to be left behind or abandoned during emergency evacuation, and may be unable to access facilities, services and transportation systems. Those who do not have family members to assist them and have to rely on others for help may face an increased risk of exploitation and abuse. While research has found that services and opportunities for persons with disabilities are often better in refugee camps than in urban settings, programmes in all sites should be adapted to be more inclusive and specialized. CCCM actors should ensure that:

- Persons with disabilities are identified or counted in registration and data collection exercises; are included and able to access mainstream assistance programmes, as well as specialized or targeted services; and are not ignored in the appointment of camp leadership and community management structures.
- Facilities and services (such as shelters, food distribution points, water points, latrines and bathing areas, schools, health centers, camp offices, etc.) are designed and renovated according to the principles of universal design and/or reasonable accommodation. Problems of physical accessibility can often be worse for persons with disabilities who live in urban areas where there are fewer opportunities to adapt or modify physical infrastructure.
- Accommodations are made for those requiring assistance to get food and other supplies needed on a daily basis.
- Specialized health care, counseling services, and mental health and psychosocial support for persons with disabilities are available.

(Adapted from **Women's Refugee Commission. 2008. "Disabilities among Refugees and Conflict-Affected Populations"**, <http://womensrefugeecommission.org/press-room/journal-articles/1000-disabilities-among-refugees-and-conflict-affected-populations>)

Integrating GBV Risk Reduction into: CCCM POLICIES

1. Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of CCCM programmes.
 - Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in CCCM activities. These can include, among others:
 - Procedures for coordinating service delivery and distribution of food and non-food items to those at risk of GBV within the affected population.
 - Guidelines on which distribution partner is responsible for the sustained delivery of key GBV-related non-food items (e.g. hygiene and dignity kits; lighting for personal use; fuel and fuel alternatives; etc.).
 - Housing policies for at-risk groups within the camp population.
 - Interventions to reduce GBV risks associated with insecure areas and activities (e.g. fuel collection).
 - Policies for ensuring women and other at-risk groups are represented in site governance.
 - Policies for the provision of separate spaces for interviewing women and girls and other at-risk groups during registration.



- Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.
 - ▶ Circulate these widely among CCCM staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.). Encourage community members to raise key concerns with site management agencies.
 - ▶ Advocate for the adoption of CCCM minimum gender commitments as best practice.
- 2. Advocate for the integration of GBV risk-reduction strategies into national and local policies and plans related to CCCM, and allocate funding for sustainability.**
- ▶ Support government and other stakeholders to review CCCM policies and plans and integrate GBV-related measures for safety and security, including:
 - Provisions for a GBV specialist to advise government on CCCM-related GBV risk reduction in situations of cyclical natural disasters.
 - Where/how to establish sites.
 - Allocation of law enforcement and other security personnel.
 - The construction of women-, adolescent- and child-friendly spaces from the onset of an emergency.
 - Camp closure and exit strategies that take GBV-related risks into consideration.
 - ▶ Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. Undertake awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.
 - ▶ Work with national authorities and affected populations—including women and other at-risk groups—to develop site closure and exit strategies that take into consideration GBV-related risks.



Integrating GBV Risk Reduction into: CCCM COMMUNICATIONS and INFORMATION SHARING

1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure CCCM staff has the basic skills to provide them with information on where they can obtain support.
 - ▶ Ensure that all CCCM personnel who engage with affected populations have written information about where to refer survivors for care and support. Regularly update the information about survivor services.
 - ▶ Camp managers should ensure all CCCM personnel who engage with affected populations are trained in gender, GBV, women's/human rights and psychological first aid (e.g. how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).



ESSENTIAL TO KNOW

Referral Pathways

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.



LESSON LEARNED

In Haiti, the increase in the presence of camp management teams on site led to an increase in the reporting of GBV cases: between March and May 2010, 12 cases were reported to CCCM teams; between June and September, the number had more than tripled. In the period between March and August 2010, 98% of GBV cases were reported directly to an IOM camp manager or camp field team on site. Eighty-three percent of survivors interviewed by IOM Protection teams reported that they had no idea who to report the case to other than the camp management staff, or where they should go to seek medical assistance. Of those who did know of the existence of a nearby health facility, 100% reported they did not have the means to reach these facilities or were afraid to go alone. This experience highlights the importance for camp managers to place GBV-related messages (where to report risk and how to access care) in visible locations throughout camps, and also of the need to provide adequate training to camp managers on basic skills and information to provide referrals in cases where survivors disclose violence.

(Adapted from **IOM. 2010. CCCM Gender-based Violence Strategy**, https://www.iom.int/jahia/webdav/shared/shared/mainsite/published_docs/brochures_and_info_sheets/CCCM_GBV_Strategy.pdf)

2. Ensure that CCCM programmes sharing information about reports of GBV within the CCCM sector or with partners in the larger humanitarian community abide by safety and ethical standards.
 - ▶ Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community.
3. Incorporate GBV messages into CCCM-related community outreach and awareness-raising activities.
 - ▶ Work with GBV specialists to integrate community awareness-raising on GBV into CCCM outreach initiatives (e.g. community dialogues; workshops; meetings with community leaders; GBV messaging; etc.).



- Ensure this awareness-raising includes information on prevention, survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
- Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).
- Engage women, girls, boys and men (separately when necessary) in the development of messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.
- ▶ Engage males, particularly leaders in the community, as agents of change in CCCM outreach activities related to the prevention of GBV.
- ▶ Consider the barriers faced by women, adolescent girls and other at-risk groups to their safe participation in community discussion forums (e.g. transportation; meeting times and locations; risk of backlash related to participation; need for childcare; accessibility for persons with disabilities; etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.) so that participants feel safe to raise GBV issues.
- ▶ Provide community members with information about existing codes of conduct for CCCM personnel, as well as where to report sexual exploitation and abuse committed by CCCM personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.
- ▶ Place GBV-related messages in visible and accessible locations (e.g. greeting/reception centers for new arrivals; evacuation centers; day care centers; schools; local government offices; health facilities; etc.).



ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. **When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**



PROMISING PRACTICE

Leyte Province in The Philippines, known to be a hub for trafficking activities, was badly damaged by Typhoon Haiyan in 2013. Following the typhoon, there were concerns that trafficking would increase due to a lack of resources and a breakdown in basic services. With support from the GBV Working Group, CCCM Cluster members hung hundreds of small laminated posters in public places to help raise awareness among community members about the illegality of trafficking. The posters incorporated prevention messages as well as information about where those at risk could access support and who community members should call if they identified a trafficking case.

(Information provided by Devanna de la Puente, GBV AoR Rapid Response Team member, Personal Communication, March 13, 2014)





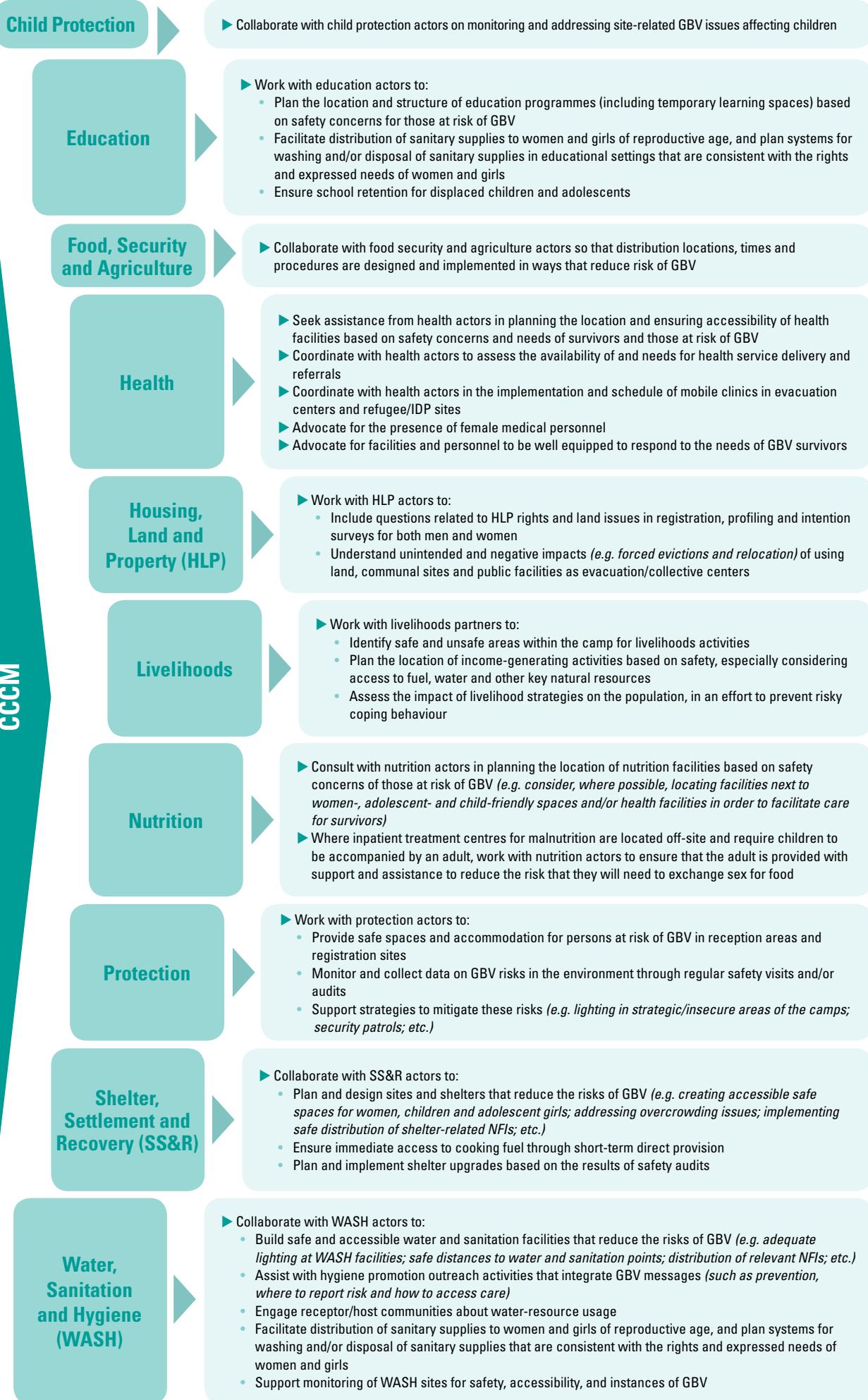
KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, CCCM programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist CCCM actors to:

- ▶ Design and conduct CCCM assessments that examine the risks of GBV related to CCCM programming, and strategize with CCCM actors about ways for such risks to be mitigated.
- ▶ Provide trainings for CCCM staff on issues of gender, GBV, and women's/human rights, and how to respectfully and supportively engage with survivors.
- ▶ Identify where survivors who report instances of GBV exposure to CCCM staff can receive safe, confidential and appropriate care, and provide CCCM staff with the basic skills and information to respond supportively to survivors.
- ▶ Provide training and awareness raising for the affected community on issues of gender, GBV, and women's/human rights as they relate to CCCM.
- ▶ Provide advice regarding women-, adolescent- and child-friendly spaces to make sure that the selected locations and designs are safe and secure.

In addition, CCCM programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, CCCM actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.







KEY GBV CONSIDERATIONS FOR:

MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in CCCM assessments ⁵	$\frac{\# \text{ of CCCM assessment that include GBV-related questions* from the GBV Guidelines} \times 100}{\# \text{ of CCCM assessment}}$ <small>* See page XX for GBV areas of inquiry that can be adapted to questions in assessments</small>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	$\frac{\# \text{ of assessment respondents who are female} \times 100}{\# \text{ of assessment respondents and}}$ $\frac{\# \text{ of assessment team members who are female} \times 100}{\# \text{ of assessment team members}}$	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

⁵ Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Consultations with the affected population on GBV risk factors in sites	<i>Quantitative:</i> # of sites* assessed through consultations with the affected population on GBV risk factors in and around sites x 100 <i>Qualitative:</i> What types of GBV-related risk factors do affected persons experience in and around sites? <small>* Sites can include water points, latrines, food and NFI distribution sites, safe spaces</small>	Organizational records, focus group discussion (FGD), key informant interview (KII), assessment reports	100%			
<i>Disaggregate consultations by sex and age</i>	# of sites			✓	✓	
Staff knowledge of referral pathway for GBV survivors	# of CCCM staff* who, in response to a prompted question, correctly say the referral pathway for GBV survivors x 100 <i>Qualitative:</i> # of surveyed CCCM staff <small>* Staff includes all employees and volunteers who engage with the affected population</small>	Survey	100%		✓	✓
RESOURCE MOBILIZATION						
Inclusion of GBV risk reduction in CCCM funding proposals or strategies	# of CCCM funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines x 100 <i>Qualitative:</i> # of CCCM funding proposals or strategies	Proposal review (at agency or sector level)	100%	✓	✓	
Training of CCCM staff on the GBV Guidelines	# of CCCM staff who participated in a training on the GBV Guidelines x 100 <i>Qualitative:</i> # of CCCM staff	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	
IMPLEMENTATION						
▶ Programming						
Risk factors of GBV in assessed sites	<i>Quantitative:</i> # of affected persons who report concerns about experiencing GBV when asked about sites* (in and around) x 100 <i>Qualitative:</i> Do affected persons feel safe from GBV when in and around sites? What types of safety concerns does the affected population describe in and around sites? <small>* Sites can include water points, latrines, food and NFI distribution sites, safe spaces</small>	Survey, FGD, KII, participatory community mapping	100%			
	# of affected persons asked about sites (in and around)			✓	✓	

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME	Stage of Programme
IMPLEMENTATION (continued)							
► Programming (continued)							
Existence of designated women, adolescent and child-friendly spaces* in displacement site <i>Disaggregate by women, adolescent and child friendly spaces</i>	<p><i>Quantitative:</i></p> $\# \text{ of displacement sites that have a designated safe space for women/adolescents/children} \times 100$ $\# \text{ displaced persons per site}$ <p><i>Qualitative:</i> How do women perceive access to women-friendly spaces? How do children perceive access to these spaces? How do adolescent girls perceive access to these spaces?</p>	Direct observation, KII, safety audit, Displacement Tracking Matrix (DTM)	Determine in the field		✓	✓	
Female participation in CCCM governance structures⁶	<p><i>Quantitative:</i></p> $\# \text{ of affected persons who participate in CCCM governance structures who are female} \times 100$ $\# \text{ of affected persons who participate in CCCM governance structures}$ <p><i>Qualitative:</i> How do women perceive their level of participation in CCCM governance structures? What are barriers to female participation in CCCM committees?</p>	Site management reports, DTM, FGD, KII	50%		✓	✓	
Female staff in CCCM programmes	$\# \text{ of staff in CCCM programmes who are female} \times 100$ $\# \text{ of staff in CCCM programmes}$	Organizational records	50%	✓	✓		
Existence of security patrols in displacement sites <i>Disaggregate security patrols by sex</i>	<p><i>Quantitative:</i></p> $\# \text{ of security patrols present in displacement site} \times 100$ $\# \text{ of displaced persons in displacement site}$ <p><i>Qualitative:</i> How often are patrols carried out in the displacement site?</p>	KII, CCCM regular coordination meeting, safety audit, DTM	Determine in the field		✓	✓	
Number of principal infrastructure with functional lighting structure	$\# \text{ of main points* with functional lighting structure} \times 100$ $\# \text{ main points}$ <p><i>* Main points are defined by community mapping exercise and can include latrines, water points, gathering places</i></p>	Observation	Determine in the field		✓	✓	
Feedback complaints about safety received and acted on by CCCM staff⁶	$\# \text{ of complaints about safety gathered by CCCM feedback mechanisms and acted on*} \times 100$ $\# \text{ of complaints about safety gathered by CCCM feedback mechanisms}$ <p><i>* Where complaints are not acted on, a clear response is provided to the affected population</i></p>	Survey, FGD, KII, participatory community mapping	100%		✓	✓	

(continued)

⁶ United Nations Office for the Coordination of Humanitarian Affairs. Humanitarian Indicator Registry. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
<p>► Policies</p> <p>Inclusion of GBV prevention and mitigation strategies in CCCM policies, guidelines or standards</p> <p># of CCCM policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines x 100 $\frac{\# \text{ of CCCM policies, guidelines or standards}}{\# \text{ of surveyed staff}}$</p> <p>Desk review (at agency, sector, national or global level)</p> <p>Determine in the field</p>									
<p>► Communications and Information Sharing</p> <p>Staff knowledge of standards for confidential sharing of GBV reports</p> <p># of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100 $\frac{\# \text{ of surveyed staff}}{\# \text{ of surveyed staff}}$</p> <p>Survey (at agency or programme level)</p> <p>100%</p>									
<p>Inclusion of GBV referral information in CCCM community outreach activities</p> <p># of CCCM community outreach activities programmes that include information on where to report risk and access care for GBV survivors x 100 $\frac{\# \text{ of CCCM community outreach activities}}{\# \text{ of CCCM community outreach activities}}$</p> <p>Desk review, KII, survey (at agency or sector level)</p> <p>Determine in the field</p>									
COORDINATION									
<p>Coordination of GBV risk reduction activities with other sectors</p> <p># of non-CCCM sectors consulted with to address GBV risk reduction activities in sites* x 100 $\frac{\# \text{ of existing non-CCCM sectors in a given humanitarian response at site level}}{\# \text{ of surveyed staff}}$</p> <p>KII, meeting minutes (at agency or sector level)</p> <p>Determine in the field</p>									

* See page X for list of sectors and GBV risk reduction activities



RESOURCES

Key Resources

- **Norwegian Refugee Council (NRC). 2008.** *Camp Management Toolkit*, "Chapter 10: Prevention of and Response to Gender-Based Violence", p. 319-323, <http://www.globalcccmcluster.org/tools-and-guidance/publications/camp-management-toolkit>
- **Camp Coordination and Camp Management (CCCM) Global Cluster. 2010.** *Collective Centre Guidelines*, <http://www.globalcccmcluster.org/tools-and-guidance/publications/collective-centre-guidelines>
- **Gender-based Violence Area of Responsibility (GBV AoR). 2014.** *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*. "Annex 36: Camp GBV Safety Audit", http://www.unicef.org/protection/files/GBV_Handbook_Long_Version.pdf
- **International Organization for Migration (IOM) and CCCM Cluster. 2011.** *Standard Operating Procedures for Camp Managers. Prevention and Response to GBV in IDP sites, Haiti*. http://www.eshelter-cccmhaiti.info/pdf/sop_sgbv_generic_2011.pdf
- For a checklist to assess gender equality programming, see **Inter-Agency Standing Committee (IASC). 2006.** *Gender Handbook in Humanitarian Action*, [http://www.humanitarianinfo.org/iasc/documents/subsidi/tf_gender/IASC%20Gender%20Handbook%20\(Feb%202007\).pdf](http://www.humanitarianinfo.org/iasc/documents/subsidi/tf_gender/IASC%20Gender%20Handbook%20(Feb%202007).pdf)

Additional Resources

- **Schulte, J. and Rizvi, Z. 2012.** "In Search of Safety and Solutions: Somali Refugee Adolescent Girls at Sheder and Aw Barre Camps, Ethiopia." New York: Women's Refugee Commission. http://womensrefugeecommission.org/resources/cat_view/68-reports/70-youth
- **United Nations High Commissioner for Refugees (UNHCR). 2011.** "Working with Lesbian, Gay, Bisexual, Transgender, & Intersex Persons in Forced Displacement." Switzerland: UNHCR. <http://www.unhcr.org/refworld/docid/4e6073972.html>
- **House, S., Mahon, T., and Cavill, S. 2012.** *Menstrual hygiene matters. A resource for improving menstrual hygiene around the world*, <http://www.wateraid.org/what-we-do/our-approach/research-and-publications/view-publication?id=02309d73-8e41-4d04-b2ef-6641f6616a4f>
- **Reproductive Health Response in Conflict Consortium. 2004.** *Gender-based Violence Tools Manual: For Assessment, Program Design, Monitoring and Evaluation in Conflict-Affected Settings*. http://www.rhrc.org/resources/gbv/gbv_tools/manual_toc.html
- **International Committee of the Red Cross (ICRC).** 2006. *Addressing the Needs of Women Affected by Armed Conflict*. Geneva. <http://www.refworld.org/category,POLICY,ICRC,,46e943780,0.html>
- **UNHCR. 2006.** *Operational Protection in Camps and Settlements. A Reference Guide of Good Practices in the Protection of Refugees and Other Persons of Concern*, <http://www.refworld.org/docid/44b381994.html>



CHILD PROTECTION



THIS SECTION APPLIES TO:

- Child protection coordination mechanisms
- Child protection actors (staff and leadership): NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups related to child protection
- Other child protection stakeholders including national and local governments, community leaders, and civil society groups

Why Addressing Gender-based Violence is a Critical Concern of the Child Protection Sector

Children and adolescents often face a heightened risk of violence in humanitarian settings due to the lack of rule of law, the breakdown of family and community protective mechanisms, their limited power in decision-making, and their level of dependence. The strain on adults caused by humanitarian crises may increase children's risk of physical abuse, corporal punishment, and other forms of domestic violence. Children and adolescents are also at risk of being exploited by persons in authority (e.g. through child labour, commercial sexual exploitation, etc.). Proximity to armed forces, overcrowded camps, and separation from family members further contribute to an increased risk of violence.

During emergencies, both girls and boys are at risk of sexual assault. Many other types of violence against children—including sexual exploitation and abuse, trafficking for sex, female genital mutilation/cutting,



ESSENTIAL TO KNOW

Considering the Best Interests of the Child

In all actions concerning children and adolescents, **the best interests of the child** shall be a primary consideration. This principle should guide the design, monitoring, and adjustment of all humanitarian programmes and interventions. Where humanitarians take decisions regarding individual children, agreed procedural safeguards should be implemented to ensure this principle is upheld. **Children are people under 18 years of age. This category includes infants (up to 1 year old) and most adolescents (10–19 years). Adolescents are normally referred to as people between the ages of 10 and 19.**

(**Child Protection Working Group [CPWG]. 2012. Minimum Standards for Child Protection in Humanitarian Action**, pps. 15 and 221, http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1103/Minimum-standards-Child_Protection.pdf. For additional information see UNHCR, 2008. *Guidelines on Determining the Best Interests of the Child*. <http://www.unhcr.org/4566b16b2.pdf>)



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery through Child Protection

ASSESSMENT, ANALYSIS AND PLANNING

Promote the active participation of children and adolescents—particularly adolescent girls—in all child protection assessment processes (according to the principle of participation).

Assess the level of participation and leadership of women, adolescent girls and other at-risk groups in the design, implementation and monitoring of child protection monitoring groups; etc.)

Identify the cultural practices, expected behaviours and social norms that constitute GBV and/or increase risk of GBV against girls and boys (e.g. preference for exclusion from education; domestic responsibilities for girls; child labour; recruitment of children into armed forces/groups; etc.)

Identify the environmental factors that increase children's and adolescents' risk of violence, understanding the different risk factors faced by girls, boys, and adolescents (e.g. for firewood/water collection, to school, to work; overcrowded camps or collective centers; status as separated or unaccompanied child; being in conflict areas).

Map community-based child protection mechanisms that can be fortified to mitigate the risks of GBV against children, particularly adolescent girls (e.g. community-based organizations; families and kinship networks; religious structures; etc.)

Identify response services and gaps in services for girl and boy survivors (including child-friendly health care; mental health and psychosocial support; security services; etc.)

Assess the capacity of child protection programmes and personnel to recognize and address the risks of GBV against girls and boys and to apply the principles of child protection.

Review existing/proposed community outreach material related to child protection to ensure it includes basic information about GBV risk reduction (including GBV prevention and mitigation).

RESOURCE MOBILIZATION

Develop proposals for child protection programmes that reflect awareness of GBV risks for the affected population and strategies for reducing these risks.

Prepare and provide trainings for government, humanitarian workers, national and local security and law enforcement, child protection personnel, teachers and other professionals on GBV prevention and mitigation, recognizing the differential risks and safety needs of girls and boys.

Train child protection actors who work directly with affected populations to recognize GBV risks for children and adolescents and to inform survivors and their communities.

Target women and other at-risk groups for job skills training related to child protection, particularly in leadership roles to ensure their presence in decision-making.

IMPLEMENTATION

► Programming

Involve women, adolescent girls, and other at-risk groups in relevant aspects of child protection programming (with due caution where this poses a potential security risk).

Support the capacity of community-based child protection networks and programmes to prevent and mitigate GBV (e.g. strengthen existing community protection mechanisms; establish new ones; etc.).

Support the provision of age-, gender-, and culturally-sensitive multisectoral care and support for child survivors of GBV (including health services; mental health and psychosocial support; etc.).

Where there are gaps in services for children and adolescents, support the training of medical, mental health and psychosocial, police, and legal/justice actors.

Monitor and address the risks of GBV for separated and unaccompanied girls and boys (e.g. establish separate reception areas for unaccompanied girls and boys; provide specific services for separated and unaccompanied children; etc.).

Incorporate efforts to address GBV into activities targeting children associated with armed forces/groups (e.g. disarmament, demobilization and reintegration).

Ensure the safety and protection of children in contact with the law, taking into account the particular risks of GBV within detention facilities.

► Policies

Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of child protection programmes (e.g. standards for equity and non-discrimination; policies on GBV prevention and mitigation; information about GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse; etc.).

Support the reform of national and local laws and policies (including customary laws) to promote and protect the rights of children and adolescents to be free from GBV and other forms of violence, particularly those who are separated or unaccompanied, and other at-risk groups of children).

► Communications and Information Sharing

Ensure that child protection programmes sharing information about reports of GBV within the child protection sector or with partners in the larger humanitarian context (e.g. NGOs, UN agencies, etc.) do not compromise the identity of or pose a security risk to child survivors, their caretakers or the broader community)

Incorporate GBV messages (including prevention, where to report risk and how to access care) into child protection-related community outreach and awareness campaigns.

COORDINATION

Undertake coordination with other sectors to address GBV risks and ensure protection for girls and boys at risk

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a child protection focal point to regularly participate in GBV coordination meetings.

MONITORING AND EVALUATION

Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduction activities.

Evaluate GBV risk-reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making and programming.

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for child protection actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**. Also refer to the Minimum Standards for Child Protection in Humanitarian Action, http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1103/Minimum-standards-Child_Protection.pdf.

at the Programme Cycle

	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
o ethical standards and processes)	✓	✓	✓	✓
protection programmes (e.g. ratio of male/female child protection staff; participation in child	✓	✓	✓	✓
cial treatment of boys; child marriages; female genital mutilation/cutting; gender-based	✓	✓	✓	✓
nd particularly at-risk groups of children (e.g. presence of armed forces/groups; unsafe routes with the law; existence of child trafficking networks; etc.)	✓	✓		
child protection committees; community watch committees; child-friendly safe spaces;	✓	✓		
ity response; legal/justice processes; etc.)	✓	✓		
principles of child-friendly care when engaging with girl and boy survivors	✓	✓	✓	✓
ing prevention, where to report risk and how to access care)	✓	✓	✓	✓
<hr/>				
s	✓	✓	✓	✓
s, legal/justice sector actors, community leaders, and relevant community members on	✓	✓	✓	✓
their caregivers about where they can obtain care and support	✓	✓		
-making processes	✓	✓	✓	✓
<hr/>				
ential security risk or increases the risk of GBV)	✓	✓	✓	✓
tection mechanisms; support creation of girl- and boy-friendly spaces; etc.)		✓	✓	✓
al health and psychosocial support; security/police response; legal/justice services; etc.)	✓	✓	✓	✓
ctors in how to engage with child survivors in age-, gender-, and culturally-sensitive ways	✓	✓	✓	✓
nd boys; ensure family reunification and foster care programmes monitor and mitigate potential	✓	✓	✓	✓
ion programmes)		✓	✓	✓
	✓	✓	✓	✓
ual employment of females; procedures and protocols for sharing protected or confidential	✓	✓	✓	✓
ree from GBV (with recognition of the particular vulnerabilities, rights and needs of girls and	✓		✓	✓
<hr/>				
n community abide by safety and ethical standards (e.g. shared information does not reveal the	✓	✓	✓	✓
ess-raising activities		✓	✓	✓
<hr/>				
3V coordination meetings	✓	✓	✓	✓
<hr/>				
education activities throughout the programme cycle	✓	✓	✓	✓
nd ensure accountability		✓	✓	✓

honour killing, child marriage, differential access to food and services, and differential access to education — disproportionately affect girls and young women because of gender-based discrimination against females. In situations of armed conflict, girls and boys are at risk of being abducted by armed forces/groups and subjected to different forms of violence. Girls in particular are often the targets of sexual slavery and other forms of sexual violence and exploitation. Girls who are unaccompanied or orphaned, single heads of households, child mothers, and girls with disabilities are among the most at risk.¹

WHAT THE MINIMUM STANDARDS FOR CHILD PROTECTION IN HUMANITARIAN ACTION SAY:

Standard 8:

- ▶ Girls and boys are protected from physical violence and other harmful practices, and survivors have access to age-specific and culturally appropriate responses.

Standard 9:

- ▶ Girls and boys are protected from sexual violence, and survivors of sexual violence have access to age-appropriate information as well as safe, responsive and holistic response.

(Child Protection Working Group [CPWG]. 2012. *Minimum Standards for Child Protection in Humanitarian Action*. http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1103/Minimum-standards-Child_Protection.pdf)

Child protection actors can play a central role in enhancing the safety and well-being of children and adolescents by integrating GBV prevention and mitigation measures into their programming, and by supporting child-friendly systems of care (i.e. referral pathways) for survivors. Actions taken by the child protection sector to prevent and respond to GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. Child protection actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)

When establishing programmes aimed at preventing, mitigating and responding to GBV against children and adolescents, child protection actors should remain attentive to how the particular needs and vulnerabilities of girls in emergency settings may differ from the needs and vulnerabilities of boys. Addressing all forms of violence against girls requires understanding and challenging the social norms and traditions that place females in a subordinate position to males. Addressing specific forms of violence against boys through a gender lens will often focus on the negative effects for boys of socially determined norms of masculinity. The needs and vulnerabilities of transgender and intersex children tend to be particularly hidden, and require correspondingly close attention and collaboration with local experts or aid workers experienced in working with these populations. Efforts to address violence against children and adolescents will be most effective when there is a thorough analysis of gender-related risk and protective factors.

¹ For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines. *The Minimum Standards for Child Protection in Humanitarian Action* refer to at-risk groups of children as those who are likely to be excluded from care and support. Some of the categories of children most often identified as excluded are children with disabilities, child-headed households, LGBTI children, children living and working on the streets, children born as a result of rape, children from ethnic and religious minorities, children affected by HIV, adolescent girls, children in the worst forms of child labour, children without appropriate care, children born out of wedlock, and children living in residential care or detention (p 157).



ESSENTIAL TO KNOW

Children Associated with Armed Forces/Groups

The internationally agreed definition for a child associated with an armed force or armed group (child soldier) is any person below 18 years of age who is, or has been, recruited or used by an armed force or armed group in any capacity. This includes but is not limited to children, boys and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities.

(Adapted from **UNICEF. 2007. Paris Principles: Principles and Guidelines on Children Associated with Armed Forces or Armed Groups.**
<http://www.unicef.org/emerg/files/ParisPrinciples310107English.pdf>)

Addressing Gender-based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by child protection actors working in humanitarian settings. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with child protection actors working in partnership with other sectors as well as with GBV specialists.

The information generated from these areas of inquiry should be analyzed to inform planning of child protection programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.



ESSENTIAL TO KNOW

Collecting and Reporting Information Related to Children

The process of collecting and reporting information on physical violence and harmful practices affecting children should be in line with international ethical standards for researching violence against children. It should also be in line with national law, and, when possible, the Inter-Agency Child Protection Information Management System and the *Minimum Standards for Child Protection in Humanitarian Action*. Only staff trained on child-specific interviewing techniques should interview children.

(For more general information on safe and ethical assessment, data collection, and data sharing, see **Part Two: Background to Thematic Area Guidance**.)

KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in child protection: governments; humanitarian workers; civil societies; local authorities; police; teachers; family members and caregivers; community leaders and community members; child protection committees; faith-based organizations; GBV, gender and diversity specialists
- Affected populations and communities, including children and adolescents where appropriate
- In IDP/refugee settings, members of receptor/host communities



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Child Protection PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female child protection staff, including in positions of leadership?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are children, adolescents, and others who may be at particular risk for GBV consulted on child protection programming?
 - Is this done in an age-, gender-, and culturally-sensitive manner?
 - Are they involved in community-based activities related to protection, and in leadership roles when possible (e.g. *community child protection committees, etc.*)?
- c) Are the lead actors in child protection aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation strategies into their activities?

GBV-related Child Protection Environment

- d) What cultural practices, behaviors and social norms within the affected population constitute GBV or increase risk of GBV and other forms of violence against girls and boys (e.g. *preferential treatment of boys; child marriages; female genital mutilation/cutting; gender-based exclusion from education, particularly for adolescent girls at the secondary school level; domestic responsibilities; recruitment of children into armed forces/groups; child labour; etc.*)?
 - How do these practices and norms impact children of different ages and from different at-risk groups (e.g. *violence against children and adolescents with disabilities*)?
 - How have these changed (increased or decreased) as a result of the humanitarian emergency?
- e) What cultural practices, behaviors, and social norms help protect girls and boys from GBV and other forms of violence? How have these changed as a result of the emergency?
- f) What environmental factors increase girls' and boys' risk of GBV and other forms of violence (e.g. *presence of armed forces; unsafe routes for firewood/water collection, to school, to work; overcrowded camps or collective centers; status as a separated or unaccompanied child; being in conflict with the law; existence of child trafficking networks; etc.*)?
 - What are the different risk factors faced by girls and boys?
 - Are there groups of children or adolescents who are particularly at-risk and/or excluded from care and support?
- g) What are the capacities of children and their caregivers to deal with these risks factors?
 - What community structures and supports (including informal avenues) might children and adolescents turn to for help when they have experienced or are at risk of GBV and other forms of violence?
 - What community-based protection mechanisms (e.g. *child protection committees; watch committees; child-friendly spaces; community-based organizations; families and kinship networks; religious structures and other traditional mechanisms; etc.*) can be mobilized or developed to monitor and mitigate the risk of GBV and other forms of violence?

Child-Friendly Response Services

- h) What services are in place for child survivors of GBV and other forms of violence (e.g. *health care; mental health and psychosocial support; security/law enforcement; legal aid; judicial processes; etc.*)?
 - Do these services address the differential needs of girl and boy survivors?
 - Are services provided in a safe, confidential, child-friendly and respectful way?
 - Are they provided in compliance with statutory laws and international standards, particularly in relation to informed consent of child survivors and mandatory reporting laws and policies?
 - Are providers trained in issues of gender, GBV, women's and children's rights, as well as in child-friendly principles and approaches to care?
 - Are there Standard Operating Procedures (SOPs) in place to ensure quality of care and safe and effective coordination and referral?
- i) What social, attitudinal, physical, and informational barriers might exclude children and adolescents from accessing services?
 - What systems need to be put in place to ensure access?
 - Are services provided based on universal design and/or reasonable accommodation² to ensure accessibility for all children and adolescents, including those with disabilities (e.g. *physical disabilities; injuries; sensory impairments; cognitive impairments; etc.*)?

(continued)

²For more information regarding universal design and/or reasonable accommodation, see **definitions in Annex 4**.



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

GBV-Related Child Protection Needs of Specific At-Risk Groups

- j) Are reception areas for **separated and unaccompanied children** staffed with mixed teams (males and females)? Are these teams trained to provide immediate care and support for girl and boy survivors of GBV and other forms of violence?
 - Do alternative care and family reunification programmes monitor and address potential GBV risks, even after long-term placement or reunification?
- k) Do programmes for **children associated with armed forces/groups** take into account their GBV-related risks and support needs?
 - Do disarmament, demobilization, and reintegration processes have ways of identifying girls who may otherwise be overlooked because they are dependents or “wives” of members of armed forces/groups?
 - Are non-stigmatizing support systems in place for reintegrating children formerly associated with armed forces/groups who have been exposed to GBV and other forms of violence?
 - Has support been provided to families and communities of reintegrated boys and girls to ensure non-stigmatizing care of these children?
- l) Are detention centers for **children in conflict with the law** monitored for GBV-related risks?
 - Are girls and boys (as well as children and adults) held in separate facilities?
 - Are safe alternative systems of care available for children at risk and for those who are unduly incarcerated?

Areas related to Child Protection POLICY

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of child protection programmes?
 - Are women, girls and other at-risk groups meaningfully engaged in the development of child protection policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Are these policies, standards and guidelines communicated to women, girls, boys and men (separately when necessary)?
 - Is child protection staff properly trained and equipped with the necessary skills to implement these policies?
- b) What are the national, local, and customary laws and policies related to children’s rights and GBV against children?
 - Are these aligned with constitutional and international standards and frameworks that promote the rights and safety of girls and boys, gender equality, and the empowerment of girls?

Areas related to Child Protection COMMUNICATIONS and INFORMATION SHARING

- a) Has training been provided to child protection outreach staff on:
 - Issues of gender, GBV, women’s rights and children’s rights?
 - How to supportively engage with child survivors and their caregivers and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- b) Do child protection-related community outreach activities raise awareness within the community about children’s rights and GBV and other forms of violence against children and adolescents?
 - Does this awareness-raising include information on prevention, survivor rights (including confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV and other forms of violence?
 - Is this information provided in age-, gender- and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these outreach activities as agents of change?
- c) Are child protection-related discussion forums age-, gender-, and culturally-sensitive? Are they accessible to girls and other at-risk groups (*e.g. facilitated by trained professionals; confidential; located in secure settings; with females as facilitators of girls’ discussion groups; etc.*) so that participants feel safe to raise GBV issues?





KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for child protection programming. Whether requesting pre-/emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**. Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.



HUMANITARIAN NEEDS OVERVIEW

- ▶ Does the proposal articulate specific GBV-related safety risks, protection needs and rights of girls and boys? Is this information disaggregated by sex, age, disability and other relevant vulnerability factors?
- ▶ Are risks for specific forms of GBV (*such as sexual assault; commercial sexual exploitation; child marriage; intimate partner violence and other forms of domestic violence; female genital mutilation/cutting; etc.*) described and analysed, rather than a broader reference to “GBV”?



PROJECT RATIONALE/ JUSTIFICATION

- ▶ When drafting a proposal for emergency response:
 - Is there an explanation of how the project will address the immediate GBV-related child protection needs and promote safety from GBV exposure (*e.g. ensuring child protection monitoring addresses links between general child protection issues and GBV risk; supporting safe and secure environments in camps and other settings for children and adolescents; building capacity of service providers to offer care and support to girl and boy survivors; etc.*)?
 - Is there a clear description of how the project will address and mitigate the particular risks of violence against sub-groups of children (*e.g. separated and unaccompanied girls and boys; girls and boys associated with armed groups; girls and boys in conflict with the law; etc.*)?
 - Are additional costs required to ensure the safety and effective working environments for female staff in the child protection sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
 - Is there a strategy for preparing and providing trainings for government, humanitarian workers, national and local security and law enforcement, child protection personnel, teachers, legal/justice sector actors, community leaders, and relevant community members on violence against children and adolescents—recognizing the differential risks and safety needs of girls and boys?
 - Are additional costs required to ensure any GBV-related community outreach materials are available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- ▶ When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how the project will contribute to sustainable strategies that promote the safety and well-being of children and adolescents, and to long-term efforts to reduce specific types of GBV against children?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

(continued)

C. PROJECT DESCRIPTION

- ▶ Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for integrating GBV-related work?
- ▶ Do the proposed activities illustrate linkages with other humanitarian actors/sectors in order to maximize resources and work in strategic ways?
- ▶ Are there activities that help in changing/improving the environment by addressing the underlying causes of and contributing factors to GBV (*e.g advocating for laws and policies that promote gender equality and the empowerment of girls and other at-risk groups, etc.*)?
- ▶ Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as child protection staff and in community-based child protection structures?

KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some common GBV-related considerations when implementing child protection programming in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs, and identified resources of the target community.

Integrating GBV Prevention and Response into: Child Protection PROGRAMMING

1. **Involve women, adolescent girls and other at-risk groups in relevant aspects of child protection programming (with due caution in situations where this poses a potential security risk or increases the risk of GBV).**
 - ▶ Strive for at least 50% represent of females within child protection programme staff. Provide women with formal and on-the-job training as well as targeted support to assume leadership and training positions.
 - ▶ Ensure women (and where appropriate, adolescent girls) are actively involved in community-based child protection-related committees, associations, and meetings. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.



ESSENTIAL TO KNOW

LGBTI Children and Adolescents

In most areas of the world, transgender and intersex children and adolescents are at an increased risk of violence due to institutionalized discrimination and oppression based on their gender identity. Lesbian, gay and bisexual adolescents face similarly higher risks due to their sexual orientation. Both of these groups may face discrimination at the hands of police or security personnel due to prejudice or criminalization laws. When assessing the risk factors for children and adolescents in emergencies, **child protection actors should work with lesbian, gay, bisexual, transgender, and intersex (LGBTI) experts to assess the particular challenges faced by LGBTI children and adolescents when accessing protection from violence.** Capacity-building—including on the GBV-related protection rights and needs of LGBTI children—may need to be integrated into broader training initiatives. LGBTI persons should be consulted (if this can be done in a safe and confidential way) on factors that increase or decrease their sense of safety. When working with survivors, a safe and confidential space should be made available to enable any child to discuss his/her gender identity and/or sexual orientation with an expert in LGBTI issues.



- ▶ Employ adults from at-risk groups (e.g. persons with disabilities, indigenous persons and religious or ethnic minorities, LGBTI persons, etc.) in child protection staff, leadership, and positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.

2. Support the capacity of community-based child protection networks and programmes to prevent and mitigate GBV.

- ▶ Strengthen the ability of community protection mechanisms (e.g. child protection committees, watch committees, child protection monitoring and outreach staff, community-based organizations, families and kinship networks, religious structures and other traditional mechanisms) to monitor risks of GBV against children and adolescents. Build their capacity to provide information in an ethical, safe, and confidential manner to girls and boys (and/or their caregivers) about where to report risk and how to access care.
- ▶ Integrate GBV prevention and mitigation strategies into the design and implementation of child-friendly community spaces.
 - Ensure community spaces are accessible to girls and other at-risk children (e.g. ensure community spaces are located in safe areas; monitor safety of children traveling to/from spaces and provide escorts where possible; ensure opening times meet the needs of different groups of children; provide accessibility features for children with disabilities; provide childcare for adolescent mothers; etc.). Seek out and consult



ESSENTIAL TO KNOW

Adolescent Girls

Adolescent girls between the ages of 10 and 19 constitute one of the most at-risk groups for GBV due to their physical development and age. These factors can lead to high levels of sexual assault, sexual exploitation, child marriage, intimate partner violence and other forms of domestic violence. Services must be put in place (such as school and community-based programmes to increase their social skills; programmes that generate economic opportunities; etc.) that help them to develop in healthy ways and take into account their specific needs (e.g. child care responsibilities; obligations in the household; levels of literacy; etc.).

(Adapted from **Child Protection Working Group [CPWG]**. 2012. *Minimum Standards for Child Protection in Humanitarian Action*, pg 95. http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1103/Minimum-standards-Child_Protection.pdf)



ESSENTIAL TO KNOW

Children and Adolescents with Disabilities

Children and adolescents with disabilities may be isolated, unable to flee violent situations, or unable to comprehend risks and protect themselves from exposure to GBV and other forms of violence. They are also more likely to lack financial resources and access to information on GBV and basic services for survivors. Further, adolescent girls and boys with disabilities are often excluded from peer and social networks that might reduce their vulnerability to violence. **Efforts are needed to ensure that children with disabilities remain visible to GBV-related service providers, and that child protection activities are disability-friendly** and can be accessed by children and adolescents with disabilities, no matter where they live. Practitioners must assist children with disabilities to meet their medical needs, as well as enhance their overall functioning and connection to supports in their communities. Referral mechanisms should be developed to identify survivors, refer them to accessible protection systems, and provide them with specialized services through survivor assistance programmes. Prevention efforts should also be undertaken to reduce risks of violence for children with disabilities. Girls' programmes that focus on safe spaces, network strengthening, and mentoring should be inclusive of girls with disabilities.

(For more information, see **Women's Refugee Commission**, 2014. *Disability Inclusion: Translating Policy into Practice in Humanitarian Action*. <http://womensrefugeecommission.org/programs/disabilities/disability-inclusion>)



with hard-to-reach girls in the community to ensure that they are empowered to access community spaces and that community spaces meet their needs.

- Train all staff working in community spaces in issues of gender, GBV, women's rights and children's rights; how to respectfully and supportively engage with child survivors; and how to provide information about their rights, where to report risk and how to access care.
- Wherever possible, include a mixed team of male and female GBV caseworkers as part of the staff working in community spaces. These caseworkers can play an active role in identifying cases, providing immediate mental health and psychosocial support (such as psychological first aid), and facilitating timely referrals for additional care and support. Ensure these GBV caseworkers can apply safe and ethical procedures for addressing challenging cases (e.g. when a child survivor's family member is believed to be the perpetrator).



ESSENTIAL TO KNOW

Identifying the Signs of Child Sexual Abuse

Signs of sexual abuse can vary from child to child and may not always be apparent. Any one sign or symptom of distress—such as those listed below—does not mean that a child has been abused; however the presence of several signs may indicate that a child is at risk. It is important for child protection programme personnel and people working in community protection networks to be aware of some of the common signs of distress amongst children, and take these signs seriously as a possible indicator for sexual abuse.

Infants & Toddlers (0–5)

- Crying, whimpering, screaming more than usual.
- Clinging or unusually attaching themselves to caregivers.
- Refusing to leave “safe” places.
- Difficulty sleeping or sleeping constantly.
- Losing the ability to converse, losing bladder control, and other developmental regression.
- Displaying knowledge or interest in sexual acts inappropriate to their age.

Younger Children (6–9)

- Similar reactions to children ages 0–5. In addition:
- Fear of particular people, places or activities, or of being attacked.
- Behaving younger than their age (wetting the bed or wanting parents to dress them).
- Suddenly refusing to go to school.
- Touching their genitals a lot.
- Avoiding family and friends or generally keeping to themselves.
- Refusing to eat or wanting to eat all the time.

Adolescents (10–19)

- Depression (chronic sadness), crying or emotional numbness.
- Nightmares (bad dreams) or sleep disorders.
- Problems in school or avoidance of school.
- Displaying anger or expressing difficulties with peer relationships, fighting with people, disobeying or disrespecting authority.
- Displaying avoidance behavior, including withdrawal from family and friends.
- Self-destructive behavior (drugs, alcohol, self-inflicted injuries).
- Changes in school performance.
- Exhibiting eating problems, such as eating all the time or not wanting to eat.
- Suicidal thoughts or tendencies.
- Talking about abuse, experiencing flashbacks of abuse.

(Adapted from **IRC and UNICEF. 2013. Caring for Child Survivors of Sexual Abuse**, http://gbvresponders.org/sites/default/files/IRC_CCSGuide_FullGuide_lowres.pdf)



- Support the development of specialized programmes within community spaces to prevent and mitigate GBV (e.g. safe touch programmes for children; empowerment and skills-building programmes for adolescent girls; discussion groups for girls and boys—both separately and together—on violence and gender; sexual and reproductive health education for adolescents; parenting support groups; etc.). *Ensure parenting support groups are extended to caregivers of children with disabilities, and include disability sensitization as well as positive parenting skills or strategies.*

3. Support the provision of age-, gender-, and culturally-sensitive multisectoral care and support for child survivors of GBV.

- ▶ Work with relevant child protection and GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for child survivors of GBV. Ensure these systems of care include health and medical care, mental health and psychosocial support, security/police services, legal assistance, case management, education and vocational training opportunities, and other relevant services.
- ▶ Advocate for procedures for child survivors of GBV to be included within all Standard Operating Procedures (SOPs) for multi-sectoral GBV prevention and response.
 - Implement agreements on service-level coordination, information sharing protocols, and referral pathways among child protection actors, GBV actors, partner agencies and service providers.
 - Ensure that the SOPs provide information about how to report cases of GBV against children and adolescents—with provisions for how to address this issue when the alleged perpetrator is a family member.
- ▶ Compile a directory of child-friendly GBV-related services and make it available to child protection staff, GBV specialists, multi-sectoral service providers (e.g. health care providers, mental health and psychosocial support providers, lawyers, police, etc.) and communities.



ESSENTIAL TO KNOW

Referral Pathways

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.



PROMISING PRACTICE

In Sudan, UNICEF agreed with the police headquarters to develop a gender appropriate investigation process within the Children and Women Police Protection Units for child survivors, witnesses and offenders. In order to ensure that investigations and police support to girls are carried out sensitively, UNICEF is advocating for an increase in the number of female police.

(Adapted from Ward, J. 2007. *From Invisible to Indivisible: Promoting and Protecting the Right of the Girl Child to be Free from Violence*. p. 62. https://www.unicef.at/fileadmin/media/Infos_und_Medien/Info-Material/Maedchen_und_Frauen/From_Invisible_To_Indivisible_-_Rights_of_Girl_Child.pdf)

4. Where there are gaps in services for children and adolescents, support the training of medical, mental health and psychosocial, police, and legal/justice actors in how to engage with child survivors.

- ▶ Ensure service providers understand and apply basic steps and procedures for engaging with child survivors in age-, gender-, and culturally-appropriate ways. These include:
 - Upholding the guiding principles for working with survivors (e.g. promoting the child’s best interest; ensuring the safety of the child; comforting the child; ensuring



appropriate confidentiality; involving the child in decision-making; treating every child fairly and equally; and strengthening the child's resiliencies).

- Following informed consent/assent procedures according to local laws and the age and developmental stage of the child.
- Applying confidentiality protocols to reflect the limits of confidentiality, as in circumstances where a child is in danger.
- Assessing a child survivor's immediate health, safety, psychosocial and legal/justice needs, and using crisis intervention to mobilize early intervention services that ensure the child's health and safety.
- Providing immediate mental health and psychosocial support (including psychological first aid) to the child and, where necessary and available, providing referrals to longer-time support.
- Ensuring, where necessary, that child safety in family/social contexts is assessed in an ongoing way after disclosure of abuse, and decisive and appropriate action is taken when a child needs protection.
- Identifying strengths and needs to engage the child and family in a resilience-based care and support process.
- Proactively engaging any non-offending caregivers.
- Knowing other child-friendly service providers in the local area and initiating referrals properly.



ESSENTIAL TO KNOW

Core Child-Friendly Attitude Competency Areas

Service providers must have the ability and commitment to put child-friendly values and beliefs into practice, and to ensure child-friendly attitudes are communicated during the provision of care. The overarching values that are essential for service providers working with children include the recognition that:

- Children are resilient individuals.
- Children have rights, including the right to healthy development.
- Children have the right to care, love and support.
- Children have the right to be heard and be involved in decisions that affect them.
- Children have the right to live a life free from violence.
- Information should be shared with children in a way they understand.

In addition, there are specific beliefs that are absolutely vital for service providers to have when working with child sexual abuse survivors. They include the beliefs that:

- Children tell the truth about sexual abuse.
- Children are not at fault for being sexually abused.
- Children can recover and heal from sexual abuse.
- Children should not be stigmatized, shamed, or ridiculed for being sexually abused.
- Adults, including caregivers and service providers, have the responsibility to help a child heal by believing them and not blaming them for sexual abuse.

(Adapted from **IRC and UNICEF. 2013. Caring for Child Survivors of Sexual Abuse**, http://gbvresponders.org/sites/default/files/IRC_CCSGuide_FullGuide_lowres.pdf)



- ▶ Ensure service providers use age-appropriate lengths of time to speak with children and adolescents about their exposure to sexual assault or other forms of violence:
 - 30 minutes for children under the age of 9;
 - 45 minutes for children between 10–14 years;
 - One hour for children 15–18 years old.
- ▶ Ensure service providers understand national and/or local laws, policies and procedures related to mandatory reporting of violence. Ensure they apply best practices in settings where mandatory reporting systems exist, including:
 - Maintaining the utmost discretion and confidentiality of child survivors.
 - Knowing the case criteria that warrant a mandatory report and ensuring that mandatory reporting processes are done in accordance with the best interests of the child.
 - Making verbal and/or written reports (as indicated by law) within a specified time frame (usually 24 to 48 hours).
 - Providing only the minimum information needed to complete the report; explaining to the child and his/her caregiver what is happening and why; documenting the report in the child's case file; and following up with the family and relevant authorities.

5. Monitor and address the risks of GBV for separated and unaccompanied girls and boys.

- ▶ Staff reception areas for separated and unaccompanied children with a mixed team of male and female GBV specialists and/or child protection personnel with GBV-related expertise. Ensure they are trained to engage supportively and in an age-, gender-, and culturally-appropriate manner with girl and boy survivors and equipped to provide safe, confidential and timely referrals for immediate care and support (including in cases where children disclose violence that occurred prior to flight or in transit, and/or are encountering ongoing violence).
- ▶ Design interim care placements and shelters for separated and unaccompanied children in ways that protect against GBV risks:
 - Undertake a protection risk assessment when identifying interim care placements in order to support the best interest process.
 - Ensure privacy for children, both girls and boys (e.g. sex-segregated washing facilities and sleeping rooms).
 - Regularly monitor the placements and facilities for GBV risks. Ensure on-going monitoring processes involve safe and confidential consultation with girls and boys.



PROMISING PRACTICE

Children and adolescents of all ages can benefit from a service provider who has several methods of giving and receiving information, such as drawings, stories and/or the use of dolls. As with all interventions, these methods must be age-, gender- and culturally appropriate. In a refugee camp, a social worker interviewed a six-year-old boy about his experiences with sexual abuse. The child had been sexually abused by an older boy, and the child told the social worker that he was hurt in his "bum." The social worker wanted to make sure that she, and her child client, had the same understanding of the word "bum." So she brought out her boy doll and she asked the child survivor to show her where the bum was located on the doll. The boy took the doll and pointed to the doll's rear end. This confirmed for the social worker that she accurately understood what the child survivor was saying.

(Adapted from **IRC and UNICEF. 2013. Caring for Child Survivors of Sexual Abuse**, http://gbvresponders.org/sites/default/files/IRC_CCSGuide_FullGuide_lowres.pdf)



- ▶ When seeking long-term alternative care solutions for separated and unaccompanied children, screen kinship and foster care systems for potential GBV risks to children in placement and implement strategies to prevent exposure to GBV. Ensure follow-up visits to monitor these placements.
- ▶ Ensure staff members and caregivers in placement centers:
 - Are carefully vetted.
 - Understand and have signed a code of conduct on the prevention of sexual exploitation and abuse.
 - Receive training on gender, GBV, women's rights and children's rights, and individual needs of children in their care.
 - Understand and can implement SOPs related to confidential systems of care for child survivors.
 - Receive regular supervision and support.
- ▶ Prominently display GBV prevention messages—as well as information about where children and caregivers can report risk and how survivors can access care for GBV—in reception areas, shelters, and other interim care placements. Ensure children are aware of what constitutes abuse and what to do if abuse occurs in a placement.
- ▶ Include an analysis of GBV risks in follow-up visits to families reunified with their children. Consider the need for specialized prevention and mitigation measures for children and adolescents at high risk of GBV (e.g. targeted cash transfers and/or livelihoods support to families where poor children are at risk of commercial sexual exploitation, or where families may seek to place girls in early marriages; relocation for children who are being sexually abused by family members, taking into careful consideration the potential negative consequences of breaking family or community ties and support mechanisms; etc.).

6. Incorporate efforts to address GBV into activities targeting children associated with armed forces/groups.

- ▶ Ensure that child protection actors working to prevent and respond to child recruitment are sensitized to the differential and discrete risks for girls and for boys (e.g. risk of girls being recruited and used for sexual purposes and/or child marriage, and boys being recruited into fighting forces and/or subject to sexual abuse). Undertake advocacy and facilitate coordination with relevant authorities and community-based groups to address these discrete risks.
- ▶ Integrate strategies into disarmament, demobilization and reintegration processes that identify and assist girls who may otherwise be overlooked because they are dependents or “wives” of members of armed forces/groups. Address the particular needs of girls who are pregnant or have children, and ensure support to their children.
- ▶ Undertake non-stigmatizing social reintegration programming for children formerly associated with armed forces/groups who have been exposed to sexual and other forms of GBV. Ensure that the concerned community benefits from the reintegration support provided to boys and girls, and that family and community members are assisted in protecting and supporting child survivors rather than stigmatizing them.





PROMISING PRACTICE

In Sierra Leone's reintegration programming for girls, UNICEF worked with implementing partners to provide educational opportunities to girls formerly associated with fighting forces. These programmes combined classroom and vocational training with childcare and feeding programmes so that girls with infants could attend while their children were nearby in a positive, safe environment. Importantly, schools that received former captive children were 'rewarded' with additional supplies and books that benefited all students in the community, thereby avoiding the appearance that only former captive children received educational assistance. Additionally, accelerated schooling helped older girls gain basic literacy and math skills they missed due to the length of time spent in fighting forces.

(Adapted from Ward, J. 2007. *From Invisible to Indivisible: Promoting and Protecting the Right of the Girl Child to be Free from Violence*. p. 56. https://www.unicef.at/fileadmin/media/Infos_und_Medien/Info-Material/Maedchen_und_Frauen/From_Invisible_To_Indivisible_-_Rights_of_Girl_Child.pdf)

7. Ensure the safety and protection of children in conflict with the law.

- ▶ Monitor detention facilities where children or adolescents are held to identify potential GBV risks. Ensure that girls and boys are being held in separate facilities (or departments of facilities), and that children are being held separately from adults. Raise awareness among detention facility staff on issues of gender, GBV, women's rights and children's rights, and advocate for the establishment of complaint-reporting mechanisms in detention facilities. Ensure that the input of girls and boys is incorporated into the development of complaints mechanisms.
- ▶ Where necessary and appropriate, support the establishment of women's desks and gender desks in police stations.
- ▶ Analyze and monitor customary and informal law procedures in which children may be involved to identify risks of violence. Ensure that such procedures protect the rights of children who use or are subject to them.
- ▶ Advocate for the use of alternative sanctions in all cases to ensure that detention is only ever used as a last resort. Monitor alternative sanctions such as probation or community service to identify risks of violence.
- ▶ Advocate with authorities to ensure that children who have been exploited and abused through commercial sexual exploitation are treated as survivors and are not subject to prosecution or punishment.

Integrating GBV Prevention and Response into: Child Protection POLICIES

1. Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of child protection programmes.

- ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in child protection activities. These can include, among others:
 - Policies regarding childcare for child protection staff.
 - Standards for equal employment of females.
 - Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.



- ▶ Circulate these widely among child protection staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).

2. Support the reform of national and local laws and policies (including customary laws) to promote and protect the rights of children to be free from GBV.

- ▶ Review laws, regulations, policies and procedures, and advocate with relevant stakeholders (including governments, policymakers, customary/traditional leaders, international organizations and non-governmental entities) to promote adherence to international laws and standards regarding the rights of children, gender equality and the empowerment of girls.
- ▶ Where necessary, advocate for the revision of customary laws and processes regarding harmful traditional practices against children (e.g. child marriage, female genital mutilation/cutting, child labour, etc.) that are not aligned with constitutional and international standards.
- ▶ Advocate for, and provide technical support on, the inclusion of the rights of children in rule-of-law and security sector reform.
- ▶ Encourage attention to GBV against children and adolescents in all return, relocation and reintegration frameworks; developmental actions plans; and disarmament, demobilization and reintegration programmes. Such frameworks and action plans should contain measures to prevent and respond to GBV against children, provide adequate care and support to child survivors, and support gender equality and the empowerment of girls.
- ▶ Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. Undertake sensitization and awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.

Integrating GBV Prevention and Response into: Child Protection COMMUNICATIONS and INFORMATION SHARING

- ### **1. Ensure that child protection programmes sharing information about reports of GBV within the child protection sector or with partners in the larger humanitarian community abide by safety and ethical standards.**
- ▶ Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to child survivors, their caretakers or the broader community. Consider using the international Gender-based Violence Information Management System (GBVIMS), and explore linkages between the GBVIMS and existing Child Protection Information Management Systems.³



ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.

³ The GBVIMS is not meant to replace national child protection or other information systems collecting GBV information. Rather, it is an effort to bring coherence and standardization to GBV data-collection in humanitarian settings, where multiple actors often collect information using different approaches and tools. For more information, see <http://www.gbvims.com>.



2. Incorporate GBV messages into child protection-related community outreach and awareness-raising activities.

- ▶ Work with GBV specialists to integrate awareness-raising on GBV into child protection-related messaging.
 - Ensure this awareness-raising includes information on prevention, survivor rights (including confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
 - Conduct workshops with children on safe and unsafe touch and how to report abuse.
 - Disseminate child-friendly versions of referral pathways and other key information, using multiple formats and languages to ensure accessibility (e.g. braille, sign language, simplified messaging such as pictograms and pictures, etc.).
 - Target affected populations and key stakeholders (including government, humanitarian workers, local authorities, police, teachers, families, children, adolescents, religious and community leaders, and community members).
 - Engage (separately when necessary) women, girls, men and boys in the development of messages and in strategies for their dissemination so they are age-, gender- and culturally-appropriate.
- ▶ Thoroughly train child protection outreach staff on issues of gender, GBV, women's rights, children's rights, and child-friendly psychological first aid (e.g. how to engage supportively with child survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).
- ▶ Engage males, particularly leaders in the community, as agents of change in child protection outreach activities related to the prevention of GBV. Ensure that men are actively engaged in discussions about the traditionally female area of childcare and day-to-day child protection responsibilities.
- ▶ Consider the barriers faced by women, girls and other at-risk groups to their safe participation in community discussion forums and educational workshops related to child protection (e.g. transportation; meeting times and locations; risk of backlash related to participation; need for childcare; accessibility for persons with disabilities; etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of separate girls' discussion groups, etc.) so that participants feel safe to raise GBV issues.
- ▶ Provide community members with information about existing codes of conduct for child protection personnel, as well as where to report sexual exploitation and abuse committed by child protection personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.





KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

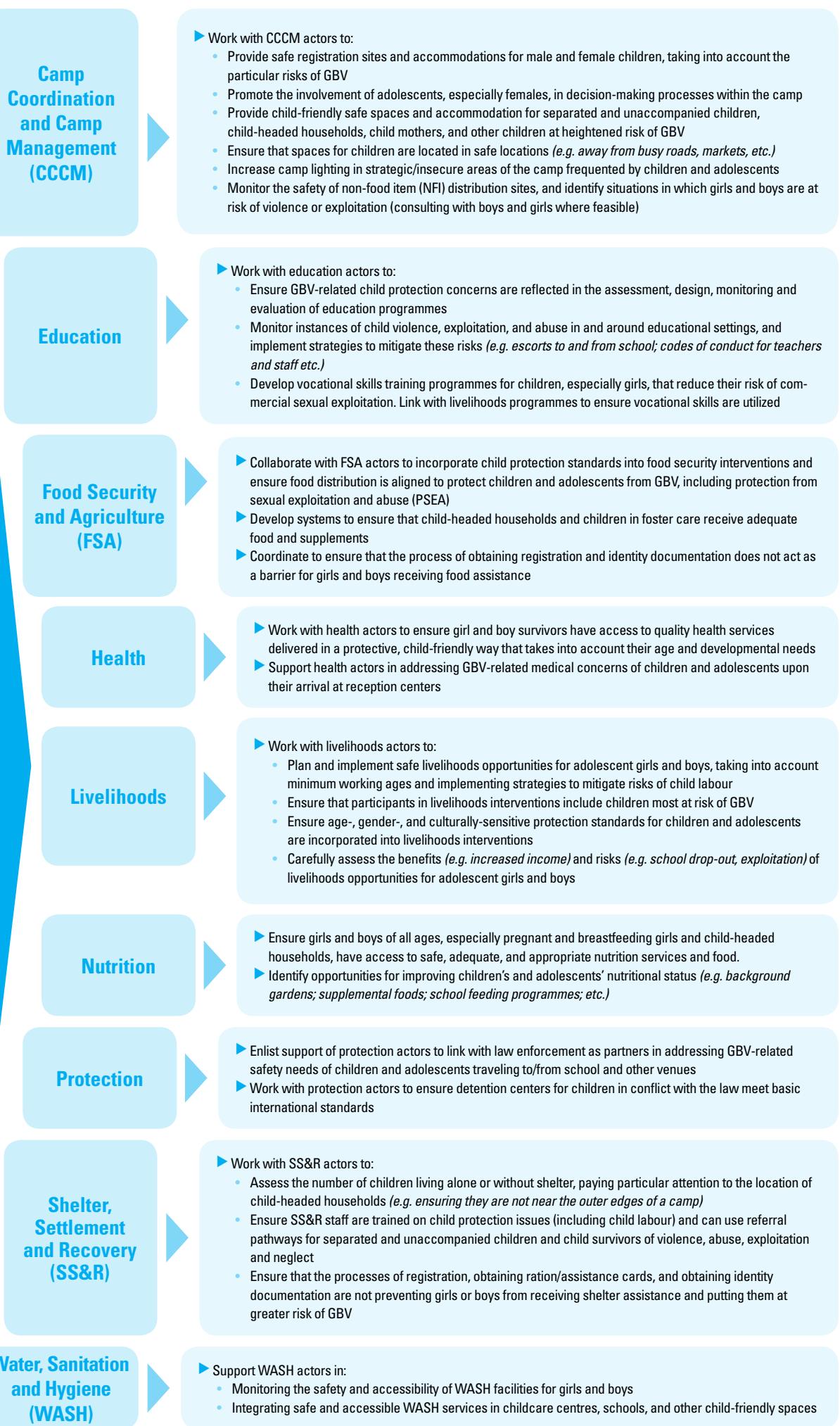
As a first step in coordination, child protection programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist child protection programmers to:

- ▶ Design and conduct safe and ethical GBV-related assessments and other data collection related to child protection, and strategize about ways these risks can be mitigated.
- ▶ Conduct background research on the nature and incidence of specific forms of GBV against children in the setting.
- ▶ Provide trainings for child protection staff on issues of gender, GBV and women's rights, and how to respectfully and supportively engage with survivors.
- ▶ Identify where survivors who may report instances of GBV exposure to child protection staff can receive safe, confidential and appropriate care, and provide child protection staff with the basic skills and information to respond supportively to survivors.
- ▶ Provide training and awareness-raising for the affected community on issues of gender, GBV, women's rights and children's rights as they relate to child protection.

In addition, child protection programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, child protection actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.



CHILD PROTECTION





KEY GBV CONSIDERATIONS FOR: MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in child protection (CP) assessments⁴	$\frac{\# \text{ of CP assessment that include GBV-related questions* from the GBV Guidelines} \times 100}{\# \text{ of CP assessment}}$ <small>* See page 54 for GBV areas of inquiry that can be adapted to questions in assessments</small>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	$\frac{\# \text{ of assessment respondents who are female} \times 100}{\frac{\# \text{ of assessment respondents and } \# \text{ of assessment team members who are female} \times 100}{\# \text{ of assessment team members}}}$	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

⁴ Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Existence of child-friendly safe spaces in a community during the assessment⁵	$\frac{\# \text{ of targeted communities that have a safe space for children during the assessment} \times 100}{\# \text{ of targeted communities during the assessment}}$	Direct observation, W matrix	Determine in the field			
Existence of child-friendly multi-sectoral services for child survivors of GBV⁶	$\frac{\# \text{ of targeted communities with child-friendly multi-sectoral services* for child survivors of GBV} \times 100}{\# \text{ of targeted communities}}$ <p>* Multi-sectoral services includes child-friendly health care, mental health and psychosocial support, security and legal/justice response</p>	W matrix	Determine in the field			
RESOURCE MOBILIZATION						
Inclusion of GBV risk reduction in child protection funding proposals or strategies	$\frac{\# \text{ of CP funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines} \times 100}{\# \text{ of CP funding proposals or strategies}}$	Proposal review (at agency or sector level)	100%			
Training of child protection staff on the GBV Guidelines	$\frac{\# \text{ of CP staff/agencies who participated in a training on the GBV Guidelines} \times 100}{\# \text{ of CP staff/agencies}}$	Training attendance, meeting minutes, survey (at agency or sector level)	100%			
IMPLEMENTATION						
► Programming						
Female staff in child protection programmes	$\frac{\# \text{ of staff in CP programmes who are female} \times 100}{\# \text{ of staff in CP programmes}}$	Organizational records	50%			
Ratio of boys and girls in child-friendly community spaces <i>Disaggregate by age groups (aged 0-6, 7-12, 13-18)</i>	<p><i>Quantitative:</i></p> $\frac{\# \text{ of girls attending child-friendly community spaces}}{\# \text{ of boys attending child-friendly community spaces}}$ <p><i>Qualitative:</i> What are barriers to girls' participation in child-friendly safe environments? What are barriers to boys' participation?</p>	W matrix, Organizational records, focus group discussion (FGD), key informant interview (KII)	Determine in the field			

(continued)

⁵ United Nations Office for the Coordination of Humanitarian Affairs. *Humanitarian Indicator Registry*. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
► Programming									
Consultations with the affected population on accessing services for child survivors of GBV⁵	<p><i>Quantitative:</i></p> <p># of services* for child GBV survivors conducting consultations with the affected population to accessing the service x 100</p> <hr/> <p># of services for child GBV survivors</p> <p><i>Qualitative:</i></p> <p>What types of barriers do children experience in accessing services for GBV?</p> <p>* Services include health care, mental health and psychosocial support, security and legal/justice response</p>	Organizational records, FGD, KII	100%						
<i>Disaggregate consultations by sex and age</i>				✓	✓				
Service provider knowledge of Core Child-Friendly Attitude Competency Areas	<p># of service providers* who, in response to a prompted question, correctly say the core child-friendly attitude competency areas** x 100</p> <hr/> <p># of surveyed service providers</p> <p>* Service providers include medical, mental health and psychosocial, police and legal/justice response; criteria should be determined in the setting</p> <p>** See page 61 for description of core child-friendly attitude competency areas</p>	Survey	Determine in field		✓	✓			
Placements for separated and unaccompanied children that are receiving visits to monitor risk factors of GBV⁵	<p># of placements for separated/unaccompanied children that are receiving visits to monitor risk factors of GBV x 100</p> <hr/> <p># of placements for registered separated/unaccompanied children</p>	W matrix, CP Information Management System	Determine in the field	✓	✓				
Coverage of services for child survivors of GBV participating in disarmament, demobilization and reintegration (DDR) programs	<p># of DDR programs that provide services for child survivors of GBV x 100</p> <hr/> <p># of DDR programs</p> <p>* Services include medical, mental health and psychosocial, police and legal/justice response</p>	Organizational records, KII	Determine in the field	✓	✓				
Existence of alternative measures for children in conflict of the law	# of specified locations with measures other than detention for children in conflict of the law	KII, desk review	100%	✓	✓				
► Policies									
Inclusion of GBV prevention and mitigation strategies in child protection policies, guidelines or standards	<p># of CP policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines x 100</p> <hr/> <p># of CP policies, guidelines or standards</p>	Desk review (at agency, sector, national or global level)	Determine in the field	✓	✓				

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
► Communications and Information Sharing									
Staff knowledge of standards for confidential sharing of GBV reports	# of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100 <hr/> # of surveyed staff	Survey (at agency or programme level)	100%	✓		✓			
Inclusion of GBV referral information in child protection community outreach activities	# of CP community outreach activities programmes that include information on where to report risk and access care for GBV survivors x 100 <hr/> # of CP community outreach activities	Desk review, KII, survey (at agency or sector level)	Determine in the field	✓	✓				
COORDINATION									
Coordination of GBV risk reduction activities with other sectors	# of non-CP sectors consulted with to address GBV risk reduction activities x 100 <hr/> # of existing non-CP sectors in a given humanitarian response <small>* See page X for list of sectors and GBV risk reduction activities</small>	KII, meeting minutes (at agency or sector level)	Determine in the field	✓	✓				



RESOURCES

Key Resources

- **UNICEF.** 2010. "Core Commitments for Children in Humanitarian Action." New York: UNICEF. http://www.unicef.org/cholera/Chapter_1_intro/05_UNICEF_Core%20Commitments_for_Children_in_Humanitarian_Action.pdf
- **Child Protection Working Groups (CPWG). 2012.** *Minimum Standards for Child Protection in Humanitarian Action*, http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1103/Minimum-standards-Child_Protection.pdf
- **IRC, OHCHR, Save the Children, Terre des Hommes, UNHCR, and UNICEF.** 2008. *Action for the Rights of Children*, <http://www.ohchr.org/Documents/HRBodies/CEDAW/HarmfulPractices/HandicapInternationalandSavetheChildren.pdf>
- **Handicap International and Save the Children.** 2011. *Out from the Shadow. Sexual violence against Children with disabilities*, <http://www.ohchr.org/Documents/HRBodies/CEDAW/HarmfulPractices/HandicapInternationalandSavetheChildren.pdf>
- **Save the Children, UNICEF, IRC, ICRC, World Vision.** 2004. *The Guiding Principles on Unaccompanied and Separated Children*, http://www.unicef.org/protection/IAG_UASCs.pdf
- **Child Protection Working Group (CPWG) and GBV Area of Responsibility (GBV AoR).** 2014. *Fundraising Handbook for Child Protection and Gender Based Violence in Humanitarian Action*. This handbook has been developed to help field practitioners meet the expectations of donors when planning and implementing child protection and GBV responses. http://cpwg.net/wp-content/uploads/sites/2/2014/03/FUNDRAISING_HANDBOOK.pdf
- **International Rescue Committee and UNICEF.** 2012. *Caring for Child Survivors in Humanitarian Aid Settings: Guidelines for providing case management, psychosocial interventions and health care to child survivors of sexual abuse*, http://www.unicef.org/pacificislands/IRC_CCSGuide_FullGuide_lowres.pdf
- **WHO.** 2007. *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, <http://www.refworld.org/docid/468c9da62.html>
- **UNHCR.** 2008. *Guidelines on Determining the Best Interests of the Child*, <http://www.unhcr.org/4566b16b2.pdf>
- **Child Protection Working Group.** 2011. Child Protection Rapid Assessment: <http://www.alnap.org/resource/7481.aspx?tag=461>. A Child Protection Rapid Assessment (CPRA) is an inter-agency, cluster-specific rapid assessment, designed and conducted by CPWG members in the aftermath of a rapid-onset emergency. It is meant to provide a snapshot of urgent child protection related needs among the affected population within the immediate post-emergency context, as well as act as a stepping-stone for a more comprehensive process of assessing the impacts of the emergency.
- **International Rescue Committee and University of California, Los Angeles, Centre for International Medicine.** 2008. *Clinical care for sexual assault survivors: A multimedia training tool, Facilitators guide*, <http://clinicalcare.rhrc.org/docs/facguide.pdf>

Additional Resources

- **INEE.** 2011. *The Minimum standards for education: preparedness, response, recovery*, http://www.ineesite.org/eietworkmodule/cases/learningistheirfuture/pdf/Minimum_Standards_English_2010.pdf
- **Ward, J.** 2007. "From Invisible to Indivisible: Promoting and Protecting the Right of the Girl Child to be Free from Violence." New York: UNICEF. https://www.unicef.at/fileadmin/media/Infos_und_Medien/Info-Material/Maedchen_und_Frauen/From_Invisible_To_Indivisible_-_Rights_of_Girl_Child.pdf
- **UNHCR.** 2008. *Handbook for the Protection of Women and Girls*, <http://www.unhcr.org/protect/PROTECTION/47cae612.html>
- **Child Soldiers International.** 2012. "Louder than words: An agenda for action to end state use of child soldiers." http://child-soldiers.org/global_report_reader.php?id=562/. For more information, see also <http://www.warchild.org.uk/issues/child-soldiers>
- **Handicap International, n.d.** *Disability Checklist for Emergency Response*. This booklet provides general guidelines for the protection and inclusion of injured persons and persons with disabilities in humanitarian settings, and includes a page on protection related to women and children with disabilities. http://www.handicap-international.de/fileadmin/redaktion/pdf/disability_checklist_booklet_01.pdf
- **Save the Children UK.** 2008. *No one to turn to*, http://pseatackforce.org/uploads/tools/noonetoturnunderreportingofchild-seabayaiddworkersandpeacekeepers_savethechildrenuk_english.pdf
- **NGO Advisory Council for Follow-Up to the UN Study on Violence Against Children.** 2011. *Five Years On: A Global Update on Violence Against Children*, http://www.crin.org/docs/Five_Years_On.pdf
- **UN Secretary-General.** 2006. *World Report on Violence Against Children*, [http://www.unicef.org/lac/full_text\(3\).pdf](http://www.unicef.org/lac/full_text(3).pdf)







EDUCATION

THIS SECTION APPLIES TO:

- Education coordination mechanisms
- Education actors (staff and leadership): NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, etc.) related to education
- Other education stakeholders, including national and local governments, community leaders, and civil society groups

Why Addressing Gender-based Violence is a Critical Concern of the Education Sector

In many humanitarian settings, attending school can be a risky endeavour. Because of the erosion of standard protection mechanisms caused by humanitarian emergencies, students and education personnel—particularly females—may face an increased risk of sexual harassment, sexual assault, or abduction while travelling to and from school. Lack of supervisory staff increases the risk of bullying, sexual harassment and sexual assault occurring on school grounds, by peers as well as teachers and other adults.

Unethical teachers may take advantage of their positions and sexually exploit students. A report by UNHCR/Save the Children UK (2002) drew widespread attention to the exploitation of girls and young women by humanitarian workers in refugee camps in West Africa. Teachers were identified as one of the key groups of perpetrators, taking advantage of their authority over students and offering good grades and other school privileges in return for sex.

Access to education is often a challenge during emergencies as traditional education systems become disrupted. For example:

- ▶ Refugee children living in urban areas may have difficulty attending school if they cannot afford the fees or if schools are already overcrowded.
- ▶ Educational programmes in camp settings may be non-existent or limited to primary school level.
- ▶ Children with disabilities may be prevented from participating in education programmes that do not adhere to principles of universal design and/or reasonable accommodation.¹
- ▶ Parents may be afraid to send girls to school for fear of their exposure to GBV in or on the way to school.

¹ For more information regarding universal design and/or reasonable accommodation, see definitions in Annex 4.



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



PART 3: GUIDANCE

at the Programme Cycle

	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
female/female education staff; strategies for hiring and retaining females and other at-risk groups (e.g. girls; etc.)	✓	✓	✓	✓
measures that may prevent girls from going to school; child and/or forced marriage; pregnancy; lack of	✓	✓	✓	✓
safe spaces for girls and boys; adequate lighting within and around buildings; school safety patrols;	✓	✓	✓	✓
where survivors can report risk and access care; linkages between education programming	✓	✓	✓	✓
systems; standard reporting mechanisms and systems of care; confidentiality measures; students' education personnel; etc.)	✓	✓		
gender equality, GBV, sexual and reproductive health, etc.)	✓	✓	✓	
prevention, where to report risk and how to access care)	✓	✓	✓	✓
<hr/>				
emergency education kits; school uniforms or other appropriate clothing; sanitary supplies for	✓	✓	✓	✓
safe design and implementation of education programmes that mitigate the risk of GBV	✓	✓	✓	✓
ing processes	✓	✓	✓	✓
<hr/>				
reduces the risk of GBV)	✓	✓	✓	✓
additional education programmes; funding for school-related costs; re-enrolment programmes for		✓	✓	✓
of learning centres; distance from households; safety patrols along paths; safe and separate toilets	✓	✓	✓	✓
on gender, GBV, and women's/human rights; ensure all education personnel understand and have	✓	✓	✓	✓
as the basic skills to provide information to them on where they can obtain support		✓	✓	✓
ender norms and promotes a culture of non-violence and respect for women, girls, and other			✓	✓
relationship skills, GBV, and conflict transformation; etc.)				✓
<hr/>				
employment of females; codes of conduct for teachers and education personnel related to sexual	✓	✓	✓	✓
ity (e.g. address discriminatory practices hindering girls and other at-risk groups from safe			✓	✓
<hr/>				
they abide by safety and ethical standards (e.g. shared information does not reveal the identity of or	✓	✓	✓	✓
rising activities		✓	✓	✓
<hr/>				
coordination meetings	✓	✓	✓	✓
<hr/>				
duction activities throughout the programme cycle	✓	✓	✓	✓
nd ensure accountability		✓	✓	✓

- ▶ Impoverished families may prioritize boys' education and not have the money to pay for girls' school fees, uniforms, and other supplies. This puts girls at an economic disadvantage and heightens their risk of sexual exploitation in exchange for school-related fees. When girls are denied the opportunity to attend school (and boys are given priority), this in itself constitutes a form of GBV.

In addition, lack of sanitation facilities and supplies—as well as cultural taboos and stigma around menstruation—can contribute to low attendance and high dropout rates among adolescent girls who are menstruating. Family caretaking responsibilities, child marriage, and pregnancy are additional barriers to girls taking up or continuing their schooling. Even where girls are enrolled in high numbers, dropout rates toward the end of primary school are often high in many humanitarian settings.

School curricula and other teaching materials may reinforce traditional notions about gender roles and sexuality that underpin GBV. This problem is exacerbated in school settings where there are few female teachers (especially in positions of authority). Intersex, transgender, lesbian, gay, and bisexual children and youth are particularly at risk of bullying in schools. School authorities may have little understanding of sexual orientation and gender identity issues and may exclude students suspected of being different. As trusted adults, teachers may be required to be first responders to children and youth experiencing GBV and other forms of violence. How they respond to disclosures is critical to the outcome for the child.

While poorly designed education programmes can exacerbate the problem of GBV, **education programmes that are well-designed can be critical to reducing GBV:**

- ▶ **If designed properly, educational facilities can provide a protective environment for children and youth at risk of GBV.** Students' risk of exposure to different forms of GBV can be mitigated through: thoughtful planning of education delivery strategies and structures; placement of learning centers away from danger zones in urban areas and/or camps; careful employment and training of teachers and school administrators; and sensitization and awareness-raising for students and the community. Additionally, girls who are kept in school through the secondary education level are less likely to enter early marriages or engage in sexually exploitative income-earning activities.
- ▶ **School is a place where cultural norms can be challenged and re-shaped to support gender equality and prevent GBV.** As well as teaching traditional academic subjects, both

WHAT THE INEE MINIMUM STANDARDS SAY:

Access and Learning Environment, Standard 2

- ▶ ‘learning environments are secure, promote the protection and mental and emotional well-being of learners’.
- ▶ “Students, especially minorities and girls, often become targets for abuse, violence, recruitment or abduction when going to and from school. In these cases students’ security can be improved by a combination of community information campaigns and by having adults from the community escort them...In addition, education programmes should include monitoring of the level of harassment experienced by girls and women”.

Teaching and Learning, Standard 4

- ▶ “Assessment and evaluation should be developed and implemented according to a code of ethics. Assessments and evaluations should be considered fair and reliable and should be conducted in a way that does not increase fear and trauma. Care should be taken that there is no harassment of learners in return for good marks or promotions within a school or programme”.

Teachers and Other Education Personnel, Standard 2

- ▶ Codes of conduct should state, among other things, that education personnel:
 - “exhibit professional behaviour by maintaining a high standard of conduct, self-control and moral/ethical behaviour;
 - participate in creating an environment in which all students are accepted;
 - maintain a safe and healthy environment, free from harassment (including sexual harassment), intimidation, abuse and violence, and discrimination...”

(Excerpted from **The Inter-Agency Network for Education in Emergencies. 2010. Minimum Standards for Education: Preparedness, Response, Recovery.** <http://toolkit.ineesite.org/toolkit/Toolkit.php?PostID=1002>)



primary and secondary education programmes provide an opportunity for promoting a culture of non-violence, equality, and respect for women, girls, and other at-risk groups.² Schools are effective sites for educating boys and girls on issues such as gender norms, human rights, abuse prevention, conflict mediation, and healthy communication skills. Community outreach measures can build trust between schools and parents and create communities that reinforce the positive norms and practices students are learning in schools.

- ▶ **Reaching those at risk of GBV through life skills programmes**—both within and outside of the education system—helps prevent GBV by developing positive leadership abilities and supporting the empowerment of girls and female youth. It also provides an opportunity to work with young and adolescent boys to challenge long-held beliefs about masculinity and what it means to ‘be a man.’
- ▶ **Education is a valuable asset for future economic and social opportunities for women, girls and other at-risk groups.** It empowers them to overcome systemic gender oppression and provides them with knowledge and skills. In conflict-affected settings, ensuring access to quality education through the secondary level also prepares them to play important roles in community reconstruction efforts that contribute to lasting peace.

Actions taken by the education sector to prevent and respond to GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. Education actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)

Addressing Gender-based Violence Throughout The Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by education actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with education actors working in partnership with other sectors as well as with GBV specialists.

The information generated from these areas of inquiry should be analyzed to inform planning of education programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.

² For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



The areas of inquiry below should be used to complement existing guidance materials addressing gender and GBV concerns in education, particularly the **INEE Minimum Standards for Education: Preparedness, Response, Recovery** (<http://toolkit.ineesite.org/toolkit/Toolkit.php?PostID=1002>). The **Joint Needs Assessment Toolkit** (http://www.savethechildren.org.uk/sites/default/files/docs/Ed_NA_Toolkit_Final_1.pdf) of the Global Education Cluster is also a key guidance document for conducting education assessments in emergencies.

KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in education: government; civil societies; local and religious leaders; school administrators; teachers; students; parents and parent-teacher associations (PTAs); GBV, gender and diversity specialists
- Affected populations and communities
- In IDP/refugee settings, members of the receptor/host communities

PROMISING PRACTICE

Flexible programmes designed in consultation with communities and youth have been proven to support local ownership and sustainability (Rahim and Holland, 2006; UNHCR, 2001). While simpler to accomplish, the disproportionate targeting of community elites has proven counterproductive as it strengthens existing inequities. Since training is a form of empowerment, the most vulnerable youth must be identified, approached and engaged, and parents and guardians must be involved in programme activities for programmes to be successful (Sommers, 2001a). Programmes cannot rely solely on the demand of the affected population that is visible, but must make concerted efforts to reach girls, especially, who may be “invisible” in the community. Involving local communities and youth may require the adoption of simpler language and the translation of materials into local languages (Sommers, 2001a).

While participatory and inclusive approaches can delay programme implementation, they are essential to achieving sustainable success (Hayden, 2007).

(Adapted from Zeus, B. and Chaffin, J. 2011. *Education for Crisis-Affected Youth: A Literature Review*. INEE Adolescent and Youth Task Team. http://www.ineesite.org/uploads/files/resources/AYTT_LitReview_2012-02-14.pdf)

POSSIBLE AREAS OF INQUIRY

(Note: This list is not exhaustive)

Areas related to Education PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female education staff, including in positions of leadership?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are women, adolescent girls and other at-risk groups actively involved in community-based activities related to education (e.g. parent-teacher associations, community committees, etc.)? Are they in leadership roles when possible?
- c) Are there female para-professionals or other women in the community who could be involved in teaching, mentoring, or other ways of supporting girls—especially female youth—in schools?
- d) Are the lead actors in education response aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation strategies into their activities?

Cultural and Community Norms and Practices

- e) How has the crisis impacted the access to and availability of education programmes, particularly for girls and other at-risk groups?
- f) Which children and youth are not attending—or face barriers to attending—school at primary and/or secondary levels (e.g. adolescent girls, child heads of households, girl-mothers, sexual assault survivors, children associated with armed forces/groups, girls and boys with disabilities, LGBTI children, refugee children in urban settings, etc.)?
 - What cultural barriers do girls face in accessing education (e.g. gender norms that prioritize education of boys over girls; gender-discriminatory attitudes toward girls in education settings; child and/or forced marriage; domestic responsibilities; etc.)?
 - What cultural barriers do other at-risk groups of children face in accessing education (e.g. stigma; discrimination; poverty; sexuality norms that result in families disowning LGBTI youth or refusing to support

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

their education; social exclusion or detention of children associated with armed forces/groups; refugee children living in urban areas denied equal access to local education facilities; etc.)?

- Are there strategies in place for reintegration and re-enrollment for those who have dropped out?
- g) What is the situation regarding parental/community involvement in education?
 - Do parent-teacher associations (PTAs) or similar structures exist?
 - To what extent are women and men involved?
 - Are there any cultural restrictions to women's involvement?
- h) What are boys' attitudes toward girls in education settings, and girls' attitudes toward other girls? What are girls' and boys' attitudes toward boys?
 - Is there evidence of gender inequitable attitudes or practices?
 - Are these attitudes or practices supported and/or internalized by girls (particularly adolescent females)?
- i) What safety precautions are girls expected to take when attending or traveling to school? Are there any violence-related risks that boys face when going to school (whether gender-based or not)?
- j) What are the normal help-seeking behaviors of child survivors of GBV and other forms of violence? What are the risks (safety, stigma) related to reporting an incident?

Infrastructure and Safety

- k) Are schools and other learning environments located in areas that are safe and equally accessible for women, girls and other at-risk groups?
 - Are women and girls involved in decisions about the location of safe learning environments?
 - Are all levels of schooling equally accessible (not only lower grades)?
 - Are education centres built based on universal design and/or reasonable accommodation to ensure accessibility for all persons, including those with disabilities (e.g. physical disabilities, injuries, visual or other sensory impairments, etc.)?
- l) Are the distances and routes to be travelled to school safe for all students—particularly girls—and acceptable to parents?
 - Are strategies in place to accompany students to learning environments as necessary?
 - Has safety mapping been conducted with students and teachers to identify at-risk zones in and around learning environments?
 - Are there safety patrols for potentially insecure areas?
- m) Are learning environments physically secure?
 - Is there sufficient lighting?
 - Are toilets accessible, private, safely located, adequate in number and sex-segregated?
 - Are sanitary supplies available in schools for female students and teachers of reproductive age?
- n) What are the common GBV-related safety risks faced by students and education personnel—especially women, girls and other at-risk groups—while accessing education (e.g. sexual exploitation by teachers or staff; harassment or bullying on school grounds; students, particularly girls or transgender students, engaging in exploitative sexual relationships to cover school fees; etc.)?

Reporting Mechanisms and Systems of Care (i.e. Referral Pathways)

- o) Are there referral pathways through which survivors of GBV can access appropriate care and support, and are these pathways linked to educational settings?
 - Is information provided to students and education personnel on reporting mechanisms and follow-up for exposure to GBV, including sexual exploitation and abuse?
 - Are there gender and age-responsive materials and services available to support survivors of GBV in the learning environment?
 - Do legal frameworks put survivors at risk if they report same-sex abuse to their teachers, or put teachers at risk if they respond to such reports?
 - Are students regularly asked to provide feedback/input on the quality of reporting and referral systems?
- p) Has training been provided to education staff on:
 - How to respectfully and supportively engage with survivors who may disclose incidents of GBV?
 - How to provide immediate referrals in an ethical, safe and confidential manner?
 - How to best support a survivor to remain in or return to school once a report has been disclosed?
- q) Are there community groups that provide support to survivors of GBV? Are these linked to the learning environment?

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Teaching Capacity and Educational Curricula

- r) Are teachers and administrators trained to address specific topics related to health and empowerment of girls—especially adolescent females?
 - Do teacher training curricula explicitly integrate sexuality education and other gender-related education issues (*i.e. gender-sensitive teaching methods; factors affecting girls' and boys' access, enrollment, and achievement levels; etc.*)?
 - Are these trainings and educational curricula age-, gender- and culturally-appropriate?
- s) Are learning materials inclusive of and relevant to girls and other at-risk groups?
 - Do they avoid gender stereotypes?
 - Do primary and secondary school teaching methods respect girls as equals (*i.e. are girls encouraged to ask and answer as many questions as boys; are boys encouraged to not dominate group work; are classroom cleaning tasks equally divided between girls and boys; etc.*)?
- t) Do learning materials provide information—building upon indigenous knowledge and practices—on issues such as gender equality, GBV, HIV, human rights, relationship skills, etc.? Is high quality, accurate, and relevant sexuality education offered to all students in ways that are age-, gender-, and culturally-appropriate?

Areas related to Education POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of education programmes?
 - Are women, girls and other at-risk groups meaningfully engaged in the development of education policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Have these policies, standards and guidelines been communicated to women, girls, boys and men (separately when necessary)?
 - Is education staff properly trained and equipped with the necessary skills to implement these policies?
- b) Do national and local education sector policies discriminate against girls and other at-risk groups or hinder their safe access to educational opportunities (*e.g. are adolescent girls who become pregnant excluded from continuing their education?*)?
- c) Do national and local education sector policies and plans integrate GBV-related risk reduction strategies? Do they allocate funding for sustainability of these strategies?

Areas related to Education COMMUNICATIONS and INFORMATION SHARING

- a) Do education programmes raise awareness within the community (*e.g. through PTAs or community-parent school coalitions*) about GBV risks and protective factors related to education?
 - Does this awareness-raising include information on prevention, survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Is information provided in age-, gender-, and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these awareness-raising activities as agents of change?
- b) Are education-related discussion forums age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential; with females as facilitators of women's and girls' discussion groups; etc.*) so that participants feel safe to raise GBV issues?



KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for education programming. Whether requesting pre-/emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**. Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.



A. HUMANITARIAN NEEDS OVERVIEW

- ▶ Does the proposal articulate the GBV-related safety risks, protection needs and rights of the affected population in educational settings?
- ▶ Are risks for specific forms of GBV (*such as sexual assault, sexual exploitation, child and/or forced marriage, etc.*) described and analysed, rather than a broader reference to “GBV”?
- ▶ Are issues of physical safety and access to learning centres understood and disaggregated by sex, age, disability, and other relevant vulnerability factors? Are the related risk factors of young and adolescent girls—and others who may be particularly at risk of GBV—recognized and described?
- ▶ Does the proposal reference:
 - Enrolment, attendance, and retention ratios between boys and girls at both primary and secondary levels of education?
 - Reports of exploitation and abuse disaggregated by sex, age, disability, and other relevant vulnerability factors?
 - Ratio of male to female school administrators and teachers?
- ▶ Are anticipated challenges to addressing GBV within the education sector analysed and addressed (*e.g. security risks in and around the learning center; attitudes and beliefs about violence, sexuality, and gender norms in the community and in the school; institutional capacity of the learning center to prevent and respond to GBV; etc.*)?

B. PROJECT RATIONALE/ JUSTIFICATION

- ▶ When drafting a proposal for emergency preparedness:
 - Is there an anticipation of the types of age-, gender-, and culturally-appropriate supplies that should be pre-positioned in order to facilitate a rapid education response that incorporates GBV risk mitigation (*e.g. development of gender-sensitive “school in a box” or other emergency kits; sturdy locks and lights for toilets; school uniforms or other appropriate clothing; sanitary supplies for female students and teachers of reproductive age; features to improve accessibility for persons with disabilities; etc.*)?
 - Is there a strategy for preparing and providing trainings for government, education personnel (including “first responder” education actors), and relevant community members on the safe design and implementation of education programmes that mitigate risks of GBV?
 - Are additional costs required to ensure any student learning and GBV-related community outreach materials will be available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- ▶ When drafting a proposal for emergency response:
 - Is there a clear description of how education programmes will mitigate exposure to GBV (*e.g. in terms of the curriculum and the location/design of learning environments*)?
 - Do strategies meet standards promoted in the Sphere Handbook?
 - Are additional costs required to ensure the safety and effective working environments for female staff in the education sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
- ▶ When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how the education project will contribute to sustainable strategies that promote the safety and well-being of those at risk of GBV, and to long-term efforts to reduce specific types of GBV (*e.g. by providing support to governments to ensure both primary and secondary education curricula promote gender equality and empowerment of girls, particularly adolescent girls*)?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

C. PROJECT DESCRIPTION

- ▶ Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for education programmes that may work with survivors of GBV?
- ▶ Do the proposed activities illustrate linkages with other humanitarian actors/sectors in order to maximise resources and work in strategic ways?
- ▶ Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as education staff and in community-based education committees?





KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some of the common GBV-related considerations when implementing education programming in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

Integrating GBV Risk Reduction into: EDUCATION PROGRAMMING

- 1. Involve women and other at-risk groups as staff and leaders in education programming**
(with due caution in situations where this poses a potential security risk or increases the risk of GBV).
 - ▶ Strive for 50% representation of females within education programme staff. Provide women with formal and on-the-job training as well as targeted support to assume leadership and training positions (e.g. employing them in high-profile positions where possible and not only in early year classes and “soft” subjects).
 - ▶ Ensure women (and where appropriate, adolescent girls) are actively involved in community-based education-related committees and associations. Be aware of potential tensions that may be caused by attempting to change the role of women and adolescent girls in communities and, as necessary, engage in dialogue with males to ensure their support.
 - ▶ Engage support of community leaders, religious leaders, and other community members in implementing strategies to create an environment in which female teachers and administrators feel safe and supported.
 - ▶ Employ persons from at-risk groups in education staff, leadership and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.



PROMISING PRACTICE

In South Sudan there are very few female teachers. This means that there is a lack of female role models and mentors for girls in school. The **Empowering Village Education (EVE)** project—started in 2008 by the African Educational Trust (AET) and in coordination with the Government of South Sudan and state Ministries of Education (MoEs)—developed the **School Mother** scheme to help fill this gap. One hundred women from the EVE communities were selected to be trained as School Mothers. The main aim of this approach was to provide a supportive school environment in order to enroll and retain more girls in school. School Mothers supported and encouraged girls with their education both in and out of school by providing advice, assistance and information on issues such as health and sanitation. They represented girls’ views and needs to head teachers, PTAs and MoEs; undertook advocacy work within the community; conducted home visits; and raised awareness of the importance of and right to education for girls.

(Adapted from the **African Educational Trust**. 2011. “Empowering Village Education: Improving Enrolment and Retention of Girls in Primary Schools in South Sudan.” <http://www.africaeducationaltrust.org/userfiles/AET%20EVE.pdf>)



2. Implement strategies that maximize accessibility of education programmes for women, girls and other at-risk groups.

- ▶ Building upon indigenous expertise and in consultation with women, girls, boys and men, promote the rapid (re)establishment of primary and secondary level educational facilities following the onset of an emergency. Where schools do not exist, create new schooling venues in order to provide safe spaces for students and avoid any discontinuation of educational programmes.
- ▶ Consider implementing alternative, informal, or non-traditional education programmes (e.g. night classes; distance learning; after-school or community activities; temporary learning spaces; computer-based interactive learning; accelerated learning; open learning programmes; etc.). These alternatives can be helpful in situations where traditional classrooms are not available and/or cannot be accessed by certain students (e.g. persons with disabilities; girl-mothers; children prevented from attending traditional school due to domestic responsibilities; children associated with armed forces/groups; etc.).
- ▶ Address logistical and cultural obstacles to the participation of women, girls and other at-risk groups in education programming:
 - Ensure locations and times of traditional and non-traditional education programmes meet the needs of women and adolescent girls who have domestic and family-related responsibilities.



PROMISING PRACTICE

The World Food Programme's (WFP) flagship school-feeding programme has helped increase the enrolment and retention of girls in school. Education is one of the most important factors in stopping violence against women. WFP case studies in Chad and the Democratic Republic of Congo (DRC) indicate that providing take-home rations for girls in their last two years of primary school contributed to a decrease in the frequency of early marriage. In Kenya, food assistance to boarding schools in the arid and semi-arid northern region has helped girls remain in school. WFP has also provided support to government boarding schools which accommodate girls who have run away from early or forced marriages.

(Excerpted from **G. Pattugalan**, "Linking food security, food assistance and protection from gender-based violence: WFP's experience", Humanitarian Exchange, Number 60, pp. 30-33. <http://www.odihpn.org/humanitarian-exchange-magazine/issue-60>)



PROMISING PRACTICE

While other children returned home after school, some pupils in Uganda's northern Amuru and Gulu regions stayed behind to make sanitary pads using cheap, locally available materials, to ensure girls did not miss school during menstruation. Girls and boys were taught to make sanitary towels using soft cotton cloth covered in polythene. These towels, which can be washed repeatedly and last for months, were a welcome alternative to the expensive sanitary pads sold in local shops (which cost on average 5,000 Ugandan shillings, or about US\$2.50, and which few families can afford).

Lack of sanitary pads—in addition to few or no private toilet facilities for girls and a shortage of female teachers—all contribute to adolescent girls' absenteeism from school. In Gulu, efforts to improve girls' retention in primary schools included supporting children to make sanitary towels and sensitizing the community on the need to educate girls. Development partners helped to build changing rooms for girls in some schools, and trained female teachers on guidance and counseling skills. At Awich Primary School, where the project was launched in 2010, girls' enrolment increased from 268 in 2010 to 310 in 2011.

(Adapted from <http://www.irinnews.org/report/93291/uganda-sanitary-pads-keep-girls-in-school>)



- Provide safe childcare for women and girl-mothers participating in educational activities.
 - Ensure new buildings are constructed based on universal design, and ensure existing structures take into account reasonable accommodation so that they are accessible to persons with disabilities.
 - When possible, provide assistance through alternative funding for those who can't afford school-related costs (e.g. scholarships, conditional cash transfers, school materials, uniforms, in-school feeding, etc.).
- Implement strategies to reduce drop-out and reach out-of-school children and youth (e.g. age-, gender-, and culturally-sensitive outreach programmes; re-enrolment programmes for girls and boys associated with armed forces/groups; bridging programmes for out-of-school youth; database systems for enrolled students; etc.).
- Ensure that gender issues in the community—particularly as they relate to young and adolescent girls' participation in school—are properly understood and addressed.
 - Take measures to mitigate any increased risk of GBV for girls attending—or wanting to attend—school at both the primary and secondary levels.

3. Implement strategies—in consultation with women, girls, boys and men—that maximize physical safety in and around education environments.

- Minimize potential GBV-related risks within the education environment (e.g. provide private and sex-segregated dormitories, toilets, and bathing facilities; locate schools that do not have their own water and sanitation facilities near existing water supplies and monitor paths for safety; provide adequate lighting and safety evacuation pathways; etc.).
- Where appropriate, build upon existing community protection mechanisms to conduct safety patrols of potential risk areas in and around schools (such as toilets, school yards, paths to and from school, etc.). Collaborate as needed with security personnel (including peacekeeping forces, where applicable) and the wider community. If necessary, provide escorts to and from school for students.
- Establish emergency safety protocols for responding to risky situations (e.g. use of cell phones for emergency calls, buddy systems, bystander interventions, etc.).

4. Enhance the capacity of education personnel to mitigate the risk of GBV in educational settings through ongoing support and training.

- Building upon indigenous practices and using gender- and culturally-sensitive language and approaches, train all primary and secondary level education staff (including administration, security guards, etc.) in issues of gender, GBV, and women's/human rights. Train teachers in gender-sensitive teaching strategies. Institutionalize knowledge of GBV and support sustainability by training a team of teachers to become trainers of others in the future. Address culturally-specific attitudes and practices among staff that may condone or ignore GBV in learning environments.
- Ensure all teachers and other education personnel understand and have signed a code of conduct related to the prevention of violence against children and youth. Ensure that the code of conduct has specific provisions related to sexual exploitation and abuse of students by teachers.

- ▶ Link with existing mental health and psychosocial programmes to provide support to teachers who are coping with their own GBV-related issues as well as those of their students. This can help to reduce teachers' negative or destructive coping behaviours that increase the risk of GBV for both teachers and students.
- ▶ Engage male teachers and education staff in discussions around creating a culture of non-violence; challenging beliefs around masculinity that condone GBV; and what their role can be in creating safe and non-threatening environments for all students and teachers.
- ▶ Link efforts to reduce GBV to larger efforts within schools to reduce general violence against children.

PROMISING PRACTICE

Two projects from South Africa focus on how teachers can make a difference. Part of a training programme at the School of Public Health at the Western Cape asks primary school teachers to evaluate their own attitudes towards gender-based violence and reflect on the implicit messages conveyed through their words and actions. Understanding the dynamics of gender-based violence in schools enables these teachers to incorporate activities to reduce the problem into their daily routines. A manual "Opening Our Eyes: Addressing Gender-based Violence in South African Schools" was created for teachers and school administrators as a tool for professional development and a starting point from which to develop whole-school approaches and policies. The manual makes the very important link between GBV and HIV and also provides some very concrete strategies for creating safer schools.

(Excerpted from **Ward, J. 2007. From Invisible to Indivisible; Promoting and Protecting the Right of the Girl Child to be Free from Violence.** UNICEF. http://www.unicef.at/fileadmin/media/Infos_und_Medien/Info-Material/Maedchen_und_Frauen/From_Invisible_To_Indivisible_-_Rights_of_Girl_Child.pdf. For more information, see **Department of Education, Republic of South Africa. 2011. Opening Our Eyes: Addressing Gender-based Violence in South African Schools.** Canada-South Africa Education Management Programme. http://www.unicef.org/southafrica/SAF_request_openingoureyes.pdf)

PROMISING PRACTICE

The International Rescue Committee (IRC) implements programmes that focus on ensuring that children and youth who have experienced conflict and crisis are able to heal and have the skills to remain resilient, learn and develop. Education programmes that are safe, free from abuse and exploitation, model a caring and supportive learning environment, and integrate academic learning with age/developmentally appropriate social and emotional learning are essential for providing a quality education in conflict-affected countries. The **Healing Classrooms** approach is based on 30 years of IRC's education work in conflict and crisis-affected areas, as well as four years of research and field-testing in Afghanistan, Ethiopia, Sierra Leone and Guinea. The approach focuses on expanding and supporting the ways in which teachers can create and maintain "healing" learning spaces where children can recover, grow and develop.

Healing Classrooms are designed to strengthen the role that schools and teachers play in promoting the psychosocial recovery, well-being and social and emotional learning of children and youth. Healing Classrooms recognize that in order for teachers to play a positive role during and after crises, they must receive meaningful support and training that reflects an understanding of their experiences, motivation, well-being and priorities. IRC's programme in the Democratic Republic of Congo uses three key interventions to create safe and healing classroom environments and improve teaching quality:

- a curriculum that integrates the Healing Classroom approach;
- a school-based system providing continuous in-service teacher training and coaching; and
- support to school management committees and parent teacher associations in order to increase community participation and decrease violence in education.

(Adapted from **Fancy, K. and McAslan Fraser, E. 2014. "DFID Guidance Note on Addressing Violence Against Women and Girls (VAWG) in Education Programmes,"** p. 13. <https://www.gov.uk/government/publications/violence-against-women-and-girls-addressing-violence-against-women-and-girls-in-education-programming>)



5. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure education staff has the basic skills to provide them with information on where they can obtain support.
 - ▶ Provide all education personnel with written information about where to refer survivors for services, with particular attention to female teachers who may be more likely to be approached by child survivors. Make information about services readily available in learning centers to both teachers and students, and ensure that information about referral pathways is regularly updated.
 - ▶ Train all primary and secondary level education personnel in how to recognize the many different and localized forms of GBV (verbal harassment and bullying, sexual exploitation, etc.). Ensure they are also trained on how to respectfully and supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care.
 - ▶ Where possible, employ a specialized GBV caseworker at the learning facility to provide immediate assistance to survivors and ensure follow-up care.
6. After the emergency wanes, work with the Ministry of Education to develop and implement school curricula that contributes to long-term shifts in inequitable gender norms and promotes a culture of non-violence and respect for women, girls, and other at-risk groups.
 - ▶ Integrate age-, gender-, and culturally-appropriate curricula on GBV-related issues and comprehensive sexual health into primary and secondary level educational programming for both males and females. Ensure this curricula includes: basic information on how the body works; bodily changes and puberty; sexuality; healthy menstruation management; gender equality; relationship skills and health communication; sexually transmitted infections, including HIV; safe sex; family planning; and causes and contributing factors to various forms of GBV, such as sexual assault, dating violence, child and/or forced marriage, intimate partner violence and other forms of domestic violence.
 - ▶ Prevent peer-to-peer violence by expanding curricula to cover and promote conflict-sensitive and peace-building education (e.g. conflict transformation, women's and children's rights, peace education, diversity training, respect and tolerance, non-violent masculinity, etc.). Organize discussions with boys and girls—both separately and together—to explore beliefs about violence and gender. Include age-, gender-, and culturally-appropriate content about relationships and sexuality for youth where possible.
 - ▶ Promote the empowerment of women, girls, and other at-risk groups through targeted programming (e.g. leadership development training; life skills education; vocational

! ESSENTIAL TO KNOW

Referral Pathways

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.



training linked to employment or livelihoods programming; opportunities for sports, art, and other recreation; safe spaces for girls—particularly adolescent girls—to meet, share skills and build community; etc.). Consider whether a school-based model or a model that targets out-of-school youth is more appropriate for the population.

Integrating GBV Risk Reduction into: EDUCATION POLICIES

1. Incorporate relevant GBV prevention and response strategies into the policies, standards and guidelines of education programmes.

- ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, girls and other at-risk groups as students, education staff, and leaders in community-based education activities. These can include, among others:
 - Policies regarding childcare for education staff.
 - Standards for equal employment of females.
 - Policies requiring in-service training on GBV and sexual/reproductive health for education staff.
 - Policies that allow pregnant girls to attend school.
- ▶ Where they don't already exist, enable the line ministry for education to implement mandatory codes of conduct (CoCs) for teachers and other education personnel that include a commitment to maintaining a protective environment free from GBV and sexual exploitation and abuse.
 - When designing and/or rolling out a CoC, use participatory methods that include regular discussions with and input from all stakeholders (including teachers, parents, students, community members, and—if relevant—government authorities and unions).
 - Put in place confidential complaint mechanisms and procedures to report, investigate, document, and take disciplinary action in cases of sexual exploitation and abuse and/or violation of the code of conduct. Develop setting-specific strategies to deal with non-action.



LESSON LEARNED

In 2009, Sierra Leone's Ministry of Education launched a national professional Code of Conduct for teachers with support from UNFPA and UNICEF. Multi-stakeholder consultations were held throughout Sierra Leone to inform the development of the final version. A training manual was also developed by UNICEF, with every school receiving training through a 3-day workshop on how to implement the Code of Conduct. This included training on classroom and positive behaviour management; commitment/attitude to the teaching profession; human and children's rights; child exploitation and abuse; and governance, accountability, corruption and record-keeping. Key lessons learned include:

- Importance of close collaboration between the Ministry of Education and teachers unions in developing the code;
- Key role of teachers unions in implementing and enforcing the code at the national and local level;
- Importance of having parallel systems to monitor and document cases of abuse and complaints; and
- Recognising the links between poverty and sexual abuse, so that enforcing a teachers' Code of Conduct should be accompanied by efforts to improve teachers' pay and working conditions.

(Adapted from Fancy, K. and McAslan Fraser, E., 2014. "DFID Guidance Note on Addressing Violence Against Women and Girls (VAWG) in Education Programmes," p. 13. <https://www.gov.uk/government/publications/violence-against-women-and-girls-addressing-violence-against-women-and-girls-in-education-programming>)



- ▶ Encourage government, school boards, school management, PTAs, teachers and students to work together to create (or build upon existing) school-based action plans related to GBV. Include strategies to address the risks that exist in specific school contexts (e.g. forming gender-balanced community “safety committees”; arranging escorts to school and/or community-based security patrols; etc.).
- ▶ Develop and ensure the implementation of standardized survivor-centered GBV reporting mechanisms and systems of care (i.e. referral pathways), including for sexual exploitation and abuse within learning centers.
- ▶ Circulate these policies, standards and guidelines widely among education personnel and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).

2. Advocate for the integration of GBV risk-reduction strategies into national and local laws and policies related to education, and allocate funding for sustainability.

- ▶ Support governments, customary/traditional leaders, and other stakeholders to review and reform laws and policies (including customary law) to address discriminatory practices hindering girls and other at-risk groups from safe access to education. For example:
 - Promote policies that reduce costs related to schooling, such as free access to primary and secondary education and feeding programmes.
 - Advocate that refugee/IDP schools be recognized as official schools and are entitled to the same services and monitoring of safety by government authorities.
 - Draft policies to deploy emergency teachers who are trained in gender, GBV, and women’s/human rights in the earliest stages of emergency.
 - Ensure laws and policies protect the rights of girls to complete primary and secondary levels of schooling.
- ▶ Ensure national education policies and plans include GBV-related security measures for students and education personnel (e.g. encourage national regulations or codes of conduct prohibiting and penalizing violence and exploitation in educational settings).
- ▶ Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. To encourage community support and mitigate backlash, undertake awareness-raising campaigns highlighting how such policies will benefit communities.



PROMISING PRACTICE

In Nepal, the post-conflict education strategy included stipends for girls and low-caste, indigenous and disabled children, creating incentives for their parents to send them to school.

(Excerpted from Holmes, R. 2010. *The Role of Social Protection Programmes in Supporting Education in Conflict-Affected Situations*. United Nations Educational, Scientific and Cultural Organization. <http://unesdoc.unesco.org/images/0019/001913/191354e.pdf>)

Integrating GBV Risk Reduction into: EDUCATION COMMUNICATIONS AND INFORMATION SHARING

1. Ensure that education programmes sharing information about reports of GBV within the education sector or with partners in the larger humanitarian community abide by safety and ethical standards.

- Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to child survivors, their caretakers or the broader community. Consider using the international Gender-based Violence Information Management System (GBVIMS), and explore linkages between the GBVIMS and existing education-related Information Management Systems.³

2. Incorporate GBV messages into education-related community outreach and awareness-raising activities.

- Work with GBV specialists to integrate community awareness-raising on GBV into education outreach initiatives (e.g. community dialogues; workshops; meetings with community leaders; GBV messaging; meetings with PTAs and parent groups; etc.).
 - Ensure this awareness-raising includes information on prevention, survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
 - Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).
 - Work with communities to discuss the importance of school-based GBV programming.
 - Engage (separately when necessary) women, girls, men and boys in the development of messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.
- Thoroughly train education outreach staff on issues of gender, GBV, women's/human rights, and psychological first aid (e.g. how to engage supportively with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).
- Engage men and boys, particularly leaders in the community, as agents of change in building a supportive environment for the education of women and girls (e.g. through workshops, trainings, meetings with community leaders, discussions on gender and rights issues, etc.).
- Consider the barriers faced by women, girls and other at-risk groups to their safe participation in education-related community discussion forums (e.g. transportation; meeting times and locations; risk of backlash because of participation; need for childcare; etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential; with females as facilitators of women's and girls' discussion groups; etc.) so that participants feel safe to raise GBV issues.



ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. **When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**

³ The GBVIMS is not meant to replace national information systems collecting GBV information. Rather, it is an effort to bring coherence and standardization to GBV data-collection in humanitarian settings, where multiple actors often collect information using different approaches and tools. For more information, see <http://www.gbvims.com>.





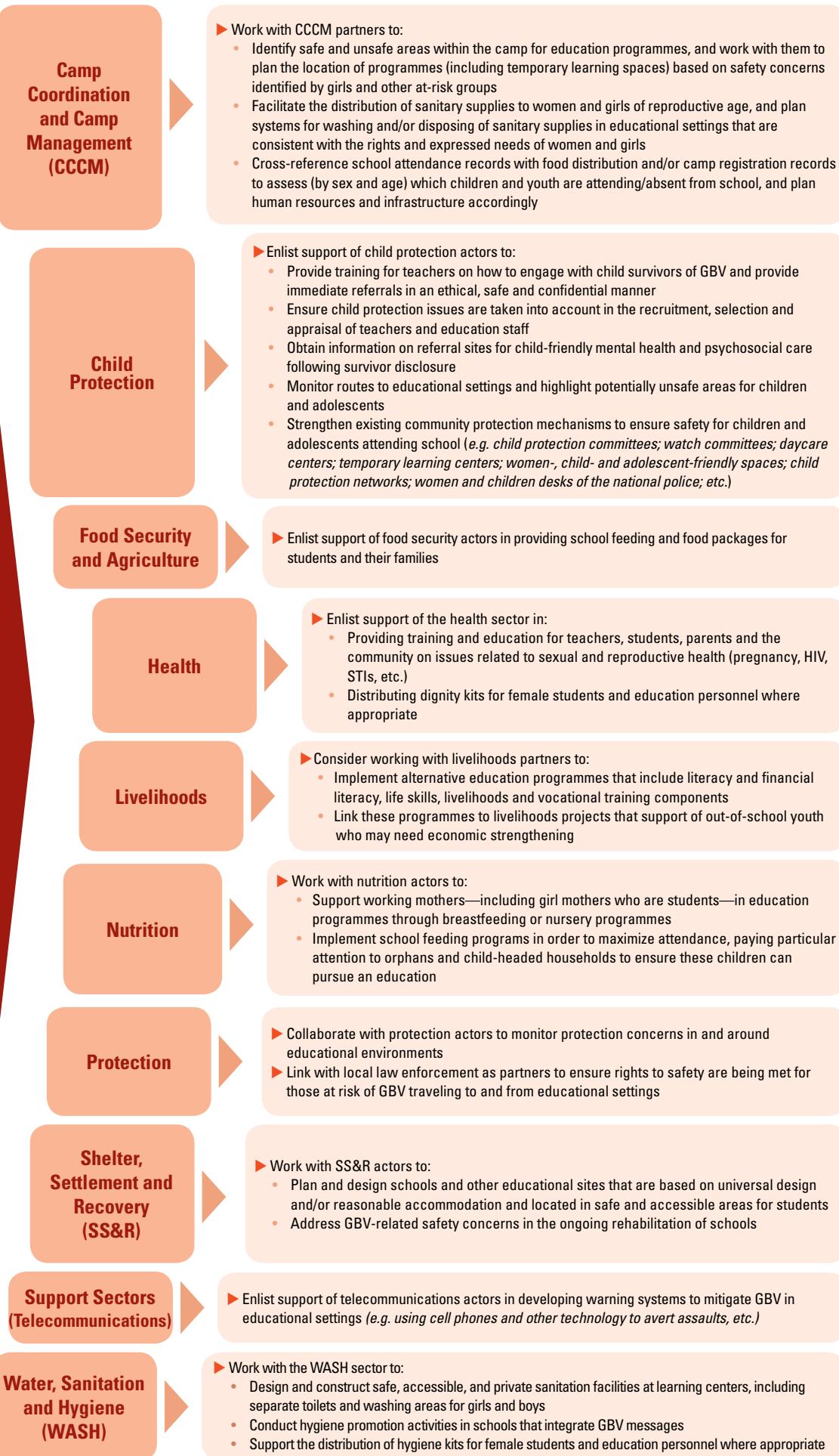
KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, education programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist education actors to:

- ▶ Design and conduct education assessments that examine the risks of GBV related to education programming, and strategize with education actors about ways these risks can be mitigated.
- ▶ Provide trainings for education staff on issues of gender, GBV, and women's/human rights, and how to respectfully and supportively engage with survivors.
- ▶ Develop a standard referral pathway for GBV survivors who may disclose to education staff, and ensure education personnel have the basic skills and information necessary to provide safe, ethical and confidential referrals.
- ▶ Provide training and awareness-raising for the affected community on issues of gender, GBV, and women's/human rights as they relate to education.

In addition, education programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, education actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see [Part Two: Background to Thematic Area Guidance](#).







KEY GBV CONSIDERATIONS FOR:

MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators

INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in education assessments ⁴	# of education assessment that include GBV-related questions* from the GBV Guidelines x 100 <hr/> $\frac{\text{# of education assessment}}{\text{# of education assessment}}$	Assessment reports or tools (at agency or sector level)	100%	✓	✓	

* See page 74 for GBV areas of inquiry that can be adapted to questions in assessments

(continued)

⁴ Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Female participation in assessments	$\frac{\# \text{ of assessment respondents who are female} \times 100}{\# \text{ of assessment respondents and } \# \text{ of assessment team members who are female} \times 100}$ $\# \text{ of assessment team members}$	Assessment reports (at agency or sector level)	50%		✓	✓
Consultations with the affected population on GBV risk factors in and around learning environments⁵ <i>Disaggregate consultations by sex and age</i>	<p>Quantitative:</p> $\frac{\# \text{ of learning environments conducting consultations with the affected population to discuss GBV risk factors in and around the learning environment} \times 100}{\# \text{ of learning environments}}$ <p>Qualitative: What types of GBV-related risk factors do affected persons experience in and around learning environment?</p>	Organizational records, focus group discussion (FGD), key informant interview (KII)	100%		✓	✓
Risk factors of GBV for females to attend learning environments	<p>Quantitative:</p> $\frac{\# \text{ of females who report risk factors of GBV when asked about attending learning environments} \times 100}{\# \text{ of females asked about attending learning environments}}$ <p>Qualitative: What types of safety concerns do females describe in attending learning environments?</p>	Survey, FGD	0%		✓	✓
RESOURCE MOBILIZATION						
Inclusion of GBV risk reduction in education funding proposals or strategies	$\frac{\# \text{ of education funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines} \times 100}{\# \text{ of education funding proposals or strategies}}$	Proposal review (at agency or sector level)	100%		✓	✓
Training of education staff on the GBV Guidelines	$\frac{\# \text{ of education staff who participated in a training on the GBV Guidelines} \times 100}{\# \text{ of education staff}}$	Training attendance, meeting minutes, survey (at agency or sector level)	100%		✓	✓

(continued)

⁵ United Nations Office for the Coordination of Humanitarian Affairs. *Humanitarian Indicator Registry*. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION									
► Programming									
Female participation in education community-based committees⁵	<p><i>Quantitative:</i></p> $\frac{\# \text{ of persons who participate in education community-based committees* who are female} \times 100}{\# \text{ of persons who participate in education community-based committees}}$ <p><i>Qualitative:</i> How do women perceive their level of participation in education community-based committees? What are barriers to female participation in education committees?</p> <p>* Education community-based committees include parent-teacher associations or other community committees</p>		Assessment reports, FGD, KII	50%					
Ratio of female and male teachers teaching in affected area⁵	$\frac{\# \text{ of female teachers teaching in affected areas}}{\# \text{ of male teachers teaching in affected areas}}$	Organizational records	50%		✓	✓			
Ratio of affected boys and girls attending learning spaces/schools in affected areas⁵	$\frac{\# \text{ of females attending learning spaces/schools in affected areas}}{\# \text{ of males attending learning spaces/schools in affected areas}}$	Joint education needs assessment, W matrix	Determine based on pre-crisis data		✓	✓			
<i>Disaggregate by age group (5-13 and 14-18) and at-risk groups</i>									
Active-duty education staff who have signed a code of conduct⁵	$\frac{\# \text{ of active-duty education staff who have signed a code of conduct} \times 100}{\# \text{ of active-duty education staff}}$	Organization records	100%		✓	✓			
Reporting and referral mechanism for GBV survivors in schools/learning sites	$\frac{\# \text{ of schools/learning sites with a reporting and referral mechanism for GBV survivors} \times 100}{\# \text{ of schools/learning sites}}$	KII	100%		✓	✓			
► Policies									
Inclusion of GBV prevention and response strategies in education policies, guidelines or standards	$\frac{\# \text{ of education policies, guidelines or standards that include GBV prevention and response strategies from the GBV Guidelines} \times 100}{\# \text{ of education policies, guidelines or standards}}$	Desk review (at agency, sector, national or global level)	Determine in the field		✓	✓			

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
► Communications and Information Sharing									
Staff knowledge of standards for confidential sharing of GBV reports	# of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100 <hr/> # of surveyed staff	Survey (at agency or programme level)	100%		✓				
Inclusion of GBV referral information in education community outreach activities	# of education community outreach activities programmes that include information on where to report risk and access care for GBV survivors x 100 <hr/> # of education community outreach activities	Desk review, KII, survey (at agency or sector level)	Determine in the field		✓	✓			
COORDINATION									
Coordination of GBV risk reduction activities with other sectors	# of non-education sectors consulted with to address GBV risk reduction activities* x 100 <hr/> # of existing non-education sectors in a given humanitarian response	KII, meeting minutes (at agency or sector level)	Determine in the field		✓	✓			
<i>* See page X for list of sectors and GBV risk reduction activities</i>									



RESOURCES

Key Resources

- The **Inter-Agency Network for Education in Emergencies (INEE)** and its Gender Task Team have created a series of resources, including:
 - *Preventing and Responding to Gender Based Violence In and Through Education.* Inter-Agency Network for Education in Emergencies. http://ineesite.org/toolkit/INEEcms/uploads/1113/Preventing_and_Responding_to_GBV.pdf
 - INEE Toolkit: toolkit.ineesite.org/toolkit/Home.php
 - INEE Toolkit's Gender Section: <http://toolkit.ineesite.org/toolkit/Toolkit.php?PostID=1059>
 - *Gender Equality in and through Education: INEE Pocket Guide to Gender:* http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1009/INEE_Pocket_Guide_to_Gender_EN.pdf
- The **Joint Education Needs Assessment Toolkit** has been developed by the Global Education Cluster to enable Education Cluster staff and partners in the field to:
 - undertake preparedness planning for emergency assessments
 - collectively design and conduct an education needs assessment (rapid and/or comprehensive)
 - generate reliable, comprehensive and timely information needed to guide effective inter-agency education in emergencies responses
 - highlight immediate, critical education issues and ensure effective coordination across education partners in an emergency. http://www.savethechildren.org.uk/sites/default/files/docs/Ed_NA_Toolkit_Final_1.pdf
- The **Good School Toolkit** by Raising Voices in Uganda contains a set of ideas and tools that will help educators explore what a good school is and guide them through a process that will help them create one. It was developed with the help of schools in Uganda and deliberately focuses on ideas and activities that do not require specific financial resources—just commitment and perseverance. http://www.raisingvoices.org/children/good_school.php
- For a training manual for students on preventing school-related violence against girls, see: **USAID. 2009. "DOORWAYS 1: Student Training Manual On School-Related Gender-Based Violence Prevention and Response."** http://pdf.usaid.gov/pdf_docs/pnado240.pdf
- The IASC has created an online course that provides the basic steps a humanitarian worker must take to ensure gender equality in programming, including education. To access the course see **IASC. 2010. Different Needs - Equal Opportunities: Increasing Effectiveness of Humanitarian Action for Women, Girls, Boys and Men,** <http://www.interaction.org/iasc-gender-elearning>
- For a checklist for ensuring gender-equitable programming in the education sector, see **IASC. 2006. Gender Handbook in Humanitarian Action,** [http://www.humanitarianinfo.org/iasc/documents/subsidi/tf_gender/IASC%20Gender%20Handbook%20\(Feb%202007\).pdf](http://www.humanitarianinfo.org/iasc/documents/subsidi/tf_gender/IASC%20Gender%20Handbook%20(Feb%202007).pdf)
- For a toolkit and recommendations from UNHCR on preventing and responding to VAWG in refugee schools, see **United Nations High Commissioner for Refugees (UNHCR). 2007. "Safe Schools and Learning Environment: How to Prevent and Respond to Violence in Refugee Schools."** Geneva: Technical Support Section, Division of Operational Services, UNHCR. http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1048/Codes_of_Conduct_Refugee_Schools.PDF
- **Fancy, K. and McAslan Fraser, E. 2014. "DFID Guidance Note on Addressing Violence Against Women and Girls (VAWG) in Education Programmes."** London: VAWG Helpdesk. <https://www.gov.uk/government/publications/violence-against-women-and-girls-addressing-violence-against-women-and-girls-in-education-programming>
- **UNFPA and Save the Children. 2009. "Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings."** <https://www.unfpa.org/public/global/publications/pid/4169>. This toolkit provides information and guidance to advocate for adolescent sexual and reproductive health (ASRH) and implement adolescent-inclusive SRH interventions.
- For a curriculum to help facilitate dialogue between adults and young people on issues related to adolescent reproductive health, see **Program for Appropriate Technology in Health (PATH). 2006. "Tuko Pamoja: Adolescent Reproductive Health and Life Skills Curriculum."** Nairobi: http://www.popcouncil.org/pdfs/frontiers/Manuals/KARHP_guide1.pdf
- **Women's Commission for Refugee Women and Children. 2005. "Don't Forget Us: The Education and Gender-Based Violence Protection Needs of Adolescent Girls from Darfur in Chad."** New York: WRC. <http://www.preventgbvafrica.org/resources/dont-forget-us-education-and-gender-based-violence-protection-needs-adolescent-girls>
- **World Bank. n.d. "Addressing Violence Against Women Within the Education Sector."** <http://siteresources.worldbank.org/INTGENDER/Resources/Education.pdf>
- **UNHCR and Save the Children UK. 2002. "Note for Implementing and Operational Partners: Sexual Violence & Exploitation: The Experience of Refugee Children in Guinea, Liberia, and Sierra Leone."** http://www.savethechildren.org.uk/sites/default/files/docs/sexual_violence_and_exploitation_1.pdf
- For programme strategies targeting work with boys to end VAWG, see: **Oxfam GB and KAFA. 2011. "Women and Men... Hand in Hand Against Violence. Strategies and approaches of working with men and boys for ending violence against women."** [\(ENG\); <http://www.kafa.org.lk/StudiesPublicationPDF/PRpdf18.pdf>](http://www.oxfam.org.uk/resources/learning/gender/women-men-against-violence.html)
- For tools and resources for life skills facilitators, see **WarChild Holland's "Deals" series:** <http://www.warchildlearning.org/>
- For a report documenting and sharing some of the key successes and examples of best practice emerging from one of the organisation's flagship multi-country girls' education initiatives, see **ActionAid. 2013. "Stop Violence Against Girls in School: Success Stories."** <http://www.actionaidusa.org/publications/stop-violence-against-girls-school-cross-country-analysis-change-ghana-kenya-and>



Additional Resources

- **Bharadwaj, S. & A. Patkar.** 2004. *Menstrual Management in Developing Countries: Taking Stock*. Mumbai, India: Junction Social Development Consultants. <http://www.schoolsanitation.org/Resources/ReadingsGenderAspects.html>
- **Burgers, L., & V. Tobin.** 2003. "Water, Sanitation and Hygiene in Schools: Accelerating Progress for Girls' Education". *Education Update* 6. Pp 8-9. <http://www.schoolsanitation.org/Resources/Readings/GirlsEducationUNICEFLessonsLearned.pdf>
- **UNESCO.** 2011. *The Hidden Crisis: Armed conflict and education. Education for All Global Monitoring Report*. <http://unesdoc.unesco.org/images/0019/001907/190743e.pdf>
- **Herz, B. and Sperling, G.** 2004. "What Works in Girls' Education: Evidence and Policies from the Developing World." Council on Foreign Relations Press. <http://www.cfr.org/education/works-girls-education/p6947>
- **Snel, M.** 2003. *The School Sanitation and Hygiene Education Notes & News*. Special Issue on 'How does school hygiene, sanitation and water affect the life of adolescent girls?' <http://www.irc.nl/page/22823>
- **Kane, E.** 2004. "Girls' Education in Africa: What Do We Know About Strategies That Work?" Africa Region human development working paper series, no. 73; Africa regional educational publications. Washington, DC: World Bank. <http://documents.worldbank.org/curated/en/2004/05/6042697/girls-education-africa-know-strategies-work>
- **Kirk, J. and Sommer, M.** 2006. *Menstruation and Body Awareness: Linking Girls' Health with Girls' Education*. Gender and Health Special. Royal Tropical Institute (KIT), Amsterdam. http://www.kit.nl/specials/html/gh_guest_contributions.asp
- **Kirk, J. and Sommer, M.** 2005. *Menstruation and Body Awareness: Critical Issues for Girls' Education*. EQUALS, Beyond Access: Gender, Education and Development, Nov/Dec 2005. 15. Pp 4-5, (<http://k1.ioe.ac.uk/schools/efps/GenderEducDev/Equals%20Issue%20No.%2015.pdf>)
- **Lidonde, R.** 2004. *Scaling up School Sanitation and Hygiene Promotion and Gender Concerns*. Paper presented at School Sanitation & Hygiene Education Symposium, Delft, the Netherlands. <http://www.schoolsanitation.org/Resources/Readings/Global-Lidonde-Scalingup.pdf>
- **Snel, M.** 2003. *School Sanitation and Hygiene Education: Thematic Overview Paper*. IRC International Water and Sanitation Centre, <http://www.sswm.info/library/536>
- **World Bank.** 2005. *Toolkit on Hygiene, Sanitation, and Water in Schools*. <http://www.wsp.org/Hygiene-Sanitation-Water-Toolkit/index.html>
- For a resource on sexuality education that addresses LGBTI populations, see **Haberland et. al.** 2009. *It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV, and Human Rights Education*. Population Council. http://www.popcouncil.org/uploads/pdfs/2011PGY_ItsAllOneGuidelines_en.pdf





FOOD SECURITY AND AGRICULTURE



THIS SECTION APPLIES TO:

- Food security and agriculture (FSA) coordination mechanisms
- Actors (staff and leadership) involved in the provision of food assistance such as food products, cash and vouchers, and seed/tools for agricultural and livestock interventions: community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth older persons, etc.) related to FSA
- Other FSA stakeholders, including national and local governments, community leaders, and civil society groups

Why Addressing Gender-based Violence is a Critical Concern of the Food Security and Agriculture¹ Sector

The causes of food insecurity are complex and numerous. They can include droughts, floods, tsunamis, earthquakes, wars, climate change, government failures, population growth, rising prices, and land and natural resource degradation. Whatever the origins, food insecurity affects entire communities in surprisingly similar ways across different settings—including in terms of how it contributes to the risk of GBV. For example:

- ▶ In many settings, women and girls are primarily responsible for procuring and cooking food for the family. Activities that require them to travel to remote or unfamiliar locations (e.g. to tend agricultural lands or livestock; to collect water, firewood and other non-food items for cooking; to go in search of feed, water or shelter materials for livestock; etc.) may place them at risk of sexual assault. In addition, their lack of

! ESSENTIAL TO KNOW

Cash and Voucher-Based Interventions

Although food distribution is still the predominant food relief response in humanitarian emergencies, there is growing awareness that cash- and voucher-based interventions can be used to address a range of commodity-based needs—particularly in urban settings where markets and banking systems are in place. Cash and vouchers can also be useful in rural areas and in camps where markets grow increasingly dynamic as more people settle in these areas. New technologies—such as money transfers through mobile phones—can facilitate the dispersal of assistance in insecure contexts; however, the selection must be context specific.

(UNHCR. 2012. *An Introduction to Cash-based Interventions in UNHCR Operations*, p. 5, <http://www.unhcr.org/515a959e9.pdf>)

¹ The term food security and agriculture (FSA) is used throughout to refer to a wide variety of methods used for food production, including agriculture, forestry and fisheries, aquaculture, apiculture, livestock, etc.



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery through

ASSESSMENT, ANALYSIS AND PLANNING

Promote the active participation of women, girls and other at-risk groups in all food security and agricultural assessment processes

Assess the level of participation and leadership of women, adolescent girls and other at-risk groups in the design, construction, and monitoring of FSA activities (*e.g. food assistance management groups, committees and other relevant organizations; etc.*)

Assess community norms and practices and how they relate to food insecurity, with a focus on the barriers faced by women, girls and other at-risk groups in a *restricted access to lands, water, cooking fuel, or FSA programmes; etc.*)

Assess the physical safety risks associated with FSA activities (*e.g. distance and routes travelled for distribution/work sites and agriculture/livestock activities; patrols and other security measures for those traveling to distribution/work sites; accessibility features at distribution sites for persons with disabilities; etc.*)

Assess awareness of FSA staff on basic issues related to gender, GBV, and women's/human rights (*including knowledge of where survivors can report risk and access services; etc.*)

Review existing/proposed community outreach material related to FSA to ensure it includes basic information about GBV risk reduction (*including where to report risk and access services; etc.*)

RESOURCE MOBILIZATION

Develop proposals for FSA programmes that reflect awareness of GBV risks for the affected population and strategies for reducing these risks

Prepare and provide trainings for government, staff and community groups engaged in FSA on the safe design and implementation of FSA programming that minimizes GBV risk

IMPLEMENTATION

► Programming

Involve women and other at-risk groups in the planning, design, and implementation of all FSA activities (*with due caution where this poses a potential security risk to individual survivors, their families or the broader community*)

Design commodity- and cash-based interventions in ways that minimize the risk of GBV (*e.g. transfer modalities that meet food requirement needs; food rations; food programmes; etc.*)

Take steps to address food insecurity for women, girls and other at-risk groups through agriculture and livestock programming (*e.g. include interventions that increase women's ownership of livestock assets for women, girls and other at-risk groups; etc.*)

Implement strategies that increase the safety in and around food security and agricultural livelihoods activities (*e.g. adhere to Sphere standards for safe locations; etc.*)

Incorporate safe access to cooking fuel and alternative energy into programmes (*e.g. consult local populations to create strategies for accessing cooking fuel and alternative energy; etc.*)

► Policies

Incorporate GBV prevention and mitigation strategies into the policies, standards and guidelines of FSA programmes (*e.g. standards for equal employment of female staff; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse; etc.*)

Advocate for the integration of GBV risk-reduction activities into national and local policies and plans related to FSA, and allocate funding for sustainability (*e.g. policies and plans for GBV risk-reduction in agricultural diversification and livestock programmes, protection of natural resources and related skills-building; etc.*)

► Communications and Information Sharing

Consult with GBV specialists to identify safe, confidential and appropriate systems of care (*i.e. referral pathways*) for survivors, and ensure FSA staff has the knowledge and skills to respond effectively

Ensure that FSA programmes sharing information about reports of GBV within the FSA sector or with partners in the larger humanitarian community abide by strict confidentiality and do not pose a security risk to individual survivors, their families or the broader community

Incorporate GBV messages (*including where to report risk and how to access care*) into community outreach and awareness-raising activities related to FSA

COORDINATION

Undertake coordination with other sectors to address GBV risks and ensure protection for women, girls and other at-risk groups

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign an FSA sector focal point to regularly participate in GBV coordination meetings

MONITORING AND EVALUATION

Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduction activities

Evaluate GBV risk-reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making and programming

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for food security and agriculture actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see Part Two: Background to Thematic Area Guidance.

at the Programme Cycle

	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
activities (e.g. ratio of male/female staff; representation of women and other at-risk person in	✓	✓	✓	✓
chieving food security (e.g. decision-making in the family; roles related to agriculture/livestock;	✓	✓	✓	✓
es; distribution/work times and locations; existence of safety		✓	✓	✓
and access care; linkages between FSA programming and GBV risk reduction; etc.)	✓	✓	✓	✓
port risk and how to access care)	✓	✓	✓	✓
tigates the risk of GBV	✓	✓	✓	✓
ity risk or increases the risk of GBV)	✓	✓	✓	✓
ation cards assigned without discrimination; girls and boys included in school feeding		✓	✓	✓
ncrease agricultural production and diversification into humanitarian response; facilitate	✓	✓	✓	✓
cations; carry out food distribution during daylight hours; consider sex-segregated distribution		✓	✓	✓
; encourage use of fuel-efficient stoves and fuel-saving cooking techniques; etc.)		✓	✓	✓
emales; procedures and policies for sharing protected or confidential information about GBV	✓	✓	✓	✓
. policies for safe access to cooking fuel; plans to promote the participation of women and other	✓		✓	✓
basic skills to provide them with information on where they can obtain support	✓	✓	✓	✓
safety and ethical standards (e.g. shared information does not reveal the identity of or pose a	✓	✓	✓	✓
coordination meetings	✓	✓	✓	✓
duction activities throughout the programme cycle	✓	✓	✓	✓
nd ensure accountability		✓	✓	✓

information about or access to food assistance (commodity and cash-based interventions) can cause household tensions that increase their risk of intimate partner and other forms of domestic violence.

- ▶ When commodity and cash-based interventions or agricultural livelihoods programming are insufficient to meet a family's food needs, are not contextualized, or only target male heads of households, certain at-risk groups² (particularly woman and child heads of households and single women) may be forced or coerced to provide sex in exchange for food and agricultural inputs.
- ▶ Unsafe locations of distribution sites for food and agricultural inputs, long distances required to travel to sites, and heavy weight of food rations or agricultural inputs (that require women and girls to seek assistance when transporting them) all pose risks for sexual assault and exploitation.
- ▶ In some cases, food insecurity may put pressure on families to marry daughters at young ages in order to gain bride wealth, ensure the economic well-being of the girl, or lessen food needs within the family.

Exposure to GBV can, in turn, heighten food insecurity by undermining the physical and psychosocial well-being of survivors. Injuries or illness can affect a survivor's capacity to work, limiting their ability to produce or secure food for themselves and their families. Stigma and exclusion may further reduce survivors' access to food distributions, food- and agriculture-related technical trainings, and other forms of support.

Effective, safe and efficient strategies of the food security and agriculture (FSA) sector can only be achieved if the risks of GBV are factored into programme design and delivery. This requires assessing and addressing gender issues that affect food security and agricultural livelihoods in emergencies, as well as agricultural rehabilitation after a crisis. Women, girls and other at-risk groups must be actively engaged in decisions about how to best implement FSA activities.

Actions taken by the FSA sector to prevent and mitigate GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. FSA actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)



ESSENTIAL TO KNOW

Pillars of Food Security

Food security is based on four pillars, all of which must be fulfilled simultaneously in order to realize food security objectives:

- Physical **AVAILABILITY** of food
- Economic and physical **ACCESS** to food
- Food **UTILIZATION**
- **STABILITY** of the other three dimensions over time.

(Adapted from European Commission and Food and Agriculture Organization. 2008. *An Introduction to the Basic Concepts of Food Security*, <http://www.fao.org/docrep/013/al936e/al936e00.pdf>)

² For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



Addressing Gender-based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are *recommendations* for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring undertaken by FSA actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with FSA actors working in partnership with other sectors as well as with GBV specialists.

The areas of inquiry below should be used to complement existing guidance materials, such as assessment checklists found in the **Livestock Emergency Guidelines and Standards** (<http://www.livestock-emergency.net>). Ideally, nutrition and FSA assessments should overlap to identify barriers to adequate nutrition as well as interventions to improve the availability and optimal utilisation of food intake.

The information generated from these areas of inquiry should be analyzed to inform planning of FSA programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.

KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in FSA: governments; civil societies; local leaders; local food assistance committees; nutrition actors; livelihoods actors; GBV, gender and diversity specialists
- Affected populations and communities, including agricultural workers, farmers and livestock owners, market traders, etc.
- In IDP/refugee settings, members of receptor/host communities

POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Food Security and Agriculture PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female FSA staff working directly with affected populations, including in positions of leadership?
 - What is the ratio of males to females in food distribution teams, particularly at distribution sites?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are women and other at-risk groups actively involved in community-based activities related to FSA (e.g. *community food assistance or agricultural rehabilitation committees*)? Are they in leadership roles when possible?
- c) Are the lead actors in food assistance response aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation strategies into their activities?

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Cultural and Community Norms and Practices

- d) How has the humanitarian emergency impacted the ability of different at-risk groups to secure and use food?
 - Who makes decision about food use and access within the household?
 - Are any at-risk groups being denied access to food?
- e) What strategies do members of the affected community use to secure food, and how has the humanitarian emergency affected these strategies (*e.g. access to grazing and to water resources for livestock; daily and seasonal movements; natural resources; the gender division of labour; etc.*)?
 - What are the different roles of males and females in agricultural production, fisheries, forestry, etc.?
 - What are the different roles of males and females in livestock ownership, control, care and management—including use and disposal rights?
 - How do agriculture and livestock ownership and management affect household food security?
- f) Are there cultural norms that restrict women, girls and other at-risk groups from accessing agricultural lands, water points, seed and tool dispersal programmes, or food/cash/voucher distribution programmes?
- g) Is there a risk of conflict between different groups using natural resources (*i.e. agriculturalists and pastoralists*) that could in turn increase the risks of GBV for women, girls and other at-risk groups?
- h) Are there school meal programmes for students? Do these programmes take into account security risks for programme participants (*e.g. attacks between school and home in the case of take-home rations*)?

Physical Safety and Risks of GBV

- i) Are women and other at-risk groups involved in decisions about food/asset baskets and planned agriculture or livestock activities (*e.g. seed or livestock distribution*)?
 - Has the transfer modality of assistance (*e.g. food, cash/in-kind, vouchers*) been designed in a way that reduces the risks of GBV?
- k) Are distribution sites safe for women, girls and other at-risk groups?
 - What specific measures are being taken to prevent, monitor and respond to GBV risks (*e.g. segregating men and women through a physical barrier or offering separate distribution times; awareness among distribution teams about appropriate conduct and penalties; presence of female staff to oversee off-loading, registration, distribution and postdistribution of food; etc.*)?
 - Are distribution sites protected from raiding by fighting forces in conflict situations?
 - Do distribution/work sites adhere to standards of universal design and/or reasonable accommodation³ to ensure accessibility for all persons, including those with disabilities (*e.g. physical disabilities, injuries, visual or other sensory impairments, etc.*)?
- l) Are the distances and routes to be travelled to distribution sites, work sites, and agriculture or livestock activities safe for women, girls and other at-risk groups?
 - Are they clearly marked, accessible and frequently used by other members of the community?
 - Has safety mapping been conducted with women, girls and other at-risk groups to identify security concerns related to accessing water, fuel, agriculture lands and distribution sites?
- m) Do interventions reduce the burden that receiving food assistance may pose for women, girls, men and boys (*e.g. are food distribution points located as close to living/cooking areas as possible; are the sizes and weights of food packages manageable for women, girls and at-risk groups; are distributions timed in a way that minimizes GBV risks; are women and other at-risk groups provided with alternative modes of receiving their food assistance if the situation permits; etc.*)?
- n) Is there a system for security personnel to patrol potentially insecure areas in and around distribution sites, agricultural lands, water points, firewood collection sites and/or markets?
 - Does this system include women from the community? Are there any security risks associated with their participation?
- o) How are ration cards being issued (*e.g. can women and other at-risk groups be issued cards directly*)?
- p) Are cash, vouchers, and food-for-work and training programmes available specifically for GBV survivors? If so, have measures been taken to ensure these programmes don't stigmatize survivors or exacerbate their risk of re-victimization?

(continued)

³ For more information regarding universal design and/or reasonable accommodation, see definitions in Annex 4.



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Food Security and Agriculture POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of FSA programmes?
- Are women, girls and other at-risk groups meaningfully engaged in the development of FSA policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Are these policies, standards and guidelines communicated to women, girls, boys and men (separately when necessary)?
 - Is FSA staff properly trained and equipped with the necessary skills to implement these policies?
- c) Do national and local FSA sector policies and plans integrate GBV-related risk reduction strategies? Do they allocate funding for sustainability of these strategies?
- Are there policies for safe access to cooking fuel?
 - Do they address discriminatory practices hindering women and other at-risk groups from safe participation (as staff, in community-based groups, etc.) in the FSA sector? Are there standards to promote the participation of women and other at-risk groups in agricultural diversification and livestock programmes?
 - Are there standards for the allocation and protection of natural resources?

Areas related to Food Security and Agriculture COMMUNICATIONS and INFORMATION SHARING

- a) Has training been provided to FSA staff on:
- Issues of gender, GBV, and women's/human rights?
 - How to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- b) Do FSA-related community mobilization activities raise awareness about general safety and GBV risk reduction?
- Does this awareness-raising include information on survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Is this information provided in age-, gender- and culturally appropriate ways?
 - Are males, particularly leaders in the community, engaged in these awareness-raising activities as agents of change?
- c) Are FSA discussion forums age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.*) so that participants feel safe to raise GBV issues?





KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for FSA sector programming. Whether requesting pre-/emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**.

Two: Background to Thematic Area Guidance. Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.

A. HUMANITARIAN NEEDS OVERVIEW

- ▶ Are the different roles and responsibilities for food management, livestock management and agriculture (in both the home and wider community) understood and disaggregated by sex, age, disability, and other relevant vulnerability factors? Are the related risk factors of GBV for women, girls and other at-risk groups recognized and described?
- ▶ Are risks for specific forms of GBV (*such as sex for food, sexual assault, forced and/or coerced prostitution, child and/or forced marriage, intimate partner violence and other forms of domestic violence, etc.*) described and analysed, rather than a broader reference to “GBV”?

B. PROJECT RATIONALE/ JUSTIFICATION

- ▶ When drafting a proposal for emergency preparedness:
 - Is there a strategy for preparing and providing trainings for government, staff and community groups engaged in the FSA sector on the safe design and implementation of programming that mitigates the risk of GBV?
 - Are additional costs required to ensure any GBV-related community outreach materials will be available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- ▶ When drafting a proposal for emergency response:
 - Is there a clear description of how food assistance programmes will mitigate exposure to GBV (*e.g. location and time of food distributions; provision of ration cards to women and other at-risk groups, where appropriate; size of food packages; transportation support to and from distribution sites; etc.*)?
 - Do strategies meet standards promoted in the Sphere Handbook?
 - Are additional costs required to ensure the safety and effective working environments for female staff in the food assistance sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
- ▶ When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how the project will contribute to sustainable strategies that promote the safety and well-being of those at risk of GBV, and to long-term efforts to reduce specific types of GBV (*e.g. provide agricultural input to enhance production; ensure national and local policies address discriminatory practices hindering access to land and ownership of livestock for women and other at-risk groups; contribute to women's access to livelihoods which can support wider changes in gender roles in the household and community; support women as full participants in farm activities; etc.*)?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?



C. PROJECT DESCRIPTION

- ▶ Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for integrating GBV-related work?
- ▶ Do the proposed activities illustrate linkages with other humanitarian actors/sectors in order to maximize resources and work in strategic ways?
- ▶ Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as FSA staff and in agriculture and livestock management?



KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some common GBV-related considerations when implementing FSA programmes in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

Integrating GBV Risk Reduction into: Food Security and Agriculture PROGRAMMING

1. **Involve women and other at-risk groups as staff and leaders in the planning, design and implementation of all FSA activities** (*with due caution in situations where this poses a potential security risk or increases the risk of GBV*).
 - ▶ Strive for 50% representation of females within FSA programme staff. Provide women with formal and on-the-job training as well as targeted support to assume leadership and training positions.
 - ▶ Ensure women (and where appropriate, adolescent girls) are actively involved in FSA committees and management groups. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.
 - ▶ Employ persons from at-risk groups in FSA staff, leadership, and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.



ESSENTIAL TO KNOW

LGBTI Persons

Lesbian, gay, bisexual, transgender and intersex persons (LGBTI) face unique difficulties in food assistance programmes. For example, food assistance may be based on assumptions of heterosexual relationships and may exclude lesbian, gay and bisexual persons. LGBTI persons may be further marginalized or forced out of lines during food and/or agricultural inputs distributions. Exclusion or delays in food distribution may force LGBTI persons to engage in risky practices like survival sex. **When possible, food assistance programmers should consult with local LGBTI organizations and specialists to consider how targeted food assistance may impact the food security of LGBTI persons, and develop culturally-sensitive strategies that ensure their basic rights and needs are addressed in a way that minimizes the risks of GBV.**

(Information provided by Duncan Breen, Human Rights First, Personal Communication, May 20, 2013)



2. Design commodity- and cash-based interventions in ways that minimize the risks of GBV.

- ▶ Establish clear, consistent and transparent systems for distribution that are known by all members of the community. Regularly provide information (written, verbal, and illustrated) to inform women, girls, boys and men about policies and procedures, including who qualifies for assistance. This can help to minimize the risk of GBV related to distribution and assistance (e.g. escalation of intimate partner violence as spouses fight over control of assistance; exposure to sexual assault after food and/or agricultural inputs distributions; reprisal attacks on women for their participation in cash- or food-for-work activities; etc.).
- ▶ Ensure that the chosen transfer modality is substantial enough to meet food requirements so that women, girls and other at-risk groups are deterred from having to exchange sex for food and/or agricultural inputs.
- ▶ Carefully consider, in collaboration with the community, how to assign and monitor the use of food ration cards and/or agricultural inputs vouchers. This helps to ensure that needs are being met regardless of a person's marital status, sexual orientation or gender identity.
- ▶ Consider innovative ways of ensuring that GBV survivors have access to food, particularly if they are unable to travel to the distribution sites (for example, providing daily food requirements in health centers). Ensure that programmes do not increase survivors' sense of exclusion or stigma.
- ▶ Ensure students in need of food support have access to school feeding programmes (such as those that provide take-home rations) and cash or voucher assistance where appropriate.
- ▶ In contexts where there are polygynous households, each wife and her children should be treated as a separate household, or provisions should be made to allow second and third wives to claim their cash/food as a separate family unit.



PROMISING PRACTICE

From mid-2013 to April 2014, UNICEF Mali and Catholic Relief Services implemented a cash transfer programme to assist displaced and host family households that faced food insecurity in the Bamako and Mopti regions. Households received cash transfers through direct distribution or electronic transfer. The goal of the programme was to provide unconditional cash transfers to meet food and other basic needs, while decreasing risky coping strategies and other protection risks, including the exchange of sex for food. Despite the complexity of the operation (i.e. actual cash transfers), final evaluation results and participant feedback revealed the programme's success in reaching planned targets, improving the protection of women and children, decreasing and preventing risky coping strategies, and overall participant satisfaction. Cash transfers improved households' access to food, access to education and health services, lodging conditions, and ability to invest and establish long-term revenue. Moreover, participants reported that the assistance contributed toward maintaining their dignity under difficult circumstances.

(Information provided by the Mali GBV Sub-Cluster, Personal Communication, September 24, 2014).



PROMISING PRACTICE

In the Democratic Republic of Congo, the World Food Programme (WFP) distributed food to survivors of sexual violence admitted to the hospital, allowing them to rest and heal with adequate nutrition. According to hospital staff in one center—the Panzi Hospital in Bukavu, South Kivu—the contribution made a significant difference in the healing process. WFP also sought other methods of providing food assistance to survivors after being discharged from the hospital, such as facilitating survivors' participation in food-for-training projects. Through these projects, survivors acquired marketable skills that helped them obtain independent income generation, thereby supporting their socio-economic reintegration. This type of project was particularly important to those who were not allowed or chose not to return to their families or communities due to stigma.

(Adapted from **World Food Programme of the United Nations. 2011. Enhancing Prevention and Response to Sexual and Gender-based Violence in the Context of Food Assistance in Displacement Settings**, p.10)

3. Take steps to address food insecurity for women, girls and other at-risk groups through agriculture and livestock programming.

- ▶ Proactively include interventions that increase agricultural production and diversification in humanitarian response. Identify appropriate livestock responses that do not increase the labour burden—or reduce access to key assets—for women and other at-risk groups.
- ▶ Working in partnership with local organizations, ensure women, adolescent girls and other at-risk groups receive the necessary tools, inputs and training to carry out locally viable and sustainable agricultural activities (e.g. training in: technical skills for food production, process, preparation and storage; livestock maintenance; marketing and distribution of food products; etc.).
- ▶ Seek ways to increase ownership and control of agriculture and livestock assets for women, adolescent girls, and other at-risk groups. Ensure these assets are age-, gender-, and culturally-appropriate (for example, in certain contexts it is more culturally acceptable for women to control the production, end sale, and use of horticultural products and poultry rather than staple grains and crops).

4. Implement strategies that increase the safety in and around food security and agricultural livelihoods activities.

- ▶ Adhere to Sphere standards in selecting secure and centralized locations for food and agricultural asset distribution points. Ensure that roads to and from the distribution points are clearly marked, accessible, and frequently used by other members of the community. When security concerns restrict access to distribution sites, work with protection actors to provide escorts and patrols to protect women, adolescent girls and other at-risk groups or establish a community-based security plan for distribution sites and departure roads.
- ▶ Address safety in the design and layout of food and asset distribution sites by:
 - Scheduling distribution at times that are easily accessible and safe for women, girls and other at-risk groups (e.g. begin and end distributions during the day to allow safe return home).
 - Ensuring there are female staff members from the implementing organization present during distributions, and setting up women-friendly spaces at food and asset distribution sites.
 - Placing women as guardians (with vests, whistles, agency logos, etc.) to oversee off-loading, registration, distribution, and post-distribution of food and assets.



LESSON LEARNED

In 2013 during the response to Typhoon Haiyan in the Philippines, the military used aerial food drops to reach people in remote and otherwise inaccessible island and mountain areas. The food security and agriculture cluster advocated that ground-level coordination be put in place for safe distribution. Without this coordination—where food is simply dropped from the sky—there is often a rush to grab food, during which those that are physically stronger tend to get the most food. This exacerbates existing power/resource imbalances and provides an opportunity for those with food to extort favours from those without, heightening the risk of sexual exploitation and other forms of GBV. The cluster advocated that airdrops should only be done when a team was in place on the ground to coordinate.

(Information provided by Food Security and Agriculture Cluster in the Philippines, Personal Communication, March 22, 2014)

- Providing, as necessary, sex-segregated distribution sites and monitoring these sites to ensure that the risks of GBV are not increased (e.g. if a single woman is easily identified when leaving the site).
- ▶ Design interventions to reduce the burden that the receipt of food and agricultural assets may pose on affected population (e.g. place food distribution points as close to living/cooking areas as possible; ensure the weight of food packages is manageable for women, children and persons with disabilities; develop transport strategies for heavy packages; etc.).
- ▶ When setting up agricultural plots for cultivation, make sure they are located in secure and centralized settings. This helps protect women, adolescent girls and other at-risk persons who are working alone or in small groups, and might otherwise be at risk of attack while working or traveling to and from their plots. Consider contextually appropriate security methods (e.g. escorts, patrols, safe passage, etc.).

5. Incorporate safe access to cooking fuel and alternative energy into programmes.

- ▶ Consult with the affected population to create a strategy for accessing cooking fuel, including safe and sustainable access to natural resources. Recognize and respect preferences associated with cooking fuel needs. When feasible and appropriate, provide emergency rations of cooking fuel along with food rations.
- ▶ Encourage the use of fuel-efficient stoves and fuel-saving cooking techniques—including in schools and therapeutic feeding centers or stabilisation centers. Provide people with the means of accessing fuel-efficient stoves, and provide technical training on stove use and maintenance to decrease cooking fuel consumption.
- ▶ Because women are often dependent on the sale of firewood for household income, consider linking alternative energy programmes with women's livelihood programmes to support safer, more sustainable income-generating activities.





PROMISING PRACTICE

In 2009, WFP launched the Safe Access to Firewood and alternative Energy (SAFE) programme in North Darfur to help address protection threats, faced mostly by females, when collecting firewood and other types of cooking fuel. The programme includes 33 centers where women make fuel-efficient stoves and fuel briquettes, resulting in women having to venture out less frequently to collect firewood and buy charcoal. This, in turn, has decreased exposure to rape and other types of sexual assault. The SAFE programme has also created safe social spaces where women can be trained in income generation, literacy, nutrition, improved hygiene and community reforestation.

(Adapted from **Pattugalan, G. 2014.** "Linking food security, food assistance and protection from gender-based violence: WFP's experience", Humanitarian Exchange Magazine, Issue 60, <http://www.odihpn.org/humanitarian-exchange-magazine/issue-60>)

Integrating GBV Risk Reduction into: Food Security and Agriculture POLICIES

- 1. Incorporate GBV prevention and mitigation strategies into the policies, standards and guidelines of FSA programmes.**
 - ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in FSA activities. These can include, among others:
 - Policies regarding childcare for FSA staff.
 - Standards for equal employment of females.
 - Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.
 - ▶ Circulate these widely among FSA staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).
- 2. Advocate for the integration of GBV risk-reduction strategies into national and local policies and plans related to food security and agricultural livelihoods, and allocate funding for sustainability.**
 - ▶ Support government, customary and traditional leaders, and other stakeholders to review and reform national and local policies and plans to address discriminatory practices hindering women and other at-risk groups from safe participation (as staff and/or community advisors) in the FSA sector.
 - ▶ Ensure national FSA sector policies and plans include GBV-related measures (e.g. policies for safe access to cooking fuel; plans to promote the participation of women and other at-risk groups in agricultural diversification and livestock programmes, protection of natural resources, and related skills-building; etc.).
 - ▶ Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. Undertake awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.



Integrating GBV Risk Reduction into: Food Security and Agriculture COMMUNICATIONS and INFORMATION SHARING

- 1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure that staff has the basic skills to provide them with information on where they can obtain support.**
 - ▶ Ensure all FSA personnel who engage with affected populations—including agricultural extension workers—have written information about where to refer survivors for care and support. Regularly update information about survivor services.
 - ▶ Train all FSA personnel who engage with affected populations—including agricultural extension workers—in gender, GBV, women's/human rights and psychological first aid (e.g. how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).
- 2. Ensure that FSA programmes sharing information about reports of GBV within the FSA sector, or with partners in the larger humanitarian community, abide by safety and ethical standards.**
 - ▶ Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community.
- 3. Incorporate GBV messages into FSA-related community outreach and awareness-raising activities.**
 - ▶ Work with GBV specialists to integrate community awareness-raising on GBV into FSA outreach initiatives (e.g. community dialogues; workshops; meetings with community leaders; GBV messaging; etc.).
 - Ensure this awareness-raising includes information on survivor rights (including the right to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
 - Raise awareness with local communities, affected populations and humanitarian partners through workshops and campaigns about the link between cooking fuel and GBV (e.g. firewood collection, selling rations for cooking fuel or developing risky coping behaviour to secure fuel). Foster discussion, research and development of safe options and strategies.
 - Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).



ESSENTIAL TO KNOW

Referral Pathways

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.



ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. **When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**

- Engage women, girls, men and boys (separately when necessary) in the development of messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.
- ▶ Engage males, particularly leaders in the community, as agents of change in FSA outreach activities related to the prevention of GBV.
- ▶ Consider the barriers faced by women, girls and other at-risk groups to their safe participation in community discussion forums and educational workshops (e.g. transportation; meeting times and locations; risk of backlash related to participation; need for childcare; accessibility for persons with disabilities; etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of separate women’s and girls’ discussion groups, etc.) so that participants feel safe to raise GBV issues.
- ▶ Provide community members with information about existing codes of conduct for FSA personnel, as well as where to report sexual exploitation and abuse committed by staff providing food and agricultural assistance. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.



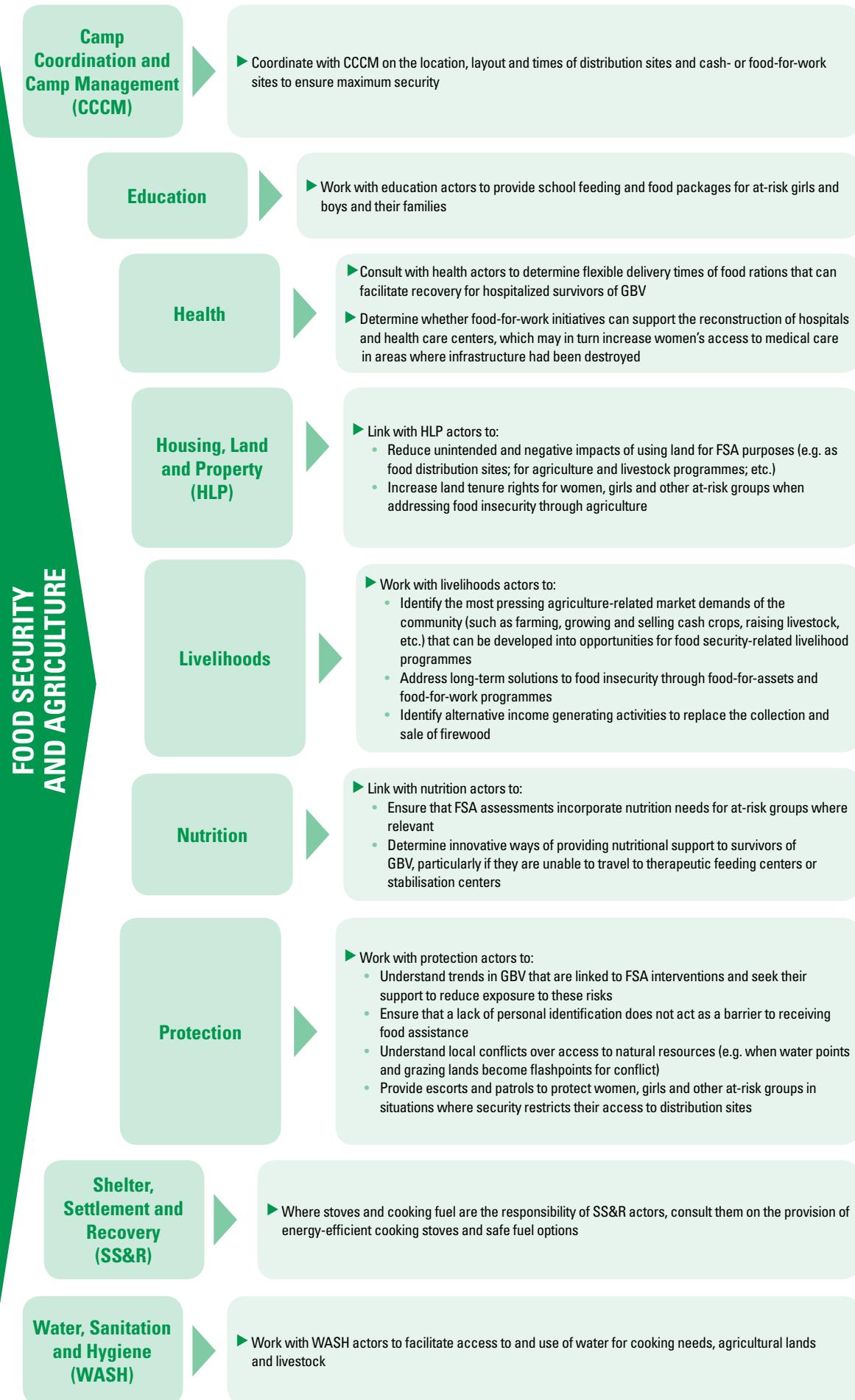
KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, FSA programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist FSA actors to:

- ▶ Design and conduct food security and agricultural assessments that examine the risks of GBV related to food security and agricultural programming, and strategize with FSA actors about ways for such risks to be mitigated.
- ▶ Provide trainings for FSA staff on issues of gender, GBV, and women’s/human rights.
- ▶ Identify where survivors who may report instances of GBV exposure to FSA staff can receive safe, confidential and appropriate care, and provide FSA staff with the basic skills and information to respond supportively to survivors.
- ▶ Provide training and awareness-raising for the affected community on issues of gender, GBV, and women’s/human rights as they relate to food security and agricultural interventions.

In addition, FSA programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, FSA actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.







KEY GBV CONSIDERATIONS FOR: MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators					Stage of Programme	
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in assessments conducted by the food security and agriculture (FSA) sector ⁴	# of assessment by FSA sector that include GBV-related questions* from the GBV Guidelines x 100 <small>* See page 95 for GBV areas of inquiry that can be adapted to questions in assessments</small>	Assessment reports or tools (at agency or sector level)	100%		✓	✓
Female participation in assessments	# of assessment respondents who are female x 100 # of assessment respondents and # of assessment team members who are female x 100 # of assessment team members	Assessment reports (at agency or sector level)	50%		✓	✓

(continued)

⁴ Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Consultations with the affected population on GBV risk factors in FSA activities⁵	<p><i>Quantitative:</i></p> $\frac{\text{\# of FSA activities* conducting consultations with the affected population to discuss GBV risk factors in accessing the service} \times 100}{\text{\# of FSA activities}}$ <p><i>Qualitative:</i> What types of GBV-related risk factors do affected persons experience in accessing FSA activities?</p> <p>*FSA activities include commodity and cash-based interventions and agriculture and livestock programming</p>	Organizational records, focus group discussion (FGD), key informant interview (KII)	100%			
<i>Disaggregate consultations by sex and age</i>				✓	✓	
Female participation prior to programme design⁵	<p><i>Quantitative:</i></p> $\frac{\text{\# of affected persons consulted before designing a programme who are female} \times 100}{\text{\# of affected persons consulted before designing a programme}}$ <p><i>Qualitative:</i> How do women and girls perceive their level of participation in the programme design? What enhances women and girls' participation in the design process? What are barriers to female participation in these processes?</p>	Organizational records, FGD, KII	Determine in the field		✓	
Staff knowledge of referral pathway for GBV survivors	$\frac{\text{\# of FSA staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors} \times 100}{\text{\# of surveyed FSA staff}}$	Survey	100%	✓	✓	

RESOURCE MOBILIZATION			
Inclusion of GBV risk reduction in FSA funding proposals or strategies	$\frac{\text{\# of FSA funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines} \times 100}{\text{\# of FSA funding proposals or strategies}}$	Proposal review (at agency or sector level)	100%
Training of FSA staff on the GBV Guidelines	$\frac{\text{\# of FSA staff who participated in a training on the GBV Guidelines} \times 100}{\text{\# of FSA staff}}$	Training attendance, meeting minutes, survey (at agency or sector level)	100%

(continued)

⁵ United Nations Office for the Coordination of Humanitarian Affairs. *Humanitarian Indicator Registry*. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION									
► Programming									
Female participation in FSA-related community-based committees⁵	<p><i>Quantitative:</i></p> $\frac{\# \text{ of affected persons who participate in FSA-related community-based committees who are female}}{\# \text{ of affected persons who participate in FSA-related community-based committees}} \times 100$ <p><i>Qualitative:</i> How do women perceive their level of participation in FSA-related community-based committees? What are barriers to female participation in FSA-related committees?</p>	Site management reports, Displacement Tracking Matrix, FGD, KII	50%	✓	✓				
Female staff in FSA activities	$\frac{\# \text{ of staff in FSA activities who are female}}{\# \text{ of staff in FSA activities}} \times 100$	Organizational records	50%	✓	✓				
Risk factors of GBV in commodity or cash based interventions	<p><i>Quantitative:</i></p> $\frac{\# \text{ of affected persons who report concerns about experiencing GBV when asked about participating in commodity or cash based interventions}}{\# \text{ of affected persons asked about participating in commodity or cash based interventions}} \times 100$ <p><i>Qualitative:</i> Do affected persons feel safe from GBV when participating in commodity or cash based interventions? What types of safety concerns does the affected population describe in these interventions?</p>	Survey, FGD, KII, participatory community mapping	100%	✓	✓				
Control over agricultural inputs or livestock by female affected persons	$\frac{\# \text{ of females who report retaining control over agricultural inputs and/or livestock}}{\# \text{ of surveyed females}} \times 100$	Survey	100%	✓	✓				
Risk factors of GBV in and around FSA-related distribution sites	<p><i>Quantitative:</i></p> $\frac{\# \text{ of affected persons who report risk factors of GBV when asked about FSA-related distribution sites}}{\# \text{ of affected persons asked about FSA-related distribution sites}} \times 100$ <p><i>Qualitative:</i> What types of safety concerns does the affected population describe in and around FSA-related distribution sites?</p>	Survey, FGD, KII, participatory community mapping	100%	✓	✓				
Change in time, frequency and distance for collecting fuel or firewood	$\frac{(\text{endline time/frequency/distance for collecting fuel or firewood} - \text{baseline time/frequency/distance for collecting fuel or firewood})}{\text{endline time/frequency/distance for collecting fuel or firewood}} \times 100$	Survey	Determine in the field	✓	✓				

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
<p>► Policies</p> <p>Inclusion of GBV prevention and mitigation strategies in FSA policies, guidelines or standards</p> <p># of FSA policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines x 100 _____ # of FSA policies, guidelines or standards</p> <p>Desk review (at agency, sector, national or global level)</p> <p>Determine in the field</p> <p>✓ ✓</p>									
<p>► Communications and Information Sharing</p> <p>Staff knowledge of standards for confidential sharing of GBV reports</p> <p># of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100 _____ # of surveyed staff</p> <p>Survey (at agency or programme level)</p> <p>100%</p> <p>✓</p>									
<p>Inclusion of GBV referral information in FSA community outreach activities</p> <p># of FSA community outreach activities programmes that include information on where to report risk and access care for GBV survivors x 100 _____ # of FSA community outreach activities</p> <p>Desk review, KII, survey (at agency or sector level)</p> <p>Determine in the field</p> <p>✓ ✓</p>									
COORDINATION									
<p>Coordination of GBV risk reduction activities with other sectors</p> <p># of non-FSA sectors consulted with to address GBV risk reduction activities* x 100 _____ # of existing non-FSA sectors in a given humanitarian response</p> <p>KII, meeting minutes (at agency or sector level)</p> <p>Determine in the field</p> <p>✓ ✓</p>									



RESOURCES

Key Resources

- For a checklist for ensuring gender-equitable programming in food security, food distribution and nutrition in emergencies, see the **Inter-Agency Standing Committee (IASC). 2006. Gender Handbook in Humanitarian Action**, [http://www.humanitarianinfo.org/iasc/documents/subsidi/tf_gender/IASC%20Gender%20Handbook%20\(Feb%202007\).pdf](http://www.humanitarianinfo.org/iasc/documents/subsidi/tf_gender/IASC%20Gender%20Handbook%20(Feb%202007).pdf)
- **Sphere Project. 2011. Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response.** <http://www.spherehandbook.org/>
- **Food and Agriculture Organization of the United Nations (FAO). 2011. The State of Food and Agriculture 2010-2011. Women in Agriculture. Closing The Gender Gap For Development.** FAO: Rome, <http://www.fao.org/docrep/013/i2050e/i2050e00.htm>
- **FAO. 2012. Voluntary Guidelines on the Responsible Governance of Tenure of Land, Fisheries and Forests in the Context of National Food Security.** Rome, <http://www.fao.org/docrep/016/i2801e/i2801e.pdf>
- **FAO. 2013. Governing Land for Women and Men. A Technical Guide to Support the Achievement of Responsible Gender-Equitable Governance of Land Tenure.** Rome, <http://www.fao.org/docrep/017/i3114e/i3114e.pdf>
- **United Nations High Commissioner for Refugees (UNHCR). 2012. An Introduction to Cash-based Interventions in**

Additional Resources

- **Global Food Security Cluster.** The Cluster coordinates the food security response during a humanitarian crisis, addresses issues of food availability, access and utilization. A range of resources can be accessed through this site. For more information: <http://foodsecuritycluster.net/>
- **FAO. 2002. The State of Food Insecurity in the World 2001.** FAO: Rome. <http://www.fao.org/docrep/003/y1500e/y1500e00.htm>
- **FAO. 2005. Voluntary Guidelines to support the progressive realization of the right to adequate food in the context of national food security.** <http://www.fao.org/docrep/009/y7937e/y7937e00.htm>
- **FAO. 2008. Beyond Relief: Food Security in Protracted Crises,** <http://www.fao.org/docrep/015/a0778e/a0778e00.pdf>
- **WFP. 2002. Emergency Field Operations Pocketbook,** <http://reliefweb.int/report/world/emergency-field-operations-pocketbook>
- **WFP. 2009. Emergency Food Security Assessment Handbook,** second edition, <http://www.wfp.org/content/emergency-food-security-assessment-handbook>
- **WFP. 2012. Protection Policy,** <http://documents.wfp.org/stellent/groups/public/documents/eb/wfpdoc061670.pdf>
- **WFP. 2013. Protection in Practice Handbook,** <http://reliefweb.int/sites/reliefweb.int/files/resources/wfp254460.pdf>
- **Women's Refugee Commission.** "How to Use the SAFE Tools: A Holistic Approach to Cooking in Humanitarian Settings." E-learning Course. This training will help individuals use the tools developed by the Inter-Agency Standing Committee (IASC) Task Force on Safe Access to Firewood and alternative Energy (SAFE) to determine safe and appropriate means of meeting cooking fuel needs under difficult circumstances, <http://www.womensrefugeecommission.org/elearning>
- **Livestock Emergency Guidelines and Standards (LEGS).** The LEGS provide a set of international guidelines and standards for the design, implementation and assessment of livestock interventions to assist people affected by humanitarian crises. LEGS aims to improve the quality of emergency response by increasing the appropriateness, timeliness and feasibility of livelihoods-based interventions: <http://www.livestock-emergency.net/>
- **Maxwell D., Webb P., Coates J., and Wirth, J. 2008. Rethinking Food Security in Humanitarian Response.** Paper Presented to the Food Security Forum Rome, April 16–18, 2008. Tufts University and Friedman School of Nutrition Science and Policy and Feinstein International Center, http://www.fanrpan.org/documents/d00523/Rethinking_food_security_Humanitarian_Response_Apr2008.pdf
- **United Nations Environment Programme (UNEP), United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), United Nations Peacebuilding Support Office (PBSO) and United Nations Development Programme (UNDP). 2013. Women and Natural Resources. Unlocking the Peacebuilding Potential,** www.unep.org/conflictsanddisasters
- **HelpAge International. 2012. Food Security and Livelihoods Interventions for Older People in Emergencies.** <https://www.humanitarianresponse.info/system/files/documents/files/Livelihoods-FINAL.pdf>







HEALTH

THIS SECTION APPLIES TO:

- Health coordination mechanisms
- Health actors (staff and leadership): NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, older persons, etc.) related to health
- Other health stakeholders, including national and local governments, community leaders, and civil society groups

Why Addressing Gender-based Violence is a Critical Concern of the Health Sector

Health services are often the first—and sometimes, the only—point of contact for survivors seeking assistance for gender-based violence (GBV). In order to facilitate care, survivors must have safe access to health facilities (e.g. safe transit to/from facilities; adequate lighting at facilities; non-stigmatizing and confidential entry points for services; no-cost services; etc.). It is also critical that health providers working in emergencies are equipped to offer non-discriminatory, quality health services for survivors.

Many survivors will not disclose violence to a health care provider (or any other provider) due to fear of repercussions, social stigma, rejection from partners/families, and other reasons. If health care providers are not well trained, they may not be able to detect the indicators of violence. Survivors may be inadvertently discouraged from asking for help for GBV-related health problems. This can occur if the provider does not ask the right questions; if communication materials in the facility do not make clear the types of services that are available, and that they are available for all; or if the provider makes remarks or in some other way implies that the disclosure of GBV will not be met with respect, sympathy and confidentiality.

! ESSENTIAL TO KNOW

Defining “Health”

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

(Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States [Official Records of the World Health Organization, no. 2, p. 100] and entered into force on 7 April 1948. Available online at http://www.who.int/governance/eb/who_constitution_en.pdf.)

Emergencies put additional stress on health systems that are often already overburdened. Even so, overlooking the physical and mental health implications of GBV is not just a missed opportunity: it can be a violation of medical ethics.

Health care workers may fail to provide necessary—even life-saving—care, such as post-exposure prophylaxis (PEP) for HIV; emergency contraception; treatment for sexually transmitted infections (STIs); mental health and psychosocial support;



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



PART 3: GUIDANCE

Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery through

ASSESSMENT, ANALYSIS AND PLANNING

Promote the active participation of women, girls and other at-risk groups in all health assessment processes

Investigate cultural and community perceptions, norms and practices related to GBV and GBV-related health services (e.g. stigma that may prevent survivors from seeking care; existing community supports for survivors; providers' attitudes toward survivors; etc.)

Assess the safety and accessibility of existing GBV-related health services (e.g. safety traveling to/from facilities; cost; language, cultural and/or/physical mobile clinics; etc.)

Assess the quality of existing GBV-related health services (e.g. range of health services provided; privacy and confidentiality; representation of females in and ethical case documentation and information-sharing processes; availability of appropriate drugs and equipment; etc.)

Assess awareness of **specialized** (clinical) staff in the provision of targeted care for survivors (including how to provide clinical care for adult and child survivors; and use of multi-sectoral referral pathways; how to provide care for intimate partner violence and other forms of domestic violence; how to provide courtship and support services; etc.)

Assess awareness of all health personnel on basic issues related to gender, GBV, and women's/human rights

Investigate national and local laws related to GBV that might affect the provision of GBV-related health services (e.g. legal definitions of rape and other forms of GBV; etc.)

With the leadership/involvement of the Ministry of Health (MOH), assess whether existing national policies and protocols related to the clinical care and response to GBV include provisions for GBV prevention, GBV risk reduction, GBV response, GBV recovery, and GBV resilience (e.g. emergency contraception; abortion/post-abortion care; mandatory reporting; etc.)

Review existing/proposed health-related community outreach material to ensure it includes basic information about GBV (including prevention; where to report risk; health effects; etc.)

RESOURCE MOBILIZATION

Develop proposals for GBV-related health programming that reflect awareness of GBV risks for the affected population and strategies for health sector partners

Pre-position trained staff and appropriate supplies to implement clinical care for GBV survivors in a variety of health delivery systems (e.g. medical drugs)

Prepare and provide trainings for government, health facility administrators and staff, and community health workers (including traditional birth attendants)

IMPLEMENTATION

► Programming

Involve women, adolescent girls and other at-risk groups in the design and delivery of health programming (with due caution where this poses a potential security risk to individual survivors, their family members or the broader community)

Increase the accessibility of health and reproductive health facilities that integrate GBV-related services (e.g. provide safe and confidential escorts to facilitate service delivery; eliminate service fees; etc.)

Implement strategies that maximise the quality of GBV-related care at health facilities (e.g. implement standardized guidelines for the clinical care of sexual assault survivors; provide follow-up services; etc.)

Enhance the capacity of health providers to deliver quality care through GBV-related training, support and supervision (and, where feasible, include a GBV caseload)

Implement all health programmes within the framework of sustainability beyond the initial crisis stage (e.g. design plans for rebuilding health centers; provide resources for long-term recovery; etc.)

► Policies

Develop and/or standardize protocols and policies for GBV-related health programming that ensure confidential, compassionate and quality care of survivors

Advocate for the reform of national and local laws and policies that hinder survivors or those at risk of GBV from accessing quality health care and other services, and address the underlying causes of GBV

► Communications and Information Sharing

Ensure that health programmes sharing information about reports of GBV within the health sector or with partners in the larger humanitarian community abide by strict confidentiality and do not pose a security risk to individual survivors, their family members or the broader community

Incorporate GBV messages into health-related community outreach and awareness-raising activities (including prevention; where to report risk; health effects; etc.)

COORDINATION

Undertake coordination with other sectors to address GBV risks and ensure protection for women, girls and other at-risk groups

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a health focal point to regularly participate in GBV coordination meetings

MONITORING AND EVALUATION

Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduction activities

Evaluate GBV risk-reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making and resource allocation

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for health actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**.

at the Programme Cycle

	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
ors from accessing health care; community awareness about the physical and mental health	✓	✓	✓	✓
l barriers to services, especially for minority groups and persons with disabilities; existence of clinical and administrator positions; policies and protocols for clinical care of survivors; safe	✓	✓	✓	✓
survivors of sexual assault; how to safely and confidentially document cases of GBV; knowledge testimony when appropriate; etc.)	✓	✓	✓	✓
GBV; legal age of consent; legal status of abortion and emergency contraception; etc.)	✓	✓	✓	✓
referral of GBV are in line with international standards (e.g. post-exposure prophylaxis [PEP];	✓	✓		
t risk; health effects of GBV; benefits of health treatment; and how to access care)	✓	✓	✓	✓
revention and response	✓	✓	✓	✓
s, equipment, administrative supplies, mental health and psychosocial support, referrals, etc.)	✓	✓		
and traditional healers) on sexual assault-related protocols	✓	✓	✓	✓
curity risk or increases the risk of GBV)	✓	✓	✓	✓
es; make opening times convenient; ensure universal access for persons with disabilities;	✓	✓	✓	✓
assault; establish private consultation rooms; maintain adequate supplies and medical drugs;		✓	✓	✓
eworker on staff at health facilities)		✓	✓	✓
more frequent and intensive training of health workers; develop longer-term supply management			✓	✓
Referrals and referral pathways for multi-sectoral support	✓	✓	✓	✓
allocate funding for sustainability	✓		✓	✓
Confidentiality by safety and ethical standards (e.g. shared information does not reveal the identity of or pose a	✓	✓	✓	✓
risks to different forms of GBV; benefits of health treatment; and how to access care)		✓	✓	✓
ation meetings	✓	✓	✓	✓
ation meetings	✓	✓	✓	✓
Communication activities throughout the programme cycle	✓	✓	✓	✓
nd ensure accountability		✓	✓	✓

and appropriate referrals for legal and other services that can support survivors and prevent their re-victimization.

Furthermore, when health care providers are not trained in the guiding principles of working with survivors—such as when providers do not respect patient confidentiality or understand how to address the particular needs of children—survivors may be at heightened risk of additional violence from partners, family and/or community members.

From the earliest stages of an emergency, health care systems should have good quality services in place to provide clinical care for sexual assault survivors as per the standard of the Minimum Initial Service Package (MISP). In addition—and as quickly as possible in emergencies—health sector actors should be equipped to provide clinical care for other forms of GBV (e.g. injuries and pregnancy complications from intimate partner violence; health effects of early sexual debut and pregnancies related to child marriages; complications related to female genital mutilation/cutting; etc.). It is essential to inform communities about the benefits of and locations for seeking care once services are established.

Adequate health services are not only vital to ensuring life-saving care for women, girls, and other at-risk groups¹, but they are also a key building block for any setting seeking to overcome the devastation of humanitarian emergency. When health care programmes are safe, confidential, effectively designed, sensitive, accessible (both in terms of location and physical access), and of good quality, they can:

- ▶ Facilitate immediate care for survivors.
- ▶ Initiate a process of recovery—one which not only incurs physical and mental health benefits for individual survivors, but can have wide ranging benefits for families, communities and societies.

Actions taken by the health sector to prevent and respond to GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. Health actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)

¹ For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protectionn rights and needs of each of these groups, see page XXX of these Guidelines.

WHAT THE SPHERE HANDBOOK SAYS:

Essential health services—sexual and reproductive health

standard 1: Reproductive health

- ▶ People have access to the priority reproductive health services of the Minimum Initial Service Package (MISP) at the onset of an emergency and comprehensive reproductive health as the situation stabilises.

Key Actions:

- Implement measures to reduce the risk of sexual violence, in coordination with other relevant sectors or clusters.
- Inform populations about the benefits and availability of clinical services for survivors of sexual violence.

Health systems standard 2: Human resources

Guidance Note 1: Staffing levels

- ▶ ...the presence of just one female health worker or one representative of a marginalized ethnic group on a staff may significantly increase the access of women or people from minority groups to health services.

Health systems standard 5: Health information management

Guidance Note 4: Confidentiality

- ▶ Adequate precautions should be taken to protect the safety of the individual, as well as the data itself...Data that relate to injury caused by torture or other human rights violations including sexual assault must be treated with the utmost care.

(Sphere Project. 2011. *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*, <http://www.spheredproject.org/resources/download-publications/?search=1&keywords=&language=English&category=22>)



ESSENTIAL TO KNOW

The Minimum Initial Service Package

During the acute phase of an emergency, the priority is to provide a Minimum Initial Service Package (MISP). This package ensures that basic health needs are met and helps to mitigate negative long-term effects of violence on survivors. The MISP is a coordinated series of priority actions designed to prevent and manage the consequences of sexual violence against women and girls; prevent reproductive health-related morbidity and mortality; reduce HIV transmission; and plan for comprehensive reproductive health services in the early phase of emergencies.

(For more information about the MISP, see the Women's Refugee Commission website: <http://womensrefugeecommission.org/programs/reproductive-health/misp>)

Addressing Gender-based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

*Although the assessment process is key to planning and programming, implementation of the Minimum Initial Service Package (MISP)—including clinical care of sexual assault—is a standard responsibility based on the knowledge that sexual assault will be occurring in emergencies. Therefore, **no assessment is required** in order to activate the MISP. Even so, GBV-related health assessments should be undertaken at the earliest opportunity in emergency preparedness/response in order to obtain a broad picture of GBV-related health practices, needs, and available services.*

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by health actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with health actors working in partnership with other sectors as well as with GBV specialists.

The information generated from these areas of inquiry should be analyzed to inform planning of health programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.



KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in health sector: governments; civil societies; local and religious leaders; community members; health sector administration and staff; health ministry staff; health care workers (physicians, nurses, midwives, allied health professionals such as social workers and psychologists, community health workers, traditional birth attendants, traditional healers, etc.); GBV, gender and diversity specialists
- Affected populations and communities
- In IDP/refugee settings, members of receptor/host communities

POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Health PROGRAMMING

Participation and Leadership

- a) Is there age-, gender-, and disability-related diversity in health staff?
 - What is the ratio of male to female staff in health delivery and administrator positions?
 - Are systems in place for training and retaining female staff?
 - Are there temporary systems in place to allow female non-health workers to accompany female survivors for services that are conducted by male health workers?
- b) Are women and other at-risk groups actively involved in community-based activities related to the planning and oversight of health services (*e.g. community-based health committees*)? Are they in leadership roles when possible?
- c) Are the lead actors in health response aware of international standards (including these Guidelines) for addressing GBV in health programming for emergencies?

Cultural and Community Perceptions, Norms and Practices

- d) Are community members aware of:
 - The physical and mental health consequences of sexual violence and other forms of GBV?
 - The benefits of seeking GBV-related health care?
 - Where GBV survivors can access services?
- e) Do community members perceive the available GBV-related health services to be safe, confidential and supportive?
- f) What are the cultural, emotional, and other obstacles that survivors face when seeking GBV-related health care (*e.g. stigma; lack of privacy or confidentiality; language and/or cultural issues; lack of knowledge about benefits and/or location of services; getting to and from the facility; costs; etc.*)?
- g) Who are the existing community supports (*midwives, women's organizations, family members, religious leaders*) that can support survivors in seeking health care?

Infrastructure

- h) What is the number, location, safety, and accessibility of health facilities that provide clinical care—including mental health and psychosocial support—for survivors of rape and care/support for other forms of GBV (*e.g. intimate partner violence and other forms of domestic violence; female genital mutilation/cutting; etc.*)?
 - Are clinics in safe areas, and do they have female guards?
 - Are there private rooms in health facilities where survivors can receive confidential treatment?
 - Is trained staff available 24 hours/day, 7 days/week?
 - What is the availability of medical drugs, equipment, and administrative supplies to support care of sexual assault and other forms of GBV?
 - Is health staff able to provide the necessary care to in-patients who do not have family or friends to care for them?
 - Are there options for mobile clinics for rural populations?
 - Do services adhere to standards of universal design and/or reasonable accommodation² to ensure accessibility for all survivors, including those with disabilities (*e.g. physical disabilities, injuries, visual or other sensory impairments, etc.*)?
 - Has the mapping of services been compiled in a reference document (*such as a directory of services*) that is available to communities, health staff, and other service providers (*e.g. lawyers; police; mental health and psychosocial support providers specialized in the care of survivors; etc.*)?
- i) Wherever possible, have services for survivors been integrated into existing health care centers in a non-stigmatizing way (rather than created as stand-alone centers) so that survivors can seek care without being easily identified by the community?

(continued)

² For more information regarding universal design and/or reasonable accommodation, see definitions in Annex 4.

POSSIBLE AREAS OF INQUIRY

(Note: This list is not exhaustive)

Services

- j) What is the range of health services provided to support the medical needs of GBV survivors (*e.g. PEP to prevent HIV; emergency contraception; treatment for STIs; pregnancy care; safe access to abortion where it is legal; basic mental health care; etc.*)?
 - Are follow-up services available (*e.g. ensuring adherence to the full course of PEP against HIV; voluntary counseling and testing at prescribed intervals; provision of long term mental health and psychosocial support as needed; etc.*)?
 - Is a trained GBV caseworker available at the health facility to provide care and support to survivors?
- k) Are there agency-specific policies or protocols in place for the clinical care of sexual assault and other forms of GBV?
 - Do these policies/protocols adhere to ethical and safety standards (*privacy, confidentiality, respect, non-discrimination, and informed consent*)?
 - Do they include: *medical history, examination, collection of forensic evidence where possible, treatment, referral and reporting, pregnancy counseling, survivor safety planning, mental health and psychosocial support, record-keeping, and coordination with other sectors and actors*?
 - Can these policies/protocols be easily referenced or accessed? Is staff aware of them?
 - Do they include information about providing care and support to male survivors of sexual violence?
 - Are women, girls and other at-risk groups meaningfully engaged in the development of health policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
- l) What referral pathways for GBV survivors are in place in health facilities (*to security/police, safe shelter, mental health and psychosocial support, legal services, community services, etc.*)?
 - Are these institutions safe (*i.e. do they expose the survivor to further risks*)?
 - Is there a system for following up after providing referrals?
- m) What is the documentation process for GBV reports and referrals?
 - Are consent forms, medical examination forms and medico-legal certificates physically available in local languages?
 - What are the most prevalent types of GBV being documented?
 - Who is responsible for documentation?
 - Are records kept in a secure place and appropriately coded (*e.g. with unique identifying numbers*) to ensure confidentiality?
- n) What are the methods of information sharing, coordination, feedback, and system improvements amongst health actors, as well as between health actors and other multi-sectoral service providers?
 - Are all actors/organisations aware of each other's activities?
 - How are gaps and problems in service delivery identified?
 - Have Standard Operating Procedures (SOPs) been developed for multi-sectoral prevention and response to GBV? Have health actors have signed on to these?
- o) What are health care workers' attitudes toward GBV survivors and the services provided (*e.g. attitudes toward emergency contraception and abortion care in settings where these services are legal*)? How is this reflected in the type and level of care provided?
- p) Do specialized health staff (*e.g. doctors and nurses who conduct medical examinations of survivors; psychiatrists, psychologists and social workers; etc.*) receive ongoing supervision, and have they been trained on:
 - The clinical care of sexual assault, including mental health and psychosocial support?
 - How to screen for and treat various other forms of GBV without breaching confidentiality or privacy, or placing patients at additional risk of harm?
 - Providing safe and ethical referrals?
- q) Have community health workers (*including traditional health providers*) been trained on:
 - The physical and mental health implications of different types of GBV?
 - How to respond immediately to survivors?
 - Providing safe and ethical referrals?

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Health POLICIES

- What are the national and local laws related to GBV?
 - What types of GBV are mentioned and how are they defined (*e.g. intimate partner violence and other forms of domestic violence; sexual assault; sexual harassment; female genital mutilation/cutting; child and/or forced marriage; honour crimes; sexual abuse of children; forced and/or coerced prostitution; etc.*)?
- What is the legal age of consent for sexual activity? Does this differ for boys and girls? Is sexual activity considered illegal outside the context of marriage? How might this impact survivors' ability to access and receive care?
- What is the legal status of emergency contraception and abortion, including of pregnancies resulting from rape? How might this impact survivors' ability to access and receive care?
- Are there national policies/protocols in place for the clinical care and referral of sexual assault and other forms of GBV (*e.g. PEP; emergency contraception; abortion/post-abortion care; documentary evidence requirements; mandatory reporting; laws related to children; etc.*)?
 - Do these policies/protocols adhere to international ethical and safety standards?
 - Is relevant health staff familiar with these policies/protocols?
- What are the national and sub-national policies and plans to prevent GBV?
 - What types of GBV do the plans target?
 - How is the health sector involved?

Areas related to Health COMMUNICATIONS and INFORMATION SHARING

- Do health-related community outreach activities raise awareness within the community about GBV risks and protective factors?
 - Does this awareness-raising include information on referral pathways for survivors?
 - Is this information provided in age-, gender-, and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these education activities as agents of change?
- Are health-related discussion forums age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.*) so that participants feel safe to raise GBV issues?



LESSON LEARNED

When the International Refugee Committee (IRC) undertook an assessment to implement health services in Haagadera Refugee Camp in Dadaab, Kenya, they identified many issues with the health facility's capacity to respond to survivors—including no private consultation rooms for survivors, no trained staff, lack of supplies, and poor organization of service delivery. In tracing the survivor's route through this health facility, it was discovered that a survivor had to make six stops to receive care. This not only threatened survivors' confidentiality and privacy, but also risked re-traumatizing them as they were forced to retell their stories several times.

The health team in Dadaab created an action plan in which health workers and hospital administrators provided training for all staff, both clinical and non-clinical (including the security guards). This training aimed to protect patient confidentiality, increase awareness about sexual assault, improve attitudes towards survivors, and increase technical knowledge of direct patient care. Under this action plan, the health team gathered all missing resources—including consent forms, supplies for exams, and patient information materials—and developed a referral database and appointment cards. Finally, they had a staff member and target completion date devoted to each piece of the plan to ensure it was carried out effectively.

Survivors now receive all services in one private and confidential place. Protocols are available and on display, and a trained staff doctor is on-call. A private and safe room with necessary equipment is available 24 hours/day to receive survivors. Medicines and supplies are gathered in one place, and a locked filing cabinet for records is available so that patient information is kept confidential. Finally, counseling is provided in the same center and a referral network for other psychosocial and legal services is defined, with contacts posted in visible locations.

(Adapted from **Smith Transcript. 2011. Johns Hopkins Training Series**, <http://moodle.ccghe.net/course/search.php?search=GBV>)





KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for health programming. Whether requesting pre-emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.

It is important to note that the MISP considers the prevention and management of sexual violence to be a life-saving activity that prevents illness, trauma, disability and death. As a result, the MISP meets the life-saving criteria for the Central Emergency Response Fund (CERF), making these funds available for health care programmes.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**. Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.



A.

HUMANITARIAN NEEDS OVERVIEW

- ▶ Does the proposal articulate the GBV-related safety risks, protection needs and rights of the affected population as they relate to the provision of health care?
- ▶ Are risks for specific forms of GBV (*such as sexual assault, intimate partner violence and other forms of domestic violence, female genital mutilation/cutting, child marriage, etc.*) described and analysed, rather than a broader reference to "GBV"?

B.

PROJECT RATIONALE/ JUSTIFICATION

- ▶ When drafting a proposal for emergency preparedness:
 - Is there a strategy for establishing and/or implementing agreed-upon policies and protocols for the clinical care of sexual assault? For other forms of GBV?
 - Is there a strategy for preparing and providing trainings for government, health facility staff, and community health workers (*including traditional birth attendants and traditional healers*) on these protocols?
 - Is there a strategy for pre-positioning well-trained and specialized staff?
 - Is there a strategy for pre-positioning age-, gender-, and culturally-appropriate supplies (*e.g. PEP kits, medical drugs, privacy screens, etc.*)?
 - Are additional costs required to ensure any GBV-related community outreach materials will be available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- ▶ When drafting a proposal for emergency response:
 - Is there a clear description of how the health programme will respond to the physical and mental health rights and needs of GBV survivors (*in terms of infrastructure, human resources, protocols and policies, implementation of clinical care for sexual assault and other forms of GBV, etc.*)?
 - Should an emergency response team be mobilized to fill gaps?
 - Are additional costs required to ensure the safety and effective working environments for female staff in the health sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
- ▶ When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how health programming will contribute to sustainable strategies to meet the health and safety needs of survivors and reduce specific types of GBV?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

C.

PROJECT DESCRIPTION

- ▶ Do the proposed activities reflect and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for addressing GBV? Do they follow ethical and safety guidelines for providing clinical care to survivors?
- ▶ Does the project support facilities that are safe and accessible to GBV survivors, and make provisions to ensure they are equipped with proper supplies and staff? Does the project promote early reporting of sexual assault and other forms of GBV? Are monitoring services in place to ensure commodities and follow-up care are consistently available for survivors?
- ▶ Does the project promote/support community-based health systems and structures? Does it facilitate the participation and empowerment of survivors and those at risk of GBV within those structures?
- ▶ Are there activities that help to change or improve the environment by addressing the underlying causes and contributing factors of GBV (*e.g. through health education aimed at prevention*)?





KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some of the common GBV-related considerations when implementing health programming in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources in the target community.

Integrating GBV Prevention and Response into: **HEALTH PROGRAMMING**

- 1. Involve women, adolescent girls and other at-risk groups in the design and delivery of health programming (with due caution in situations where this poses a potential security risk or increases the risk of GBV).**
 - ▶ Employ women in clinical and non-clinical staff, administrator and training positions to ensure a gender balance in all aspects of health programming and provision of health care to survivors. Provide them with formal and on-the-job training as well as targeted support to assume leadership and training positions.
 - ▶ Ensure the active participation and leadership of women (and where appropriate, adolescent girls) in local health committees and community groups. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.
 - ▶ Employ persons from at-risk groups in health staff, leadership, and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.
- 2. Increase the accessibility of health and reproductive health facilities that integrate GBV-related services.**
 - ▶ Maximize safety within and around health facilities. This can include, among other things, installing adequate lighting; employing female guards at facilities; ensuring lockable sex-segregated latrines and washing facilities; and linking with community health workers to provide survivors safe, supportive and confidential escorts to and from facilities.
 - ▶ Reduce or eliminate fees for GBV-related services.
 - ▶ Make opening times convenient for women, girls and other at-risk groups based on their household duties and school times. Provide 24-hour services for sexual assault when possible.
 - ▶ Ensure facilities are universally accessible by older persons and persons with disabilities.
 - ▶ Ensure the presence of same-sex, same-language health workers when possible. Provide translators and sign-language interpreters who are trained in guiding principles for survivor care.
 - ▶ Consider whether to integrate GBV services into existing facilities (especially Primary Health Care and Reproductive Health services) and/or as stand-alone centres. Give due consideration to issues of stigma that may discourage survivors from entering facilities in which they may be easily identified.
 - ▶ Introduce mobile clinics to remote areas.



- ▶ Work with national and local government health officials and GBV specialists to compile a directory of GBV-related health services. Make this directory available to communities, health staff, and other service providers (e.g. mental health and psychosocial support providers specialized in the care of survivors; lawyers; police; etc.).
- ▶ Where mobile phone networks allow, establish an emergency phone line, staffed 24 hours/day and 7 days/week and widely advertised in public spaces. This can serve to improve rapid response to a health emergency and offer an anonymous point of first contact for survivors who are struggling to disclose.

3. Implement strategies that maximise the quality of GBV-related care available to survivors at health facilities.

- ▶ Ensure health facilities have and abide by standardized guidelines for the clinical care of survivors of sexual assault. Ensure they are in line with relevant national and sub-national protocols as well as accepted international standards, and support service providers to:
 - Obtain informed consent³ prior to performing a physical examination.
 - Perform physical examinations and provide treatment (including PEP for HIV exposure; emergency contraception; STI prevention and syndromic treatment; care of wounds and life threatening complications; and pregnancy counseling).
 - Provide psychological first aid and survivor-centered mental health and psychosocial care (adapted to the local context and monitored for benefits and adverse effects).
 - Collect minimum forensic evidence based on local legal requirements (only if the survivor consents and the capacity exists to use the information).
 - Discuss immediate safety issues and make a safety plan with the survivor.
 - Provide safe and confidential referrals to other services as needed (for example, when more long-term or specialized care is indicated).
 - Keep a careful written record of all actions and referrals (medical, mental health and psychosocial, security, legal, community-based support) to facilitate follow-up care. Ensure documentation is available for prosecution if the survivor chooses to pursue it.
 - If the survivor provides informed consent, advocate on their behalf with relevant health, social, legal, and security agencies. Follow up with these agencies as necessary and as requested by the survivor.
- ▶ Take into account specific measures to meet the needs of various at-risk groups (e.g. child survivors, LGBTI survivors, survivors with disabilities, etc.).

³ See Annex 4 for a description of informed consent.

! ESSENTIAL TO KNOW

Transgender Persons

Because of social stigma and marginalization, transgender women, transgender men, and other people who do not conform to culturally-based gender norms can be at particular risk of violence. At the same time, many cannot access care or support because of further discrimination, harassment and even violence at health care facilities. Health programmes must ensure that all transgender and gender non-conforming persons are able to access the full spectrum of health care services they require, including sexual and reproductive health care. Health actors must also understand the different ways in which transgender women and men experience violence, and ensure that health staff are adequately trained to meet the needs of all transgender survivors.

(For more information see http://www.transequity.org/Resources/Factsheet_TransSexualandReproHealth_April2012.pdf)



ESSENTIAL TO KNOW

Confidentiality

The right to privacy of health information is protected under international human rights law. This includes information about a person's reproductive health, sexual life or sexuality, and any incidents of GBV. Under this right to privacy, service providers and others who collect health-related data are obligated to keep this information confidential. In a health-care setting, information about the health status of a patient may only be shared with those directly involved in the patient's care if this information is necessary for treatment.

A person's right to privacy includes their right to be seen in private; this means that family members or anyone else who accompanies them to a health facility may be asked to wait outside. A patient's privacy may be violated if their health status is discussed with someone else without the patient's authorization. This breach of confidentiality would not only infringe on that person's right to privacy, but could also cause significant protection problems for the person concerned—such as rejection by family members or the community, violence or threats of violence, or discriminatory treatment in accessing services.

Key points to keep in mind include:

- The confidentiality of an individual who provides information about her/his health or reproductive health status, including incidents of GBV, must be protected at all times.
- Anyone providing information about her/his health or reproductive health status, including incidents of GBV, must give informed consent before participating in a data-gathering activity.

The right to confidentiality also applies to children within the health-care setting. Although information on the health status of children should not be disclosed to third parties (including parents) without the child's consent, this is of course subject to the age and maturity of the child, as well as to a determination of his or her best interests.

(Adapted from **Inter-agency Working Group on Reproductive Health in Crises**. 2010. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Testing*, page 66. http://www.iawg.net/resources/field_manual.html. For more information about issues of confidentiality when working with child survivors, see **IRC & UNICEF**. 2012. *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. http://www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf)

- ▶ Establish private consultation and examination rooms to ensure the privacy and safety of survivors seeking care.
- ▶ Equip health facilities with proper supplies to provide care for GBV:
 - Maintain adequate amounts of medical drugs, supplies and equipment for the clinical care of: sexual assault; injuries and pregnancy complications from intimate partner violence; reproductive health issues related to child marriage and early pregnancies; health problems associated with female genital mutilation/cutting; and other kinds of GBV.
 - Equip private consultation rooms with toys for children.
 - Ensure consent forms, medical examination forms, and medico-legal certificates are physically available in local languages.
- ▶ Ensure provisions are made for the care (e.g. feeding, washing, assistance to toilets) of hospitalized survivors without family or friends.
- ▶ Implement standardized data collection within health facilities and ensure safe and ethical documentation, including coding of case files to ensure confidentiality and secure storage of medical records.
- ▶ Ensure follow-up services are provided for survivors. This can include follow-up to ensure survivors are adhering to the full course of PEP against HIV; voluntary counseling and testing at prescribed intervals; and long-term mental health and psychosocial support as needed.





ESSENTIAL TO KNOW

Persons with Disabilities

It is important to adapt and develop procedures during admission, treatment and discharge of persons with disabilities. For example:

- If health care staff must rely on a third party (e.g. a sign language interpreter) to provide communication or care for a survivor with disabilities, the survivor's confidentiality and privacy might be compromised. Any third parties should be trained in the guiding principles of working with survivors and sign contracts with confidentiality provisions.
- Health and community services should be physically accessible with ramps, handrails, adapted toilets and medical equipment such as stretchers. Persons with disabilities and injuries should be offered supportive/ assistive devices (e.g. crutches, wheelchairs, tricycles, hearing aids, glasses, orthotics and prosthetics) to minimize exclusion and isolation.
- Health and prevention messages should be communicated in accessible ways (e.g. with large prints; braille; sign language; simplified messaging such as pictograms and pictures; etc.).
- Health care and community staff must be trained to provide disability-sensitive services and report data with disability-disaggregated information.
- Health care staff should work toward preventing disability and/or deterioration of impairments as a result of injury, illness or violence.

(Information provided by Handicap International, Personal Communication, February 7, 2013)

4. Enhance the capacity of health providers to deliver quality care through GBV-related training, support and supervision.

- ▶ Train all health facility staff (including administration, security guards, receptionists, etc.) and community health workers in issues of gender, GBV, women's/human rights and psychological first aid to ensure a receptive environment for survivors. Use sensitivity training to address discriminatory attitudes amongst staff that may inhibit ethical care for female and male survivors. Ensure all health facility staff understand and have signed a Code of Conduct on the prevention of sexual exploitation and abuse.
- ▶ Designate and train specific providers with clear responsibilities related to the care of survivors (e.g. triage, clinical care, mental health and psychosocial support and referral, etc.).



ESSENTIAL TO KNOW

Child and Adolescent Survivors

Health facilities and health providers should be aware of the rights and needs of child and adolescent survivors to ensure these survivors have access to safe and ethical care. Girls of a certain age (or girls who are unmarried) may not be permitted to participate in reproductive health services. Because of this, the presence of these girls in those areas of a health center will be noted and questioned, preventing their anonymity, confidentiality and access.

Persons interviewing and assisting child and adolescent survivors should:

- Possess basic knowledge of child development and sexual violence.
- Use creative methods (e.g. games, dolls, story-telling, and drawing) as well as age-, gender-, and culturally-appropriate language and terms.
- When appropriate, include trusted family members to ensure that the child/adolescent is believed, supported, and assisted in returning to normal life.

(For more information on working with child survivors see the thematic area on Child Protection. Also see **IRC & UNICEF. 2012. Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings.** http://www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf)



- Ideally, a broad pool of service providers should be trained in specialized GBV services to account for high staff turnover and prevent stigmatization of survivors who access services from a single designated provider.
 - Train and provide on-going supervision to specialized health providers (i.e. doctors and nurses who conduct medical examinations of survivors; psychiatrists, psychologists, and social workers) on specific protocols for compassionate and confidential care.
 - Ensure health care providers are informed of relevant laws and policies governing cases of GBV (e.g. abortion laws; process of pursuing legal justice; interactions with the police; police forms; mandated reporting laws; testifying in court; etc.).
 - Where feasible, include a GBV caseworker on staff at health facilities to provide care and support to survivors.
- Consider training health providers in screening for sexual violence and other forms of GBV (e.g. systematically asking women, girls, and other at-risk groups about experiences of violence/abuse). *Note that health facilities should not conduct routine screening until health providers are well-trained and experienced in providing services for various forms of GBV; can ensure clients' privacy, safety, and confidentiality; and can receive regular supervision to ensure no harm is caused through screening processes.*

ESSENTIAL TO KNOW

Male Survivors

All clinicians have a professional and ethical responsibility to respond in a sensitive and competent manner to male survivors of sexual assault. In order to do so, they must recognize that male sexual assault does occur and be aware of the need to ask sensitive questions in their assessments. If there is physical evidence indicative of sexual abuse or rape, clinicians should inquire, counsel, treat and refer the male survivor to appropriate care and support. When there is an absence of physical rape-related injuries requiring men to seek medical attention, clinicians must be attentive to other behavioral indicators of sexual assault. The presence of a number of symptoms (such as anxiety following a trigger event; sleep disturbance and nightmares; fears of an intruder; inexplicable anger; sexual problems; drug or alcohol abuse; low self-esteem; and avoidant eye contact) may be indicative of possible sexual assault. If a clinician witnesses a number of these 'red flags' in a male patient's behavior, it is important to initiate a discussion with open-ended questions, followed by more direct follow-up questions, depending on the patient's response. It may be appropriate to have an established set of interview questions to use as prompts in order to assist clinicians.

(Adapted from **Yeager, J. and Fogel, J. 2006.** "Male Disclosure of Sexual Abuse and Rape", Topics in Advanced Practice Nursing eJournal. 2006;6(1). For more information, see <http://www.medscape.com/viewarticle/528821>)

ESSENTIAL TO KNOW

Female Genital Mutilation/Cutting

Reproductive health service providers must be able to interview and conduct physical examinations of women who have undergone female genital mutilation/cutting (FGM/C). They must also be able to provide appropriate information, counseling, support, treatment and/or referral for further management of the complications of FGM/C. All of this must be done in a confidential, private, and non-judgmental manner. In settings where Type III FGM/C (infibulation) is common, health providers must be trained in opening an infibulation when indicated or know when and where to refer for this procedure. When undertaking prevention efforts, health workers should work in close collaboration with local stakeholders—particularly women's NGOs and professional organizations—to support joint decision by the community to abandon the practice.

(Adapted from **Inter-agency Working Group on Reproductive Health in Crises. 2010. Inter-Agency Field Manual for Reproductive Health in Emergencies,** <http://iawg.net/resources2013/tools-and-guidelines/field-manual/>)



- ▶ Implement cross-training between health care workers and other providers within the multi-sectoral system—including the police and legal sectors—to enhance coordination and collaboration.
- ▶ Provide opportunities for health care workers to discuss the emotional impact of working with survivors and address issues of “burn-out.”

5. Implement all health programmes within the framework of sustainability beyond the initial crisis stage.

- ▶ After the emergency wanes, design sustainable strategies led by governments and civil societies for the ongoing provision and expansion of survivor services. Such strategies can include, among others: rebuilding health services; expanding professional curricula for doctors, nurses, midwives, and other health workers to include clinical care of sexual assault and other forms of GBV; providing more frequent and intensive training of health workers; developing longer-term supply management strategies; and improving protocols for medico-legal evidence collection.

Integrating GBV Prevention and Response into: HEALTH POLICIES

1. Develop and/or standardize protocols and policies for GBV-related health programming that ensure confidential, compassionate and quality care of survivors and referral pathways for multi-sectoral support.
 - ▶ Establish agreed-upon protocols for the clinical care of sexual assault survivors that meet international standards, standards. Establish protocols for addressing health needs linked with intimate partner violence, early marriage and forced genital mutilation/cutting. Ensure these protocols are widely distributed and implemented.
 - ▶ Consult with GBV specialists to develop and institute standardized systems of care (i.e. referral pathways) and procedures (such as Standard Operating Procedures) that safely and confidentially link survivors with additional services (e.g. legal/justice support, mental health and psychosocial support, police services, etc.). Ensure these systems and procedures are locally relevant and endorsed by key health administrators and providers.
 - ▶ Provide all health personnel who engage with affected populations with written information about where to refer survivors for services. Regularly update information about referral pathways.

2. Advocate for the reform of national and local laws and policies that hinder survivors or those at risk of GBV from accessing quality health care and other services and allocate funding for sustainability.

- ▶ Advocate for the rights of GBV survivors to receive safe and ethical health care. Support national and local authorities, NGOs, INGOs, and other



stakeholders in the development and implementation of national action plans (e.g. health strategies) that integrate GBV concerns.

- ▶ Support the review and reform of laws (including customary law), legal definitions, and policies related to GBV that may impede survivors' access to quality care (e.g. access to PEP; policies regarding emergency contraception; laws regarding abortion/post-abortion care; legal definitions of rape; etc.).
- ▶ Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. Undertake awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.
- ▶ Work with Ministries of Health and other key stakeholders to ensure health care for various forms of GBV is integrated into medical school curricula and health-related continuing education programmes.



ESSENTIAL TO KNOW

Dual Loyalty and GBV

In some cases, two ethical obligations may be in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may not give consent to being examined for such purposes or to having the information gained from the examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring perpetrators of abuse are brought to justice.

The fundamental principle of "do no harm" must feature prominently in consideration of such dilemmas. **Health professionals should seek solutions that promote justice without breaking the patient's right to confidentiality, safety and security.** Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Survivors should never be coerced or forced into agreeing to have their confidential information shared with authorities. Any health care provider that is mandated to report an incident should inform a survivor of that mandate before undertaking an interview with the survivor.

(For more information on dual loyalty, see **WMA's Ethical Guide:** http://www.wma.net/en/30publications/30ethicsmanual/pdf/ethics_manual_en.pdf and the **Istanbul Protocol:** <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>. See also **Physicians for Human Rights and University of Cape Town. 2002. Dual Loyalty & Human Rights In Health Professional Practice: Proposed Guidelines & Institutional Mechanisms,** https://s3.amazonaws.com/PHR_Reports/dualloyalties-2002-report.pdf)

Integrating GBV Prevention and Response into: HEALTH COMMUNICATIONS AND INFORMATION SHARING

1. **Ensure that health programmes sharing information about reports of GBV within the health sector or with partners in the larger humanitarian community abide by safety and ethical standards.**
 - ▶ Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community consider using the international Gender-based Violence Information Management System (GBVIMS), and explore linkages between the GBVIMS and existing Health Information Management Systems.⁴

⁴ The GBVIMS is not meant to replace national health or other information systems collecting GBV information. Rather, it is an effort to bring coherence and standardization to GBV data-collection in humanitarian settings, where multiple actors often collect information using different approaches and tools. For more information, see <http://www.gbvims.com>.



- 2. Incorporate GBV messages into health-related community outreach and awareness-raising activities.**
- ▶ Work with GBV specialists to design and integrate information about GBV into health outreach initiatives (e.g. community dialogues, workshops, meetings with community leaders, health messaging, etc.).
 - Ensure this awareness-raising includes information about risks and contributing factors; victim blaming/rejection/isolation; availability of services for female and male survivors; importance of prompt care for sexual assault; multi-sectoral services; prevention messaging; and survivor rights, including to confidentiality at the service delivery and community levels.
 - Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).
 - Engage women, girls, men and boys (separately when necessary) in the development of messages and in strategies for their dissemination so they are age-, gender- and culturally-appropriate.
 - ▶ Thoroughly train health outreach staff on issues of gender, GBV, women's/human rights, and psychological first aid (e.g. how to engage supportively with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).
 - ▶ Provide men and adolescent boys with information about the health risks of sexual violence for both males and females, as well as the importance of survivors accessing care. Engage males, particularly leaders in the community, as agents of change in prevention efforts related to GBV and in promoting the rights of survivors to receive care.
 - ▶ Develop strategies to address the barriers faced by women, adolescent girls and other at-risk groups to their safe participation in community outreach activities and discussion forums (e.g. transportation, risk of backlash, childcare, etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.) so that participants feel safe to raise GBV issues.
 - ▶ Provide community members with information about existing codes of conduct for health personnel, as well as where to report sexual exploitation and abuse committed by health personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.



ESSENTIAL TO KNOW

Informing Communities about Services

Once health services are established for survivors, providers should inform communities about what to do after experiencing GBV, the benefits of seeking health care, and the location, days and hours of services. Field-tested pictorial templates that are universal and adaptable are available online at <http://iawg.net/iec2013/template-g/>. These templates allow agencies to customize to the socio-cultural context and to insert their own logos and information about the location, days and hours of services. **When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**





PROMISING PRACTICE

Clinic staff in North Darfur distributed emergency contraception (EC) to village midwives, along with a flyer (in Arabic) developed by the MISP Coordinator on the benefits and availability of care for survivors of sexual violence. African Union (AU) commanders in North Darfur were informed by the MISP Coordinator to refer all rape survivors to a local clinic for treatment. The AU civilian police (CIVPOL) patrol also distributed informational flyers. The MISP Coordinator conducted meetings with CIVPOL members about the importance of the clinical management of rape survivors, and traditional birth attendants delivered messages on sexual violence to the community. In West Darfur, midwives were identified as sexual violence protection focal points; internally displaced women could approach these focal points confidentially, and the focal points would refer them to appropriate medical care. In South Darfur, women's health teams conducted community outreach to survivors of sexual violence. Some agencies immediately established women's centers in camps; these centers not only provided a safe place for women and girls, but also provided a space for survivors of sexual violence to receive confidential, holistic care in an environment that minimized any social stigma. The following key strategies helped to make this programme effective and could be adapted by other programmes:

- Information about emergency contraception was distributed by known healthcare providers in local languages.
- Police were engaged in referring rape survivors early.
- Education about sexual violence and the care available was distributed by an authoritative staff.
- Different focal points were identified based on who was respected and accessible in the community.

(Adapted from **Women's Refugee Commission. 2006 [revised 2011].** "Minimum Initial Service Package [MISP] for Reproductive Health in Crisis Situations: A Distance Learning Module." <http://misp.rhrc.org/>. For case studies related to implementing the MISP, see: http://www.rhrc.org/rhr_basics/mispcasesstudies.html)



KEY GBV CONSIDERATIONS FOR:

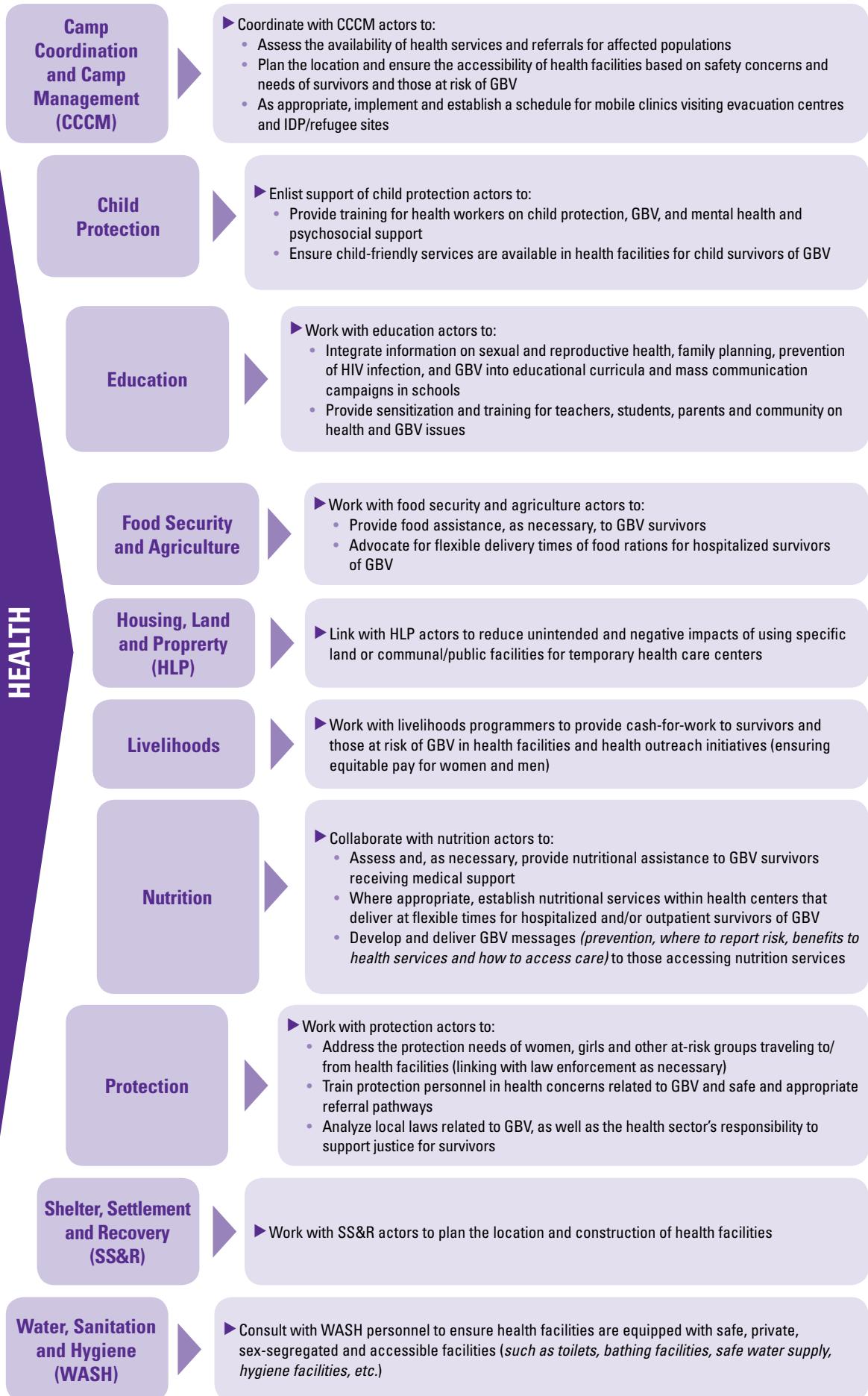
COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, health programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist health actors to:

- ▶ Design and conduct health assessments that examine the risks of GBV related to health programming, and strategize with health actors about ways these risks can be mitigated.
- ▶ Provide trainings for health staff (including medical and non-medical personnel) on issues of gender, GBV, and women's/human rights, and how to respectfully and supportively engage with survivors and provide compassionate care.
- ▶ Develop a standard referral pathway for GBV survivors who may disclose to health staff, and ensure training for health personnel on how to provide safe, ethical, and confidential referrals.
- ▶ Identify existing national health guidelines and protocols for the clinical care of GBV, and advocate as needed to ensure they meet international standards.
- ▶ Conduct training and awareness-raising for the affected community on issues of gender, GBV, and women's rights/human rights as they relate to health.

In addition, health programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, health actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance.**







KEY GBV CONSIDERATIONS FOR: MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators					Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME	
ASSESSMENT, ANALYSIS AND PLANNING							
Inclusion of GBV-related questions in health assessments ⁵	$\frac{\text{\# of health assessment that include GBV-related questions* from the GBV Guidelines} \times 100}{\text{\# of health assessment}}$ <small>* See page 113 for GBV areas of inquiry that can be adapted as questions in assessments</small>	Assessment reports or tools (at agency or sector level)	100%	✓	✓		
Female participation in assessments	$\frac{\text{\# of assessment respondents who are female} \times 100}{\text{\# of assessment respondents and \# of assessment team members who are female} \times 100}$ $\frac{\text{\# of assessment team members who are female} \times 100}{\text{\# of assessment team members}}$	Assessment reports (at agency or sector level)	50%	✓	✓		

(continued)

⁵ Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Consultations with the affected population on accessing GBV-related health services⁶	<i>Qualitative:</i> $\frac{\# \text{ of health services conducting consultations with the affected population to discuss access to GBV-related services} \times 100}{\# \text{ of health services}}$	Organizational records, focus group discussion (FGD), key informant interview (KII)	100%		✓	✓
<i>Disaggregate consultations by sex and age</i>	<i>Qualitative:</i> What types of barriers do affected persons experience in accessing GBV-related health services?					
Health facilities with trained clinical staff* on clinical care for sexual assault (CCSA) and other forms of GBV	 $\frac{\# \text{ of health facilities with clinical staff who are trained on CCSA and other forms of GBV} \times 100}{\# \text{ of health facilities}}$	Health facility assessment	100%		✓	✓
<i>Disaggregate trained clinical staff by sex</i>						
RESOURCE MOBILIZATION						
Inclusion of GBV prevention and response in health funding proposals or strategies	 $\frac{\# \text{ of health funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines} \times 100}{\# \text{ of health funding proposals or strategies}}$	Proposal review (at agency or sector level)	100%		✓	✓
Training of health staff on the GBV Guidelines	 $\frac{\# \text{ of health staff who participated in a training on the GBV Guidelines} \times 100}{\# \text{ of health staff}}$	Training attendance, meeting minutes, survey (at agency or sector level)	100%		✓	✓
Stock availability of pre-positioned supplies for CCSA⁶	 $\frac{\# \text{ of CCSA supplies that have stock levels below minimum levels} \times 100}{\# \text{ of CCSA supplies}}$	Planning or procurement records, health facility assessment	0%		✓	✓

(continued)

⁶ United Nations Office for the Coordination of Humanitarian Affairs. *Humanitarian Indicator Registry*. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME	Stage of Programme
IMPLEMENTATION							
► Programming							
Female participation prior to programme design⁶	<p><i>Qualitative:</i></p> $\frac{\# \text{ of affected persons consulted before designing a programme who are female} \times 100}{\# \text{ of affected persons consulted before designing a programme}}$ <p><i>Qualitative:</i> How do women and girls perceive their level of participation in the programme design? What enhances women and girls' participation in the design process? What are barriers to female participation in these processes?</p>	Organizational records, FGD, KII	Determine in the field			✓	
Female staff in health service provision⁶	$\frac{\# \text{ of staff who provide health services who are female} \times 100}{\# \text{ of staff who provide health services}}$	Organizational records	50%	✓	✓		
Risk factors in and around health centers providing services for CCSA and other forms of GBV	<p><i>Quantitative:</i></p> $\frac{\# \text{ of affected persons who report concerns about experiencing GBV when asked about access to health centers providing services for CCSA and other forms of GBV} \times 100}{\# \text{ of affected persons asked about access to health centers providing services for CCSA and other forms of GBV}}$ <p><i>Qualitative:</i> Do affected persons feel safe from GBV when accessing health centers providing services for CCSA and other forms of GBV? What types of safety concerns does the affected population describe?</p>	Survey, FGD, KII, participatory community mapping	100%		✓	✓	
Availability of free services for CCSA and other forms of GBV in health facilities	$\frac{\# \text{ of health facilities with CCSA with no fee for CCSA and other forms of GBV} \times 100}{\# \text{ of health facilities with CCSA}}$	Health facility assessment, KII	0%	✓		✓	
Community knowledge of health services for CCSA and other forms of GBV	$\frac{\# \text{ of affected persons who, in response to a prompted question, correctly say where to locate health services for CCSA and other forms of GBV} \times 100}{\# \text{ of surveyed affected persons}}$	Survey	100%	✓		✓	
Safe provision of quality CCSA treatment at health facilities	$\frac{\# \text{ of health facilities that can provide* emergency contraceptive pills, post-exposure prophylaxis and sexually transmitted infection (STI) presumptive treatment in a private room} \times 100}{\# \text{ of assessed health facilities}}$ <p><i>* Provision includes supplies, trained staff and World Health Organization (WHO) standardized protocols</i></p>	MISP Needs Assessment Health Facility Questionnaire	Determine in the field	✓		✓	

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
<p>► Programming</p> <p>Staff knowledge of Standard Operating Procedures for multi-sectoral care for GBV</p> <p># of health staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors x 100 _____ # of surveyed health staff</p>									
		Survey	100%	✓	✓				
<p>► Policies</p> <p>Existence of a standard referral pathway for GBV survivors</p> <p># of health sites with a standard referral pathway for GBV survivors x 100 _____ # of health sites</p>									
		KII	100%	✓	✓				
<p>Existence of national policies meeting international standards for CCSA</p> <p># of reviewed national policies* that follow WHO standards for CCSA x 100 _____ # of reviewed national policies</p> <p>* National policies include mandatory reporting, PEP, emergency contraception, abortion/post-abortion care</p>									
		Desk review	0%	✓		✓			
<p>► Communications and Information Sharing</p> <p>Staff knowledge of standards for confidential sharing of GBV reports</p> <p># of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100 _____ # of surveyed staff</p>									
		Survey (at agency or programme level)	100%	✓		✓			
<p>Inclusion of information about the location and benefits of timely care for CCSA and other forms of GBV in community outreach activities</p> <p># of health community outreach activities programmes that include information about the location and benefits of timely care for CCSA and other forms of GBV x 100 _____ # of health community outreach activities</p>									
		Desk review, KII	Determine in the field	✓	✓				
COORDINATION									
<p>Coordination of GBV risk reduction activities with other sectors</p> <p># of non-health sectors consulted with to address GBV risk reduction activities* x 100 _____ # of existing non-health sectors in a given humanitarian response</p> <p>* See page X for list of sectors and GBV risk reduction activities</p>									
		KII, meeting minutes (at agency or sector level)	Determine in the field	✓	✓				

RESOURCES

Key Resources

Clinical Care for Sexual Assault and other forms of GBV

- **World Health Organization. 2003.** "Guidelines for medico-legal care of victims of sexual violence" Geneva. <http://whqlibdoc.who.int/publications/2004/924154628X.pdf>
- For an example of a medical history and examination form which can be used as a guide when treating survivors of violence against women and girls, see **WHO, UNFPA, UNHCR. 2004.** "Clinical Management of Rape Survivors: Developing Protocols for use with Refugees and Internally Displaced Persons-Revised Edition," pgs. 44-47. <http://www.who.int/reproductive-health/publications/emergencies/924159263X/en/>
- **IRC. 2009 (revised 2014).** "Clinical Care for Sexual Assault Survivors," <http://www.iawg.net/ccsas>. The goal of this training tool is to improve the clinical care of sexual assault survivors in low resource settings by encouraging compassionate, competent, and confidential care in keeping with international standards.
- **UNHCR/UNFPA/WHO. 2009.** *Clinical Management of Rape e-Learning Programme*, <http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/> The course is a self-instructional, interactive e-learning programme based on the content of the WHO/UNHCR guidance on *Clinical Management of Rape Survivors*, and the training materials used by UNHCR and UNFPA in field-based face-to-face training sessions.
- **WHO. 2013.** "Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines." <http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>
- **UNFPA/UNICEF Joint Programme on Female Genital Mutilation/Cutting, 2009.** "The End is in Sight: Moving Toward the Abandonment of Female Genital Mutilation/Cutting." http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/endisinsight_2009report.pdf
- For guidelines for the clinical care of FGM/C designed for application in England and Wales, see **HM Government, 2011.** "Multi-Agency Practice Guidelines: Female Genital Mutilation." www.fco.gov.uk/fgm
- **UNFPA, 2012.** "Research, Health Care, and Preventative Measures for FGM/C and the Strengthening of Leadership and Research in Africa." <http://www.unfpa.org/public/home/publications/pid/11732>

- **WHO. 2014.** *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook.* WHO/RHR/14.26, Field testing version, September 2014. <http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/index.html>

- **Yeager, J. and Fogel, J. 2006.** "Male Disclosure of Sexual Abuse and Rape", Topics in Advanced Practice Nursing eJournal. 2006;6(1) <http://www.medscape.com/viewarticle/528821>

Minimum Initial Service Package

- **Women's Refugee Commission. 2006 (revised 2011).** "Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning Module." <http://misp.rhrc.org/>. For case studies related to implementing the MISP, see: http://www.rhrc.org/rhr_basics/mispcaestudies.html
- **Inter-agency Working Group on Reproductive Health in Crises. 2010.** "Inter-agency Field Manual on Reproductive Health in Humanitarian Settings," http://www.iawg.net/resources/field_manual.html. This field manual includes information on the Minimum Initial Services Package (MISP) and comprehensive reproductive health. One chapter is devoted to gender-based violence, and addresses sexual violence, intimate partner violence, female genital mutilation, and child and/or forced marriage.
- **Inter-Agency Working Group on Reproductive Health in Crises. 2008.** "Inter-Agency Reproductive Health Kits for Crisis Situations," (Fourth edition). <http://www.rhrc.org/resources/index.cfm?sector=er> The essential drugs, equipment and supplies to implement the MISP have been assembled into a set of specially designed prepackaged kits, the Inter-Agency Reproductive Health Kits. The kits complement the objectives laid out in Reproductive Health in Humanitarian Settings: An Inter-agency Field Manual. The resource is also available in French and Spanish.
- **Women's Refugee Commission.** "Universal & Adaptable Information, Education & Communication (IEC) Templates on the MISP." In an effort to provide clear and consistent messages on the MISP for Reproductive Health, the Women's Refugee Commission developed information, education and communication (IEC) templates on two of the MISP-related objectives to better inform communities on the importance of seeking care, knowing when and how to seek care, and what services to expect from field agencies. Electronic and hard copies of a facilitator's toolkit are available from the Women's Refugee Commission. <http://iawg.net/iec-misp/>



Working with Child and Adolescent Survivors

- **IRC & UNICEF.** 2012. *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings.* http://www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf
- **UNFPA and Save the Children.** 2009. "Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings", <https://www.unfpa.org/public/global/publications/pid/4169>
- **UNFPA and Save the Children.** *E-learning course on Adolescent and Sexual Reproductive Health in Humanitarian Settings.* www.iawg.net/resources/arhtoolkit.html This e-learning course is an introduction to adolescents' sexual and reproductive health needs in humanitarian settings.

Mental Health and Psychosocial Support

- **IASC.** 2010. *Caring for Survivors Training Pack,* <http://oneresponse.info/GlobalClusters/Protection/GBV/Pages/default.aspx> This Training Pack can be used to develop multi-sectoral skills (e.g. health, psychosocial, legal/justice and security) and is designed for professional health care providers, as well as for members of the legal professionals, police, women's groups and other concerned community members, such as community workers, teachers and religious workers. The training includes a facilitator guide for medical management of sexual assault.
- **WHO, UNFPA, UNICEF, and UNAction.** 2012. "Mental Health and Psychosocial Support for Conflict-Related Sexual Violence: Principles and Interventions," http://www.who.int/reproductivehealth/publications/violence/rhr12_18/en/
- **IASC.** 2007. *Guidelines on Mental Health and Psychological Support in Emergency Settings.* http://www.who.int/hac/network/interagency/news/mental_health_guidelines_checklist/en/index.html
- **WHO, War Trauma Foundation, and World Vision International.** 2011. "Psychological first aid: Guide for field workers." Available in 10+ languages at http://www.who.int/mental_health/publications/guide_field_workers/en/
- **IASC Reference Group,** 2013. "Mental Health and Psychosocial Support Assessment Guide." The purpose of this document is to provide agencies with tools containing key assessment questions that are of common relevance to all actors involved in Mental Health and Psychosocial Support (MHPSS) independent of the phase of the emergency. <http://mhpss.net/?get=219/1384515558-201304IASCRGonMHPSSAssessment-Guide.pdf>
- **WHO, UNFPA, UNHCR, UNICEF, and UNAction,** 2012. "Mental health and psychosocial support for conflict-related sexual health: 10 myths." http://www.unicef.org/protection/files/Policy_brief_10_myths_English_19-7.pdf
- **Sveaass, N., Drews, D., Salvesen, K., Christie, H., Dahl S., With, A. & Langdal, E.** 2014. *Mental health and gender-based violence: Helping survivors of sexual violence in conflict – a training manual,* <http://hhri-gbv-manual.org>

Data Collection

- **GBVIMS.** The GBVIMS has been implemented in Burundi, Colombia, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Guinea, Iraq, Kenya, Liberia, Nepal, Sierra Leone, Southern Sudan, Thailand, and Uganda. To gain access to the GBVIMS tools and to learn about implementing the GBVIMS, organizations must:
 - Participate in a GBVIMS Orientation in person or via webinar.
 - Submit a brief questionnaire to the Steering Committee to ensure that it is applicable to your context and programme of the requesting organization.
 - Participate in a consultation with a member of the GBVIMS Global Team. This provides access to the expertise of organizations that developed the GBVIMS and have implemented the GBVIMS in multiple countries.

For more information on the GBVIMS, see <http://www.gbvims.com>. You can also **watch a short GBVIMS Website Tour:** http://www.youtube.com/watch?v=8Ziqef2X4aA&utm_source=Listserve+Emails+September&utm_campaign=defe51ceea-GBVIMS_Website_Updates10_29_2012&utm_medium=email

- **WHO.** 2007. *Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies.* http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf
- **UN Action Guidance Note.** 2008. *Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries: Dos and Don'ts.* www.stopapenow.org/pdf/UN%20ACTION_Dosand-Donts.pdf

Standard Operating Procedures

- **IASC Gender Sub-working Group.** 2008. *Establishing Standard Operating Procedures for multi-sectoral and inter-organization-al prevention and response to GBV in humanitarian settings.* http://www.globalprotectioncluster.org/_assets/files/tools_and_guidance/gender_based_violence/GBV_Standard_Operational_Procedures_2008_EN.pdf The guide includes detailed guidance on the process of developing referral pathways and other procedures for GBV prevention and response in humanitarian emergency settings.
- The **GBV SOP Workshop Package** was developed by the Gender-based Violence Area of Responsibility Global Working Group (GBV AOR) in the Global Protection Cluster. Development of these materials was a collaborative process jointly led by UNHCR's Community Development, Gender Equality and Children Section and UNFPA's Humanitarian Response Branch. **The SOP Guide and workshop package can be downloaded from:** <http://oneresponse.info/GlobalClusters/Protection/GBV/Pages/Tools%20and%20Resources.aspx>



Additional Resources

- For an overview of health sector responsibilities in humanitarian settings, see the Conflict/Post-Conflict Module at the **UN Women Virtual Knowledge Centre to End Violence Against Women and Girls**. The Centre website also contains a programming module on Health that does not focus specifically on humanitarian contexts, but nevertheless contains links to many key tools and resources relevant to health care providers working in emergencies. See: www.endvawnow.org
- For a checklist for ensuring gender-equitable health programming, see **Inter-Agency Standing Committee. 2006. Gender Handbook in Humanitarian Action**, http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-genderh
- **Sphere Project. 2011. Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response**. <http://www.spherehandbook.org/>
- **IPPF. 2010. Resource Manual: Improving the Health Sector Response to Gender-Based Violence.**
<https://www.ippfwhr.org/en/publications/improving-the-health-sector-response-to-gender-based-violence>
This manual provides tools and guidelines that health care managers can use to improve the health care responses to gender-based violence in developing countries. It includes practical tools to determine provider attitudes to gender-based violence, legal definitions, the responsibilities of health care providers, and the quality of care.
- **World's Abortion Laws Map** <http://worldabortionlaws.com/map/>
Since 1998, the Center for Reproductive Rights has produced the World's Abortion Laws map to visually compare the legal status of abortion across the globe. The interactive map is updated in real time to keep pace with changes in how countries are protecting – or denying – women's reproductive freedom.
- **UNHCR. 2012. Working with men and boy survivors of sexual and gender-based violence in forced displacement.** <http://www.refworld.org/docid/5006aa262.html>
- For a documentary from UNAIDS on **Handicap International's work on GBV and HIV mainstreaming** in Kenya during the post-election violence in 2007-2008, see: <http://www.youtube.com/watch?v=DW8qFVJJtQg&feature=email>





HOUSING, LAND AND PROPERTY



THIS SECTION APPLIES TO:

- Housing, land and property (HLP) coordination mechanisms
- Actors (staff and leadership) engaged in HLP work: NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, older persons, etc.) related to HLP
- Other HLP stakeholders: national and local governments (e.g. Housing, Land, Agriculture, Planning, Environment, Public Works, Justice. etc.); community leaders; professional organizations (such as lawyers) and relevant civil society groups; and national and local experts in HLP issues, particularly those familiar with customary and statutory laws and judicial processes

Why Addressing Gender-based Violence is a Critical Concern of the Housing, Land and Property Sector

Humanitarian crises are often characterized by high levels of displacement, both of refugees and internally displaced populations (IDPs). Existing land grievances, evictions, and confiscation or occupation of housing, land and property (HLP) all play an important role in this displacement. In many situations, refugees, IDPs and returnees:

- ▶ Live in disrupted environments where traditional protection mechanisms may no longer exist.
- ▶ Lack documentation of their rights to HLP.
- ▶ Live in camp-like situations for many years without knowing when/if they will return to their homes.
- ▶ Come into conflict over land with host communities while seeking temporary or permanent settlement.
- ▶ Live in informal settlements or occupy public/private buildings with the risk of forced eviction.
- ▶ Return home to claim land/property that has been taken up as residence by secondary occupants.



ESSENTIAL TO KNOW

Defining “HLP”

The concept of HLP embraces a variety of access rights to housing, land and property—both public and private—that aim to provide a home: a place that offers somewhere to live and the ability to secure livelihoods. HLP rights are held by tenants, cooperative dwellers, customary land tenure owners and users, and informal sector dwellers without secure tenure.

(Adapted from **NRC. 2014. "Life Can Change: Securing Housing Land and Property Rights for Displaced Women"**, <http://womenshlp.nrc.no>)



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery throughout the Humanitarian Cycle

ASSESSMENT, ANALYSIS AND PLANNING

Promote the active participation of women, girls and other at-risk groups in all HLP assessment processes

Assess the level of participation and leadership of women, adolescent girls and other at-risk groups in all aspects of HLP programming (e.g. ratio of male/female staff; etc.)

Assess the barriers faced by women, adolescent girls and other at-risk groups to accessing and controlling HLP, and how these barriers may contribute to partner violence and other forms of domestic violence; etc.)

Examine HLP rights related to return, resettlement or reintegration for women, adolescent girls and other at-risk groups

Assess whether existing institutions protect the HLP rights of women, adolescent girls and other at-risk groups (e.g. mechanisms to increase independence and autonomy; dispute resolution mechanisms; community leaders who will speak to uphold women's HLP rights; etc.)

Assess national and local laws and policies related to HLP rights that in turn may increase the risk of GBV (e.g. unequal marital and inheritance rights for girls; etc.)

Assess awareness of HLP staff on basic issues related to gender, GBV and women's/human rights (including knowledge of where survivors can report risks and abuses)

Review existing/proposed community outreach material related to HLP to ensure it includes basic information about GBV risk reduction (including where to report risks and abuses)

RESOURCE MOBILIZATION

Develop proposals that reflect awareness of particular GBV risks related to HLP (e.g. lack of adequate housing during displacement and/or resettlement in urban setting; women and girls marginalized in urban setting who rent can be exposed to abuse and exploitation by landlords; etc.)

Prepare and provide trainings for government, humanitarian workers and volunteers engaged in HLP work on the safe design and implementation of HLP programmes

IMPLEMENTATION

► Programming

Involve women and other at-risk groups as staff and leaders in HLP programming (with due caution where this poses a potential security risk or increases the risk of GBV)

Support national and local efforts to promote the HLP rights of women, girls and other at-risk groups in order to minimize their vulnerability to GBV

Provide and strengthen legal assistance for women, girls and other at-risk groups to obtain security of tenure and control of HLP (e.g. secure official records; fair mechanisms; etc.)

► Policies

Incorporate GBV prevention and mitigation strategies into the policies, standards and/or guidelines of HLP programmes (e.g. standards for equal employment opportunities; policies to prevent and respond to GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse; etc.)

Advocate for the integration of GBV risk-reduction strategies into national and local laws and policies related to HLP, and allocate funding for sustainability

► Communications and Information Sharing

Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure HLP staff has the skills to support them

Ensure that HLP programmes sharing information about reports of GBV within the HLP sector or with partners in the larger humanitarian community abide by strict confidentiality and do not pose a security risk to individual survivors, their families or the broader community

Incorporate GBV messages (including where to report risk and how to access care) into HLP-related community outreach and awareness-raising activities

COORDINATION

Undertake coordination with other sectors to address GBV risks and ensure protection for women, girls and other at-risk groups

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign an HLP focal point to regularly participate in GBV coordination

MONITORING AND EVALUATION

Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduction activities

Evaluate GBV risk-reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for HLP actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**.

at the Programme Cycle

	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
female HLP staff; participation in committees related to HLP; etc.)	✓	✓	✓	✓
various forms of GBV (e.g. exploitation and abuse resulting from forced eviction; intimate	✓	✓	✓	✓
nt registration of land and housing in women's names; gender-responsive restitution and		✓		
irls and boys; forced eviction laws; tenant's rights; etc.)		✓		
and access care; linkages between HLP programming and GBV risk reduction; etc.)	✓	✓	✓	✓
o report risk and how to access care)	✓	✓	✓	✓
ay contribute to women and girls engaging in forced and/or coerced prostitution; poor and	✓	✓	✓	✓
programmes that mitigate the risk of GBV	✓	✓	✓	✓
risk of GBV)	✓	✓	✓	✓
acilitate free legal assistance; establish gender-responsive restitution and dispute resolution	✓	✓	✓	✓
females; procedures and protocols for sharing protected or confidential information about	✓	✓	✓	✓
	✓		✓	✓
basic skills to provide them with information on where they can obtain support	✓		✓	✓
e by safety and ethical standards (e.g. shared information does not reveal the identity of or	✓	✓	✓	✓
	✓	✓	✓	✓
ation meetings	✓	✓	✓	✓
duction activities throughout the programme cycle	✓	✓	✓	✓
ng and ensure accountability		✓	✓	✓

Pre-existing inequality and discrimination exacerbate these issues and increase the risk of gender-based violence (GBV) for women and girls. For example, occupation of land or property, destruction of housing, and forced evictions are often deliberate strategies used by warring parties during armed conflicts. In such cases, those left at home (often women) may get into arguments, negotiations or confrontations with those evicting them, putting them at risk of abuse, beatings, sexual assault and murder.

Lack of adequate housing during displacement and resettlement—whether in urban slums, squatter settlements, collective centres, refugee settlements or with host families—may contribute to sexual assault and exploitation. The poor and marginalized who rent can be exposed to abuses and exploitation by landlords.

In return situations where laws and customs prohibit women, girls and other at-risk groups¹ from renting, owning, or inheriting HLP, these persons may have few opportunities for recourse. Widows and separated/divorced women are often particularly vulnerable because they may not be documented as heads of households with land tenure rights. Those who do own land may be subjected to customary practices such as forced marriages or obligated to stay in violent domestic situations so that family members can retain rights and access to the land. Those with insecure land tenure may also face exploitation and violence by family or community members, especially if they have increased the value of their land (i.e., by preparing and cultivating crops).

Separated or unaccompanied children and those living in child-headed households may similarly face challenges with HLP. Even if they own land, they may not be able to cultivate it or build housing for themselves due to lack of skills, physical challenges or difficulty obtaining support from relevant organizations. For example, they may not be able to receive housing assistance if they don't have documentation to prove ownership over their house, land or property. These barriers may be further exacerbated by their inability to access justice when their land rights are violated.

WHAT THE PINHEIRO PRINCIPLES SAY:

The normative framework for addressing HLP rights in the context of displacement is summarized in the 2005 *Principles on Housing and Property Restitution for Refugees and Displaced Persons*. Known as the “Pinheiro Principles,” this document reaffirms that all displaced persons—whether internally displaced or refugees, and whether or not they return—shall be protected from arbitrary and unlawful deprivation of any housing, land and/or property. They shall also retain the right to have such property restored to them or be adequately compensated. It recognizes the need to undertake positive measures to ensure that the rights of women and girls to HLP restitution are guaranteed.

Principle 4 reaffirms the right to equality between men and women, and the equal rights of boys and girls, to HLP restitution. This includes legal security of tenure; property ownership; equal access to inheritance; and the use, control of and access to HLP. It specifically states that HLP restitution programmes, policies and practices shall not disadvantage women and girls. States should adopt positive measures to ensure gender equality in this regard.

(Adapted from **UN Sub-Commission on the Promotion and Protection of Human Rights. 2005. *Principles on Housing and Property Restitution for Refugees and Displaced Persons*, E/CN.4/Sub.2/2005/17, <http://www.refworld.org/docid/41640c874.html>**)

¹ For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



Survivors of GBV are also at an increased risk of HLP problems. In urban areas they may find themselves unable to work or pay rent. In camp settings where residents are allocated land but required to build housing themselves, some survivors may be too physically or emotionally incapacitated to undertake such a task.

HLP programmes that identify the context-specific links between HLP and GBV can develop strategies to mitigate the risks of violence against women, girls and other at-risk groups. When effectively designed, these programmes can:

- ▶ Challenge inequitable social norms and promote gender equality by assisting women, girls and other at-risk groups in claiming HLP rights after the humanitarian emergency.
- ▶ Improve family security during economic and social transitions.
- ▶ Have a positive impact on post-crisis reconstruction and long-term development.

Actions taken by the HLP sector to prevent and mitigate GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. HLP actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)



Addressing Gender-based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by HLP actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with HLP actors working in partnership with other sectors as well as with GBV specialists.

The information generated from these areas of inquiry should be analyzed to inform planning of HLP programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.

KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in HLP: government offices (e.g. Housing, Land, Agriculture, Planning, Environment, Public Works, Justice, etc.); national and local experts in HLP issues, particularly those familiar with customary and statutory laws/institutions (e.g. lawyers, civil society organizations, etc.); environmental groups; GBV, gender and diversity specialists
- Affected populations and communities
- In IDP/refugee settings, members of receptor/host communities

POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to HLP PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female HLP staff, including in positions of leadership?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are women and other at-risk groups actively involved in community activities related to HLP (*e.g. community HLP committees*)? Are they in leadership roles when possible?
- c) Are the lead actors in HLP response aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation strategies into their activities?

Security of Land Tenure and Ownership

- d) Are questions related to HLP rights and issues (for both men and women) included in registration, profiling, and intention surveys (*e.g. pre-emergency living arrangements; pre-emergency arrangements regarding access to and control of land and property, such as individual or family ownership, statutory or customary ownership, pastoral rights, social tenancy, or rental agreements; possession or absence of supporting documents, including written reports of property destruction or occupation; etc.*)?
- e) What cultural barriers do women, adolescent girls and other at-risk groups face in renting, squatting, or land ownership and tenure (*e.g. stigma, discrimination, social norms, etc.*)?
- f) Are women, adolescent girls and other at-risk groups being dispossessed of their HLP rights?
 - What kinds of rights do tenants have? Are there controls in place to protect these rights, such as controls over rent-inflation?
 - Is there a deliberate strategy of forced evictions being applied?
 - Are squatters and landless people excluded from receiving assistance?
- g) Do HLP issues increase risks of GBV? In what ways (*e.g. sexual violence and exploitation by landlords; threat of violence related to lack of documentation and/or evictions; child and/or forced marriage; engagement in harmful practices such as exchanging sex for land rights or money; intimate partner violence and other forms of domestic violence; staying in abusive relationships; etc.*)?
- h) Do women, adolescent girls and other at-risk groups have access to documentation and/or evidence that proves their ownership of HLP (*e.g. deeds, leases, squatters' certificates, etc.*)?
 - In whose name are the documents that provide evidence of HLP rights written?
 - Were women, adolescent girls or other at-risk groups forced to surrender such documentation or sign over their property under duress?
 - Do they possess alternative means of documenting their rights?
- i) Are different types of tenure (*e.g. renters, squatters, homeless, tenants, etc.*) considered in remedial programmes? Do women and men have equal opportunities to participate in all stages of interventions affecting their HLP rights?
- j) Are women, girls and other at-risk groups denied access to their HLP upon return?
 - What are the economic, cultural, legal and geographic obstacles for them in accessing HLP rights in these locations?
 - How are they coping?
 - When younger generations that were born in camps cannot locate land boundaries—and do not have access to the knowledge of their elders about these boundaries—what arrangements are in place to ensure their access to property?
 - Are female ex-combatants considered in reintegration, resettlement and access to land programmes?

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

- k) What land tenure arrangements—including statutory and customary access rights to land, water, grazing, and other natural resources—are in place for areas that will be used, for example, in camp set-ups?
- How will these affect the rights of host communities—particularly women, adolescent girls and other at-risk groups?
 - Who will benefit financially and socially from the control of such resources?

Institutional Infrastructure

- l) Are national or local institutions in place to deal with land disputes and other issues?
- What is the capacity and infrastructure of these institutions? Can they provide effective, accessible and impartial remedies?
 - Are they accessible to women, adolescent girls and other at-risk groups (*e.g. widows, divorcees, etc.*)?
 - Are there barriers to accessing these mechanisms for women, adolescent girls and other at-risk groups (*e.g. cost; location; attitudes of those managing the mechanism; fear of retribution; illiteracy; etc.*)?
- m) Are there any national or local institutions working to increase registration of HLP rights (*including inheritance rights*) in women's names?
- n) How are undocumented rights dealt with in national or local institutions (*e.g. is oral evidence accepted to support women's claims?*)

Areas related to HLP POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of HLP programming
- Are women, girls and other at-risk groups meaningfully engaged in the development of HLP policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Are these policies, standards and guidelines communicated to women, girls, boys and men (separately when necessary)?
 - Is HLP staff properly trained and equipped with the necessary skills to implement these policies?
- b) What national laws and sector policies are relevant to HLP and broader land issues (*e.g. land and housing laws; forced evictions, relocation or resettlement; right to privacy in the home; etc.*)?
- Do the laws and policies discriminate against women, girls and/or other at-risk groups?
 - How do they deal with housing abandonment after flight?
- c) Can women, adolescent girls and other at-risk groups claim rights pertaining to land and immovable property?
- Are women being denied their HLP rights to the benefit of male relatives (*e.g. due to inheritance laws, customs or practices, etc.*)?
 - Do spouses have joint rights to property?
 - Are land titles and other documents given in the names of men and women, or only in the name of the head of household?
 - Is authorization of both parties required for land and property sales?
- d) How are women, girls and other at-risk groups protected from evictions?
- Are there any national and local laws aimed at preventing and regulating forced evictions?
 - Are there any community-driven initiatives to provide viable and sustainable solutions to forced eviction?
 - How are the particular rights and needs of women, girls and other at-risk groups taken into account when evictions happen?
- e) Are there inconsistencies between customary and statutory law related to HLP (*e.g. with regard to marital rights and inheritances*)? Have actors involved in the application of customary and statutory law been adequately trained in HLP policies and the rights of women and other at-risk groups?
- f) What is the status of land reform with reference to equal rights for all?
- Is there a national land reform policy?
 - To what extent do the land reform laws improve the rights of women, girls and other at-risk groups?
 - Is there a national land commission? To what extent are women, adolescent girls and other at-risk groups involved?

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to HLP COMMUNICATIONS and INFORMATION SHARING

- a) Has training been provided to HLP outreach staff on:
 - Issues of gender, GBV, and women's/human rights?
 - How to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- b) Do HLP-related community outreach activities raise awareness within the community about general safety and GBV risk reduction?
 - Does this awareness-raising include information on survivor rights (including confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Is this information provided in age-, gender-, and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these activities as agents of change?
- c) Are discussion forums on HLP age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.*) so that participants feel safe to raise GBV issues?



KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for HLP programming. Whether requesting pre-emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**.

Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.



A. HUMANITARIAN NEEDS OVERVIEW

- Does the proposal articulate the GBV-related safety risks, protection needs and rights of the affected population as they relate to land ownership and tenure (*e.g. forced evictions, absence of documentation, etc.*)?
- Are risks for specific forms of GBV (*such as sexual assault, sexual exploitation, sexual harassment, forced and/or coerced prostitution, child and/or forced marriage, etc.*) described and analysed, rather than a broader reference to “GBV”?
- Are vulnerabilities of women, girls and other at-risk groups recognized and described?

B. PROJECT RATIONALE/ JUSTIFICATION

- When drafting a proposal for emergency preparedness:
 - Is there an understanding of how contextual issues may prevent displaced populations—particularly women, girls and other at-risk groups—from accessing HLP in their new location (*e.g. cultural barriers that prevent women, adolescent girls and other at-risk groups from renting, squatting, or owning land; absence of national or local institutions to deal with land disputes and issues; etc.*)?
 - Are additional costs required to ensure any GBV-related community outreach materials will be available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
 - Is there a strategy for preparing and providing trainings for government, humanitarian staff and community members on the safe design and implementation of HLP activities that mitigate the risk of GBV?
- When drafting a proposal for emergency response:
 - Is there a clear description of how the planned intervention(s) will mitigate the risks of GBV for women, girls and other at-risk groups (*e.g. providing legal assistance to women and adolescent girls seeking secure tenure of HLP*)?
 - Are additional costs required to ensure the safety and effective working environments for female staff in the HLP sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
- When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how the planned intervention(s) will contribute to sustainable strategies that support the HLP rights of women, girls and other at-risk groups (*e.g. advocating for the inclusion of women in discussions on land reform and peace processes*)?
 - Has the project taken into consideration the potential positive and negative cultural changes that returnees may face in accessing their HLP rights?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

C. PROJECT DESCRIPTION

- Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for integrating GBV-related work?
- Do the proposed activities illustrate linkages with other humanitarian actors/ sectors in order to maximize resources and work in strategic ways?
- Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as HLP staff and in community-based land and housing-related committees?



 KEY GBV CONSIDERATIONS FOR:
IMPLEMENTATION

The following are some common GBV-related considerations when implementing HLP programming in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

**Integrating GBV Risk Reduction into:
HLP PROGRAMMING**

- 1. Involve women and other at-risk groups as staff and leaders in HLP programming (with due caution in situations where this poses a potential security risk or increases the risk of GBV).**
 - ▶ Strive for 50% representation of females within HLP programme staff. Provide them with formal and on-the-job training as well as targeted support to assume leadership and training positions.
 - ▶ Ensure women (and where appropriate, adolescent girls) are actively involved in community-based HLP committees and land management groups. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.
 - ▶ Employ persons from at-risk groups into HLP staff, leadership, and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.

**ESSENTIAL TO KNOW****Transgender Persons**

People who are transgender—especially transgender women—are often severely marginalized and face unique difficulties in accessing housing. For example, where laws do not protect them, they may not be consulted properly regarding the possession of their homes and may be forced to vacate with little compensation or fair alternative housing. They may be harassed and threatened by landlords or officials on the basis of their perceived sexual orientation or gender identity, resulting in the loss of HLP rights and even the denial of basic services. This, in turn, can force them to engage in sex work or other risky income-earning activities in order to survive. When possible, HLP programmers should consult with LGBTI specialists and local LGBTI organizations to explore culturally-sensitive ways of ensuring that the basic rights and needs of transgender persons are addressed in HLP programming.

(Information provided by Duncan Breen, Human Rights First, Personal Communication, May 20, 2013)

- 2. Support national and local efforts to promote the HLP rights of women, girls and other at-risk groups in order to minimize their vulnerability to GBV.**
 - ▶ Provide technical support so that questions related to HLP rights and broader land issues are included in registration, profiling and intention surveys for displaced women and men. These questions can help protect and secure the HLP rights of women and other at-risk groups from both displaced and host communities, making them less vulnerable to GBV. HLP actors should inquire about:
 - Origin and living arrangements before the emergency.
 - Arrangements made before the emergency regarding access to land and property (such as individual or family ownership, statutory or customary ownership, pastoral rights, social tenancy, rental arrangements, etc.).



- Land tenure arrangements (such as access to land, water, grazing and other natural resources, etc.) made during the emergency for displaced camps and other types of settlements.
 - Possession or absence of supporting documents.
 - Any written reports of property destruction or occupation.
- Support local human rights and women's organizations in their efforts to monitor and advocate for the HLP rights of women, girls and other at-risk groups, including:
- Access to HLP for women, girls and other at-risk groups.
 - Their security of tenure over land and natural resources.
 - Equal inheritance rights for girls and boys.
- Conduct trainings for government officials and customary/traditional leaders involved with the rule of law and land-related administration on:
- The rights and needs of women and other at-risk groups related to protecting and securing land rights.
 - The linkages between lack of HLP rights and GBV.
- Ensure adequate procedures for land administration and management. Promote:
- The registration of HLP rights for women and other at-risk groups.
 - Joint registration of land rights in the names of men and women.
 - Accessible procedures for registering HLP rights (taking into consideration the cost, location, attitudes of those managing the process, etc.).

3. Provide and strengthen legal assistance for women, girls and other at-risk groups to obtain security of tenure and control of HLP.

- Increase awareness, knowledge and skills of women, girls and other at-risk groups about how to claim and seek legal enforcement of their HLP rights. Link with GBV specialists to monitor and mitigate potential risk factors resulting from land claims, such as intimate partner violence and other forms of domestic violence.
- Work to secure official HLP records that may be at risk of tampering or destruction. Support the development of programmes to restore—or where relevant, create new—HLP registration systems.
- Facilitate access to free legal assistance for landless at-risk persons (e.g. woman- and child-headed households, widows, etc.).
- Working with governments, increase access to justice in land matters by establishing and supporting mechanisms for gender-responsive restitution and dispute resolution (including the acceptance of oral evidence; translation of procedures into local languages; provision of legal assistance; etc.).





PROMISING PRACTICE

In Liberia, as in many countries, land rights tend to be held by men or kinship groups controlled by men. Women generally have access to land only through a male relative—usually a father or husband. Decisions about ownership, inheritance and use of the land are most often made via customary laws, despite there being statutory laws in place that could better protect women. This system leaves women acutely vulnerable, dependent on men, and unable to leave violent situations or relationships. Several women who accessed support through a GBV project of the Norwegian Refugee Council (NRC) reported they feel unable to leave the family home even when a male relative has sexually assaulted them or their daughter. The women feel they have nowhere else to go given their dependence on the land for their own economic survival.

In an effort to address these issues, the NRC GBV project requested the assistance of NRC's Information, Counseling and Legal Assistance (ICLA) team to facilitate one-day trainings on land, property and inheritance rights. These trainings were provided for NRC's "WISE" sensitization groups, where 25 women would meet once a month to discuss, learn and exchange ideas on women's rights. The trainings made use of a pictorial flip book, jointly developed by the GBV and ICLA teams, that uses pictures and simple terminology to explain the different options that Liberian women have in accessing and utilizing land (through either the formal legal system or customary system). This was the first time that many women had a chance to ask, in a safe space, what rights they had to refuse decisions made by customary leaders. This initiative has since been adapted and implemented in South Sudan, Afghanistan and Colombia. Initial results have shown that ongoing awareness-raising on women's rights—and the mechanisms that are accessible to them—can be effective in enforcing these rights.

(Information provided by NRC, Personal Communication, February 10, 2014)

Integrating GBV Risk Reduction into: HLP POLICIES

1. Incorporate GBV prevention and mitigation strategies into the policies, standards and guidelines of HLP programmes.

- ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in HLP activities. These can include, among others:
 - Policies regarding childcare for HLP staff.
 - Standards for equal employment of females.
 - Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.
- ▶ Circulate these widely among HLP staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).

2. Advocate for the integration of GBV risk-reduction strategies into national and local laws and policies related to HLP and allocate funding for sustainability.

- ▶ Support government, customary/traditional leaders, and other stakeholders in the review and reform of laws and policies (including customary law) to address



discriminatory practices related to HLP rights and land issues (e.g. laws dealing with marital property; title registration; property ownership; inheritance; rental housing; forced evictions; squatting; etc.). Ensure these laws and policies conform to international law and human rights standards.

- ▶ Support relevant line ministries in developing implementation strategies for GBV-related policies. Undertake awareness-raising campaigns highlighting how such policies will benefit communities in order to encourage community support and mitigate backlash.
- ▶ Promote the participation of women and other at-risk groups—including persons belonging to minority and indigenous groups—in peace negotiations, agreements and land reform processes.



PROMISING PRACTICE

Understanding and engaging with context-specific mechanisms can help to resolve HLP disputes. According to a report by the Special Rapporteur on violence against women, the rules of sharia and their scholarly interpretation in Afghanistan are not always clearly understood: *"Reportedly most judges, prosecutors, members of local councils and other persons called upon to apply law do not have sufficient legal training to distinguish between tribal customs and the sharia. Practices that blatantly violate Islamic teachings, such as child marriage, and denial of the rights of widows and women's inheritance rights are thus assumed to be in accordance with the sharia."* The Norwegian Refugee Council's (NRC) ICLA programmes support displaced people through the provision of information, counselling, legal assistance and collaborative dispute resolution. In Afghanistan, advice and support given to returnee women engaging with the customary system can help them to obtain access to land and uphold their inheritance claims.

(Adapted from NRC. 2014. "Life Can Change: Securing Housing Land and Property Rights for Displaced Women", <http://wom-enshlp.nrc.no>. Quotation from UN Economic and Social Council. 2006. *Report of the Special Rapporteur on violence against women, its causes and consequences, Yakin Ertürk, Mission to Afghanistan, [9 to 19 July 2005]*, E/CN.4/2006/61/Add.5, para 27, http://www.glow-boell.de/media/de/txt_rubrik_2/Afghanistan_visitreport_05.pdf)

Integrating GBV Risk Reduction into:

HLP COMMUNICATIONS AND INFORMATION SHARING

- 1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure HLP staff has the basic skills to provide them with information on where they can obtain support.**

- ▶ Ensure that all HLP personnel who engage with affected populations have written information about where to refer survivors for care and support. Regularly update the information about survivor services.
- ▶ Train all HLP personnel who engage with affected populations in gender, GBV, women's/ human rights and psychological first aid (e.g. how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and



ESSENTIAL TO KNOW

Referral Pathways

A "referral pathway" is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.



options to report risk and access care).

2. Ensure that HLP programmes sharing information about reports of GBV within the HLP sector or with partners in the larger humanitarian community abide by safety and ethical standards.

- Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community.

3. Incorporate GBV messages into HLP-related community outreach and awareness-raising activities.

- Work with GBV specialists to integrate community awareness-raising on GBV into HLP outreach initiatives (e.g. community dialogues; workshops; meetings with community leaders; GBV messaging; etc.).

- Ensure this awareness-raising includes information on prevention, survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
- Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).
- Engage women, girls, men and boys (separately when necessary) in the development of messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.
- Encourage broad-based community dialogue regarding HLP among women and men. Raise awareness among community and religious leaders about the economic and social benefits of equal rights to HLP—including equal inheritance for females and males. Engage males, particularly leaders in the community, as agents of change in the prevention of GBV related to HLP.
- Consider the barriers faced by women, adolescent girls and other at-risk groups to their safe participation in community discussion forums and educational workshops related to HLP (e.g. transportation; meeting times and locations; risk of backlash related to participation; need for childcare; accessibility for persons with disabilities; etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.) so that participants feel safe to raise GBV issues.
- Provide community members with information about existing codes of conduct for HLP personnel, as well as where to report sexual exploitation and abuse committed by HLP personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.



ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. **When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**





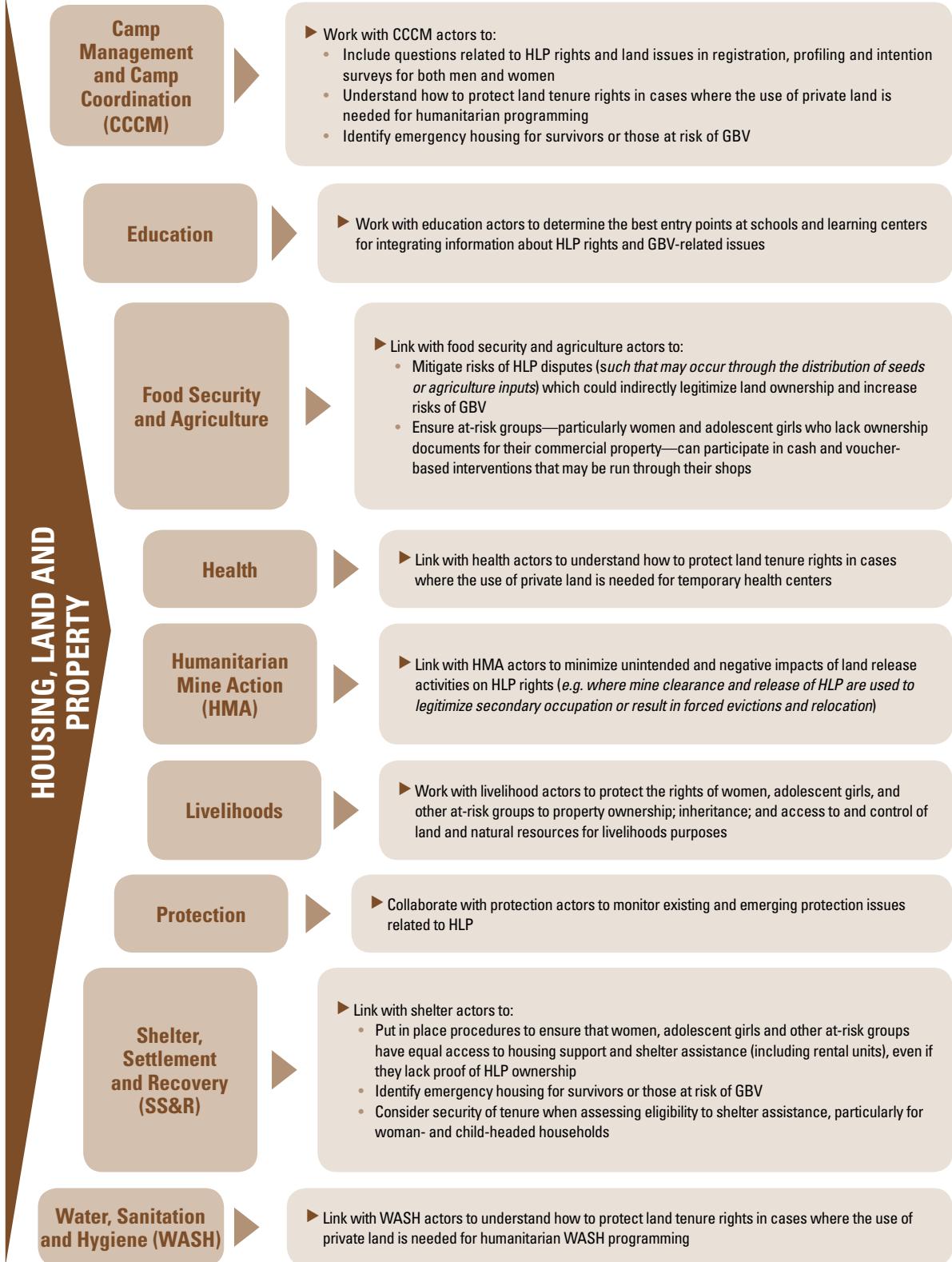
KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, HLP programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist HLP actors to:

- ▶ Design and conduct HLP assessments that examine the risks of GBV related to HLP programming, and strategize with HLP actors about ways for such risks to be mitigated.
- ▶ Provide trainings for HLP staff on issues of gender, GBV, and women's/human rights.
- ▶ Identify where survivors who may report instances of GBV exposure to HLP staff can receive safe, confidential and appropriate care, and provide HLP staff with the basic skills and information to respond supportively to survivors.
- ▶ Provide training and awareness-raising for the affected community on issues of gender, GBV, and women's/human rights as they relate to HLP rights.

In addition, HLP programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, HLP actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.







KEY GBV CONSIDERATIONS FOR: MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in HLP assessments ²	# of HLP assessment that include GBV-related questions* from the GBV Guidelines x 100 # of HLP assessment <small>* See page 133 for GBV areas of inquiry that can be adapted to questions in assessments</small>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	# of assessment respondents who are female x 100 # of assessment respondents and # of assessment team members who are female x 100 # of assessment team members	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

² Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Existence of institutions promoting HLP rights of women and other GBV at-risk groups	# of institutions promoting HLP rights of women and other GBV at-risk groups	Key informant interview (KII)	Determine in the field	✓	✓	
Consultations with the affected population on GBV risk factors in accessing HLP³ <i>Disaggregate consultations by sex and age</i>	<i>Quantitative:</i> # of displacement sites conducting consultations with the affected population to discuss GBV risk factors in accessing HLP x 100 <i>Qualitative:</i> What types of GBV-related risk factors do affected persons experience in accessing a HLP?	Organizational records, focus group discussion (FGD), key KII	100%	✓	✓	
Staff knowledge of referral pathway for GBV survivors	# of HLP staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors x 100 # of surveyed HLP staff	Survey	100%	✓	✓	
RESOURCE MOBILIZATION						
Inclusion of GBV risk reduction in HLP funding proposals or strategies	# of HLP funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines x 100 # of HLP funding proposals or strategies	Proposal review (at agency or sector level)	100%	✓	✓	
Training of HLP staff on the GBV Guidelines	# of HLP staff who participated in a training on the GBV Guidelines x 100 # of HLP staff	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	
IMPLEMENTATION						
▶ Programming						
Female participation in HLP community-based committees³	<i>Quantitative:</i> # of affected persons who participate in HLP community-based committees who are female x 100 # of affected persons who participate in HLP community-based committees <i>Qualitative:</i> How do women perceive their level of participation in HLP community-based committees? What are barriers to female participation in HLP committees?	Site management reports, Displacement Tracking Matrix, FGD, KII	50%	✓	✓	

(continued)

³ United Nations Office for the Coordination of Humanitarian Affairs. *Humanitarian Indicator Registry*. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
► Programming									
Female staff in HLP programmes	# of staff in HLP programmes who are female x 100 # of staff in HLP programmes	Organizational records	50%	✓	✓				
Risk factors of GBV in accessing HLP	<i>Quantitative:</i> # of females without adequate HLP who report concerns about experiencing GBV x 100 <i>Qualitative:</i> Do women without adequate HLP feel safe from GBV? What types of GBV-related safety concerns do women without HLP describe?	Survey, FGD, KII, participatory community mapping	100%	✓		✓			
Availability of legal assistance for women to recover HLP	# of legal aid organizations providing legal assistance services for women to recover HLP in a specified location	KII	Determine in the field	✓	✓				
► Policies									
Inclusion of GBV prevention and mitigation strategies in HLP policies, guidelines or standards	# of HLP policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines x 100 # of HLP policies, guidelines or standards	Desk review (at agency, sector, national or global level)	Determine in the field	✓		✓			
► Communications and Information Sharing									
Staff knowledge of standards for confidential sharing of GBV reports	# of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100 # of surveyed staff	Survey (at agency or programme level)	100%	✓					
Inclusion of GBV referral information in HLP community outreach activities	# of HLP community outreach activities programmes that include information on where to report risk and access care for GBV survivors x 100 # of HLP community outreach activities	Desk review, KII, survey (at agency or sector level)	Determine in the field	✓	✓				

COORDINATION						
Coordination of GBV risk reduction activities with other sectors	# of non-HLP sectors consulted with to address GBV risk reduction activities* x 100 # of existing non-HLP sectors in a given humanitarian response	KII, meeting minutes (at agency or sector level)	Determine in the field			
				✓	✓	
	* See page X for list of sectors and GBV risk reduction activities					



RESOURCES

Key Resources

- **Housing Land and Property Area of Responsibility (HLP AoR).** 2013. *The HLP Coordination Toolkit*, <http://www.globalprotectioncluster.org/en/areas-of-responsibility/housing-land-and-property.html>
- **EU-UN Interagency Framework Team for Preventive Action.** 2012. *Toolkit and Guidance for Preventing and Managing Land and Natural Resources Conflict*. http://www.un.org/en/events/environmentconflictday/pdf/GN_Land_Consultation.pdf
- **NRC.** 2014. "Life Can Change: Securing Housing Land and Property Rights for Displaced Women," <http://womenshlp.nrc.no>
- **NRC and International Federation of Red Cross and Red Crescent Societies (IFRC).** 2013. *Security of Tenure in Humanitarian Shelter Operations*. <http://www.ifrc.org/Global/Documents/Secretariat/201406/NRC%20IFRC%20Security%20of%20Tenure.pdf>
- **Food and Agriculture Organization of the United Nations (FAO).** No date. *Guidance Note. Gender-Based Violence and Livelihood Interventions: Focus on populations of humanitarian concern in the context of HIV*. http://www.fao.org/fileadmin/templates/dimitra/pdf/guidance_note_gbv_livelihoods.pdf
- **UN Sub-Commission on the Promotion and Protection of Human Rights.** 2005. *Principles on Housing and Property Restitution for Refugees and Displaced Persons*, E/CN.4/Sub.2/2005/17, <http://www.refworld.org/docid/41640c874.html>
- **FAO.** 2012. *Voluntary Guidelines on the Responsible Governance of Tenure of Land, Fisheries and Forests in the Context of National Food Security*. Rome, <http://www.fao.org/docrep/016/i2801e/i2801e.pdf> This is a technical guide to assist with the implementation of FAO's Voluntary Guidelines on the Responsible Governance of Tenure of Land, Fisheries and Forests in the Context of National Food Security.
- **Sphere Project.** 2011. *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*. <http://www.spheredhandbook.org/>
- **FAO.** 2003. *Gender and Access to Land*, <http://www.fao.org/docrep/005/Y4308E/Y4308E00.HTM>
- **Office of the High Commissioner for Human Rights 2012.** "Women and the Right to Adequate Housing," http://www.ohchr.org/Documents/Publications/WomenHousing_HR.PUB.11.2.pdf
- **UNHABITAT.** 1999. *Women's Rights to Land, Housing and Property in Post-conflict Situations and During Reconstruction: A Global Overview*, http://www.unhabitat.org/downloads/docs/1504_59744_Land.pdf2.pdf
- **UNHABITAT.** 2004. *Women's Rights to Land and Property*, <http://www.unhabitat.org/programmes/landtenure/documents/CSDWomen.pdf>
- **UNHABITAT.** 2005. *Shared Tenure Options for Women: A Global Overview*, <http://www.unhabitat.org/pmss/listItemDetails.aspx?publicationID=2304>
- **UNHABITAT.** 2006. *Progress Report on Removing Discrimination against Women in respect of Property & Inheritance Rights, Tools on Improving Women's Secure Tenure*, Series 1, <http://www.unhabitat.org/campaigns/tenure/documents/Removing%20Discrimination%20Against%20Women.pdf>
- **UNHABITAT-GLTN.** 2008. "Land Registration in Ethiopia: Early Impacts on Women," http://siteresources.worldbank.org/NEWS/Resources/land_registration_in_ethiopia.pdf
- **UNIFEM.** 2001. "Women's Land and Property Rights in Situations of Conflict and Reconstruction," <http://www.refworld.org/docid/46cadad90.html>



Additional Resources

- **United Nations High Commissioner for Refugees (UNHCR), FAO, NRC, Inter-Agency Internal Displacement Division (IDD), OHCHR, UN-HABITAT. 2007. Handbook on Housing and Property Restitution for Refugees and Displaced Persons: Implementing the 'Pinheiro Principles'** http://www.ohchr.org/Documents/Publications/pinheiro_principles.pdf
- **Mooney, E. 2004. Liberia and the Implications of Women's Inheritance Rights for IDP Return and Reintegration: Findings and Recommendations from Mission in April-May – 2004,** http://www.globalprotectioncluster.org/_assets/files/field_protection_clusters/Liberia/Women_s_Inheritance_Rights_IDP_Return_Liberia_2004_EN.pdf
- **UNWOMEN. 2012. Colombia's law on victims and restitution: a challenge for gender-sensitive transitional justice.** <http://landwise.landesa.org/record/1934>
- **Centre on Housing Rights and Evictions (COHRE):** <http://www.cohre.org/topics/women-housing-rights>
- **Protection and Early Recovery Working Groups. 2009. Humanitarian Coordinator & Resident Coordinator Checklist Of Housing, Land And Property Rights & Broader Land Issues Throughout The Displacement Timeline From Emergency To Recovery,** http://www.globalprotectioncluster.org/_assets/files/tools_and_guidance/housing_land_property/HLP_Checklist_for_Humanitarian_Coordinators_and_Resident_Coordinators-EN.pdf
- **Richardson, A. and Hanney, L. for Norwegian Refugee Council (NRC). 2013. Violence Against Women and Housing, Land and Property in Monrovia.** www.nrc.no/womenhlp
- **Global Land Tool Network (GLTN):** <http://www.glttn.net/index.php/land-tools/cross-cutting-issues/gender>
- **Urban Humanitarian Response Portal:** <http://www.urban-response.org/>





HUMANITARIAN MINE ACTION



THIS SECTION APPLIES TO:

- Humanitarian mine action (HMA) coordination mechanisms
- HMA actors (staff and leadership) who engage in: land release (non-technical survey, technical survey and clearance, and handover of released land); mine risk education (working with communities to avoid behaviors that would put people at risk of having accidents with mines); and victim assistance (including rehabilitation and reintegration)
- NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, older persons, etc.) related to HMA
- Other HMA stakeholders, including national and local governments, community leaders, and civil society groups

Why Addressing Gender-based Violence is a Critical Concern of the Humanitarian Mine Action Sector

The work of the Humanitarian Mine Action (HMA) sector is critical to ensuring the safety of civilian populations living in contaminated areas. It also supports the recovery and reintegration of survivors of landmines/explosive remnants of war (ERW). While men and boys make up a larger number of those directly affected by landmines/ERW, the impacts on women and girls—either directly through personal injury or indirectly through the death or injury of a family breadwinner—are also considerable.



ESSENTIAL TO KNOW

Defining “Land Release”

In the context of mine action, the term “land release” describes the process of applying all reasonable effort to identify, define, and remove all presence and suspicion of mines/ERW through non-technical survey, technical survey and/or clearance. The criteria for “all reasonable effort” shall be defined by the National Mine Action Authority.

(Excerpted from **United Nations Mine Action Service (UNMAS)**. 2013. *International Mine Action Standards*.

“Glossary of terms and definitions.” IMAS 04.10,
<http://www.mineactionstandards.org>)

People who are directly injured by landmines/ERW are more likely to face discrimination, isolation, and stigmatization due to their disabilities, in turn increasing their risk of gender-based violence (GBV). Pre-existing inequality and discrimination will exacerbate these issues for women, girls, and other at-risk groups¹. When they are directly injured in a blast they may be less likely to receive support for their physical rehabilitation and socio-economic reintegration. Their disability may also increase their risk of intimate partner violence and other forms of domestic violence.

¹ For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery through

ASSESSMENT, ANALYSIS AND PLANNING

Promote the active participation of women, girls and other at-risk groups in all HMA assessment processes (e.g. community mapping; transect walks; land assessments; etc.)

Assess the level of participation and leadership of women and other at-risk groups in the design and monitoring of land release, MRE, victim assistance, and related to HMA; etc.)

Analyse physical safety of and access to land release activities and victim assistance programmes to identify associated risks of GBV (e.g. travel to/from

Assess awareness of HMA staff on basic issues related to gender, GBV, and women's/human rights (including knowledge of where GBV survivors can report re

Review existing/proposed community outreach materials related to HMA to ensure they are reaching women and girls and include basic information about GBV ris

RESOURCE MOBILIZATION

Develop proposals for HMA programming that reflect awareness of GBV risks for the affected population and strategies for reducing these risks

Prepare and provide trainings for government, HMA staff and volunteers, and community HMA groups on the safe design and implementation of HMA activit

IMPLEMENTATION

► Programming

Involve women and other at-risk groups as staff and leaders in the design, implementation, monitoring and evaluation of land release, mine risk education and increases the risk of GBV)

Support and reinforce the land rights of women, girls, and other at-risk groups when releasing land previously contaminated with landmines/ERW

Implement strategies that increase the safety, availability, and accessibility of victim assistance activities for women, girls, and other at-risk groups (e.g. offer emergency services to women, girls, and other at-risk groups directly affected by landmines/ERW; provide childcare at health and rehabilitation centers; consider providing separate accommodation for females and males)

Support the inclusion of women, adolescent girls, and other at-risk groups in socio-economic reintegration and benefits initiatives (giving particular attention to women, girls, and other at-risk groups)

► Policies

Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of HMA programmes (e.g. standards for equal employment opportunities; policies about GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse; etc.)

Advocate for the integration of GBV risk-reduction strategies into national and local sector policies and plans related to HMA, and allocate funding for sustai

► Communications and Information Sharing

Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for GBV survivors, and ensure HMA staff ha

Ensure that HMA programmes sharing information about reports of GBV within the HMA sector or with partners in the larger humanitarian community about GBV survivors, their families or the broader community) pose a security risk to individual GBV survivors, their families or the broader community)

Incorporate GBV messages (including where to report risk and how to access care) into HMA-related community outreach and awareness-raising activities

Promote the participation of women, girls and other at-risk groups in mine risk education activities (such as public information dissemination, education and tra

COORDINATION

Undertake coordination with other sectors to address GBV risks and ensure protection for women, girls and other at-risk groups

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign an HMA focal point to regularly participate in GBV coordi

MONITORING AND EVALUATION

Identify, collect, and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduc

Evaluate GBV risk-reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for HMA actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**.

at the Programme Cycle

Stage of Emergency Applicable to Each Action

	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
mine/explosive remnant of war [ERW] impact surveys; incident/injury surveillance; threat	✓	✓	✓	✓
and other HMA activities (e.g. ratio of male/female HMA staff; participation in committees)	✓	✓	✓	✓
in health and rehabilitation facilities; accessibility features for persons with disabilities; etc.)		✓	✓	✓
risk and access care; linkages between HMA programming and GBV risk reduction; etc.)	✓	✓	✓	✓
risk reduction (including where to report risk and how to access care)	✓	✓	✓	✓
	✓	✓	✓	✓
ties that mitigate the risk of GBV	✓	✓	✓	✓
and victim assistance programming (with due caution where this poses a potential security risk or	✓	✓	✓	✓
emergency and longer-term medical care and physical rehabilitation to all persons and age		✓	✓	✓
(d males; etc.)		✓	✓	✓
to women- and child-headed households and women with disabilities)		✓	✓	✓
movement of females; procedures and protocols for sharing protected or confidential information	✓	✓	✓	✓
ainability	✓		✓	✓
as the basic skills to provide them with information on where they can obtain support	✓	✓	✓	✓
ide by safety and ethical standards (e.g. shared information does not reveal the identity of or	✓	✓	✓	✓
aining, and community liaison services)	✓	✓	✓	✓
	✓	✓	✓	✓
nation meetings	✓	✓	✓	✓
duction activities in HMA programming	✓	✓	✓	✓
ng and ensure accountability		✓	✓	✓

Even if not directly injured, women, girls, and other at-risk groups may find themselves in a precarious economic situation if the primary breadwinner in the household is killed or injured by landmines/ERW. The loss of land as a result of contamination can also have a devastating impact on family livelihoods. Single and widowed women and girls are at particular risk of being dispossessed of their land due to difficulties in obtaining land certificates or post-clearance titles. Increased levels of poverty, in turn, can lead to heightened exposure to sexual exploitation and abuse.

There are a number of ways in which HMA programmes can integrate GBV risk reduction into their activities. For example:

- A thorough assessment of the differing rights, needs and roles within the affected population related to land use is key to land clearance prioritization. This assessment process offers an opportunity to understand GBV risks associated with land ownership, land dispossession, and livelihoods.
- Mine risk education activities can integrate information about GBV (such as where to report risk and how to access care) into their programmes.
- Victim assistance and rehabilitation facilities for landmine/ERW survivors can provide a confidential environment for those who are seeking information about where to report risk and/or access care for GBV.

Actions taken by the HMA sector to prevent and mitigate GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. HMA actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)

Addressing Gender-based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by HMA actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with HMA actors working in partnership with other sectors as well as with GBV specialists.

The information generated from these areas of inquiry should be analyzed to inform planning of HMA programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.



KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in HMA: government; local and international mine action actors (*e.g. UNMAS, International Committee of the Red Cross, UNICEF, UNDP, UNOPS, WHO, etc.*); local leaders; GBV, gender and diversity specialists
- Affected populations and communities, including agricultural workers, farmers and livestock owners
- In IDP/refugee settings, members of receptor/host communities

POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to HMA PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female staff in land release, mine risk education and victim assistance programmes, including in positions of leadership?
 - Are both women and men hired for technical survey and clearance activities? Are the working arrangements gender-sensitive (*e.g. with sex-segregated teams/facilities/transport if necessary; adequate parental leave and childcare provisions; etc.*)?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are women and other at-risk groups actively involved in community-based activities related to HMA (*e.g. in community mine action committees; as community liaisons or mine risk educators; etc.*)? Are they in leadership roles when possible?
- c) Are the lead actors in land release, mine risk education and victim assistance programmes aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation into their activities?

Land Release

- d) Is information about landmine/ERW contamination collected from women, girls, men and boys in the affected communities?
 - Is this information collected by mixed or same-sex teams (*as culturally appropriate to ensure teams can access women, girls and other at-risk groups*)?
 - Have team members signed a code of conduct on prevention of sexual exploitation and abuse?
- e) What are the differing rights, needs and roles within the affected population related to use of land?
 - How does this affect land clearance prioritization? Are women, girls, and other at-risk groups involved in the process of prioritizing which areas to clear?
 - Is there any indication that women, girls and other at-risk groups may be exposed to sexual assault, exploitation or other forms of GBV due to issues associated with land ownership, land dispossession, and land use?
- f) Are women, girls, and other at-risk groups involved in the process of deciding how the land, once cleared, should be handed over to communities?
- g) What cultural barriers do women, adolescent girls and other at-risk groups face in obtaining land certificates of post-clearance titles? Do these barriers increase their risk of GBV (*e.g. forced and/or coerced prostitution, sexual exploitation, etc.*)?
- h) Are there local or international groups working to address the issue of land access and ownership for women and other at-risk groups? Have HMA established links with these groups?

HMA Victim Assistance

- i) Are there cultural restrictions that prevent women, girls and other at-risk groups from receiving assistance?
 - Do women and girls directly injured by landmines/ERW have equal access to emergency and/or longer-term medical care, including physical rehabilitation and prostheses?
 - Do they have access to safe and ethical economic assistance, livelihood support, and other social and economic reintegration measures?
- j) How do victim assistance services take into consideration the needs of women, girls and other at-risk groups indirectly affected by landmines/ERW (*e.g. if the head of household or primary breadwinner in the family was killed or injured by landmines/ERW*)?

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to HMA POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of land release, mine risk education and victim assistance programmes?
 - Are women, girls and other at-risk groups meaningfully engaged in the development of HMA policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Are these policies, standards and guidelines communicated to women, girls, boys and men (separately when necessary)?
 - Is HMA staff properly trained and equipped with the necessary skills to implement these policies?
- b) Do national and local sector policies and plans promote the rights of persons with disabilities due to landmine/ERW explosions? Do they address discriminatory practices hindering women and other at-risk groups from safe participation (*as staff, in community-based groups, etc.*) in the HMA sector?

Areas related to HMA COMMUNICATIONS and INFORMATION SHARING

- a) Are mine risk education (MRE) activities targeting all people in the community?
 - Are women, girls and other at-risk groups involved in the development of public information messages?
 - Are signs/marks/indicators of contaminated ground (and the methods by which they are delivered) age-, gender-, and culturally-appropriate? Do images have pictures of boys and girls, men and women?
 - Are they suited for illiterate audiences, those with visual impairments, and persons with other disabilities?
 - Are education and training activities and community liaison services accessible to women, girls and other at-risk groups?
- b) Has training been provided to HMA staff—and partners providing risk education and victim assistance to affected communities—on:
 - Issues of gender, GBV, and women's/human rights?
 - How to supportively engage with GBV survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- c) Do HMA-related community outreach activities—including for mine risk education, land clearance and return and victim assistance—include information about general safety and GBV risk reduction?
 - Does this awareness-raising include information on survivor rights (including confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Is this information provided in age-, gender- and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these activities as agents of change?
- d) Are discussion forums age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.*) so that participants feel safe to raise GBV issues?



LESSON LEARNED

In Afghanistan, NGOs implementing a national landmine survey were initially unable to recruit mixed-sex survey teams, as cultural restrictions prevented women from travelling with men. When all-male teams were employed, access to women—who had information about different tracts of land—was severely limited. To gain greater access to women and better understand their needs and concerns, the Mine Action Coordination Centre of Afghanistan (MACCA) conducted a survey specifically with women, and the Geneva International Centre for Humanitarian Demining (GICHD) conducted a gender-sensitive study on Landmines and Livelihoods.

(Adapted from **Inter-Agency Standing Committee. 2006. Gender Handbook for Humanitarian Action:** [http://www.humanitarianinfo.org/iasc/documents/subsidiary/IASC%20Gender%20Handbook%20\(Feb%202007\).pdf](http://www.humanitarianinfo.org/iasc/documents/subsidiary/IASC%20Gender%20Handbook%20(Feb%202007).pdf); **MACCA. 2009. Attitudes towards Mine Action: An Afghan Women's Perspective,** http://www.gmap.ch/fileadmin/External_documents/Afghanistan_-_Attitudes_towards_MA_An_Afghan_Women_s_Perspective.pdf; and **GICHD. 2012. Livelihoods Analysis of Landmine/ERW Affected Communities in Heart Province Afghanistan,** http://www.gmap.ch/fileadmin/Others/Landmines_and_Livelihoods_Report_-_Herat_Province_2012.pdf)





KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for HMA programming. Whether requesting pre-/emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**. Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.

A. HUMANITARIAN NEEDS OVERVIEW

- ▶ Does the proposal articulate the GBV-related safety risks, protection needs and rights of the affected population as they relate to the provision of HMA services?
- ▶ Are risks for specific forms of GBV relevant to HMA (*e.g. links between landmine-related disability and intimate partner violence and other forms of domestic violence; links between loss of land and sexual exploitation; etc.*) described and analysed, rather than a broader reference to “GBV”?

- ▶ When drafting a proposal for emergency preparedness:
 - Is there a plan for minimizing land tensions as they relate to HMA operations? Does this plan incorporate GBV risk reduction strategies?
 - Are additional costs required to ensure any GBV-related community outreach materials will be available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
 - Is there a strategy for preparing and providing trainings for government, humanitarian staff and volunteers, and community members engaged in HMA programming on the safe design and implementation of HMA activities that mitigate the risk of GBV?

- ▶ When drafting a proposal for emergency response:
 - Is there a clear description of how HMA programmes will mitigate exposure to GBV (*e.g. women's access to and use of cleared returned land; availability and accessibility of victim assistance activities; livelihoods support for women, adolescent girls, and other at-risk groups affected by landmines/ERW; etc.*)?
 - Are additional costs required to ensure the safety and effective working environments for female staff members in the HMA sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?

- ▶ When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how the HMA project will contribute to sustainable strategies that promote the safety and well-being of those at risk of GBV, and to long-term efforts to reduce specific types of GBV (*e.g. facilitating access by women, adolescent girls and other at-risk groups affected by landmines/ERW to socio-economic reintegration and benefits initiatives; supporting the development of relevant national mine action standards that incorporate gender and GBV awareness; etc.*)?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

- ▶ Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for integrating GBV-related work?
- ▶ Do the proposed activities illustrate linkages with other humanitarian actors/sectors to maximize resources and work in a strategic way?
- ▶ Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as HMA staff and in local land release, mine risk education and victim assistance committees?

B. PROJECT RATIONALE/JUSTIFICATION

C. PROJECT DESCRIPTION



KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some common GBV-related considerations when implementing HMA programming in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

Integrating GBV Risk Reduction into: HMA PROGRAMMING

- 1. Involve women and other at-risk groups as staff and leaders in the design, implementation, monitoring and evaluation of land release, mine risk education and victim assistance activities (with due caution in situations where this poses a potential security risk and/or increases the risk of GBV).**
 - ▶ Strive for 50% representation of females within HMA programme staff (including mine risk education and victim assistance activities). Increase the participation of women in land release activities, including demining where appropriate. Provide women with formal and on-the-job training as well a targeted support to assume leadership and training positions.
 - ▶ Ensure women (and where appropriate, adolescent girls) are actively involved in community-based HMA committees and management groups, including land release priority-planning groups and decisions for the handover of released land. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities, especially in situations where there are high numbers of male casualties of landmines/ERW. As necessary, engage in dialogue with males to ensure their support.
 - ▶ Employ persons from at-risk groups into HMA staff, leadership, and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.
- 2. Support and reinforce the land rights of women, girls and other at-risk groups when releasing land previously contaminated with landmines/ERW.**
 - ▶ When conducting non-technical and technical surveys, ensure that women, girls and other at-risk groups are consulted, and consider how land use, land ownership and land dispossession may heighten exposure to GBV.
 - ▶ Actively encourage women, girls and other at-risk groups to participate in decisions about which areas should be prioritized for clearance, and how the land, once cleared, should be handed over.



ESSENTIAL TO KNOW

Women and Girl Landmine/ERW Survivors

Women and girls who are injured or affected by landmines/ERW often have limited access to victim assistance services. This can include emergency and continuing medical care, physical rehabilitation (including physiotherapy, prosthetics and assistive devices), mental health and psychosocial support, and/or social and economic reintegration. In some cultural contexts, women and girls may only receive treatment from female medical staff; therefore, in areas with few or no female doctors, female survivors do not receive the healthcare needed.

(Adapted from Calza Bini, A., and Massleberg, A. 2011. "Gender-sensitive Victim Assistance," *The Journal of ERW and Mine Action*: 15.2. <http://www.jmu.edu/cisr/journal/15.2/focus/bini/bini.shtml>)



- ▶ Link with key stakeholders (i.e. national and international organizations dealing with land issues) to limit land tensions related to mine action operations.
- ▶ Support or put in place a post-clearance monitoring process to deal with land rights, claims and disputes after land is handed over. Ensure that women, girls and other at-risk groups are engaged in the process to minimize GBV risks related to land release (e.g. sexual exploitation, intimate partner violence and other forms of domestic violence, etc.).

3. Implement strategies that increase the safety, availability and accessibility of victim assistance activities for women, girls and other at-risk groups.

- ▶ Offer emergency and longer-term medical care and physical rehabilitation (including prostheses and other technical aids) to all persons *directly* affected by landmines/ERW. Offer mental health and psychosocial support (including psychological first aid) to all persons *directly* and *indirectly* affected by landmines/ERW. Ensure care and support are provided by both female and male professionals and available to all age groups.
- ▶ In situations where victim assistance is provided using schedules, work with all users to plan the schedules so that times are convenient and safe for women, girls and other at-risk groups. Develop strategies to reduce the time spent at, traveling to, and returning from health and rehabilitation facilities (e.g. organize services to avoid crowds, long waiting times, travel at dusk/night, etc.).
- ▶ Provide childcare at health and rehabilitation centers.
- ▶ Where necessary, provide separate rehabilitation accommodation and facilities for females and males.
- ▶ Consider the use of mobile rehabilitation clinics to overcome mobility and financial obstacles for women, girls and other at-risk groups affected by landmines/ERW (for example, for women unable to take time away from domestic responsibilities).



4. **Support the inclusion of women, adolescent girls and other at-risk groups in socio-economic reintegration and benefits initiatives.**
 - ▶ Work with livelihoods actors to provide support for women, adolescent girls and other at-risk groups who have been impoverished by a direct or indirect landmine/ERW injury or loss of land. Give particular attention to women and child heads of households and women with disabilities, who are often poorer and more vulnerable to GBV than other landmine/ERW survivors.
 - ▶ Provide women, adolescent girls and other at-risk groups who are affected by landmines/ERW with information on how to access livelihoods programmes and financial compensation.
 - ▶ Consider how to provide appropriate support for men who have become primary child-care providers.

Integrating GBV Risk Reduction into: **HMA POLICIES**

1. **Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of HMA programmes.**
 - ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in HMA programming. These can include, among others:
 - Policies that support the implementation of the *Gender Guidelines for Mine Action Programmes*.
 - Policies regarding childcare for HMA staff.
 - Standards for equal employment of females.
 - Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.
 - ▶ Circulate these widely among HMA staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).
2. **Advocate for the integration of GBV risk-reduction strategies into national and local sector policies and plans related to HMA, and allocate funding for sustainability.**
 - ▶ Support governments, customary/traditional leaders, and other stakeholders to incorporate gender and GBV awareness into HMA policies and plans, particularly as they relate to the vulnerability of women, girls and other at-risk persons affected by landmines/ERW.
 - ▶ Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. Undertake awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.



Integrating GBV Risk Reduction into: HMA COMMUNICATIONS and INFORMATION SHARING

1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure HMA staff has the basic skills to provide them with information on where they can obtain support.

- ▶ Ensure all HMA personnel who engage with affected populations have written information about where to refer GBV survivors for care and support. Regularly update information about GBV survivor services.
- ▶ Train all HMA personnel who engage with affected populations in gender, GBV, women's/human rights and psychological first aid (e.g. how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).

! ESSENTIAL TO KNOW

Referral Pathways

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.

2. Ensure that HMA programmes sharing information about reports of GBV within the HMA sector or with partners in the larger humanitarian community abide by safety and ethical standards.

- ▶ Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community.

3. Incorporate GBV messages into HMA-related community outreach and awareness-raising activities.

- ▶ Work with GBV specialists to integrate community awareness-raising on GBV into education outreach initiatives (e.g. community dialogues; workshops; meetings with community leaders; GBV messaging; etc.).
 - Ensure this awareness-raising includes information on prevention, survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
 - Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).
 - Engage women, girls, men and boys (separately when necessary) in the development of GBV-related messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.
- ▶ Engage males, particularly leaders in the community, as agents of change in HMA outreach activities related to the prevention of GBV.

! ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. **When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**



- ▶ Provide community members with information about existing codes of conduct for HMA personnel, as well as where to report sexual exploitation and abuse committed by HMA personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.
- 4. Promote the participation of women, girls and other at-risk groups in mine risk education activities (such as public information dissemination, education and training, and community liaison services).**
- ▶ Engage women, girls, men and boys (separately when necessary) in the development of public information messages and in the selection of signs/marks/indicators of contaminated ground that are age-, gender-, and culturally-appropriate.
 - ▶ When conducting education and training activities and providing community liaison services, consider the barriers faced by women, adolescent girls and other at-risk groups to their safe participation in these activities (e.g. transportation; meeting times and locations; risk of backlash related to participation; need for childcare; accessibility for persons with disabilities; etc.). Implement strategies to make forums age-, gender-, and culturally-sensitive (e.g. with females as facilitators of women's and girls' discussion groups, etc.).



KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

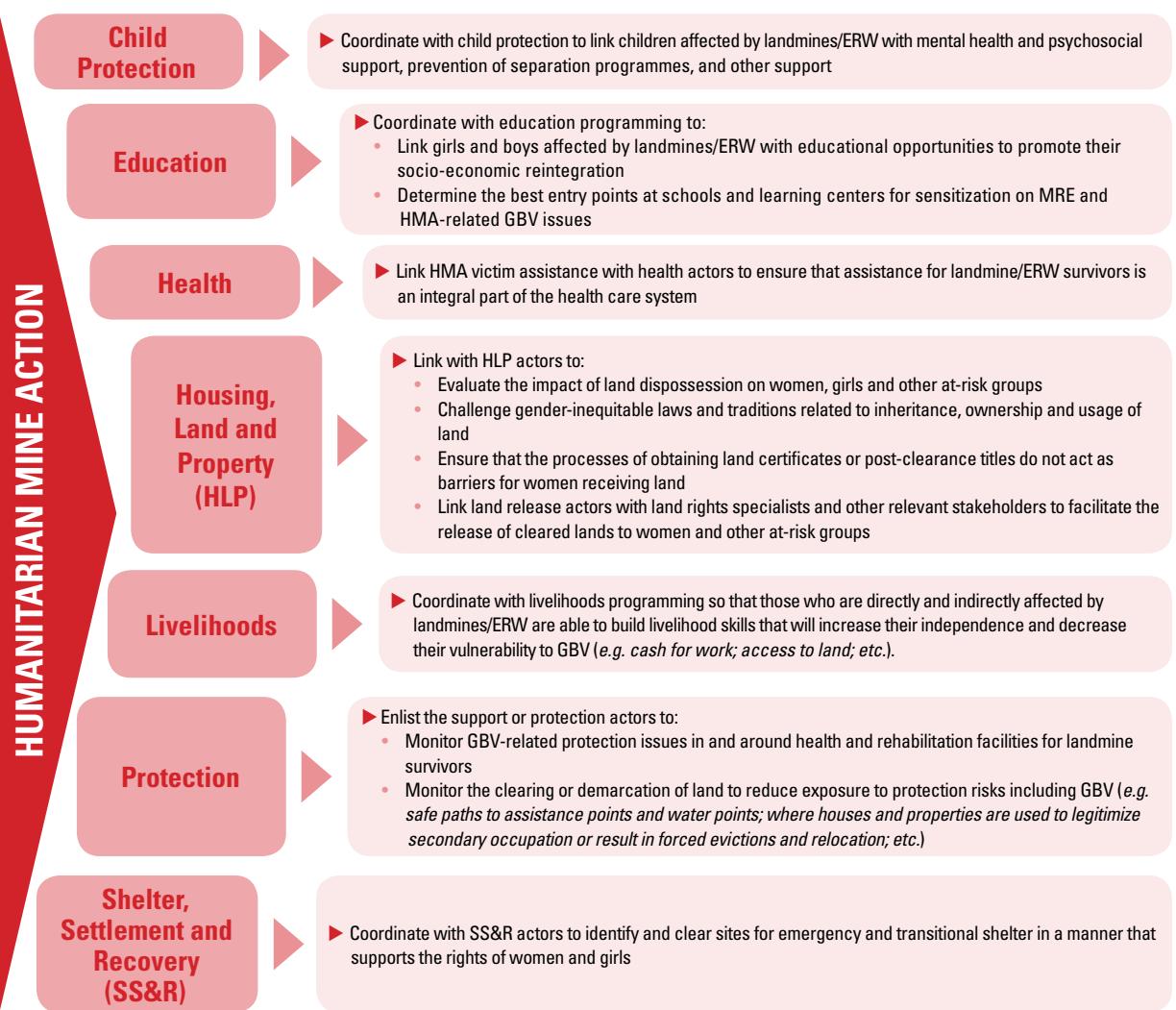
As a first step in coordination, HMA programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist HMA actors to:

- ▶ Design and conduct HMA assessments that examine the risks of GBV related to HMA programming, and strategize with HMA actors about ways for such risks to be mitigated.
- ▶ Provide trainings for HMA staff on issues of gender, GBV, and women's/human rights.



- ▶ Identify where survivors who may report instances of GBV exposure to HMA staff can receive safe, confidential and appropriate care, and provide HMA staff with the basic skills and information to respond supportively to GBV survivors.
- ▶ Provide training and awareness-raising for the affected community on issues of gender, GBV, and women's/human rights as they relate to HMA rights.

In addition, HMA programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, HMA actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.





KEY GBV CONSIDERATIONS FOR: MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in HMA assessments ²	$\# \text{ of HMA assessment that include GBV-related questions* from the GBV Guidelines} \times 100$ $\# \text{ of HMA assessment}$ <p><small>* See page 147 for GBV areas of inquiry that can be adapted to questions in assessments</small></p>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	$\# \text{ of assessment respondents who are female} \times 100$ $\# \text{ of assessment respondents and}$ $\# \text{ of assessment team members who are female} \times 100$ $\# \text{ of assessment team members}$	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

² Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Consultations with the affected population on GBV risk factors in accessing HMA activities³	<i>Quantitative:</i> $\frac{\# \text{ of HMA activities}^* \text{ conducting consultations with the affected population to discuss GBV risk factors in accessing the service} \times 100}{\# \text{ of HMA activities}}$	Organizational records, focus group discussion (FGD), key informant interview (KII)	100%	✓	✓	
	<i>Qualitative:</i> What types of GBV-related risk factors do affected persons experience in accessing HMA activities? <small>* HMA activities include those related to land release, mine risk education and victim assistance programmes</small>					
Female participation prior to programme design³	<i>Quantitative:</i> $\frac{\# \text{ of affected persons consulted before designing a programme who are female} \times 100}{\# \text{ of affected persons consulted before designing a programme}}$	Organizational records, FGD, KII	Determine in the field	✓		
	<i>Qualitative:</i> How do women and girls perceive their level of participation in the programme design? What enhances women and girls' participation in the design process? What are barriers to female participation in these processes?					
Female staff in HMA programmes	$\frac{\# \text{ of staff in HMA programmes who are female} \times 100}{\# \text{ of staff in HMA programmes}}$	Organizational records	50%	✓	✓	
Staff knowledge of referral pathway for GBV survivors	$\frac{\# \text{ of HMA staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors} \times 100}{\# \text{ of surveyed HMA staff}}$	Survey	100%	✓		✓
RESOURCE MOBILIZATION						
Inclusion of GBV risk reduction in HMA funding proposals or strategies	$\frac{\# \text{ of HMA funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines} \times 100}{\# \text{ of HMA funding proposals or strategies}}$	Proposal review (at agency or sector level)	100%	✓	✓	
Training of HMA staff on the GBV Guidelines	$\frac{\# \text{ of HMA staff who participated in a training on the GBV Guidelines} \times 100}{\# \text{ of HMA staff}}$	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	
IMPLEMENTATION						
► Programming						
Female participation in HMA governance structures³	<i>Quantitative:</i> $\frac{\# \text{ of affected persons who participate in HMA governance structures who are female} \times 100}{\# \text{ of affected persons who participate in HMA governance structures}}$	Site management reports, Displacement Tracking Matrix, FGD, KII	50%	✓	✓	
	<i>Qualitative:</i> How do women perceive their level of participation in HMA governance structures? What are barriers to female participation in HMA governance structures?					

³ United Nations Office for the Coordination of Humanitarian Affairs. *Humanitarian Indicator Registry*. <http://www.humanitarianresponse.info/applications/ir/indicators>

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
► Programming (continued)						
Female participation in decision-making on the handover of land previously contaminated with landmines	<p><i>Quantitative:</i></p> $\frac{\# \text{ of persons who participate in decision-making on the handover of land previously contaminated with landmines who are female}}{\# \text{ of persons who participate in decision-making on the handover of land previously contaminated with landmines}} \times 100$ <p><i>Qualitative:</i> What are barriers to female participation in decision-making on the handover of land previously contaminated with landmines?</p>	Organizational records, FGD, KII	Determine in the field			
Inclusion of females in victim assistance services	$\frac{\# \text{ of female affected persons receiving victim assistance services}}{\# \text{ of affected persons receiving victim assistance services}} \times 100$	Organizational records	Determine in the field	✓	✓	
Female participation in socio-economic integration and benefits initiatives	$\frac{\# \text{ of female affected persons receiving socio-economic integration services}}{\# \text{ of affected persons receiving socio-economic integration services}} \times 100$	Organizational records	Determine in the field	✓	✓	
► Policies						
Inclusion of GBV prevention and mitigation strategies in HMA policies, guidelines or standards	$\frac{\# \text{ of HMA policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines}}{\# \text{ of HMA policies, guidelines or standards}} \times 100$	Desk review (at agency, sector, national or global level)	Determine in the field	✓		✓
► Communications and Information Sharing						
Staff knowledge of standards for confidential sharing of GBV reports	$\frac{\# \text{ of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors}}{\# \text{ of surveyed staff}} \times 100$	Survey (at agency or programme level)	100%	✓		
Inclusion of GBV referral information in HMA community outreach activities	$\frac{\# \text{ of HMA community outreach activities programmes that include information on where to report risk and access care for GBV survivors}}{\# \text{ of HMA community outreach activities}} \times 100$	Desk review, KII, survey (at agency or sector level)	Determine in the field	✓	✓	
COORDINATION						
Coordination of GBV risk reduction activities with other sectors	$\frac{\# \text{ of non-HMA sectors consulted with to address GBV risk reduction activities}}{\# \text{ of existing non-HMA sectors in a given humanitarian response}} \times 100$ <p>* See page X for list of sectors and GBV risk reduction activities</p>	KII, meeting minutes (at agency or sector level)	Determine in the field	✓	✓	



RESOURCES

- For the most recent checklists for ensuring gender-equitable programming in Mine Action, see **United Nations Mine Action Service. 2010. Gender Guidelines for Mine Action Programmes**, <http://www.mineaction.org/sites/default/files/publications/MA-Guidelines-WEB.pdf>
- **Swiss Campaign to Ban Landmines. 2008. Gender and Landmines from Concept to Practice**, http://www.gmap.ch/fileadmin/Gender_and_Landmines_from_Concept_to_Practice/SCBL_-_Gender__Landmines_2008_rev_Sep09.pdf
- **Child Protection Working Group and UNICEF. 2013. Mainstreaming Mine Action into Child Protection: Key Actions for Child Protection Actors**, <http://cpwg.net/wp-content/uploads/sites/2/2013/11/Mainstreaeming-MA-CP-final-CPWG-draft.doc>
- **Calza Bini, A., and Massleberg, A. 2011. "Gender-sensitive Victim Assistance,"** The Journal of ERW and Mine Action: 15.2. <http://www.jmu.edu/cisr/journal/15.2/focus/bini/bini.shtml>
- **Handicap International and RAVIM. 2013. Shattered Dreams: Living conditions, needs and capacities of mines and Explosive Remnants of War survivors in Mozambique**, http://www.hiproweb.org/uploads/tb_hidrtdocs/ShatteredDreams.pdf
- **United Nations Mine Action Service. 2013. "Glossary of mine action terms, definitions and abbreviations, 04.10"**, <http://www.mineactionstandards.org/fileadmin/MAS/documents/imas-international-standards/english/series-04/IMAS-04-10-Ed2-Am2.pdf>
- For technical assistance, including training and capacity building to ensure that relevant gender aspects are taken into account in mine action interventions and that affected women, girls, boys and men benefit on an equal basis from mine action activities, see the **Gender and Mine Action Programme (GMAP)**: www.gmap.ch





LIVELIHOODS



THIS SECTION APPLIES TO:

- Livelihoods coordination mechanisms
- Livelihoods actors (staff and leadership): NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, older persons, etc.) related to livelihoods
- Other livelihoods stakeholders, including national and local governments, community leaders, and civil society groups

Why Addressing Gender-based Violence is a Critical Concern of Livelihoods Programmes

In the face of severe economic hardship that humanitarian emergencies and associated displacement often cause, many affected populations have limited opportunities to support themselves and their families. Refugees living in camps, for example, are often not legally allowed to work outside of the camps — and some not even within the camps. Refugees living in urban contexts may also be prohibited from working. Displaced men are at times forced into unemployment due to prevalent assumptions that they may engage in harmful activities if they are free to move and seek work.



ESSENTIAL TO KNOW

Defining “Livelihoods”

The term “livelihoods” refers to the capabilities, assets and strategies that people use to make a living.

Livelihoods programming encompasses a variety of activities, including:

- asset restoration (livestock, tools, equipment)
- training and placement programs
- building in-camp economies
- agrarian interventions
- market interventions
- microfinance
- income-generating activities (IGAs)
- enterprise development
- Village Savings and Loans Associations (VSLAs)
- cash programming (such as food for work; unconditional/conditional cash grants; cash for work [CFW]; vouchers; etc.)



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS

Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery through Livelihoods

ASSESSMENT, ANALYSIS AND PLANNING

Promote the active participation of women, girls and other at-risk groups in all livelihoods assessment processes

Assess the level of participation and leadership of women, adolescent girls and other at-risk groups in all aspects of livelihoods programming (*e.g. ratio of retaining females and other at-risk groups; etc.*)

Assess community norms and practices related to livelihoods, with a focus on the barriers faced by women, adolescent girls and other at-risk groups to access *types of work; gender-based discrimination against women in the workplace; etc.*)

Conduct market analyses in partnership with those at risk of GBV to identify profitable, accessible and desirable livelihoods activities that do not exacerbate GBV risks

Assess the physical safety of and access to livelihoods programmes to identify associated risks of GBV (*e.g. safety traveling to/from work; childcare during backlash from family or community members when women start earning money; safe strategies for storing earned money; etc.*)

Assess awareness of livelihoods staff on basic issues related to gender, GBV, and women's/human rights (*including knowledge of where survivors can report incidents; etc.*)

Review existing/proposed community outreach material related to livelihoods to ensure it includes basic information about GBV risk reduction (*including prevention, reporting, and seeking support; etc.*)

RESOURCE MOBILIZATION

Develop proposals for livelihoods programmes that reflect awareness of GBV risks for the affected population and strategies for reducing these risks

Prepare and provide trainings for government, humanitarian workers, women's groups, and community members engaged in livelihoods work on the safe delivery of services

IMPLEMENTATION

► Programming

Involve women and other at-risk groups as staff and leaders in livelihoods programming (*with due caution where this poses a potential security risk or increases the risk of GBV*)

In consultation with women, girls, men and boys, implement livelihoods programmes that are accessible to those at risk of GBV (*e.g. address logistical and cultural barriers to participation; etc.*)

In consultation with women, girls, men and boys, implement livelihoods programmes that minimize related GBV risks (*e.g. sensitize community members about supportive partners through workshops and discussions on gender issues; work with receptor or host communities to reduce competition over employment or resources; etc.*)

Promote the economic and professional empowerment of participants through business development, agricultural trainings, value chain integration, vocational training, and apprenticeships

Implement strategies that allow participants to control their assets in ways that mitigate the risk of theft or financial exploitation

Implement all livelihoods programmes within the framework of building sustainable livelihoods that are ongoing beyond the crisis stage (*e.g. develop culturally appropriate longer-term economic empowerment strategies; etc.*)

► Policies

Incorporate GBV prevention and mitigation strategies into the policies, standards and guidelines of livelihoods programmes (*e.g. standards for equal employment opportunities; policies for addressing GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse; etc.*)

Support the reform of national and local laws, policies and plans that hinder women, girls and other at-risk groups from economic and professional empowerment

► Communications and Information Sharing

Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure livelihoods staff know how to refer survivors to these systems

Ensure that livelihoods programmes sharing information about reports of GBV within the livelihoods sector or with partners in the larger humanitarian community do not pose a security risk to individual survivors, their families or the broader community

Incorporate GBV messages (*including prevention, where to report risk and how to access care*) into livelihoods-related community outreach and awareness-raising activities

COORDINATION

Undertake coordination with other sectors to address GBV risks, ensure protection, and identify livelihoods opportunities for women, girls and other at-risk groups

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a livelihoods focal point to regularly participate in GBV coordination meetings

MONITORING AND EVALUATION

Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduction activities

Evaluate GBV risk-reduction activities by measuring programme outcomes (*including potential adverse effects*) and using the data to inform decision-making and programmatic adjustments

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for livelihoods actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**.

at the Programme Cycle

Stage of Emergency Applicable to Each Action

	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
male/female livelihoods staff; participation in positions of leadership; strategies for hiring and	✓	✓	✓	✓
cessing safe livelihoods opportunities (e.g. gender norms that exclude women from certain	✓	✓	✓	✓
the risk of GB	✓	✓	✓	✓
ng the workday; exploitation by employers, clients or suppliers; work hours and locations;	✓	✓	✓	✓
ort risk and access care; linkages between livelihoods and GBV; etc.)	✓	✓	✓	✓
revention, where to report risk and how to access care)	✓	✓	✓	✓
design and implementation of livelihoods programmes that mitigate the risk of GBV	✓	✓	✓	✓
ses the risk of GBV)	✓	✓	✓	✓
cultural obstacles that prevent their participation)	✓	✓	✓	✓
GBV; work with local authorities to increase security measures; engage men and boys as natural resources; etc.)	✓	✓	✓	✓
l skills training, capacity-building and education	✓	✓	✓	✓
-sensitive exit strategies to lessen the risks of GBV; link short-term livelihoods programmes with	✓	✓	✓	✓
ent of females; procedures and policies for sharing protected or confidential information about	✓	✓	✓	✓
ent, and allocate funding for sustainability	✓		✓	✓
has the basic skills to provide them with information on where they can obtain support	✓	✓	✓	✓
nity abide by safety and ethical standards (e.g. shared information does not reveal the identity	✓	✓	✓	✓
ising activities		✓	✓	✓
groups	✓	✓	✓	✓
ordination meetings	✓	✓	✓	✓
duction activities throughout the programme cycle	✓	✓	✓	✓
nd ensure accountability		✓	✓	✓

Finding work can be difficult for both males and females in humanitarian settings; however women, adolescent girls, and other at-risk groups¹ often face particular obstacles related to gender or cultural norms. These norms may inhibit women from working outside the home, or relegate them to work that offers lower income than traditionally male jobs. Laws and practices prohibiting females from owning or accessing land and property can further limit their ability to generate income. Stigma and discrimination may exclude LGBTI persons, ethnic minorities, persons with disabilities, and other marginalized groups from economic opportunities. Single heads of households may be unable to work outside of the home if they do not have childcare.

Lack of safe and lucrative livelihoods opportunities not only increases economic dependence on others, but can also elevate vulnerability to violence. For example:

- ▶ Economic vulnerability can increase the risk of exposure to sexual exploitation by aid workers, family and community members. In order to support themselves and their families, women, girls and other at-risk groups may enter exploitative work environments, become dependent on and trapped in abusive relationships, or be forced or coerced into prostitution.
- ▶ In the absence of formal jobs, many women, adolescent girls and other at-risk groups will find work in the informal economy (e.g. collecting and selling firewood or charcoal; running small-goods kiosks; selling goods door-to-door; or engaging in domestic work with receptor or host communities). These activities may force them to travel through unsafe areas or during dangerous times of day or night.
- ▶ Women, girls, and other at-risk groups are particularly susceptible to exploitation, harassment and abuse from customers, suppliers and market administrators, especially in unregulated markets and when they must borrow money, negotiate prices, or manage a shop alone.

At the same time, introducing livelihoods programmes into humanitarian contexts without taking gender and cultural norms into account can create backlash and inadvertently heighten the risk of violence against participants, particularly females. For example, 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." In IDP/refugee settings, livelihoods initiatives that exclusively target displaced populations can increase tension with receptor/host communities, which may perceive displaced persons as taking away economic opportunities or receiving extra benefits. In addition, if new resources are not distributed or managed in safe ways, they can make recipients the target of violence and theft.

If effectively designed, however, livelihoods programmes can mitigate these risks.

Programmes that include built-in protective mechanisms to monitor and address potential risk factors can help to reduce participants' exposure to violence and exploitation, while empowering them with skills training and social and financial capital. Such programmes can:

- ▶ Provide women, girls and other at-risk groups with safe alternatives for generating income.
- ▶ Enhance their knowledge and skills-base of micro-enterprise, financial management, natural resource management and leadership.

¹ For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



- ▶ Empower and foster their independence, which may increase their ability to leave exploitative situations.
- ▶ Enhance economic, physical, and psychological well-being of individuals, families and communities.
- ▶ Create and raise awareness about issues of GBV, gender norms and power imbalances in the family and community in a sensitive way.
- ▶ Improve the management of natural resources and thereby support more sustainable or alternative livelihoods.

Actions taken by the livelihoods sector to prevent and mitigate the risks of GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. Livelihoods actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)

Addressing Gender-based Violence Throughout The Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by livelihoods actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with livelihoods actors working in partnership with other sectors as well as with GBV specialists.

The areas of inquiry below should be used to complement existing guidance materials, such as the assessment checklists found in the **Livestock Emergency Guidelines and Standards** (<http://www.livestock-emergency.net>). The information generated from these areas of inquiry should be analyzed to inform planning of livelihoods programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Areas**.

KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in livelihoods: governments; civil societies; local leaders; market sellers and firms; business groups; community members; humanitarian workers; GBV, gender and diversity specialists
- Affected populations and communities
- In IDP/refugee settings, members of receptor/host communities



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Livelihoods PROGRAMMING

Participation and Leadership

- a) Are women and other at-risk groups actively involved in all aspects of livelihoods programming design, implementation and monitoring?
- b) What is the ratio of male to female livelihoods staff, including in positions of leadership?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- c) Are the lead actors in livelihoods programming aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation strategies into their activities?

Cultural and Community Norms and Practices

- d) How has the crisis impacted communities' economic coping strategies, livestock management strategies, and access to safe livelihoods activities—particularly for females and other at-risk groups?
 - What are the harmful psychological, physical, and social impacts of changes in livelihoods activities?
- e) What cultural barriers do women, adolescent girls and other at-risk groups face in accessing markets, livelihoods activities, livestock management strategies, and financial services (*e.g. gender norms that exclude females from certain types of work; discrimination against women in the workplace or marketplace; etc.*)?
- f) What physical, logistical, legal or educational issues prevent women, adolescent girls and other at-risk groups from accessing livelihoods opportunities and/or sustain gendered divisions in income generating activities (*e.g. mobility or transportation issues; childcare and other domestic responsibilities; disabilities; legal barriers preventing refugees from accessing jobs in the formal sector; legal barriers to ownership of property, land or other productive assets; illiteracy; lack of training; etc.*)?
- g) Are there unequal gender norms that livelihoods programmes risk perpetuating (*e.g. by placing women only in caretaking and child-care jobs; by placing men only in traditionally male jobs such as guarding and mechanical maintenance; by delivering skills training programmes that reinforce stereotypes; etc.*)?
 - Do livelihoods activities shift additional burdens to women, adolescent girls, and other at-risk groups participating in the activities?
- h) Have market surveys identified livelihoods activities that are profitable and empowering, particularly for women, adolescent girls and other at-risk groups?
- i) What are the preferences and cultural habits to consider before determining the type of livelihoods activities, locations, services and goods?
 - What livelihoods practices were people engaged in before the emergency?
 - What were the roles of women, girls, men and boys with regard to livestock ownership, control, care and management?
 - What kinds of activities are forbidden to women or men by local customs?
 - What is the balance of power between women and men in accessing and controlling productive assets?
 - What are the risks of backlash associated with women, adolescent girls, and other at-risk groups engaging in economic programmes—particularly by intimate partners and/or family members?

Physical Safety and Risks of GBV

- j) What are the GBV-related risks faced by affected populations—particularly women, adolescent girls and other at-risk groups—when earning a living?
 - Which logistical and environmental issues increase the risk of sexual assault, harassment, or exploitation (*e.g. borrowing money; getting stopped by police; selling goods from house to house; traveling at night; traveling through unsafe areas; working in a shop by oneself; etc.*)?
 - Which livelihoods relationships increase the risk of sexual assault, harassment or exploitation, and which provide safety (*e.g. customers, suppliers, market administrators, intimate partners, etc.*)? Who is orchestrating, encouraging, permitting and colluding in the perpetration of violence?
- k) Does limited access to livelihoods assets force women and other at-risk groups to adopt unsafe survival strategies? If so, what are they? What might help mitigate their risk of engaging in these survival strategies?

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Livelihoods POLICIES

- Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of livelihoods programmes
 - Are women, girls and other at-risk groups meaningfully engaged in the development of livelihoods policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Are these policies, standards and guidelines communicated to women, girls, boys and men (separately when necessary)?
 - Is livelihoods staff properly trained and equipped with the necessary skills to implement these policies?
- What is the legal status of females related to legal employment, property ownership, inheritance, access to land and natural resources, and access to education? Do females have any legal protections against economic exploitation in marriage?
- What does the legislation say about refugees' entitlement to work? What are the formal/informal practices regarding refugees and livelihoods?
- What is the legal age of employment, and what are the laws around child labor?
- Are there national action plans for poverty reduction? Are there Youth and/or Gender strategies/action plans?
 - Do these plans support the economic empowerment of women, adolescent girls and other at-risk groups?
 - Are livelihoods programmes set up in alignment with these plans?

Areas related to Livelihoods COMMUNICATIONS and INFORMATION SHARING

- Has training been provided to livelihoods staff on:
 - Issues of gender, GBV, and women's/human rights?
 - How to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- Do livelihoods programmes raise awareness within the community about GBV risks and protective factors related to livelihoods activities?
 - Does this awareness-raising include information on survivor rights (including confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Is this information provided in age-, gender-, and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these awareness raising activities as agents of change?
- Are discussion forums on livelihoods age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.*) so that participants feel safe to raise GBV issues?





KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for livelihoods programming. Whether requesting pre-/emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see

Part Two: Background to Thematic Area Guidance.

Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.

A. HUMANITARIAN NEEDS OVERVIEW

- Does the proposal articulate the GBV-related safety risks, protection needs and rights of those engaging in livelihoods activities?
- Are risks for specific forms of GBV (*such as sexual assault, harassment, intimate partner violence and other forms of domestic violence, etc.*) described and analysed, rather than a broader reference to “GBV”?

B. PROJECT RATIONALE/ JUSTIFICATION

- When drafting a proposal for emergency response:
 - Is there a clear description of how the livelihoods programme will reduce the risks of GBV for participants (*e.g. the location and design of programmes; strategies for mitigating backlash within the community*); etc.?
 - Is there a strategy for preparing and providing trainings for government, humanitarian workers, women’s groups, and community members engaged in livelihoods work on the design and implementation of livelihoods programming that mitigates the risk of GBV?
 - Are additional costs required to ensure any GBV-related community outreach materials are available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how the livelihoods programme will contribute to sustainable strategies that promote the empowerment, safety and economic well-being of those at risk of GBV, and to long-term efforts to reduce specific types of GBV?
 - Does the programme recognize and support the goal of gender equality?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

C. PROJECT DESCRIPTION

- Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for integrating GBV-related work?
- Where applicable and feasible, do the activities provide opportunities for women and adolescent girls to engage in non-gender-stereotyped occupations that may be of higher income and status than traditionally female occupations?
 - Are local leaders and government partners involved as active participants in this process to enhance the sustainability of projects?
 - Are women and adolescent girls consulted as to which occupations would be safe for them, especially if these activities are not traditionally female?





KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some common GBV-related considerations when implementing livelihoods programming in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

Integrating GBV Risk Reduction into: LIVELIHOODS PROGRAMMING

- 1. Involve women and other at-risk groups within the affected population as staff and leaders in livelihoods programming (with due caution in situations where this poses a potential security risk or increases the risk of GBV).**
 - Strive for 50% representation of females within livelihoods programme staff. Provide them with targeted support to assume leadership and training positions. Be aware of potential tensions that may be caused by attempting to change the role of women in communities and, as necessary, engage in dialogue with males to ensure their support.
 - Employ persons from at-risk groups in livelihoods staff, leadership and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.



ESSENTIAL TO KNOW

Minimum Working Age

In implementing activities that involve work, agencies should conform to national legislation regarding the minimum working age and should monitor closely to ensure that livelihood activities do not promote child labour or encourage children and adolescents to miss school. However even at young ages, girls and boys can be given opportunities to build their leadership, literacy, and numeracy skills, as well as their ability to manage money.



ESSENTIAL TO KNOW

Incorporating GBV Survivors into Livelihoods Programmes

GBV survivors should not be the sole participants of a specific livelihoods programme, as this can increase stigma against them and compromise their confidentiality, safety and security. One good approach is to work with communities to identify the most vulnerable generally (e.g. female single heads of household, survivors of GBV, women with households of more than three children, persons with disabilities, LGBTI, etc.). Programmes can then target all of these groups and/or individuals in a way that does not segregate or expose survivors.

- 2. In consultation with women, girls, men and boys, implement livelihoods programmes that are accessible to those at risk of GBV.**
 - Address logistical obstacles that prevent women, adolescent girls and other at-risk groups from participating in planning meetings and livelihoods activities.
 - Ensure locations and times meet the needs of women and adolescent girls who have family-related responsibilities.
 - Ensure physical access for persons with disability.
 - Provide childcare for programme participants.
 - Address cultural obstacles that prevent women, adolescent girls and other at-risk groups from participating in livelihoods programming.



- Undertake outreach initiatives to address gender and cultural norms that prohibit females and other at-risk groups from certain kinds of work. Ensure these initiatives are age-, gender- and culturally-sensitive.
- Support local organizations, community groups and businesses to provide adolescent girls and other at-risk groups opportunities to connect with each other in a safe space, share resources and skills, and communicate about important livelihoods issues.

3. In consultation with women, girls, men and boys, implement livelihoods programmes that minimize possible GBV-related risks as a result of participation.

- ▶ Consult with participants to identify potential safety risks related to livelihoods activities, and support participants in managing and making empowered choices about these risks.
- ▶ Whenever possible, situate livelihoods activities in safe locations and schedule them during times of the day/week that minimize the risk of GBV. Ensure participants are not unnecessarily exposed to risky situations (e.g. getting stopped by police; selling goods from house to house; working in a shop by oneself; needing to travel after dark; etc.). Support communities' proposed solutions for mitigating these risky situations.
- ▶ Create linkages for participants with trustworthy vendors, transport companies and end markets to mitigate the risk of exploitation (e.g. by customers, suppliers, market administrators, police or other security personnel, etc.).



PROMISING PRACTICE

The Egyptian Sudanese Development Center in Arba wy Nuss runs a domestic service training and placement programme. The director of the programme promotes the protection and fair treatment of refugee women by accompanying graduates to their placement homes, recording the names and contact information of employers, as well as the agreed-upon salary. This small step serves to hold families accountable and illustrates the role the community center is willing to play on behalf of refugee women.

(Adapted from **Heller, L. & Timoney, J. 2009.** "Earning Money/Staying Safe: The Links Between Making a Living and Sexual Violence for Refugee Women in Cairo." New York: Women's Refugee Commission, p. 7. <http://www.womensrefugeecommission.org/programs/88-programs/livelihoods>)



PROMISING PRACTICE

A programme funded by UNHCR and run by the Coptic Evangelical Organization for Social Services (CEOSS) consists of vocational training and job placement components for refugees in Egypt. From 2007 to 2008, the programme trained 300 refugees (43 percent female) and placed 94 participants in jobs upon graduation. Market assessments were conducted by specialized consultants to identify areas for which there was identified labor demand. Those selected—including medical care/nursing, embroidery, Internet-based enterprise, computer maintenance and others—either did not require work permits or could be done from home. For refugee women, working from home decreased their risk of on-site GBV and need for child care. CEOSS developed relationships with Egyptian employers in order to create a “job bank” for referring graduates of the programme. Before sending trainees to interview at selected companies, CEOSS provided interview training. Before entering a position, many underwent an apprenticeship period where they received further, more specialized, training.

(Adapted from **Heller, L. & Timoney, J. 2009.** "Earning Money/Staying Safe: The Links Between Making a Living and Sexual Violence for Refugee Women in Cairo." New York: Women's Refugee Commission, p. 6. <http://www.womensrefugeecommission.org/programs/88-programs/livelihoods>)

► Work with local authorities, communities and other interested sectors (such as CCCM or WASH) to enhance the safety of participants. Coordinated strategies can include establishing safety patrols along routes to work, escort systems, or police and community surveillance systems; providing solar lanterns as part of core relief efforts; or installing adequate lighting along travel routes.

► Conduct ongoing analysis and consultation with both females and males in the community about how the economic empowerment of women, adolescent girls, and other at-risk groups may increase tensions within families or communities. Put strategies in place to mitigate backlash and other negative effects for participants.

- Sensitize participants, their families and community members about GBV.
- Engage men and adolescent boys as direct participants in parallel livelihoods programmes and/or as supportive partners in livelihoods programmes for women and adolescent girls.
- In IPD/refugee situations, work with receptor or host communities to reduce tensions over employment scarcity. Ensure that livelihoods programmes do not promote the unsustainable use of natural resources or put groups in direct competition over natural resources. Consider bringing members from both communities together in culturally-sensitive ways to build bonds, and monitor that members from both communities are benefitting from livelihoods activities.
- Promote understanding between different livelihoods groups (e.g. pastoralists and farmers) through group meetings, discussions, and other community formats to reduce potential conflict and encourage mutual support.



LESSON LEARNED

In camps in the Somali region of Ethiopia, the Danish Refugee Council (DRC) provided micro-grants to entrepreneurs. The programme originally only targeted female-headed households who, as a result of participation, experienced hostility, such as increased verbal abuse from men in the community. DRC responded by engaging men as participants and consulting community leaders to get buy-in for the programme.

(Adapted from: Krause-Vilmar, J. 2011. "Preventing Gender-Based Violence, Building Livelihoods: Guidance and Tools for Improved Programming." New York: Women's Refugee Commission. p. 7. http://womensrefugeecommission.org/resources/cat_view/68-reports/80-livelihoods)



4. Promote the economic and professional empowerment of participants through business development, agricultural trainings, value chain integration, vocational skills training, capacity-building and education.

- ▶ Consult with affected populations and use professional market surveys to identify entry points for profitable work. Consider diversifying income streams to promote adequate income and minimize the likelihood that affected populations, particularly women and adolescent girls, will resort to commercial sex work or other risky income alternatives.
- ▶ Take a graduated approach to economic strengthening. First, ensure that immediate needs are met through consumption support; then, connect affected populations with sustainable livelihoods strategies and/or financial services.
- ▶ As appropriate, promote non-traditional employment opportunities that can: contribute to the status and professional empowerment of women and adolescent girls; assist men to (re)enter the workforce; and create opportunities for LGBTI persons who may otherwise be excluded from traditionally male and female employment opportunities. Build upon indigenous knowledge about livelihoods practices that have been profitable and empowering, especially for women and adolescent girls.
- ▶ Provide trainings on marketable, profitable, and transferable skills such as financial literacy, business management, computer skills, and marketing.
 - Take into account the time and location of trainings, the sex of facilitators and access issues such as childcare.
 - Link trainings with work apprenticeships and/or job placement services that have been appropriately screened and monitored for safety.
 - Consider implementing non-formal education programming on topics such as literacy and numeracy for those who have not completed their schooling.

5. Implement strategies that allow participants to control their assets in ways that mitigate the risk of theft or financial exploitation.

- ▶ Consider transferring grants, earnings or loans directly to bank or mobile money accounts rather than distributing cash.
- ▶ When disbursing directly to participants, ensure safe location and timing of grant, earning and loan distribution.
- ▶ Support the development of associations, cooperatives, and other groups as appropriate to ensure that affected populations can minimize their commercial exploitation.
- ▶ Regularly consult with loan recipients to ensure their loan is not increasing their poverty level. Ensure they are not compounding their debt by accepting multiple loans from different service providers.



PROMISING PRACTICE

In the 2004 South India tsunami response, non-traditional skills training by some NGOs (such as training in masonry, repairing hand pumps and running a courier business) have challenged the norms of gender division in labour and service markets. In addition, they have raised participants' esteem in the eyes of their husbands, children and the community at large.

(Adapted from Pincha, C. 2007. *Understanding Gender Differential Impacts of Tsunami and Gender Mainstreaming Strategies in Tsunami response in Tamil Nadu, India*. Anawhim Trust and Oxfam America, p 11. https://www.gdnonline.org/resources/Gender_mainstreaming_Pincha_et.al.pdf)



6. Implement all livelihoods programmes within the framework of building sustainable livelihoods that are ongoing beyond the crisis stage.

- ▶ For short-term livelihoods programmes, assess the consequences and possible negative impacts of exiting—for example if participants will be put at economic or survival risk when the programme ends. Develop a culturally-sensitive exit strategy to ameliorate these risks (such as linking participants with job placement or loan programmes). When possible, link short-term livelihoods programmes with longer-term poverty reduction and economic empowerment strategies that are market-driven (i.e. profitable).
- ▶ Where applicable, take seasonality into account when designing programmes (e.g. provide more targeted livelihoods support toward the end of a dry season to mitigate the risks of shortage).
- ▶ Where available and appropriate, assist in coordinating insurance plans or risk transfer mechanisms to provide financial support and/or ameliorate business losses due to cyclical natural disasters.

**Integrating GBV Risk Reduction into:
LIVELIHOODS POLICIES**

1. Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of livelihoods programmes.

- ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in livelihoods programmes. These can include, among others:
 - Policies regarding childcare for livelihoods staff.
 - Standards for equal employment of females.
 - Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.
- ▶ Circulate these widely among livelihoods staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).

2. Support the reform of national and local laws, policies and plans that hinder women, girls and other at-risk groups from economic and professional empowerment and allocate funding for sustainability.

- ▶ Work with government authorities, NGOs, INGOs, and other stakeholders to develop and implement national action plans (e.g. poverty reduction strategies) that:
 - Support the promotion and inclusion of economic empowerment opportunities for women, girls and other at-risk groups.
 - Integrate GBV risk-reduction strategies into poverty reduction strategies.
- ▶ In collaboration with affected populations, advocate for the rights of women, adolescent girls, and other at-risk groups to legal employment (e.g. refugees' entitlement to work); property ownership; inheritance; protections in marriage; access to land and natural resources; and access to education and training.



- Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. Undertake awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.

Integrating GBV Risk Reduction into: LIVELIHOODS COMMUNICATIONS AND INFORMATION SHARING

- 1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure livelihoods staff has the basic skills to provide them with information on where they can obtain support.**
 - Ensure all livelihoods personnel who engage with affected populations have written information about where to refer survivors for care and support. Regularly update information about survivor services.
 - Train all livelihoods personnel who engage with affected populations in gender, GBV, women's/human rights and psychological first aid (e.g how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).
- 2. Ensure that livelihoods programmes sharing information about reports of GBV within the livelihoods sector or with partners in the larger humanitarian community abide by safety and ethical standards.**
 - Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community.
- 3. Incorporate GBV messages into livelihoods-related community outreach and awareness-raising activities.**
 - Work with GBV specialists to integrate community awareness-raising on GBV into livelihoods outreach initiatives (e.g. community dialogues, workshops, GBV messaging, etc.).
 - Ensure this awareness-raising includes information on prevention, survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
 - Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).
 - Engage women, girls, men and boys (separately when necessary) in the development of messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.



ESSENTIAL TO KNOW

Referral Pathways

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.



ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. **When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**



- ▶ Engage males, particularly leaders in the community, as agents of change in building a supportive environment for women's and adolescent girls' livelihoods programmes (e.g. through workshops, trainings, meetings with community leaders, discussions on gender and rights issues, etc.).
- ▶ Consider the barriers faced by women, adolescent girls and other at-risk groups to their safe participation in community discussion forums (e.g. transportation, risk of backlash, childcare, etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.) so that participants feel safe to raise GBV issues.
- ▶ Provide community members with information about existing codes of conduct for livelihood personnel, as well as where to report sexual exploitation and abuse committed by livelihoods personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.



PROMISING PRACTICE

The Women's Protection and Empowerment (WPE) programme of the International Rescue Committee (IRC) works to empower women socially and economically through the **EA\$E (Economic and Social Empowerment) Programme**. The EA\$E Programme 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 (VSLA).** Using the VSLA model, groups of 15-30 women come together to save money collectively and contribute to a common fund. This common fund is then used to give small loans to individual members, which they pay back at a modest interest rate. Over time VSLAs contribute to women's income and create a space of social and economic support.
- 2) **Gender dialogues – Talking about Talking Discussion Series.** 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 and other forms of domestic violence. The EA\$E Programme facilitates an ongoing discussion series for VSLA members and their spouses. These dialogues focus on household finances and economic decision-making, while also incorporating deeper issues of power imbalance, women's value in the home and alternatives to violence. These dialogues address underlying attitudes about violence against women, decision-making and relationship dynamics that economic programmes on their own do not address. At the same time, participants are able to address these topics in a non-threatening way by making the improvement of household well-being—rather than intimate partner violence—the main focus of these discussions.
- 3) **Business training.** VSLA members are trained in practical business skills that help them use loans effectively, explore profitable business opportunities, and expand small-scale business activities.

The EA\$E programme is operating in nine countries throughout Africa and conducts ongoing rigorous impact evaluations. 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 levels and acceptance of violence; it also led to an increase in women's involvement in decision-making and use of negotiation skills between spouses.

(For more information, see: **International Rescue Committee**, <http://www.rescue.org/sites/default/files/resource-file/Burundi%20EASE%20lact%20Eval%20Formatted%20Final.pdf>)



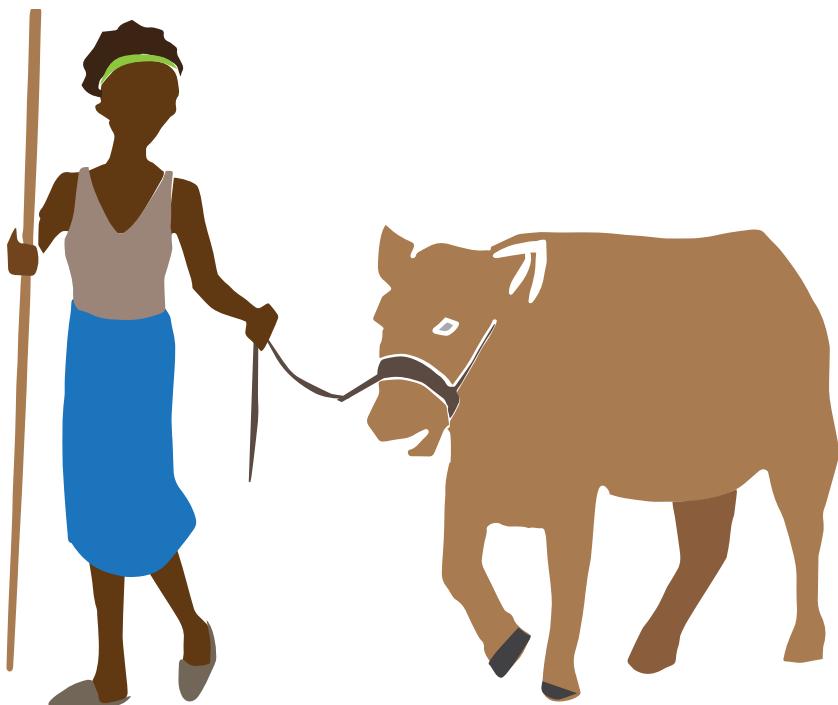


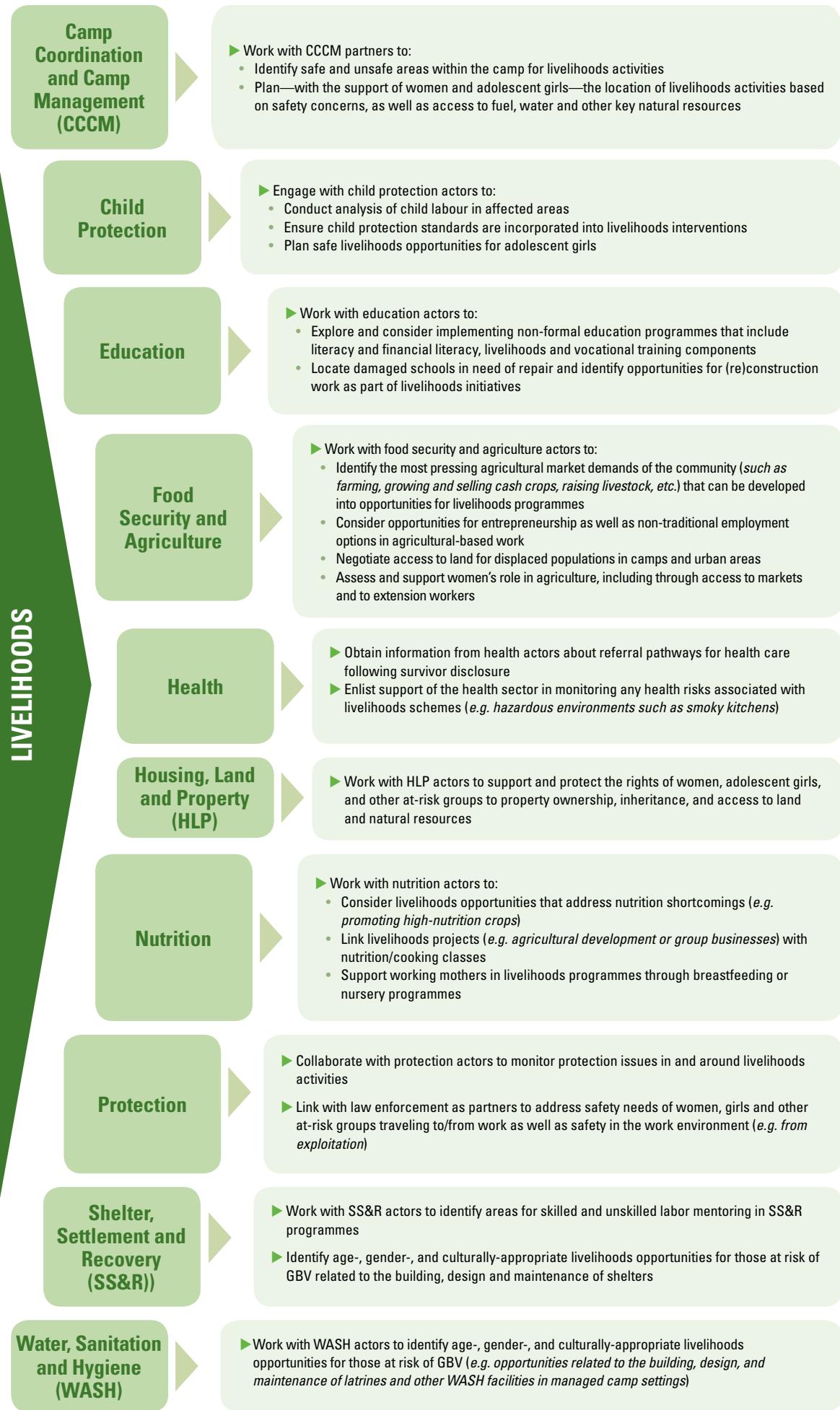
KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, livelihoods programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist livelihoods actors to:

- ▶ Design and conduct livelihoods assessments that examine the risk of GBV related to livelihoods programming, and strategize with livelihoods actors about ways for such risks to be mitigated.
- ▶ Provide trainings for livelihoods staff on issues of gender, GBV, and women's rights/human rights, and how to respectfully and supportively engage with survivors.
- ▶ Identify where survivors who may report instances of GBV exposure to livelihoods staff can receive safe, confidential and appropriate care, and provide livelihoods staff with the basic skills and information necessary to respond supportively to survivors.
- ▶ Conduct training and awareness-raising for the affected community on issues of gender, GBV, and women's/human rights as they relate to livelihoods.

In addition, livelihoods programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, livelihoods actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.







KEY GBV CONSIDERATIONS FOR: MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in livelihood assessments²	$\frac{\# \text{ of livelihood assessment that include GBV-related questions* from the GBV Guidelines} \times 100}{\# \text{ of livelihood assessment}}$ <small>* See page 159 for GBV areas of inquiry that can be adapted as questions in assessments</small>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	$\frac{\# \text{ of assessment respondents who are female} \times 100}{\# \text{ of assessment respondents and } \# \text{ of assessment team members who are female} \times 100}$ $\frac{\# \text{ of assessment team members who are female} \times 100}{\# \text{ of assessment team members}}$	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

² Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Consultations with the affected population on GBV risk factors in accessing livelihoods³	<i>Quantitative:</i> # of livelihood programmes conducting consultations with the affected population to discuss GBV risk factors in accessing livelihoods x 100 <hr/> # of livelihood programmes <i>Qualitative:</i> What types of GBV-related risk factors do affected persons experience in accessing livelihoods?	Organizational records, focus group discussion (FGD), key informant interview (KII)	100%		✓	✓
Disaggregate consultations by sex and age						
Female participation prior to programme design³	<i>Quantitative:</i> # of affected persons consulted before designing a programme who are female x 100 <hr/> # of affected persons consulted before designing a programme <i>Qualitative:</i> How do women and girls perceive their level of participation in the programme design? What enhances women and girls' participation in the design process? What are barriers to female participation in these processes?	Organizational records, FGD, KII	Determine in the field		✓	
Staff knowledge of referral pathway for GBV survivors	# of livelihood staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors x 100 <hr/> # of surveyed livelihood staff	Survey	100%	✓		✓
Design market analysis relevant to those at risk of GBV	Was the market analysis developed with input from those at risk of GBV? Does the market analysis include relevant safety and gender considerations?	Market analysis	N/A	✓		
RESOURCE MOBILIZATION						
Inclusion of GBV risk reduction in livelihood funding proposals or strategies	# of livelihood funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines x 100 <hr/> # of livelihood funding proposals or strategies	Proposal review (at agency or sector level)	100%	✓	✓	
Training of livelihood staff on the GBV Guidelines	# of livelihood staff who participated in a training on the GBV Guidelines x 100 <hr/> # of livelihood staff	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	

(continued)

³ United Nations Office for the Coordination of Humanitarian Affairs. *Humanitarian Indicator Registry*. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
IMPLEMENTATION						
► Programming						
Female participation in livelihood programmes³	<p><i>Quantitative:</i></p> $\frac{\# \text{ of affected persons who participate in livelihood programmes who are female} \times 100}{\# \text{ of affected persons who participate in livelihood programmes}}$ <p><i>Qualitative:</i> How do women and girls perceive their level of participation in livelihood programmes? What enhances women and girls' participation? What are barriers to female participation?</p>	Site management reports, Displacement Tracking Matrix, FGD, KII	50%	✓	✓	
Female staff in livelihood programmes	$\frac{\# \text{ of livelihood staff who participate in livelihood programmes who are female} \times 100}{\# \text{ of livelihood staff}}$	Organizational records	50%	✓	✓	
Risk factors of GBV when participating in livelihood programmes	<p><i>Quantitative:</i></p> $\frac{\# \text{ of affected persons who report concerns about experiencing GBV when asked about participation in livelihood programmes} \times 100}{\# \text{ of affected persons asked about participation in livelihood programmes}}$ <p><i>Qualitative:</i> Do affected persons feel safe from GBV when participating in livelihood programmes? What types of safety concerns do the affected population describe in livelihood programmes?</p>	Survey, FGD, KII, participatory community mapping	100%	✓	✓	
Income support for affected population	$\frac{\# \text{ of households in need of income support who are participating in a livelihood programme} \times 100}{\# \text{ of households in need of income support}}$ <p><i>Note: Cases where income is substituting income previously generated through survival sex or exploitative work may not indicate change in income</i></p>	Survey	Determine in field	✓	✓	
Change in net income of livelihood recipients	$\frac{(\text{endline income of livelihood recipients} - \text{baseline income of livelihood recipients}) \times 100}{\text{endline income of livelihood recipients}}$	Survey	Determine in the field	✓		✓
<i>Disaggregate by sex</i>						
► Policies						
Inclusion of GBV prevention and mitigation strategies in livelihood policies, guidelines or standards	$\frac{\# \text{ of livelihood policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines} \times 100}{\# \text{ of livelihood policies, guidelines or standards}}$	Desk review (at agency, sector, national or global level)	Determine in the field	✓		✓

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
► Communications and Information Sharing									
Staff knowledge of standards for confidential sharing of GBV reports	# of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100 # of surveyed staff	Survey (at agency or programme level)	100%		✓	✓			
Inclusion of GBV referral information in livelihood community outreach activities	# of livelihood community outreach activities programmes that include information on where to report risk and access care for GBV survivors x 100 # of livelihood community outreach activities	Desk review, KII, survey (at agency or sector level)	Determine in the field		✓	✓			
COORDINATION									
Coordination of GBV risk reduction activities with other sectors	# of non-livelihood sectors consulted with to address GBV risk reduction activities* x 100 # of existing non-livelihood sectors in a given humanitarian response * See page X for list of sectors and GBV risk reduction activities	KII, meeting minutes (at agency or sector level)	Determine in the field		✓	✓			

RESOURCES

General resources for quality livelihoods/economic recovery programming

- **The Small Enterprise Education and Promotion (SEEP) Network.** 2010. "Minimum Economic Recovery Standards." This handbook sets out strategies and interventions designed to improve income, cash flow, asset management, and growth among crisis-affected households and enterprises. http://www.seepnetwork.org/filebin/Minimum_Econ_Recovery_Standards2_web.pdf
- **The Cash Learning Partnership (CALP).** The Cash Learning Partnership aims to improve the quality of emergency cash transfer and voucher programming across the humanitarian sector. <http://www.cashlearning.org/>
- **Women's Refugee Commission.** 2009a. "Building Livelihoods: A Field Manual for Practitioners in Humanitarian Settings." New York: Women's Refugee Commission. This document gives a comprehensive overview of livelihoods programming and provides assessment, design, and monitoring and evaluation tools. <http://www.unhcr.org/4af181066.pdf>
- For an example of a "safe savings" component to microfinance programmes, see the **Intervention With Microfinance for AIDS and Gender Equity (IMAGE) study:** http://www.aidstar-one.com/promising_practices_database/g3ps/intervention_microfinance_aids_and_gender_equality_image_study

- **Emergency Market Mapping and Analysis Toolkit (EMMA).** 2011. <http://emma-toolkit.org/> The EMMA toolkit is a guidance manual for humanitarian staff in sudden-onset emergencies. It aims to improve emergency responses by encouraging and assisting relief agencies to better understand, support and make use of local market-systems in disaster zones.
- For practices and tools based on **Handicap International's** specific experience in Uganda and DRC regarding disability inclusion in livelihoods opportunities, see "**Lessons Learnt: Socio-Economic Inclusion of People with Disabilities within a Victim Assistance Framework in Uganda and Congo,**" http://www.hiproweb.org/uploads/tx_hidrtdocs/handicap_lessons_final.pdf
- **MercyCorps.** 2007. "Guide to cash-for-work programming." <http://www.mercycorps.org/files/file1179375619.pdf>
- **ICRC and the International Federation of Red Cross and Red Crescent Societies.** 2007. "Guidelines for Cash Transfer Programming." Geneva. <http://www.ifrc.org/Global/Publications/disasters/finance/cash-guidelines-en.pdf>



- **Chaffin, J. and Kalyanpur, A., 2014.** *What do we know about economic strengthening for family reintegration of separated children?* Interagency Group on Reintegration, Child Protection in Crisis, Women's Refugee Commission. <http://www.cpcnetwork.org/wp-content/uploads/2014/11/What-do-we-know-about-economic-strengthening-for-family-reintegration-of-separated-children.pdf>
- **Livestock Emergency Guidelines and Standards (LEGGS).** These guidelines provide a set of international standards for the design, implementation and assessment of livestock interventions to assist people affected by humanitarian crises. LEGGS aims to improve the quality of emergency response by increasing the appropriateness, timeliness and feasibility of livelihoods-based interventions. <http://www.livestockemergency.net>

Resources for GBV-specific livelihoods programming

- **IRC. Program Manual for Economic and Social Empowerment.** Aims to equip field-based practitioners with the skills and knowledge necessary to effectively implement an innovative model called EA\$E (Economic and Social Empowerment) which gives women more access to financial stability and provides opportunities to both women and men to create more equitable and safe gender dynamics within their households. For more information, contact: Natalia.Strigin@rescue.org
- **Women's Refugee Commission. Preventing Gender-based Violence, Building Livelihoods.** This E-Learning Tool helps practitioners, policy-makers and donors gain a better understanding of how to lessen the risk of gender-based violence through safe and effective livelihood interventions. <http://womensrefugeecommission.org/elearning>
- **Ray, S. and Heller, L. 2009.** "Peril or Protection: The link between livelihoods and gender-based violence in displaced settings." New York: Women's Refugee Commission, <http://www.womensrefugeecommission.org/peril-or-protection-making-work-safe>
- **Chynoweth, S. and Patrick, E.M. 2007.** "Sexual Violence During Firewood Collection: Income-Generation as Protection in Displaced Settings." In Terry, G. and Hoare, J. (eds.) Gender-Based Violence. Oxford: Oxfam GB.
- **Women Savings and Credit Association. 2013.** "Manual for Community Volunteers to Facilitate Group Meetings about Domestic Violence." This manual was created by WOSCA, a domestic violence programme in Tanzania, and includes tools for facilitating groups on domestic violence, gender, culture, and prevention. <http://preventgbvafrica.org/wp-content/uploads/2013/11/WOSCA.ManualforCVs-engl.pdf>

Resources for gender-specific livelihoods programming

- **United Nations Development Program. 2008.** "Empowered and equal: the United Nations Development Program's Gender Equality Strategy". UNDP: New York. <http://www.undp.org/women/docs/Gender-Equality-Strategy-2008-2011.pdf>. This document provides an excellent overview of social and economic empowerment of women, including background discussions, a conceptual framework, programme examples from around the world, practical suggestions for mainstreaming gender and a discussion of results and methods for measuring success.
- For a checklist for ensuring gender-equitable livelihoods programming, see **IASC. 2006.** *Gender Handbook in Humanitarian Action, Inter-Agency Standing Committee.* [http://www.humanitarianinfo.org/iasc/documents/subsidi/tf_gender/IASC%20Gender%20Handbook%20\(Feb%202007\).pdf](http://www.humanitarianinfo.org/iasc/documents/subsidi/tf_gender/IASC%20Gender%20Handbook%20(Feb%202007).pdf)

- **Heller, L. & Timoney, J. 2009.** "Earning Money/Staying Safe: The Links Between Making a Living and Sexual Violence for Refugee Women in Cairo." New York: Women's Refugee Commission. <http://www.womensrefugeecommission.org/programs/88-programs/livelihoods>
- **International Rescue Committee. 2012.** "Let me not die before my time: Domestic violence in West Africa." New York: International Rescue Committee. This article includes anecdotal evidence of backlash from economic strengthening. http://www.rescue.org/sites/default/files/resource-file/IRC_Report_DomViolentWAfrica.pdf?q=domesticviolencereport
- **FAO and Dimitra Project. 2009.** "Guidance Note: Gender-Based Violence and Livelihoods Interventions." http://www.fao.org/fileadmin/templates/dimitra/pdf/guidance_note_gbv_livelihoods.pdf
- **Krause-Vilmar, J. 2011.** "Preventing Gender-Based Violence, Building Livelihoods: Guidance and Tools for Improved Programming." New York: Women's Refugee Commission, pp. 13-24. http://womensrefugeecommission.org/resources/cat_view/68-reports/80-livelihoods
- **Women's Refugee Commission. 2012.** "Integrating Protection/GBV Mitigation into Livelihoods Programs." <http://womensrefugeecommission.org/resources/document/857-integrating-protectiongbv-mitigation-into-livelihood-programs-checklist>



NUTRITION



THIS SECTION APPLIES TO:

- Nutrition coordination mechanisms
- Nutrition actors (staff and leadership): NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, older persons, etc.) related to nutrition
- Other nutrition stakeholders, including national and local governments, community leaders, and civil society groups

Why Addressing Gender-based Violence is a Critical Concern of the Nutrition Sector

Nutrition, gender inequality and gender-based violence (GBV) are often interrelated. Evidence shows that higher levels of both acute and chronic malnutrition for women and girls is directly related to gender-inequitable access to nutritious foods, quality health care, and water, sanitation and hygiene (WASH) services. Gender inequitable access to food and services is a form of GBV that can, in turn, contribute to other forms of GBV.

Women, girls and other at-risk groups¹ face a heightened risk of GBV in humanitarian settings. The links between nutrition, gender inequality and the risks of GBV may also become particularly pronounced in these settings, where food and other basic needs are in short supply. For example:

- ▶ Poor families may try to ensure the nutritional needs of their daughters are met by arranging child marriages.
- ▶ Underfed women and girls may be at heightened risk of exchanging sex for food.
- ▶ Disagreements about how to manage limited household food supplies or assign food rations may contribute to intimate partner violence and other forms of domestic violence.

For GBV survivors—particularly those who are socially isolated and/or have physical limitations—access to nutrition support services may be difficult. This can be especially detrimental for survivors who have physical injuries and/or need to take medication that must be accompanied by food.

¹ For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



PART 3: GUIDANCE

Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery throughout the Humanitarian Cycle

ASSESSMENT, ANALYSIS AND PLANNING

- Promote the active participation of women, girls and other at-risk groups in all nutrition assessment process** (*including broader emergency food security assessments*)
- Assess the level of participation and leadership of women, adolescent girls and other at-risk groups in all aspects of nutrition programming (*e.g. ratio of male to female staff*)
- Assess community perceptions, norms and practices linked to nutrition that may contribute to GBV (*e.g. gender dynamics in food consumption; obstacles to access*)
- Assess physical safety of and access to nutrition services to identify associated risks of GBV** (*e.g. service hours and locations; safety traveling to/from distribution points*)
- Assess awareness of nutrition staff on basic issues related to gender, GBV, and women's/human rights (*including knowledge of where survivors can report risks and abuses*)
- Review existing/proposed community outreach material related to nutrition to ensure it includes basic information about GBV risk reduction (*including where to report risks and abuses*)

RESOURCE MOBILIZATION

- Develop proposals for nutrition programmes that reflect awareness of GBV risks for the affected population and strategies for reducing these risks**
- Prepare and provide trainings for government, nutrition staff and community nutrition groups on the safe design and implementation of nutrition programmes

IMPLEMENTATION

► Programming

- Involve women and other at-risk groups as staff and leaders in the planning, design, implementation and monitoring of nutrition activities** (*with due caution when involving GBV survivors in roles that pose a security risk to themselves or others*)
- Implement strategies that increase the safety, availability and accessibility of nutrition services for women, girls and other at-risk groups (*e.g. locate services in safe locations; consider the need to bring feeding supplements to GBV survivors and their children in safe shelters; etc.*)
- Implement proactive strategies to meet the GBV-related needs of those accessing nutrition services (*e.g. locate nutrition facilities next to women-, adolescent- and child-friendly spaces; provide training for nutrition staff; organize informal support groups for women at feeding centers; etc.*)

► Policies

- Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of nutrition programmes (*e.g. standards for equal employment opportunities; policies for reporting, investigating and responding to GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse; etc.*)
- Advocate for the integration of GBV risk-reduction strategies into national and local laws and policies related to nutrition, and allocate funding for sustainability interventions (*e.g. policies that relate to food and cooking fuel needs; land reform as it relates to securing land for agriculture and food security; etc.*)

► Communications and Information Sharing

- Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure nutrition staff has access to these systems**
- Ensure that nutrition programmes sharing information about reports of GBV within the nutrition sector or with partners in the larger humanitarian community do so in a way that does not pose a security risk to individual survivors, their families or the broader community**

Incorporate GBV messages (*including where to report risk and how to access care*) into nutrition-related community outreach and awareness-raising activities

COORDINATION

- Undertake coordination with other sectors to address GBV risks and ensure protection for women, girls and other at-risk groups**

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a nutrition focal point to regularly participate in GBV coordination meetings

MONITORING AND EVALUATION

- Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduction activities**
- Evaluate GBV risk-reduction activities by measuring programme outcomes (*including potential adverse effects*) and using the data to inform decision-making and programming

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for nutrition actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**.

at the Programme Cycle

	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
assessments, where relevant)	✓	✓	✓	✓
male/female nutrition staff; participation in nutrition-related committees; etc.)	✓	✓	✓	✓
o nutritional assistance for at-risk groups; etc.)	✓	✓	✓	✓
istribution sites; accessibility features for persons with disabilities; etc.)		✓	✓	✓
risk and access care; linkages between nutrition programming and GBV risk reduction; etc.)	✓	✓	✓	✓
here to report risk and how to access care)	✓	✓	✓	✓
	✓	✓	✓	✓
es that mitigate the risk of GBV	✓	✓	✓	✓
	✓	✓	✓	✓
where this poses a potential security risk or increases the risk of GBV)	✓	✓	✓	✓
n safe areas; establish supplemental feeding schedules in collaboration with women, girls and	✓	✓	✓	✓
- and child-friendly spaces and/or health facilities; consider including a GBV caseworker as part	✓	✓	✓	✓
ployment of females; procedures and protocols for sharing protected or confidential information	✓	✓	✓	✓
(e.g. ensure policies address: discriminatory feeding practices; protection and management of	✓		✓	✓
s the basic skills to provide them with information on where they can obtain support	✓	✓	✓	✓
nity abide by safety and ethical standards (e.g. shared information does not reveal the identity	✓	✓	✓	✓
	✓	✓	✓	✓
dination meetings	✓	✓	✓	✓
	✓	✓	✓	✓
duction activities throughout the programme cycle	✓	✓	✓	✓
nd ensure accountability		✓	✓	✓

Given that most nutrition programmes in emergencies target vulnerable groups based on physiological and social criteria—including pregnant and lactating women, adolescent girls, and children under five years of age—**nutrition actors are particularly well-positioned to monitor the safety needs of women, girls and other at-risk groups, as well as provide support to survivors.**

For example:

- ▶ Infant and young child feeding programmes can ensure privacy for breast-feeding mothers and help decrease the risk of harassment or violence against female participants.
- ▶ Therapeutic feeding centers or stabilisation centers can provide a supportive and confidential environment for women, girls, and other at-risk groups seeking information about where to report risk or access care for exposure to GBV.
- ▶ Community-based nutrition programmes can monitor households' resource scarcity and any resulting conflicts at the family and community levels; they can then share this information with GBV specialists so that preventative action can be taken at the earliest possible stage.
- ▶ Nutrition programmes can provide nutritional support to GBV survivors.

Actions taken by the nutrition sector to prevent and mitigate the risk of GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. Nutrition actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)

Addressing Gender-based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by nutrition actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with nutrition actors working in partnership with other sectors as well as with GBV specialists.

Ideally, nutrition and food security assessments should overlap to identify barriers to adequate nutrition as well as interventions to improve the availability, access and optimal utilisation of food intake. The information generated from these areas of inquiry should be analyzed to inform planning of nutrition programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance.**

KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in nutrition: governments (e.g. ministries of agriculture and health); local leaders; food security, health, and water and sanitation actors; GBV, gender and diversity specialists
- Affected populations and communities, including pregnant women, adolescent girls and other at-risk groups
- In IDP/refugee settings, members of receptor/host communities

POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Nutrition PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female nutrition staff, including in positions of leadership?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are women and other at-risk groups actively involved in community-based activities related to nutrition (e.g. *community nutrition committees*)? Are they in leadership roles when possible?
- c) Are the lead actors in nutrition response aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation into their activities?

Cultural and Community Perceptions, Norms and Practices

- d) What are the dynamics in the home around health and nutrition?
 - Who eats first? Who eats most?
 - What is the variability of health and nutrition status among family members?
 - What does data disaggregated by sex, age, disability, and other relevant vulnerability factors reveal in terms of equal access to food?
 - How do these factors influence the particular risks of GBV faced by women and girls?
- e) Are there traditional caring or feeding practices related to food insecurity and nutrition that increase the risk of GBV (e.g. *child and/or forced marriages due to food scarcity; intimate partner violence and other forms of domestic violence related to food disputes; exchange of sex for food by those who are most underfed; etc.*)?
- f) Are there cultural restrictions that prohibit women, girls and other at-risk groups—especially pregnant or lactating women—from traveling alone to access outpatient/inpatient care at therapeutic feeding centers or stabilisation centers?

Physical Safety and Access to Services

- g) Are the locations, times and methods of nutrition services safe and accessible for women and other at-risk groups?
 - Are there safety risks associated with the distance and/or route to be travelled to access nutrition services?
 - Are strategies in place to accompany those at risk of GBV if necessary?
 - Are services being offered at times that are convenient and safe for travel?
 - Is the treatment for malnourished women, adolescent girls, and child mothers offered at the same time as children?
 - Have measures been taken to avoid long waiting periods for services?
 - Who is accessing nutrition services? Is anyone being excluded?
 - Are delivery sites designed based on universal design and/or reasonable accommodation² to ensure accessibility for all persons, including those with disabilities (e.g. *physical disabilities, injuries, visual or other sensory impairments, etc.*)?
- h) Are caseworkers specialized in GBV case management present in therapeutic feeding centers or stabilisation centers?
- i) Are nutrition services being offered in close proximity to safe shelter and women-, adolescent- and child-friendly spaces to facilitate referrals as needed?
- j) Are women, adolescent girls and other at-risk groups consulted on cooking fuel needs and how to reduce the risks of GBV related to securing cooking fuel?

(continued)

² For more information regarding universal design and/or reasonable accommodation, see definitions in Annex 4.



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Nutrition POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of nutrition programmes?
 - Are women, girls and other at-risk groups meaningfully engaged in the development of nutrition policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Are these policies, standards and guidelines communicated to women, girls, boys and men (separately when necessary)?
 - Is nutrition staff properly trained and equipped with the necessary skills to implement these policies?
- b) Do national and local laws and sector policies address discriminatory practices hindering women, girls and other at-risk groups from safe participation (*as staff, in community-based groups, etc.*) in the nutrition sector?
- c) Do national and local laws and sector policies integrate GBV-related risk reduction strategies (*e.g. inclusion of a GBV specialist to advise the government on nutrition-related GBV risk-reduction, particularly in situations of cyclical natural disasters, etc.*)? Do they allocate funding for sustainability of these strategies?

Areas related to Nutrition COMMUNICATIONS and INFORMATION SHARING

- a) Has training been provided to nutrition staff on:
 - Issues of gender, GBV, and women's/human rights?
 - How to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- b) Do nutrition-related community outreach activities raise awareness within the community about general safety and GBV risk reduction?
 - Does this awareness-raising include information on survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Is this information provided in age-, gender- and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these education activities as agents of change?
- c) Are discussion forums on nutrition age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.*) so that participants feel safe to raise GBV issues?



KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for nutrition programming. Whether requesting pre-/emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**.

Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under "Coordination" below.



A. HUMANITARIAN NEEDS OVERVIEW

- Does the proposal articulate the GBV-related safety risks, protection needs and rights of the affected population as they relate to the provision of nutrition services (*e.g. poor families ensuring the nutritional needs of their daughters by marrying them at a young age; under-fed women and girls exchanging sex for food; etc.*)?
- Are roles and responsibilities (including decision-making) related to food and nutrition in the home and the wider community understood? Are the GBV-related risk factors recognized and described?
- Are specific forms of GBV (*such as child and/or forced marriage, sexual exploitation, intimate partner violence and other forms of domestic violence, etc.*) described and analysed, rather than a broader reference to "GBV"?

B. PROJECT RATIONALE/ JUSTIFICATION

- When drafting a proposal for emergency preparedness:
 - Is there a plan for how outpatient/inpatient care at therapeutic feeding centers or stabilisation centers can provide a supportive and confidential environment for women and girls to report risk and/or access care for GBV (*e.g. by including a GBV caseworker as part of nutrition staff*)?
 - Is there a strategy for preparing and providing trainings for government, nutrition staff and community nutrition groups on the safe design and implementation of nutrition programming that mitigates the risk of GBV?
 - Are additional costs required to ensure any GBV-related community outreach materials will be available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- When drafting a proposal for emergency response:
 - Is there an explanation of how the nutrition programme will mitigate exposure to GBV (*e.g. by addressing differential feeding practices; averting risks of child and/or forced marriages in families with food scarcity; etc.*)?
 - Are additional costs required to ensure the safety of and effective working environment for female staff in the nutrition sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
- When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how the nutrition programme will contribute to sustainable strategies that promote the safety and well-being of those at risk of GBV, and to long-term efforts to reduce specific types of GBV (*e.g. working to ensure that national and local policies address discriminatory feeding practices*)?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

C. PROJECT DESCRIPTION

- Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for integrating GBV-related work?
- Do the proposed activities illustrate linkages with other humanitarian actors/ sectors in order to maximize resources and work in strategic ways?
- Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as nutrition staff and in local nutrition committees?





KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some common GBV-related considerations when implementing nutrition programming in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

Integrating GBV Risk Reduction into: NUTRITION PROGRAMMING

- 1. Involve women and other at-risk groups as staff and leaders in the planning, design, implementation and monitoring of nutrition activities (with due caution in situations where this poses a potential security risk and/or increases the risk of GBV).**
 - In settings where it's not already the case, strive for 50% representation of women within nutrition programme staff. Provide them with formal and on-the-job training as well as targeted support to assume leadership and training positions.
 - Ensure women (and where appropriate, adolescent girls) are actively involved in community-based nutrition committees and groups. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.
 - Employ persons from at-risk groups in nutrition staff, leadership, and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.



PROMISING PRACTICE

In Mozambique, Food for the Hungry (FH) led a project designed to promote household-level behaviours to prevent maternal and child malnutrition and death. The project used the Care Group model, in which community-based volunteers (known as "Leader Mothers") were chosen by their peers to regularly visit 10-15 of their neighbors. During these visits, the Lead Mothers would share what they had learned from the FH Promoter, helping to facilitate behavior change at the household level. Through this project, rates of malnutrition in communities where FH worked decreased by 42% in 15 months; the under-five mortality rate decreased by 26%. Additionally, the project showed promising results in relation to GBV:

- In the baseline interview, 64% of all mothers of children 12-59 months of age had accepting attitudes of GBV.
- In the final interview, 61% of Lead Mothers who served as the main volunteers in the project said that their husbands respected them more; 64% said their community leaders respected them more; and only 3% had accepting attitudes of GBV.
- Spousal abuse of all mothers of young children appeared to have decreased during the project (from 64% of mothers with children 12-59 months in 2004 to 34% of mothers of children 0-23 months in 2010).

Because the selection criteria for interviewees at baseline and final differed, future studies will be needed to confirm how involving women in volunteer roles increases respect for them and decreases GBV, and how the increased social support amongst women reached by Care Groups may lead to a decrease in accepting attitudes about GBV and GBV itself.

(Adapted from Care Groups Info at <http://caregroupinfo.org> and information provided by Tom Davis, Chief Program Officer, Feed the Children, Personal Communication, October 29, 2014)



2. Implement strategies that increase the safety, availability and accessibility of nutrition services for women, girls and other at-risk groups.

- Coordinate with community members—and with the CCCM cluster when applicable—to ensure services (such as outpatient/inpatient care at therapeutic feeding centers or stabilisation centers) are not located near areas that present security risks (e.g. distribution points; security check points; water and sanitation facilities; entertainment centers; site perimeters; collective centers; etc.).
- In situations where supplemental feeding is provided using schedules, work with all users to plan the schedules so that times are convenient and safe for women, girls and other at-risk groups. Provide services in a manner than reduces the time spent at, traveling to, and returning from nutrition service points (e.g. organize services to avoid crowds, long waiting times, travel at night/dusk, etc.).
- Observe who is accessing nutrition services who might be excluded. Solicit feedback from programme participants about safety in and around service points (incorporating questions into regular quality-of-care assessments when possible).
- Consider the need to organize nutrition support and/or bring feeding supplements to GBV survivors and their children in safe shelters.



PROMISING PRACTICE

In Pakistan, WFP has partnered with the GBV Sub-Cluster so that families at risk or GBV survivors can be referred to nutrition services or to cash-for-work programmes. In Pakistan, this is a common form of providing food assistance and women are integral to these schemes in both planning and participating in activities. Implementing partners also participate in GBV awareness training.

(Information provided by World Food Programme in Pakistan, Personal Communication, August 20, 2013)



ESSENTIAL TO KNOW

Persons with Disabilities

Persons with illnesses, physical impairments, or physical or developmental disabilities may be unable to travel to or access therapeutic feeding centers, stabilisation centers, health care centres, and other services. Those who do not have family members to assist them and have to rely on others for help may be at increased risk of exploitation and abuse. It is important to adapt and develop procedures according to the rights and needs of persons with disabilities. For example:

- Services should be physically accessible with ramps, handrails, adapted toilets and medical equipment (such as stretchers, walkers, wheelchairs, crutches, sticks, etc.). Consideration should be given to arranging transportation to services for persons with limited mobility.
- Additional assistance should be available for people who are not able to eat on their own—for example, providing modified devices, spoons or straws for persons who have difficulties using utensils.
- Injured persons and persons with disabilities may need specific diets that are designed to ease their healing process, prevent complications and/or ensure their well-being.
- Nutrition messages should be communicated in accessible formats (e.g. with large prints; sign language; simplified messaging such as pictograms and pictures).
- Nutrition and community outreach staff must be trained on how to provide disability-sensitive services and how to report data with disability-disaggregated information.
- Awareness workshops should be conducted at the community level (with community-based organizations, family members of persons of concern) to assure that general knowledge about nutrition is widespread.

(Information provided by Handicap International, Personal Communication, February 7, 2013. For more information on nutrition issues for people with disabilities and injuries, see **Handicap International**. No date. "Disability Checklist for Emergency Response," http://www.handicap-international.de/fileadmin/redaktion/pdf/disability_checklist_booklet_01.pdf)



- Provide regular and updated information (to both IDP/refugee and receptor/host communities) about nutrition services, including who qualifies for nutrition assistance and how these services are provided.

3. Implement proactive strategies to meet the GBV-related needs of those accessing nutrition services.

- Develop nutrition programmes based on an understanding of household dynamics related to food consumption, and how these dynamics impact family members' health and nutritional statuses in different (often gendered) ways.
- Where possible, locate nutrition facilities next to women-, adolescent- and child-friendly spaces and/or health facilities. This can help to support referrals and follow-up care for persons who report instances of GBV exposure to nutrition staff.
- Include a caseworker as part of nutrition staff who is specialized in GBV case management. This caseworker can play an active role in identifying cases of GBV; provide GBV survivors with information about where to access further care; and, where warranted, accompany survivors to care and support services.
- Organize informal peer empowerment and support groups for women and adolescent girls participating in nutrition programmes about issues of concern to them (e.g. childcare, reproductive health, domestic concerns, women's/human rights, etc.).
- Where supplementary nutritional services are provided directly to households, link with food security, livelihoods, and other relevant sectors to monitor households' resource scarcity and violence levels. Link with GBV specialists to ensure that this is done in a safe and ethical manner.



ESSENTIAL TO KNOW

Safe Shelters and Women-, Adolescent- and Child-Friendly Spaces

The term "**safe shelter**" is used throughout the Guidelines to refer to any physical space or network of spaces that exclusively or incidentally offers temporary safety to individuals fleeing harm. A variety of terms—such as "safe house" or "protection/safe haven"—are used to refer to safe shelters depending on the location.

(For additional information on providing safe shelter see: **Seelinger, K.T., and Freccero, J. 2013. Safe Haven. Sheltering Displaced Persons from Sexual and Gender-Based Violence. Comparative Report.** Human Rights Center Sexual Violence Program, University of California, Berkeley, School of Law. <http://www.unhcr.org/51b6e1ff9.pdf>)

"Women-friendly spaces" are safe and non-stigmatizing locations where women may conduct a variety of activities, such as breastfeed their children, learn about nutrition, and discuss issues related to well-being (e.g. women's rights, sexual and reproductive health, GBV, etc.). Ideally, these spaces also include counseling services (which may incorporate counseling for GBV survivors) to help women cope with their situation and prepare them for eventual return to their communities. Women-friendly spaces may also be a venue for livelihood activities.

"Child-friendly spaces" and "Adolescent-friendly spaces" are safe and nurturing environments in which children and/or adolescents can access free and structured play, recreation, leisure and learning activities.

(Child Protection Working Group. 2012. Minimum Standards for Child Protection in Humanitarian Action. <http://cpwg.net/minimum-standards/>. For additional information on child-friendly spaces see: **Global Protection Cluster, IASC Mental Health and Psychosocial Support Reference Group, Global Education Cluster, and International Network of Education in Emergencies. 2011. Guidelines for Child Friendly Spaces in Emergencies.** http://www.unicef.org/protection/Child_Friendly_Spaces_Guidelines_for_Field_Testing.pdf)



Integrating GBV Risk Reduction into: NUTRITION POLICIES

1. Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of nutrition programmes.

- ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in nutrition activities. These can include, among others:
 - Policies regarding childcare for nutrition staff.
 - Standards for equal employment of females.
 - Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.
- ▶ Circulate these widely among nutrition staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).

2. Advocate for the integration of GBV risk-reduction strategies into national and local laws and policies related to nutrition, and allocate funding for sustainability.

- ▶ Support governments, customary/traditional leaders, and other stakeholders to review laws and policies (including customary law) to address discriminatory practices related to nutrition, such as:
 - Discriminatory feeding practices.
 - Protection and management of natural resources that relate to food and cooking fuel needs.
 - Land reform as it relates to securing land for agriculture and food security.
- ▶ Ensure national policies include measures to prevent and mitigate the risk of GBV against persons accessing nutrition programmes (e.g. access to health facilities and health education for adolescent girls and pregnant women; support for programmes that address harmful gender norms and practices; etc.).
- ▶ Support relevant line ministries in developing implementation strategies for GBV-related laws and policies. Undertake awareness-raising campaigns highlighting how such laws and policies will benefit communities in order to encourage community support and mitigate backlash.



Integrating GBV Risk Reduction into: NUTRITION COMMUNICATIONS AND INFORMATION SHARING

1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure nutrition staff has the basic skills to provide them with information on where they can obtain support.
 - Ensure all nutrition personnel who engage with affected populations have written information about where to refer survivors for care and support. Regularly update information about survivor services.
 - Train all nutrition personnel who engage with affected populations in gender, GBV, women's/human rights and psychological first aid (e.g. how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).



ESSENTIAL TO KNOW

Referral Pathways

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.



PROMISING PRACTICE

In Somalia, the UNICEF Chief of Nutrition Section noticed a pattern in which women and girls who were not in need of nutritional support were spending a lot of time at wet feeding centres. It was discovered that these centres were considered the only safe and secure place for them. The Nutrition Section informed the Child Protection Section, which in turn shared the information with UNICEF's GBV programmes. Case workers were sent to wet feeding centres during opening hours to create a safe and confidential space for women and girls to speak and share experiences. Those who disclosed information about sexual assault were recommended for further services, such as emotional support and clinical care for survivors of rape. The case workers also trained wet feeding centre staff on these referral systems.

(Information provided by UNICEF Somalia Child Protection Section, Personal Communication, August 2014)

2. Ensure that nutrition programmes sharing information about reports of GBV within the nutrition sector or with partners in the larger humanitarian community abide by safety and ethical standards.

- Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community.

3. Incorporate GBV messages into nutrition-related community outreach and awareness-raising activities.

- Work with GBV specialists to integrate community awareness-raising on GBV into nutrition outreach initiatives (e.g. community dialogues; workshops; meetings with community leaders; GBV messaging; etc.).



ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.



- Ensure this awareness-raising includes information on survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
- Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).
- Engage (separately when necessary), women, girls, men and boys in the development of messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.
- Place posters and other GBV messages in nutrition service delivery points (e.g. therapeutic feeding centers or stabilisation centers, etc.).
- Engage males, particularly leaders in the community, as agents of change in nutrition outreach activities related to the prevention of GBV (including outreach about unequal food consumption dynamics within the home).
- Consider the barriers faced by women, adolescent girls and other at-risk groups to their safe participation in community discussion forums and educational workshops related to nutrition (e.g. transportation; meeting times and locations; risk of backlash related to participation; need for childcare; accessibility for persons with disabilities; etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.) so that participants feel safe to raise GBV issues.
- Provide community members with information about existing codes of conduct for nutrition personnel, as well as where to report sexual exploitation and abuse committed by nutrition personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.





KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, nutrition programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist nutrition actors to:

- ▶ Design and conduct nutrition assessments that examine the risks of GBV related to nutrition programming, and strategize with nutrition actors about ways for such risks to be mitigated.
- ▶ Provide trainings for nutrition staff on issues of gender, GBV, and women's/human rights.
- ▶ Identify where survivors who may report instances of GBV exposure to nutrition staff can receive safe, confidential and appropriate care, and provide nutrition staff with the basic skills and information to respond supportively to survivors.
- ▶ Provide training and awareness-raising for the affected community on issues of gender, GBV, and women's/human rights as they relate to nutrition.
- ▶ Advocate for women-, adolescent- and child-friendly spaces to be placed near nutrition facilities to make it easier for mothers to attend nutritional activities.

In addition, nutrition programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, nutrition actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.







KEY GBV CONSIDERATIONS FOR:

MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in nutrition assessments³	$\frac{\# \text{ of nutrition assessment that include GBV-related questions* from the GBV Guidelines} \times 100}{\# \text{ of nutrition assessment}}$ <small>* See page 176 for GBV areas of inquiry that can be adapted to questions in assessments</small>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	$\frac{\# \text{ of assessment respondents who are female} \times 100}{\# \text{ of assessment respondents and } \# \text{ of assessment team members who are female} \times 100}$ $\frac{\# \text{ of assessment team members who are female} \times 100}{\# \text{ of assessment team members}}$	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

³ Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Ratio of affected females to males aged 6 – 59 months with global acute malnutrition	# of affected females aged 6 – 59 with global acute malnutrition # of affected males aged 6 – 59 with global acute malnutrition	Survey, health information system	Determine in the field	✓	✓	
Female participation prior to programme design⁴	<i>Quantitative:</i> # of affected persons consulted before designing a programme who are female x 100 <hr/> # of affected persons consulted before designing a programme <i>Qualitative:</i> How do women and girls perceive their level of participation in the programme design? What enhances women and girls' participation in the design process? What are barriers to female participation in these processes?	Organizational records, focus group discussion (FGD), key informant interview (KII)	Determine in the field		✓	
Consultations with the affected population on GBV risk factors in accessing nutrition services⁴	<i>Quantitative:</i> # of nutrition services conducting consultations with the affected population to discuss GBV risk factors in accessing the service x 100 <hr/> # of nutrition services <i>Qualitative:</i> What types of GBV-related risk factors do affected persons experience in accessing a nutrition service?	Organizational records, FGD, KII	100%	✓	✓	
Disaggregate consultations by sex and age						
Staff knowledge of referral pathway for GBV survivors	# of nutrition staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors x 100 <hr/> # of surveyed nutrition staff	Survey	100%	✓	✓	

RESOURCE MOBILIZATION

Inclusion of GBV risk reduction in nutrition funding proposals or strategies	# of nutrition funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines x 100 <hr/> # of nutrition funding proposals or strategies	Proposal review (at agency or sector level)	100%	✓	✓	
Training of nutrition staff on the GBV Guidelines	# of nutrition staff who participated in a training on the GBV Guidelines x 100 <hr/> # of nutrition staff	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	

(continued)

⁴ United Nations Office for the Coordination of Humanitarian Affairs. *Humanitarian Indicator Registry*. <http://www.humanitarianresponse.info/applications/ir/indicators>.



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
IMPLEMENTATION						
Female participation in nutrition community-based committees⁴	<p><i>Quantitative:</i></p> $\# \text{ of affected persons who participate in nutrition community-based committees who are female} \times 100$ <hr/> $\# \text{ of affected persons who participate in nutrition community-based committees}$ <p><i>Qualitative:</i> How do women perceive their level of participation in nutrition community-based committees? What are barriers to female participation in nutrition committees?</p>	Site management reports, Displacement Tracking Matrix, FGD, KII	50%	✓	✓	
Female staff in nutrition programmes	$\# \text{ of staff in nutrition programmes who are female} \times 100$ <hr/> $\# \text{ of staff in nutrition programmes}$	Organizational records	50%	✓	✓	
Risk factors of GBV in accessing nutrition services	<p><i>Quantitative:</i></p> $\# \text{ of affected persons who report concerns about experiencing GBV when asked about access to nutrition services} \times 100$ <hr/> $\# \text{ of affected persons asked about access to nutrition services}$ <p><i>Qualitative:</i> Do affected persons feel safe from GBV when accessing nutrition services? What types of safety concerns does the affected population describe?</p>	Survey, FGD, KII, participatory community mapping	100%	✓	✓	
Coverage of nutrition programmes for persons at-risk of GBV	$\# \text{ of persons at-risk of GBV in need of nutrition services and who received nutrition services} \times 100$ <hr/> $\# \text{ of persons at-risk of GBV in need of nutrition services}$ <p>* Collect this data with GBV specialists to ensure safe and ethical considerations</p>	Survey	Determine in the field	✓	✓	
<p>► Policies</p>						
Inclusion of GBV prevention and mitigation strategies in nutrition policies, guidelines or standards	$\# \text{ of nutrition policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines} \times 100$ <hr/> $\# \text{ of nutrition policies, guidelines or standards}$	Desk review (at agency, sector, national or global level)	Determine in the field	✓		✓
<p>► Communications and Information Sharing</p>						
Staff knowledge of standards for confidential sharing of GBV reports	$\# \text{ of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors} \times 100$ <hr/> $\# \text{ of surveyed staff}$	Survey (at agency or programme level)	100%	✓		

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
► Communications and Information Sharing									
Inclusion of GBV referral information in nutrition community outreach activities	# of nutrition community outreach activities programmes that include information on where to report risk and access care for GBV survivors x 100 <hr/> # of nutrition community outreach activities	Desk review, KII, survey (at agency or sector level)	Determine in the field	✓	✓				
COORDINATION									
Coordination of GBV risk reduction activities with other sectors	# of non-nutrition sectors consulted with to address GBV risk reduction activities* x 100 <hr/> # of existing non-nutrition sectors in a given humanitarian response <small>* See page X for list of sectors and GBV risk reduction activities</small>	KII, meeting minutes (at agency or sector level)	Determine in the field	✓	✓				



RESOURCES

Key Resources

- **Global Nutrition Cluster.** 2013. "Harmonised Training Package (HTP). Module 22: Gender-Responsive Nutrition in Emergencies." Forthcoming. http://www.unicef.org/nutritioncluster/index_67812.html
- **World Food Programme (WFP).** 2011. *Enhancing prevention and response to sexual and gender-based violence in the context of food assistance in displacement settings.*
- For a checklist for ensuring gender-equitable programming in the nutrition sector, see **Inter-Agency Standing Committee (IASC).** 2006. *Gender Handbook in Humanitarian Action.* [http://www.humanitarianinfo.org/iasc/documents/subsidiary/tf_gender/IASC%20Gender%20Handbook%20\(Feb%202007\).pdf](http://www.humanitarianinfo.org/iasc/documents/subsidiary/tf_gender/IASC%20Gender%20Handbook%20(Feb%202007).pdf)
- **Mucha, N.** 2012. "Enabling and equipping women to improve nutrition." Briefing Paper no. 16, Bread for the World Institute, Washington, <http://www.thousanddays.org/resource/enabling-and-equipping-women-to-improve-nutrition/>
- **Crawford, N., and Pattugaian, G. (eds.).** 2013. *Protection in Practice: Food Assistance with Safety and Dignity.* WFP: Rome. <http://reliefweb.int/sites/reliefweb.int/files/resources/wfp254460.pdf>
- **Handicap International.** No date. *Disability Checklist for Emergency Response.* This booklet contains general guidelines for the protection and inclusion of injured persons and people with disabilities in 6 key sectors, including nutrition, http://www.handicap-international.de/fileadmin/redaktion/pdf/disability_checklist_booklet_01.pdf
- **Sphere Project.** 2011. *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response.* <http://www.spheredhandbook.org/>

Additional Resources

- **Owen, M.** 2002. "Cooking Options in Refugee Situations: A Handbook of Experiences in Energy Conservation and Alternative Fuels." UNHCR: Geneva, www.fuelnetwork.org
- **Women's Refugee Commission.** 2011. "Cooking Fuel and the Humanitarian Response in the Horn of Africa. Key Messages and Guidance for Action." New York: WRC, <http://womensrefugeecommission.org/fuel-and-firewood-rss/1457-cooking-fuel-and-the-humanitarian-response-in-the-horn-of-africa?highlight=WyJjb29raW5nliwiZnVlbClslmNvb2tpbmcgZnVlbCJd>
- **Seelinger, K. T., and Freccero, J.** 2013. *Safe Haven. Sheltering Displaced Persons from Sexual and Gender-Based Violence. Comparative Report.* Human Rights Center Sexual Violence Program, University of California, Berkeley, School of Law. http://www.law.berkeley.edu/files/HRC/SS_Comparative_web.pdf
- **Global Protection Cluster, IASC Mental Health and Psychosocial Support reference group, Global Education Cluster and International Network of Education in Emergencies.** 2011. *Guidelines for Child Friendly Spaces in Emergencies,* <http://resourcecentre.savethechildren.se/library/guidelines-child-friendly-spaces-emergencies>



PROTECTION



THIS SECTION APPLIES TO:

- Protection coordination mechanisms
- National actors (staff and leadership) undertaking targeted protection activities, including governments (particularly Ministries of the Interior, Justice, Defense, Promotion of Family, Women and Children, Social Development, etc.), national and local police, members of the judiciary and legal associations, traditional justice actors, community leaders, and human rights and other protection-related civil society groups
- Specialized protection actors working within the UN and INGO system that are mobilized during emergencies to undertake targeted protection programming
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, older persons, etc.) related to protection

Why Addressing Gender-based Violence is a Critical Concern of the Protection Sector

Protection needs for all people become heightened by armed conflict, natural disasters and other humanitarian emergencies. Risks of various forms of gender-based violence (GBV) are magnified. Factors that increase people's level of risk can include, among other things: the loss of shelter; armed attacks and abuse; family separation; the collapse of family and community protection mechanisms; arbitrary deprivation of land, homes and other property; marginalization, discrimination and hostility in new settings; exposure to landmines or explosive remnants of war; long-standing gender inequalities; and the failure to address GBV prior to the emergency.

Humanitarian conditions particularly increase the frequency and level of GBV for women, girls, and other at-risk¹ groups, who often face greater obstacles in claiming their rights. The weakening of social and legal protections

WHAT THE SPHERE HANDBOOK SAYS:

Protection Principle 3:

- ▶ Protect people from physical and psychological harm arising from violence and coercion.

Guidance Note 13: Women and girls can be at particular risk of gender-based violence.

- ▶ When contributing to the protection of these groups, humanitarian agencies should particularly consider measures that reduce possible risks, including trafficking, forced prostitution, rape or domestic violence. They should also implement standards and instruments that prevent and eradicate the practice of sexual exploitation and abuse. This unacceptable practice may involve affected people with specific vulnerabilities, such as isolated or disabled women who are forced to trade sex for the provision of humanitarian assistance.

Protection Principle 4:

- ▶ Assist people to claim their rights, access available remedies and recover from the effects of abuse.

(Sphere Project. 2011. *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*, <http://www.spheredproject.org/resources/downloadpublications/?search=1&keywords=&language=English&category=22>)

1 For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; women and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



PART 3: GUIDANCE

Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery through Protection

ASSESSMENT, ANALYSIS AND PLANNING

Promote the active participation of women, girls and other at-risk groups in all protection assessment processes

Assess the level of participation and leadership of women and other at-risk groups in all aspects of targeted humanitarian protection programming (e.g. gender-based protection programming; etc.)

Assess the broader protection factors that exacerbate the risks of GBV in the particular setting (e.g. displacement; unsafe routes to work, to school, home; distribution times and locations of foods and non-food items; loss of personal identity documents; proximity to insecure zones or warring parties)

Assess the capacity of security actors to mitigate the risks of GBV and assist and support GBV survivors (e.g. ratio of male/female officers; existence of protocols, and standard operating procedures; confidential and secure environments for reporting incidents of GBV that limit re-victimization of survivors)

Assess the capacity of formal and informal justice sector/actors to safely and ethically respond to incidents of GBV (e.g. accessibility of free/law cost witnesses; how the informal justice system deals with GBV cases; etc.)

Assess awareness of protection staff on basic issues related to gender, GBV and women's/human rights (including knowledge of where survivors can report risk)

Review existing/proposed protection-related community outreach material to ensure it includes basic information about GBV risk reduction (including GBV prevention and mitigation)

RESOURCE MOBILIZATION

Develop proposals for protection programming that reflect awareness of GBV risks for the affected population and strategies for reducing these risks

Target women and other at-risk groups for job skills training related to protection, particularly in leadership roles to ensure their presence in decision-making

Prepare and provide trainings for protection actors (including expert protection actors sent to the field as part of a surge response), security and legal teams, and other relevant actors to enhance their capacity to prevent and respond to GBV (e.g. safe design and implementation of protection programmes that mitigate the risk of GBV)

IMPLEMENTATION

► Programming

Involve women and other at-risk groups in all aspects of protection programming (with due caution where this poses a potential security risk or increases the risk of GBV)

Integrate GBV prevention and mitigation into protection monitoring activities, and support the development of community-based protection strategies

Implement strategies that safeguard those at risk of GBV during documentation, profiling and registration processes (e.g. ensure participation of women, girls and other at-risk groups in all aspects of protection programming; provide safe and confidential environments for reporting incidents of GBV; prioritize programmes for women to receive, recover or replace personal documents; consider the needs of women, girls and other at-risk groups in all aspects of protection programming)

Enhance the capacity of security institutions/personnel to prevent and respond to GBV (e.g. support employment of women in the security sector; provide training to relevant actors on how to prevent and respond to GBV; support secure environments in which GBV can be reported to police; etc.)

Promote access to justice for GBV survivors by strengthening institutional capacities of state and traditional justice actors (e.g. provide training to relevant actors on how to support GBV survivors and witnesses during court processes; etc.)

► Policies

Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of targeted protection programmes (e.g. standards for the handling of GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse)

Support the reform of national and local laws and policies (including customary law) to promote access to justice and the rule of law, and allocate funding to protect women, girls and other at-risk groups (e.g. incorporate GBV-related measures in return, relocation and reintegration; etc.)

► Communications and Information Sharing

Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure that protection is a priority in all interventions

Ensure that protection programmes sharing information about reports of GBV within the protection sector or with partners in the larger humanitarian response do not compromise the safety of survivors or pose a security risk to individual survivors, their families or the broader community

Incorporate GBV messages (including where to report risk and how to access care) into protection-related community outreach and awareness-raising activities

COORDINATION

Undertake coordination with other sectors and strengthen government coordination mechanisms to address GBV risks and ensure protection for women, girls and other at-risk groups

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a protection focal point to regularly participate in GBV-related decision-making

MONITORING AND EVALUATION

Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risks and outcomes

Evaluate GBV risk-reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for protection actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions--particularly in the early stages of an emergency--the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**.

Throughout the Programme Cycle

	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
e.g. ratio of male/female humanitarian protection personnel; participation in community-to health facilities, or two collect water/firewood; safety issue for those who remain in the etc.)	✓	✓	✓	✓
and implementation of codes of conduct for security personnel and GBV-related policies, etc.)	✓	✓	✓	✓
et legal aid services; how judicial processes provide protection to GBV survivors and			✓	✓
and access care; linkages between targeted protection programming and GBV risk reduction; etc.)	✓	✓	✓	✓
g where to report risk and how to access care)	✓	✓	✓	✓
ks	✓	✓	✓	✓
-making processes	✓	✓	✓	✓
al/justice personnel, and relevant community members (such as traditional leaders) on the	✓	✓	✓	✓
es the risk of GBV)	✓	✓	✓	✓
irls and other at-risk groups in the processes; develop strategies that encourage affected d for special protection measures such as relocation and safe houses; etc.)	✓	✓	✓	✓
rk with GBV specialists to train security personnel on issues of GBV; advocate for		✓	✓	✓
nt legal/justice actors on GBV; support free and accessible legal aid; provide protection for			✓	✓
ls for equal employment of females; procedures and protocols for sharing protected or se; etc.)	✓	✓	✓	✓
g for sustainability (e.g. strengthen GBV protections; support the ratification of key human	✓		✓	✓
ion staff has the basic skills to provide them with information on where they can obtain	✓	✓	✓	✓
n community abide by safety and ethical standards (e.g. shared information does not reveal tivities	✓	✓	✓	✓
omen, girls and other at-risk groups	✓	✓	✓	✓
GBV coordination meetings	✓	✓	✓	✓
isk-reduction activities throughout the programme cycle	✓	✓	✓	✓
king and ensure accountability		✓	✓	✓

promotes a culture of impunity for perpetrators and increases the likelihood that survivors will not seek care and support.

Displacement—whether to urban settings, informal settlements, host communities, or camps—also presents new risks, which may in turn contribute to the risk of GBV:

- ▶ Loss of documents can make it difficult for displaced persons to prove their identity, in turn affecting their ability to access humanitarian assistance.
- ▶ Host authorities may have limited understanding of domestic and international laws that relate to the provision of services and support to refugees. Self-settled urban refugees may have even less assistance available to them than those in camps.
- ▶ Prejudicial feelings in the receptor/host community about IDPs/refugees may increase their exposure to violence, exploitation and abuse.
- ▶ Failure to site refugee camps sufficiently far from borders may result in abduction by armed groups from the country of origin.
- ▶ Humanitarian agencies located in remote settings may have trouble finding enough trained staff to address the needs of survivors.

Protection is a concern of all humanitarian actors; however, those working on operational responses to key protection problems have a very important role to play in addressing GBV-related security and justice issues issues in emergencies. This section sets out the GBV-related responsibilities relevant to specialized protection staff who are mobilized to undertake targeted—or “stand alone”—protection activities during a humanitarian emergency. These protection activities and the related GBV prevention and mitigation recommendations are grouped into **four major areas of targeted protection sector work**, highlighted below. Namely, specialized protection actors can:

- ▶ Ensure that all **protection monitoring** activities include an investigation of security issues that might heighten the risk of GBV. They should also ensure that any protection monitoring that specifically focuses on GBV incidents is undertaken in close collaboration with GBV specialists.
- ▶ Implement strategies that safeguard those at risk of GBV during **documentation, profiling, and registration** processes.
- ▶ **Strengthen security** by building the capacities of national and local security and legal/justice sector actors to prevent, mitigate and respond to GBV.
- ▶ **Promote access to justice** by advocating for the implementation of laws and policies that prevent GBV and ensure care and protection of survivors.

! ESSENTIAL TO KNOW

Exercising Rights

UNHCR's Executive Committee has noted that, “while forcibly displaced men and boys also face protection problems, women and girls can be exposed to particular protection problems related to their gender, their cultural and socioeconomic position, and their legal status, which mean that they may be less likely than men and boys to be able to exercise their rights”. The Executive Committee has therefore recognized “specific action in favour of women and girls may be necessary to ensure they can enjoy protection and assistance on an equal basis with men and boys”.

(**UNHCR Executive Committee. 2006. Conclusion on Women and Girls at Risk**, No. 105 [LVII], <http://www.unhcr.org/45339d922.html>)

Actions taken by the protection sector to prevent and respond to GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. Protection actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)

Addressing Gender-based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by protection actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with protection actors working in partnership with other sectors as well as with GBV specialists.

The information generated from these areas of inquiry should be analyzed to inform planning of protection programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.

KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in protection: governments (including police, armed forces and judiciary); local and traditional leaders; peacekeepers; GBV, gender and diversity specialists; protection specialists
- Affected populations and communities
- In refugee/IDP settings, members of receptor/host communities

POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to Protection PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female protection staff, including in positions of leadership?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are women, adolescent girls, and other at-risk groups actively involved in community-based activities related to protection (e.g. *community protection committees*)? Are they in leadership roles when possible?
- c) Are the lead actors in protection response aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation strategies into their activities?

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

GBV-Related Protection Environment

- d) What are the broad protection factors which may exacerbate the risks of GBV in the particular setting (*e.g. displacement; closeness to armed forces; unsafe routes for firewood/water collection, to work, to school and/or to health facilities; safety issues for those who remain in the home; distribution times and locations of food and non-food items; overcrowded camps/dwellings/shelters/apartments; family separation; placement of water and sanitation facilities; loss of personal identity documents; etc.*)?
- e) Do some groups face more or different protection risks because of their sex, age, ethnic background, nationality, sexual orientation, disability, particular status (*e.g. as urban IDPs/refugees, asylum seekers, unaccompanied minors, etc.*), or household composition (*e.g. woman- and child-headed households*)?
- f) Are there existing community-based security patrols/groups to facilitate monitoring of GBV issues?
 - When are they active (*e.g. 24 hours/day, 7 days/week*)?
 - Do they include both female and male members of the community, where appropriate?
 - Are security patrol members trained in issues of gender, GBV, and women's/human rights?
 - Are they trained to respectfully and supportively engage with survivors and provide immediate referrals in an ethical, safe and confidential manner?

Documentation, Profiling, and Registration

- g) Do IDP profiling and refugee registration processes incorporate GBV as a risk factor for vulnerability? Is profiling and registration data disaggregated by sex, age, disability, and other relevant vulnerability factors?
- h) Are there obstacles that women, girls and other at-risk groups must overcome to be included in profiling and registration (*e.g. are women not allowed to leave their houses or have their pictures taken*)?
- i) What programmes are in place to issue, recover and replace personal identity documents for affected populations (*e.g. birth certificate and registration; marriage/divorce certificates; land titles; etc.*)?
 - Is there a cost associated with receiving, recovering and/or replacing documents?
 - Is the loss of personal identity documents making it harder for women, girls, and other at-risk groups to receive humanitarian assistance (*e.g. food assistance; housing and reconstruction assistance; education, health and other social services; etc.*) or to make property claims?
 - Are identity documents being issued in the woman's name, the child's name, or jointly for spouses (*in the case of matrimonial property*)?
- j) Do registration forms and procedures restrict gender to male/female only, or do they allow for a "third gender" or "other" gender?
- k) Are there resettlement options for GBV survivors who do not have adequate care and protection in their current displacement context?

Capacity of Security Sector/Actors

- l) What is the ratio of male to female police and security personnel?
- m) What is the extent and quality of the training provided to security sector actors (*e.g. police and armed forces; peacekeepers; security personnel; administration staff; etc.*) on GBV prevention and response?
- n) Is the peacekeeping mission mandated to address sexual violence and other forms of GBV?
- o) Are there codes of conduct in place for police and other security personnel? Are there policies on discrimination, sexual harassment and violence perpetrated by security personnel?
 - Are appropriate measures documented and applied in cases of misconduct and/or policy violations?
- p) Are Standard Operating Procedures (SOPs) in place to guide security personnel in assisting GBV survivors, investigating complaints, and documenting incidents of GBV (*e.g. private meeting rooms; standard investigation and evidence collection procedures; etc.*)?
 - Do these procedures limit the risk of re-victimizing the survivor?
 - Is the referral pathway for further assistance clearly mapped out and publicly available?
- q) Are there confidential environments for reporting incidents of GBV to police (*e.g. specialized police stations; desks or tasks forces for females and other at-risk groups; specialized units to investigate GBV crimes; etc.*)?
- r) Are medico-legal forms—and other official forms used for recording incidents of GBV—gender-inclusive (*i.e. is it possible for the reports of women, men, transgender and intersex survivors to be accurately documented*)?

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

- s) Do holding/incarceration facilities have policies in place to prevent GBV and other forms of violence against women, girls, men and boys who are being held in detention?
- Are children and adult detainees held separately?
 - Are these policies inclusive of the needs of LGBTI persons?
- Capacity of Justice Sector/Actors**
- t) What is the capacity of the national justice system to deal ethically and efficiently with cases of GBV?
- Are all actors within the justice sector (*e.g. judges; lawyers; prosecutors; court administration staff; traditional leaders;*) adequately trained on issues related to gender, GBV, and women's/human rights?
 - Do judicial systems address and uphold the rights of survivors and mitigate their risk of re-victimization?
- u) Are free or low-cost legal aid services available to GBV survivors? How accessible are they (*e.g. distance to travel for services; accessibility features for persons with disabilities; privacy and confidentiality in location and delivery; etc.*)?
- v) Do judicial processes provide protection to GBV survivors and witnesses (*e.g. infrastructure such as witness and survivor protection programmes; separate or in camera hearings; etc.*)?
- Are there any networks of judges, lawyers, prosecutors, or other legal actors working to ensure that existing laws and legal procedures related to GBV are upheld? How can these networks be supported?
- w) Does the affected population rely on traditional justice or other dispute resolution mechanisms?
- What types of situations do these mechanisms address?
 - How do these mechanisms interact with the national judicial system? Do they systematically refer serious cases, including GBV cases, to the national justice system?
 - How do these mechanisms treat survivors of GBV?
 - Who are the decision makers, and what training do they have?
 - Does the affected population and/or host community support the use of these mechanisms?
 - Do men and women have different views on the value of these mechanisms?
 - Is there any risk that these mechanisms will contribute to the re-victimization of survivors?
- x) Are there any independent national and local human rights commissions?
- Does their work include monitoring and reporting on GBV cases?
 - Are civil society actors with human rights and GBV expertise permitted to visit places of detention and interact confidentially with detainees?

Areas related to Protection POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of humanitarian protection programmes?
- Are women, girls and other at-risk groups meaningfully engaged in the development of protection programming policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Are these policies, standards and guidelines communicated to women, girls, boys and men (separately when necessary)?
 - Is protection staff properly trained and equipped with the necessary skills to implement these policies?
- b) Do national and local laws support the prevention of and response to GBV, as well as the empowerment of women (*e.g. the right to legal assistance and free legal aid for survivors; prosecution for perpetrators; punishments that are commensurate with the crime; etc.*)?
- Do they conform to international law and human rights standards² (*e.g. CEDAW, CRC, etc.*)?
- c) What types of GBV are mentioned in laws, and how are they defined (*e.g. intimate partner violence and other forms of domestic violence; rape; sexual harassment; female genital mutilation/cutting; child and/or forced marriage; honour crimes; sexual abuse of children; forced and/or coerced prostitution etc.*)?
- Do definitions of rape recognize both female and male rape survivors?
 - Do definitions of rape only recognize rape using the penis, or do they recognize the use of objects?
 - Do laws restrict women's and girls' rights to marriage, divorce, and child custody?
 - Are there justifications for any GBV crimes in national and traditional laws (*e.g. crimes committed in the name of "honour"*)?
- d) Are there national policies, action plans or strategies in place that support coordinated, prompt and supportive services for GBV survivors (*e.g. national action plans on gender, youth, or the strengthening of laws*)?
- Are protection-related programmes and activities set up in alignment with these policies and plans?

(continued)

² For more information about the obligation to address GBV in international law and human rights standards, see Annex 6.



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)**Areas related to Protection COMMUNICATIONS and INFORMATION SHARING**

- a) Has training been provided to protection actors on:
 - Issues of gender, GBV, and women's/human rights?
 - How to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- b) Do protection-related community outreach activities raise awareness within the community about general safety and GBV risk reduction?
 - Does this awareness-raising include information on survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Do awareness-raising campaigns provide information to persons about their legal rights to due process and available legal services?
 - Is this information provided in age-, gender- and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these outreach activities as agents of change?
- c) Are protection-related discussion forums age-, gender-, and culturally-sensitive? Are they accessible to women, adolescent girls and other at-risk groups (e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.) so that participants feel safe to raise GBV issues?

**KEY GBV CONSIDERATIONS FOR:
RESOURCE MOBILIZATION**

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for protection programming. Whether requesting pre-emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.

**ESSENTIAL TO KNOW****Beyond Accessing Funds**

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**.

Guidance. Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.



A. HUMANITARIAN NEEDS OVERVIEW

- ▶ Does the proposal articulate specific GBV-related safety risks, protection needs and rights of the affected population as they relate to the wider protection environment (*e.g. breakdown of rule of law; capacity of security sector to respond to GBV issues; lost documentation and its impact on receiving humanitarian assistance; attitudes of humanitarian staff that may contribute to discrimination against women, girls and other at-risk groups etc.*)?
- ▶ Are issues of physical safety understood and disaggregated by sex, age, disability, and other relevant vulnerability factors? Are the specific risk factors of women, girls, and other at-risk groups recognized and described?
- ▶ Are risks for specific forms of GBV (*such as sexual assault, sexual exploitation, forced and/or coerced prostitution, intimate partner violence and other forms of domestic violence, etc.*) described and analysed, rather than a broader reference to "GBV"?

B. PROJECT RATIONALE/ JUSTIFICATION

- ▶ When drafting a proposal for emergency response:
 - Is there an explanation of how the project will address immediate GBV-related protection needs (*e.g. ensuring protection monitoring addresses links between general protection issues and GBV risk; facilitating timely recovery and replacement of personal documentation; supporting safe and secure environments in camps and other settings; etc.*)?
 - Are additional costs required to ensure the safety and effective working environments for female staff in the protection sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
 - Does a GBV specialist(s) need to be hired to ensure safe and ethical programming approaches?
 - Is there a strategy for preparing and providing trainings for protection actors (*including international protection actors sent to the field as part of a surge response*), security and legal/justice personnel, government, and relevant community members (*such as traditional leaders and women's groups*) on the safe design and implementation of protection programming that mitigates the risk of GBV?
 - Are additional costs required to ensure any GBV-related community outreach materials are available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- ▶ When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how the project will contribute to sustainable strategies that promote the safety and well-being of those at risk of GBV, and to long-term efforts to reduce specific types of GBV (*e.g. build the capacity of security and legal/justice actors and promote the rule of law; develop awareness-raising campaigns to provide information for GBV survivors of their legal rights to due process and available protective services; etc.*)?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

C. PROJECT DESCRIPTION

- ▶ Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for addressing GBV?
- ▶ Do the proposed activities illustrate linkages with other humanitarian actors/ sectors in order to maximize resources and work in strategic ways?
- ▶ Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as protection staff and in community-based protection monitoring activities?
- ▶ Are there activities that help in changing/improving the environment by addressing the underlying causes and contributing factors of GBV (*e.g. advocating for the development of a legal framework to address the lack of access to justice and impunity for violence*)?





KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some common GBV-related considerations when implementing targeted protection activities in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

Integrating GBV Prevention and Response into: Protection PROGRAMMING

- 1. Involve women and other at-risk groups in all aspects of protection programming (with due caution in situations where this poses a potential security risk or increases the risk of GBV).**
 - Strive for 50% representation of females within protection programme staff. Provide women with formal and on-the-job training as well as targeted support to assume leadership positions.
 - Ensure women (and where appropriate, adolescent girls) are actively involved in community-based protection committees, associations, and meetings. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.
 - Employ persons from at-risk groups in protection staff, leadership and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.
 - Engage women and other at-risk groups as protection-monitoring staff (including both paid and voluntary work), and ensure they have opportunities to provide protection-related input.



PROMISING PRACTICE

Many community-based protection programmes find that it is difficult to involve persons with disabilities in a meaningful way. About 10% of the people in Nepal's refugee camps have a disability (on par with global rates). Many have impaired hearing or speech. As elsewhere, persons with disabilities—especially women and girls—are at particular risk of sexual and gender based violence (SGBV). Victims of SGBV in Nepal's camps were frequently unprotected because they could not communicate with the authorities or service providers.

With its partners, UNHCR developed an alternative communications toolkit using images and taught people how to use it. Over time and in consultation with persons with disabilities, it trained a pool of teachers and interpreters in sign language and taught basic sign language to service providers and family members. In addition, it ensured that persons with disabilities were represented in camp structures.

(Adapted from **UNHCR. n.d.** "Protection Policy Paper: Understanding Community-based Protection", <http://www.refworld.org/pdfid/5209f0b64.pdf>. For additional information about protection risks and interventions for persons with disabilities, see **Women's Refugee Commission. March 2014.** "Disability Inclusion: Translating Policy into Practice in Humanitarian Action", <http://womensrefugeecommission.org/programs/disabilities/disability-inclusion>)





ESSENTIAL TO KNOW

LGBTI Persons

In most areas of the world, lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals are at increased risk of violence, discrimination and oppression based on their sexual orientation and/or gender identity. When assessing safety factors in emergencies, protection actors should work with LGBTI experts to determine whether there may be particular challenges facing LGBTI individuals in accessing protection from police or security personnel due to prejudice or criminalization laws. LGBTI persons should be consulted, when possible and in safe and appropriate ways, on factors that increase or decrease their sense of safety.

(Information provided by Duncan Breen, Human Rights First, Personal Communication, May 20, 2013)

2. Integrate GBV prevention and mitigation into protection monitoring activities and support the development of community-based protection strategies.

- ▶ When conducting protection monitoring, consider the broad protection factors that may exacerbate the risks of GBV in the particular setting (e.g. displacement; closeness to armed forces and/or international borders; unsafe routes for firewood/water collection, to work, or to school; safety issues for those who remain in the home; distribution times and locations of food and non-food items; overcrowded camps/dwellings/shelters/apartments; family separation; placement of water and sanitation facilities; access to documentation; etc.).
- ▶ Wherever possible, include a GBV specialist or at least one protection staff member who has GBV expertise. This is especially important when undertaking any protection monitoring that specifically examines GBV issues or incidents. Ensure protection monitoring processes adhere to guiding principles related to GBV.
- ▶ Support community-based strategies for monitoring high-risk areas. Combine a targeted, proactive presence around specific high-risk areas with a more widespread and mobile presence that gives protected persons and potential violators a sense that someone is “always around.” Tactics might include:
 - Community watch programmes and/or security groups.
 - Security patrols.
 - Regular and frequent field visits by protection monitors to assess GBV-related concerns in communities (camps, villages, etc.), where security allows.

3. Implement strategies that safeguard those at risk of GBV during documentation, profiling and registration processes.

- ▶ Incorporate GBV as a risk factor for vulnerability in IDP profiling and refugee registration processes.
- ▶ Carry out IDP documentation and profiling and refugee registration processes in a manner that ensures the participation of women, girls and other at-risk groups.
- ▶ Develop strategies that encourage affected populations to report their risk and/or history of GBV to staff involved in documentation, profiling and registration processes.
 - Consider separate, confidential and non-stigmatizing spaces during interviews.
 - Ensure staff are trained in interviewing techniques with different at-risk groups.
 - Ensure that any interview questions related to GBV are age-, gender-, and culturally appropriate.



- Wherever possible, include a GBV specialist on staff.
- Make female registration staff available to interview females.
- Interview adult family members separately from each other.
- ▶ Prioritize programmes that assist women and girls in receiving, recovering, or replacing personal documents (free or at low cost) so they can prove their identity, make property claims, and receive humanitarian assistance (e.g. food assistance; housing and reconstruction assistance; education, health and other social services; etc.).
- ▶ Consider the need for specialized safety measures (e.g. relocation, safe shelter) for persons at high risk of GBV. Take into careful consideration the potential negative consequences of these measures (e.g. breaking family or community ties and support mechanisms; stigma; etc.). Work with community members and leaders—especially those representing at-risk groups—to identify community-based safe housing alternatives for survivors and/or those at risk of GBV.



PROMISING PRACTICE

In Malaysia, UNHCR used an innovative approach to registration that improved the protection of all asylum seekers and refugees—particularly women and girls. Mobile registration teams were deployed to detention centres in jungle areas and in the highlands in the northeast of the country to register persons of concern. In this way, individuals with urgent protection needs who were not able to reach UNHCR's office were identified and assisted. Survivors of GBV, female heads-of-household, and unaccompanied women and children were identified early and targeted to determine refugee status and assistance. As part of this initiative, all women received individual documentation and were re-interviewed when this document was reviewed. Because of this, protection concerns that arose could be urgently addressed.

(Adapted from: **UNHCR. 2008. Handbook for the Protection of Women and Girls**, p. 117. <http://www.unhcr.org/protect/PROTECTION/47cfae612.html>)

4. Enhance the capacity of security institutions/personnel to prevent and respond to GBV.

- ▶ Advocate for the inclusion of adequate numbers of properly trained police and security personnel who are accountable for their actions. Where appropriate, advocate for and support the employment of women in the security sector (as police officers, guards, peacekeepers, etc.). Strive for 50% representation of female officers to make security services more gender representative, gender-sensitive, and responsive to GBV.
- ▶ Advocate for comprehensive and ongoing training of all actors who are part of the security sector (e.g. police and armed forces, peacekeepers, private security personnel, administration staff, community leaders, religious entities, etc.). Ensure this training includes issues of gender, GBV, and women's/human rights. Support the implementation of peacekeeping mission mandates to address sexual violence and other forms of GBV.
- ▶ Advocate for the implementation of mandatory codes of conduct (CoC) for security personnel who engage with affected populations. Ensure the CoC includes policies on discrimination, sexual harassment and violence perpetrated by security personnel, as well as procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.



- ▶ Support the creation of secure environments in which GBV incidents can be reported to security personnel. Advocate that police and other security officials/institutions:
 - Respect the confidentiality, rights, choices, and dignity of the survivor.
 - Develop, sign onto, and adhere to protocols and procedures for assisting and supporting GBV survivors (e.g. designating private meeting rooms; including same-sex police officers to work with survivors; providing locally relevant and standardized protocols for GBV survivors to access care and support services; etc.). Ensure these protocols/procedures are survivor-centered and rights-based.
 - Establish standard procedures for investigating and collecting evidence to support prosecution of cases (if the GBV survivor chooses to pursue legal recourse). Ensure these procedures are age-, gender-, and culturally-sensitive.
 - Ensure that detention centers (including for children) meet basic international standards and minimize the risk of violence against women, girls, men and boys who are being held.



PROMISING PRACTICE

A programme developed by the Unitarian Universalist Service Committee and implemented by UNIFEM in 11 camps in Darfur from 2008–2011 sought to improve women's safety by increasing their voice and agency, as well as by improving community leaders' and police capacity to address GBV. As a result of community-sensitization conducted during the programme, camp leaders formed gender committees and firewood committees so that women had access to decision-makers. Through the firewood committees, women were able to give regular feedback on patrols, and UN Police began to understand some of the women's concerns. Relations with the community changed to such an extent that the head of the Department of Peacekeeping Operations (DPKO) in Darfur agreed to train all police in gender sensitivity. The Sudanese police also requested training and agreed to deploy more female police in the camps, and men in the camps asked for training on women's rights and protection. Several camps also formed community policing groups, approximately half of whose members were women. The community police became a very effective bridge between the community and the UN Police, improving women's reporting of incidents significantly and enhancing their feelings of security.

(Adapted from **M. Thompson, M., Okumu, M. and Eclai, A.** 2014. "Building a Web of Protection in Darfur", *Humanitarian Exchange*, Number 60, pp. 24-27. <http://www.odihpn.org/humanitarian-exchange-magazine/issue-60>)

- ▶ Support the creation of specialized police stations, desks (such as women's desks), units, and/or task forces to address various GBV crimes. Ensure these specialized stations and units are non-stigmatizing and well-resourced.
- ▶ Work in conjunction with women's groups, cultural and religious leaders, and other authorities to counter victim-blaming and stigmatization and to create environments where survivors are supported to seek assistance.
- ▶ Where appropriate, support the establishment of independent self-help groups for survivors. These groups can provide mutual support and act as a bridge to services (including legal support).





PROMISING PRACTICE

In September 2011, after working with increasing numbers of individual male survivors in Uganda, Refugee Law Project encouraged five individuals who had received counseling up to that point to establish a support group. Within two years the group had grown to over 100 members in Kampala. When a similar process was begun in one of the long-established refugee settlements in western Uganda (Nakivale) in January 2013, the numbers rose to over 200 members within twelve months. These groups provide much needed practical and psychological peer support, including assisting one another with tasks such as house construction, water collection, and hospital visits. Group members have become outspoken advocates for their own issues with camp authorities and—in urban areas—with local authorities. In some instances they have also engaged with national and international media to draw attention to their specific needs.

(Personal Communication, Chris Dolan, Refugee Law Project, June 2014)

- 5. Promote access to justice for GBV survivors by strengthening institutional capacities of state and traditional justice actors (applying the principle of 'Do no harm' and exercising extreme caution in situations where promoting access to justice poses a potential security risk, such as in legal/judicial contexts that are not supportive to survivors).**
 - ▶ Support judicial processes that provide protection to GBV survivors and witnesses during court proceedings (e.g. fair trials conducted in a timely manner; infrastructure such as witness and survivor protection programmes; separate or *in camera* hearings for GBV survivors; links to mental health, psychosocial and medical support for survivors; etc.).
 - ▶ Support legal aid clinics in providing free and accessible services to GBV survivors.
 - ▶ Advocate for specialized prosecution units for GBV crimes, as well as ongoing training of all actors who are part of the justice system (e.g. judges, lawyers, prosecutors, court administration staff, traditional leaders, customary judges, police, prison officers, etc.). Ensure this training includes issues of gender, GBV, and women's/human rights.
 - ▶ Advocate for a survivor-centered approach to justice that prioritizes the rights, needs, dignity and choices of the survivor—including the survivor's choice as to whether or not to access legal and judicial services.
 - ▶ Where traditional legal systems are used for resolving GBV cases, identify and build upon the strengths of these systems to align customary laws and processes with international human rights standards. Empower community paralegals, human rights organizations, women's groups, and other community-based groups of at-risk populations to engage with customary leaders.
 - ▶ Support women's groups and national human rights commissions in monitoring whether/how adjudicated GBV cases are effectively resolved and whether/how survivor-centered and rights-based approaches are applied throughout court proceedings.
 - ▶ In settings affected by armed conflict, support reparations processes for survivors of conflict-related sexual violence.





PROMISING PRACTICE

A project implemented by the Malawi Human Rights Resource Centre (MHRRC) from 2011-2012 trained police officers to safely and effectively provide emergency contraception (EC) to survivors of sexual assault as a means of broadening access to comprehensive care. This effort was meant to capitalize on emerging findings in the region that the majority of survivors of sexual assault report to the police first. It also aimed to ensure immediate access to this critical element of post-rape care. Police officers that participated in this project were able to effectively provide EC to eligible survivors, despite systemic barriers confronting police. The collaborative effort between police and health providers under the project initiated a process for strengthening referrals between police stations and hospitals. Although a proportion of survivors who accessed EC at police stations ended up using health care services as well, further efforts must be made to reduce barriers to seeking care after referral, and to increase the proportion of survivors doing so. Notably, the vast majority of survivors reporting to police stations during this project were children.

The project findings give rise to a number of recommendations, including the following:

1. SGBV needs to be better mainstreamed within police training and services.
2. Child-friendly services must be integrated into all levels of care for SGBV survivors.
3. Efforts should be made to enhance the referral process between police and health facilities.
4. A multi-sectoral training approach, involving the joint-training of police and health providers on critical documentation, is recommended to support this intervention.

(Adapted from the **Malawi Human Rights Resource Centre. 2012.** "Testing the feasibility of police provision of emergency contraception in Malawi." <http://www.svri.org/MHRRCEVALUATIONREPORT.pdf>)

Integrating GBV Prevention and Response into: Protection-related POLICIES

- 1. Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of targeted protection programmes.**
 - ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in protection programmes and activities. These can include, among others:
 - Policies regarding childcare for protection staff.
 - Standards for equal employment of females.
 - Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.
 - ▶ Circulate these widely among protection personnel and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).



2. Support the reform of national and local laws and policies (including customary law) to promote access to justice and the rule of law, and allocate funding for sustainability.

- ▶ Review laws, regulations, policies, action plans, procedures and practices in both the formal and informal justice systems, and advocate with relevant stakeholders to strengthen prevention of and response to GBV. This can include:
 - Right to legal assistance and free legal aid for survivors.
 - Prosecution for perpetrators of GBV violations occurring during the humanitarian emergency.
 - Punishments that are commensurate with the crime.
 - Budgeting to support judicial systems in facilitating rapid and fair trials.
- ▶ Advocate for the adoption and implementation of key human rights instruments (including the Convention on the Elimination of Discrimination Against Women and the Convention on the Rights of the Child) in areas where these instruments have not been ratified by the State. Where their adoption has been accompanied by reservations, advocate for the lifting of these reservations.
- ▶ Advocate for rule-of-law and security sector reform that includes issues pertinent to fulfilling the rights of women, girls and other at-risk groups. For example, support the drafting or amending of laws related to: sexual crimes; intimate partner violence and other forms of domestic violence; women's human rights; property and inheritance rights; temporary protection orders/restraining orders; and other legal issues related to GBV.
- ▶ Encourage attention to GBV in all return, relocation and reintegration frameworks; developmental action plans; and disarmament, demobilization and reintegration programmes for women, girls, men and boys. Such frameworks and action plans should contain measures to prevent and respond to GBV and provide adequate care and support to survivors, including livelihoods support.
- ▶ Support relevant line ministries, as well as informal justice system actors, in developing implementation strategies for GBV-related laws, policies and plans. Undertake awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.



**Integrating GBV Prevention and Response into:
Protection COMMUNICATIONS and INFORMATION SHARING**

- 1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure protection staff has the basic skills to provide them with information on where they can obtain support.**
- ▶ Ensure all protection personnel who engage with affected populations have written information about where to refer survivors for care and support. Regularly update information about survivor services.



- ▶ Train all protection personnel who engage with affected populations (e.g. protection monitors; protection staff facilitating documentation, profiling and registration processes; etc.) in gender, GBV, women's/human rights and psychological first aid (e.g. how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).

2. Ensure that protection programmes sharing information about reports of GBV within the protection sector or with partners in the larger humanitarian community abide by safety and ethical standards.

- ▶ Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community. Consider using the international Gender-based Violence Information Management System (GBVIMS), and explore linkages between the GBVIMS and existing protection-related Information Management Systems.³

3. Incorporate GBV messages into protection-related community outreach and awareness-raising activities.

- ▶ Work with GBV specialists to integrate community awareness-raising on GBV into protection outreach initiatives (e.g. community dialogues; workshops; meetings with community leaders; information about documentation, profiling or registration processes; etc.).
 - Ensure this awareness-raising includes information on survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
 - With the help of other stakeholders (e.g. legal/justice institutions, government, NGOs, and INGOs), raise awareness about survivors' legal rights to due process and the human rights issues associated with perpetrating various types of GBV—particularly those that might not be perceived as criminal because they are customary practices (e.g. child and/or forced marriage). This helps to ensure that women and girls do not have to rely on males for access to this information.
 - Use multiple formats and languages to ensure accessibility (braille; sign language; simplified messaging such as pictograms and pictures; etc.).
 - Engage women, girls, men and boys (separately when necessary) in the development of messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.

³ The GBVIMS is not meant to replace national information systems collecting GBV information. Rather, it is an effort to bring coherence and standardization to GBV data-collection in humanitarian settings, where multiple actors often collect information using different approaches and tools. For more information, see <http://www.gbvims.com>.

! ESSENTIAL TO KNOW

Referral Pathways

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.

! ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.



- ▶ Engage males, particularly leaders in the community, as agents of change in protection outreach activities related to the prevention of GBV.
- ▶ Consider the barriers faced by women, adolescent girls and other at-risk groups to their safe participation in community discussion forums (e.g. household duties, transportation, risk of backlash, childcare, etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.) so that participants feel safe to raise GBV issues.
- ▶ Provide community members with information about existing codes of conduct for protection personnel, as well as where to report sexual exploitation and abuse committed by protection personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.



KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

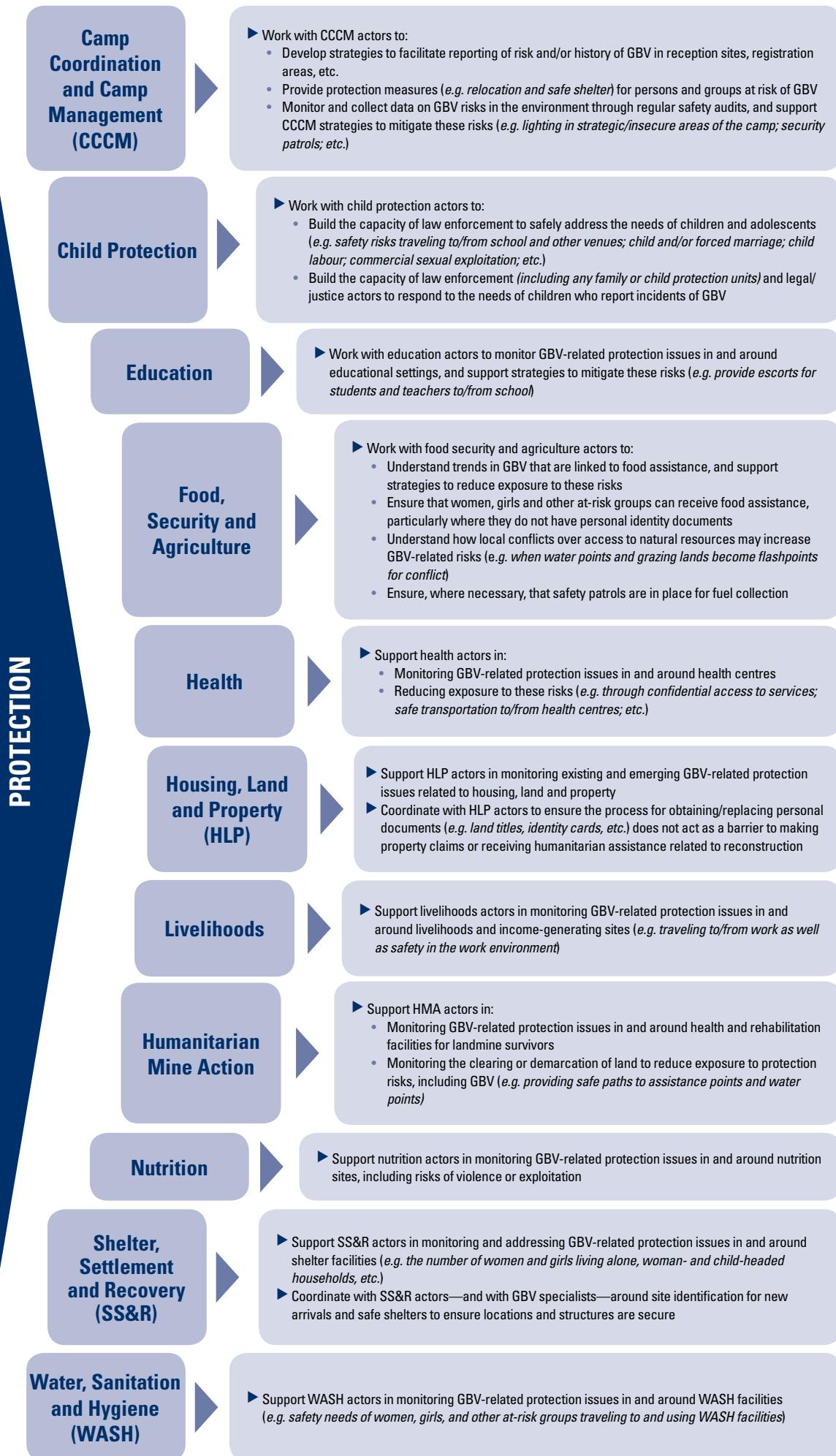
As a first step in coordination, protection staff should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist protection actors to:

- ▶ Design and conduct protection assessments that examine the risks of GBV related to protection programming, and strategize with protection actors about ways such risks can be mitigated.
- ▶ Provide comprehensive trainings for protection staff (including security sector actors and legal/justice actors) on issues of gender, GBV, and women's/human rights.
- ▶ Develop standard operating procedures (SOPs) for security sector actors.
- ▶ Identify where survivors who may report instances of GBV to protection staff can receive safe, confidential and appropriate care, and provide protection staff with the basic skills and information to respond supportively to survivors.
- ▶ Provide training and awareness-raising for the affected community on issues of gender, GBV, and women's/human rights as they relate to protection rights and needs.
- ▶ Review relevant statutory and customary laws and policies to strengthen GBV-related legal protections.

In addition, protection staff should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, protection actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.



PROTECTION



PROTECTION

COORDINATION





KEY GBV CONSIDERATIONS FOR: MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). Refer to **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction for more information** on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in protection assessments ⁴	# of protection assessment that include GBV-related questions* from the GBV Guidelines x 100 $\frac{\# \text{ of protection assessment}}{\# \text{ of protection assessment}}$ <small>* See page 191 for GBV areas of inquiry that can be adapted to questions in assessments</small>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	# of assessment respondents who are female x 100 $\frac{\# \text{ of assessment respondents and}}{\# \text{ of assessment team members who are female x 100}}$ $\frac{\# \text{ of assessment team members}}{\# \text{ of assessment team members}}$	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

⁴ Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Employment of male and female protection personnel during the assessment	# of humanitarian protection personnel who are female during the assessment # of humanitarian protection personnel who are male during the assessment	Organizational records	1:1		✓	✓
Consultations with the affected population on GBV risk factors in the site⁵ <i>Disaggregate consultations by sex and age</i>	<i>Quantitative:</i> # of sites conducting consultations with the affected population to discuss GBV risk factors in and around the site x 100 # of sites <i>Qualitative:</i> What types of GBV-related risk factors do affected persons experience in and around the site?	Organizational records, focus group discussion (FGD), key informant interview (KII)	100%		✓	✓
Existence of standard operating procedures (SOPs) for security sector to assist GBV survivors	# of sites with SOPs for security personnel to assist GBV survivors x 100 # of health sites	KII	100%		✓	✓
Staff knowledge of referral pathway for GBV survivors	# of protection staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors x 100 # of surveyed protection staff	Survey	100%		✓	✓
RESOURCE MOBILIZATION						
Inclusion of GBV risk reduction in protection funding proposals or strategies	# of protection funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines x 100 # of protection funding proposals or strategies	Proposal review (at agency or sector level)	100%		✓	✓
Training of protection staff on the GBV Guidelines	# of protection staff who participated in a training on the GBV Guidelines x 100 # of protection staff	Training attendance, meeting minutes, survey (at agency or sector level)	100%		✓	✓
IMPLEMENTATION						
► Programming						
Female staff in protection programmes	<i>Quantitative:</i> # of females staff in protection programmes <i>Qualitative:</i> What are the advantages and barriers to having female staff in these programmes?	Organizational records, FGD, KII	Determine in the field		✓	

(continued)

⁵ United Nations Office for the Coordination of Humanitarian Affairs. Humanitarian Indicator Registry. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
► Programming									
Participation of at least one GBV specialist on protection monitoring team	# of protection monitoring teams with at least one GBV specialist x 100 _____ # of protection monitoring team	KII, organizational records	100%	✓	✓				
Presence of community-based strategies to monitor GBV-related security in affected communities	# of affected communities with community-based strategies* to monitor security x 100 _____ # of affected communities <small>*Strategies include community watch programmes, security patrols and protection monitors</small>	KII, FGD	Determine in the field	✓		✓			
Inclusion of GBV as a risk factor for vulnerability in profiling, documentation or registration processes	# of registration sites that include GBV as a risk factor for vulnerability x 100 _____ # of registration sites	KII	100%	✓	✓				
Trained security staff on how to respond to incidents of GBV according to established protocols	# of security staff who participated in a training on how to respond to incidents of GBV according to established protocols* x 100 _____ # of security staff <small>*Protocols should include designating private rooms, same-sex police officers and referrals for care</small>	Training attendance, KII	Determine in the field	✓	✓				
Existence of female security personnel in a specified location	# of female security personnel present in a specified location x 100 _____ # of displaced persons in a specified location	KII, safety audit	Determine in the field	✓	✓				
Availability of free legal assistance for GBV survivors	# of legal aid organizations providing free legal assistance services for GBV survivors in a specified location x 100 _____ # of legal aid organizations	KII	Determine in the field	✓	✓				
► Policies									
Inclusion of GBV prevention and mitigation strategies in protection policies, guidelines or standards	# of protection policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines x 100 _____ # of protection policies, guidelines or standards	Desk review (at agency, sector, national or global level)	Determine in the field	✓		✓			
Existence of laws (national or local) associated with judicial processes for GBV prevention and response	# of reviewed laws* (national or local) associated with judicial processes for GBV prevention and response x 100 _____ # of reviewed laws <small>*Laws include right to free legal aid, prosecution of perpetrators, criminal punishment and rapid, fair trials</small>	Desk review	Determine in the field	✓		✓			

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION (continued)									
► Communications and Information Sharing									
Staff knowledge of standards for confidential sharing of GBV reports	# of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100 _____ # of surveyed staff	Survey (at agency or programme level)	100%	✓					
Inclusion of GBV referral information in protection community outreach activities	# of protection community outreach activities programmes that include information on where to report risk and access care for GBV survivors x 100 _____ # of protection community outreach activities	Desk review, KII, survey (at agency or sector level)	Determine in the field	✓	✓				
COORDINATION									
Coordination of GBV risk reduction activities with other sectors	# of non-protection sectors consulted with to address GBV risk reduction activities* x 100 _____ # of existing non-protection sectors in a given humanitarian response	KII, meeting minutes (at agency or sector level)	Determine in the field	✓	✓				
* See page X for list of sectors and GBV risk reduction activities									



RESOURCES

Key Resources

- **Inter-Agency Standing Committee (IASC) and Global Protection Cluster Working Group. 2010.** *Handbook for the Protection of Internally Displaced Persons*, <http://www.unhcr.org/4c2355229.pdf>
- **Global Protection Cluster.** *Coordination Toolbox and Natural Disaster Reference Sheets*. <http://www.globalprotectioncluster.org/en/tools-and-guidance/protection-cluster-coordination-toolbox.html>
- **Global Protection Cluster. 2014.** *Protection Mainstreaming Package*, <http://www.globalprotectioncluster.org/en/areas-of-responsibility/protection-mainstreaming.html>
- **United Nations High Commissioner for Refugees (UNHCR).** **2008.** *Handbook for the Protection of Women and Girls*, <http://www.unhcr.org/protect/PROTECTION/47cfae612.html>
- **UNHCR. 2011.** *Action against Sexual and Gender-Based Violence - An Updated Strategy*, <http://www.refworld.org/pdfid/4e01ffeb2.pdf>
- **UNWomen.** *Virtual Knowledge Centre to End Violence against Women and Girls*. Includes, among others, Programming Modules on Security, Justice and Legislation. <http://www.endvawnow.org>
- **Women's Refugee Commission. 2006.** *Displaced Women and Girls At Risk—Risk Factors, Protection Solutions and Resource Tools*. <http://www.womensrefugeecommission.org/programs/54-protection/protection/866-refugee-protection-resources>

Additional Resources

- **UNHCR. 2012.** *Need to Know Guidance Series:*
 - *Working with Men and Boy Survivors of Sexual and Gender-Based Violence in Forced Displacement*. <http://www.refworld.org/pdfid/5006aa262.pdf>
 - *Working with Lesbian, Gay, Bisexual, Transgender & Intersex Persons in Forced Displacement*. <http://www.refworld.org/docid/4e6073972.html>
 - *Working with Persons with Disabilities in Forced Displacement*. <http://www.refworld.org/docid/4e6072b22.html>
 - *Working with National or Ethnic, Religious and Linguistic Minorities and Indigenous Peoples in Forced Displacement*. <http://www.refworld.org/docid/4ee72a2a2.html>
- **Valasek, K. 2008.** "Security Sector Reform and Gender." In Bastick, M & Valasek, K. (eds.) *Gender and Security Sector Reform Toolkit*. Geneva: DCAF, OSCE/ODIHR, and UN-INSTRAW. <http://www.osce.org/odihr/30662>
- **Geneva Centre for the Democratic Control of Armed Forces (DCAF). 2009.** "Gender and Security Sector Reform Training Resource Package." <http://www.dcaf.ch/Publications/Training-Resources-on-Security-Sector-Reform-and-Gender>
- **Geneva Centre for the Democratic Control of Armed Forces (DCAF). 2014.** "Preventing and Responding to Sexual and Domestic Violence against Men: A Guidance Note for Security Sector Institutions." <http://www.dcaf.ch/Publications/Preventing-and-Responding-to-Sexual-and-Domestic-Violence-against-Men-A-Guidance-Note-for-Security-Sector-Institutions>
- **United Nations Division for the Advancement of Women in the Department of Economic and Social Affairs (DAW/DESA). 2010.** *Handbook for Legislation on Violence Against Women. New York*. <http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>
- **United Nations Secretary-General, 2014.** *Guidance Note on Reparations for Conflict-related Sexual Violence*. <http://www.ohchr.org/Documents/Press/GuidanceNoteReparationsJune-2014.pdf>
- **American Refugee Committee International. 2005.** "Gender-Based Violence Legal Aid: A Participatory Tool Kit." This series was designed specifically to help communities and humanitarian workers to assess the situation in their particular setting and to determine the needs and next steps to implementing comprehensive and multi-sectoral programmes to address GBV. A special emphasis has been given to the provision of legal aid, as that is a sector often neglected. http://www.arcrelief.org/site/PageServer?pagename=programs_GBV_bookspage
- **International Committee for the Red Cross (ICRC). 2013.** *Professional Standards for Protection Work*, <http://www.icrc.org/eng/assets/files/other/icrc-002-0999.pdf>



SHELTER, SETTLEMENT & RECOVERY



THIS SECTION APPLIES TO:

- Shelter, settlement and recovery (SS&R) coordination mechanisms
- Actors (staff and leadership) involved in humanitarian SS&R responses and distribution of non-food items (NFIs): NGOs, community-based organizations (including National Red Cross/Red Crescent Society), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, older persons, etc.), related to SS&R
- Other SS&R stakeholders, including national and local governments, community leaders, and civil society groups.

Why Addressing Gender-based Violence is a Critical Concern of the Shelter, Settlement and Recovery Sector

The work of the Shelter, Settlement and Recovery (SS&R) sector is critical to the survival of populations displaced by humanitarian emergencies. Whether the displacement occurs within or across national borders, a variety of shelter and settlement options may be implemented depending on the context. Failure to consider GBV-related risks in SS&R can result in heightened GBV exposure for inhabitants. For example:

- ▶ Overcrowding in urban areas or camp situations can exacerbate family tensions, which in turn can contribute to intimate partner violence and other forms of domestic violence. Overcrowding can also increase the risk of sexual assault by non-family members, particularly in multi-family tents, multi-household dwellings, or large communal spaces. Some families may arrange child marriages in order to alleviate congestion or attempt to protect their daughters from assault in communal dwellings. Even when camps are planned to avoid overcrowding, problems may arise as populations grow and additional land is not available.
- ▶ Shelters that are poorly designed (e.g. with insufficient doors and partitions in sleeping areas; inadequate locks; lack of privacy for dressing and bathing; not weatherized to



ESSENTIAL TO KNOW

Defining “shelter”

The term shelter is used throughout the text to refer to both the basic definition of shelter — a “habitable covered space providing a secure and healthy environment with privacy and dignity for those residing in the dwelling”— and the process through which this habitable space evolves from emergency shelter to durable solutions, which may take years.

(UN, DFID and Shelter Centre. 2010. “Shelter after disaster: strategies for transitional settlement and reconstruction”, p. 321, <http://sheltercentre.org/node/12873>)



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery throughout

ASSESSMENT, ANALYSIS AND PLANNING

Promote the active participation of women, girls and other at-risk groups in all SS&R assessment processes

Assess the level of participation and leadership of women, adolescent girls and other at-risk groups in all aspects of SS&R programming (e.g. ratio of male to female staff)

Assess shelter design and safety to identify associated risks of GBV (e.g. overcrowding; location of shelter; partitions for privacy; locks and lighting; cost of maintenance)

Assess whether shelters maintain family-community links while still maintaining privacy (e.g. assess if females are forced to share shelter with males who are not family members)

Analyse GBV risks associated with the distribution of SS&R assistance and non-food items (e.g. sexual exploitation or forced and/or coerced prostitution in camps)

Assess awareness of SS&R staff on basic issues related to gender, GBV and women's/human rights (including knowledge of where survivors can report risks)

Review existing/proposed community outreach material related to SS&R to ensure it includes basic information about GBV risk reduction (including where to report risks)

RESOURCE MOBILIZATION

Identify and pre-position age-, gender-, and culturally-appropriate supplies for SS&R that can mitigate risks of GBV (e.g. sheets for partitions; doors; locks; etc.)

Develop proposals that reflect awareness of GBV risks for the affected population related to SS&R assistance (e.g. heightened risk of trading sex or other violence in cramped quarters or quarters that lack privacy; etc.)

Prepare and provide trainings for government, SS&R staff and community SS&R groups on the safe design and implementation of SS&R programmes that reduce GBV risks

IMPLEMENTATION

► Programming

Involve women and other at-risk groups as staff and leaders in the design and implementation of SS&R programming (with due caution where this poses a potential security risk)

Prioritize GBV risk reduction in the allocation of shelter materials and in shelter construction (e.g. implement Sphere standards for space and density; provide sufficient personal space; etc.)

Ensure equal and impartial distribution of SS&R-related non-food items (NFIs) (e.g. establish clear, consistent and transparent distribution systems; ensure appropriate storage)

Distribute cooking sets and design cooking facilities that reduce consumption of cooking fuel, which in turn reduces the need to seek fuel in unsafe areas

► Policies

Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of SS&R programmes (e.g. standards for equal employment opportunities; policies about GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and assault; etc.)

Advocate for the integration of GBV risk-reduction strategies into national and local policies and plans related to SS&R, and allocate funding for sustainability (e.g. advocacy for the inclusion of GBV risk-reduction measures in the National Plan of Action; participation in the SS&R sector; consider the construction of women-, adolescent- and child-friendly spaces and safe shelter from the onset of an emergency)

► Communications and Information Sharing

Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure SS&R staff has the skills to support survivors

Ensure that SS&R programmes sharing information about reports of GBV within the SS&R sector or with partners in the larger humanitarian community are safe and do not pose a security risk to individual survivors, their families or the broader community

Incorporate GBV messages (including where to report risk and how to access care) into SS&R-related community outreach and awareness-raising activities

COORDINATION

Undertake coordination with other sectors to address GBV risks and ensure protection for women, girls and other at-risk groups

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a SS&R focal point to regularly participate in GBV coordination meetings

MONITORING AND EVALUATION

Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduction activities

Evaluate GBV risk-reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making and adaptation

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for shelter actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**.

SUMMARY OF ESSENTIAL ACTIONS

at the Programme Cycle

	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
/female SS&R staff; participation in committees related to SS&R; etc.)	✓	✓	✓	✓
of rent; accessibility features for persons with disabilities; etc.)	✓	✓	✓	✓
are not family members)	✓	✓	✓	✓
n exchange for shelter materials, cash for rent, work vouchers, etc.)	✓	✓	✓	✓
risk and access care; linkages between SS&R programming and GBV risk reduction; etc.)	✓	✓	✓	✓
eport risk and how to access care)	✓	✓	✓	✓
GBV risk reduction				
s; accessibility features for persons with disabilities; etc.)	✓	✓		
r favors in exchange for shelter materials, construction, and/or rent; increased risk of sexual	✓	✓	✓	✓
mitigate the risk of GBV	✓	✓	✓	✓
GBV prevention				
potential security risk or increases the risk of GBV)	✓	✓	✓	
temporary housing for those at risk of GBV; designate women-, adolescent- and child-friendly		✓	✓	✓
-risk groups have the same access to NFIs; etc.)	✓	✓	✓	✓
payment of females; procedures and protocols for sharing protected or confidential information	✓	✓	✓	✓
(e.g. address discriminatory practices hindering women, girls and other at-risk groups from safe		✓	✓	✓
; etc.)				
ne basic skills to provide them with information on where they can obtain support	✓	✓	✓	✓
bide by safety and ethical standards (e.g. shared information does not reveal the identity of or	✓	✓	✓	✓
ation meetings		✓	✓	✓
GBV response				
duction activities throughout the programme cycle	✓	✓	✓	✓
nd ensure accountability		✓	✓	✓

withstand the elements; etc.) may increase the risk of sexual harassment and assault for inhabitants. For example, when shelters become so hot that men are sleeping outdoors, women may fear attack if going outside to use the latrines at night. Transgender and intersex persons are particularly vulnerable to stigma, discrimination and physical threat if they cannot sustain an adequate level of privacy for basic activities such as dressing and bathing.

- ▶ When women, girls and other at-risk groups¹ (particularly women- and child-headed households, unaccompanied children, persons with disabilities, and older persons) are sheltered on the perimeter of camps or in areas with insufficient lighting, their risk of GBV is increased.
- ▶ In both camp and non-camp settings, inadequate or partial distribution of shelter-related non-food items (NFIs, such as cooking and heating fuel and fuel alternatives, building materials for shelter, hygiene and dignity kits, lighting for personal use, etc.) can increase vulnerability for women, girls and other at-risk groups, who might be forced to trade sex or other favours in exchange for these items.
- ▶ Lack of rental assistance (e.g. cash grants, cash-for-rent or cash-for-work) can increase vulnerability to sexual assault and exploitation by landlords. Women, girls and other at-risk groups may also be at risk of assault if they cannot secure rental property or pay their rent and are therefore obliged to seek shelter in open spaces (such as churches or mosques) or in multi-family dwellings.
- ▶ Lack of security patrols and other protection monitoring systems in and around shelter sites can create an environment of impunity for potential perpetrators.

Risks of GBV can be reduced through SS&R programming that continuously monitors for and develops strategies to address emerging GBV-related safety risks related to shelters, settlements and NFIs. This requires meeting internationally agreed-upon standards. It also requires taking into account cultural and social patterns from the onset of the emergency and into the recovery phase to build safer and more resilient communities in the long-term. SS&R actors should engage women, girls and other at-risk groups in the design and delivery of their programming; prioritize GBV risk reduction in allocation of shelter materials and shelter construction; and ensure equal and impartial distribution of SS&R-related NFIs.

These actions taken by the SS&R sector to prevent and mitigate GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. SS&R actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)

WHAT THE SPHERE HANDBOOK SAYS:

Shelter, Settlement and Non-Food Items Standard 1: Strategic Planning

- ▶ Shelter and settlement strategies contribute to the security, safety, health and well-being of both displaced and non-displaced affected populations, and promote recovery and reconstruction where possible.

Guidance Note #7:

Risk, Vulnerability and Hazard Assessments:

- ▶ Actual or potential security threats and the unique risks and vulnerabilities due to age, gender [including GBV], disability, social or economic status, the dependence of affected populations on natural environmental resources, and the relationships between affected populations and any host communities should be included in any such assessments.

(Sphere Project. 2011. *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*, <http://www.spherehandbook.org>)

¹ For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



Addressing Gender-based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are *recommendations* for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring undertaken by SS&R actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with SS&R actors working in partnership with other sectors as well as with GBV specialists.

The information generated from these areas of inquiry should be analyzed to inform planning of SS&R programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.

KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in SS&R: governments; SS&R sector administrators and staff; shelter and NFI committees; camp coordination and camp management (CCCM) actors; security personnel such as police and peacekeepers; GBV, gender and diversity specialists
- Affected populations and communities
- In urban settings, actors linked with SS&R such as municipal authorities, civil society organisations, development actors, health administrators, school boards, private business, etc.
- In IDP/refugee settings, members of receptor/host communities



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to SS&R PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female SS&R staff, including in positions of leadership?
 - Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are women and other at-risk groups actively involved in community activities related to SS&R (*e.g. community SS&R committees, etc.*)? Are they in leadership roles when possible?
- c) Are women and other at-risk groups given opportunities for livelihoods and skills training within the SS&R sector (*e.g. shelter construction, distribution, etc.*)?
- d) Are the lead actors in SS&R response aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation strategies into their activities?

Shelter Design and Safety

- e) Are there systems/criteria in place to determine how shelters are being allocated?
 - Is a vulnerability index being used for shelter assistance? If so, does it ensure that those at risk of GBV are provided with safe shelter options that minimize their risk?
 - Are there processes in place for determining access to individual accommodation for women?
 - Are there processes in place for determining access to safe communal shelter or foster homes for unaccompanied girls?
 - Are there individuals or groups who may require additional shelter support (*e.g. persons with disabilities, woman- or child-headed households, older persons, etc.*)? Are there systems in place for identifying their particular needs?
 - Where this can be done in a safe and confidential way and by experts working on these issues, are single LGBTI persons consulted on which shelter arrangements would feel safest (*e.g. sharing a shelter with other LGBTI persons, living alone, sharing with non-LGBTI persons, etc.*)?
- f) Are shelters built for safety and privacy?
 - Are shelters secured with locks on doors and windows?
 - Does shelter material prevent people outside from being able to observe whether or not the shelter is occupied—both day and night?
 - Is there sufficient lighting in and around shelters (*e.g. alternative lighting during periods with no power; adequate lightbulbs; etc.*)?
 - Are shelters built based on universal design and/or reasonable accommodation² to ensure accessibility for all persons, including those with disabilities (*e.g. physical disabilities, injuries, visual or other sensory impairments, etc.*)?
 - Are toilets, bathing facilities and water points placed at appropriate distances from sleeping structures (according to humanitarian standards)?
 - Are law enforcement personnel, security patrols and other protection monitoring systems in place in and around shelters?
- g) How many people/families share the same shelter (*including in urban settings*)?
 - Is overcrowding an issue?
 - Are measures in place to provide privacy between ages and sexes as culturally appropriate? Are rooms partitioned?
- h) In tenant situations:
 - What is the cost of rent? How are people paying, and is there any evidence of sexual exploitation or abuse by landlords?
 - Are there any programmes to help deal with high rent and cost of living, particularly for women and other at-risk groups?
 - Is there access to electricity?
- i) Is there a process in place to minimize or mediate conflicts between those needing shelter and those otherwise laying claims to the land on which shelters are being constructed (*i.e. conflicts that can lead to forced evictions, violence, or increased risk of GBV*)?
- j) Are women- and child-headed households, single women, and other at-risk groups consulted on which shelter arrangement would feel safest (*e.g. accommodated in their own dwellings or areas; living alone; etc.*)?
 - Are single mothers and their children—or any other at-risk groups, particularly when they are new arrivals—housed with people who are not part of their own family? What are the security risks to the arrangement?
- k) Are there designated communal areas in the site?
 - Are they in safe locations? Is the lighting in these spaces sufficient?
 - How is that space used? By whom?
 - Are there women-, adolescent- and child-friendly spaces? Are they clearly demarcated?

² For more information regarding universal design and/or reasonable accommodation, see definitions in Annex 4.

(continued)



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Distribution of Assistance/Non-food Items

- l) Is there a process in place to determine, as a matter of priority, which NFIs are the responsibility of the SS&R sector (*e.g. hygiene and dignity kits; lighting for personal use; etc.*)?
- m) Are there criteria in place for distributing shelter materials and shelter-related NFIs in ways that decrease the risk of sexual exploitation or abuse (*e.g. gender-disaggregated lines/zones*)?
 - Is a vulnerability index being used that recognizes the needs of women and other at-risk groups in distribution processes?
 - Are there individuals or groups (*e.g. unaccompanied children, pregnant women, persons with disabilities, survivors of GBV, etc.*) who may need additional support with shelter-related NFIs (*e.g. assistance with transporting materials and/or building their shelters*)?
- n) Are shelter materials and shelter-related NFIs being distributed in areas that are safe?
 - Do women, girls and other at-risk groups have to travel far to obtain them?
 - Are there strategies in place to ensure equal access for women, girls and other at-risk groups?
 - Are these locations routinely monitored for safety?
- o) What are the needs, issues and constraints related to cooking and heating fuel?
 - Do women, girls and other at-risk groups have to travel long distances to obtain fuel (placing them at risk of sexual assault, kidnappings, abuse, etc.)?
 - Is there a risk of sexual exploitation related to obtaining fuel (*e.g. exchanging sex for fuel*)?
 - Have security patrols been established along routes used for fuel collection?
- p) Depending on the context, are cash or voucher transfers in place?
 - Where are the distribution points and methods?
 - Is there regular monitoring of these systems?
 - Are child-headed households included as a target group for cash or voucher transfers in a safe and ethical way?

Areas related to SS&R POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of SS&R programmes?
 - Are women, girls and other at-risk groups meaningfully engaged in the development of SS&R policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Are these policies, standards and guidelines communicated to women, girls, boys and men (*separately when necessary*)?
 - Is SS&R staff properly trained and equipped with the necessary skills to implement these policies?
- b) Do national and local sector policies address discriminatory practices hindering women and other at-risk groups from safe participation (*as staff, in community-based groups, etc.*) in the SS&R sector?
- c) Do national and local SS&R sector policies and plans integrate GBV-related risk reduction strategies (*e.g. inclusion of a GBV specialist to advise the government on shelter-related GBV risk-reduction, particularly in situations of cyclical natural disasters, etc.*)? Do they allocate funding for sustainability of these strategies?

Areas related to SS&R COMMUNICATIONS and INFORMATION SHARING

- a) Has training been provided to SS&R staff on:
 - Issues of gender, GBV, and women's/human rights?
 - How to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- b) Do SS&R-related community outreach activities raise awareness within the community about general safety and GBV risk reduction?
 - Does this awareness-raising include information on survivor rights (including confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Is this information provided in age-, gender- and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these education activities as agents of change?
- c) Are discussion forums on SS&R age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.*) so that participants feel safe to raise GBV issues?





KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for SS&R programming. Whether requesting pre-/emergency funding or when accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.

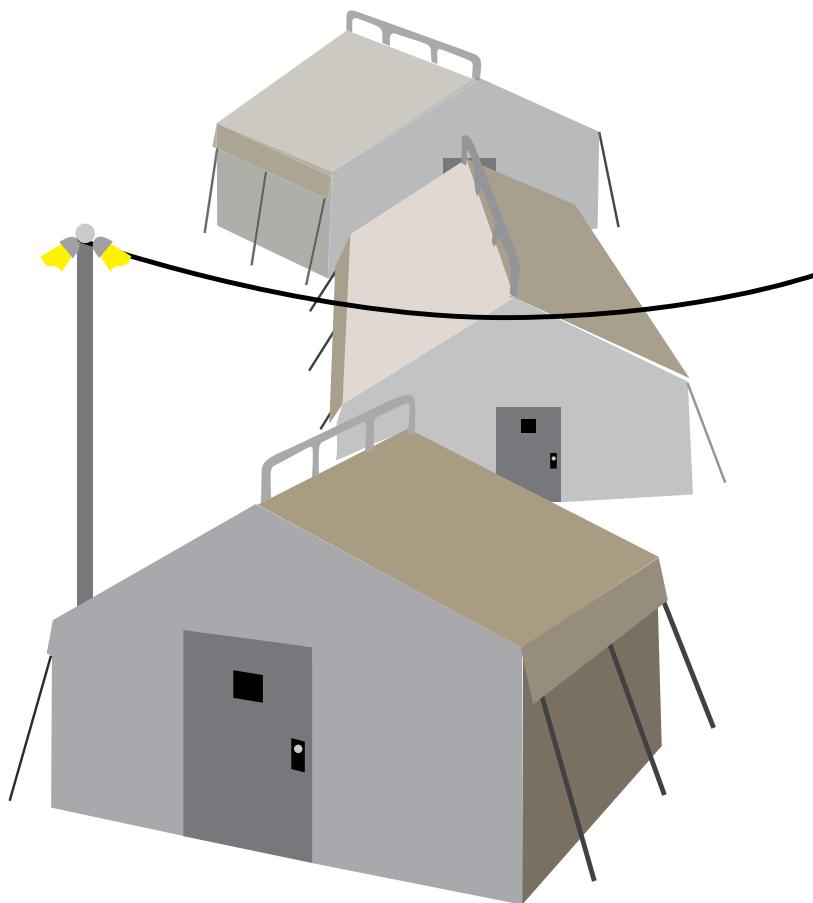


ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**.

Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.



A. HUMANITARIAN NEEDS OVERVIEW

- ▶ Does the proposal articulate the GBV-related safety risks, protection needs and rights of the affected population as they relate to the provision of shelter (*e.g. cramped quarters; lack of privacy; inadequate shelter; attitudes of humanitarian staff that may contribute to discrimination against women and other at-risk groups; etc.*)?
- ▶ Are specific forms of GBV (*such as sexual assault, intimate partner violence and other forms of domestic violence, sexual exploitation, harassment, etc.*) described and analysed, rather than a broader reference to “GBV”?
- ▶ Are the vulnerabilities and related shelter needs of particular at-risk groups (*e.g. persons with disabilities; woman and child heads of households; single women; unaccompanied/ separated children; etc.*) recognized and described?

B. PROJECT RATIONALE/ JUSTIFICATION

- ▶ When drafting a proposal for emergency preparedness:
 - Is there an anticipation of age-, gender-, and culturally-appropriate supplies that should be prepositioned in order to facilitate a rapid SS&R response that incorporates GBV risk reduction (*e.g. sheets for partitions; torches; doors; locks; features to improve accessibility for persons with disabilities; etc.*)?
 - Are additional costs required to ensure that new construction as well as renovations of existing infrastructure adhere to the principles of universal design and/or reasonable accommodation?
 - Is there a strategy in place for preparing and providing trainings for government, SS&R staff and community groups on the safe design and implementation of SS&R programming that mitigates the risk of GBV?
 - Are additional costs required to ensure any GBV-related community outreach materials will be available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- ▶ When drafting a proposal for emergency response:
 - Is there a clear explanation of how SS&R programmes will mitigate exposure to GBV, for example in terms of shelter design (*e.g. type of material used; use of partitions; availability of locks; adequate lighting; etc.*)?
 - Is there a clear explanation of how women will be involved in the distribution of shelter materials? Of how women, girls and other at-risk groups will be prioritized for the allocation of shelters?
 - Do strategies meet standards promoted in the Sphere Handbook?
 - Are additional costs required to ensure the safety and effective working environments for female staff in the SS&R sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
- ▶ When drafting for post-emergency and recovery:
 - Is there an explanation of how the project will contribute to sustainable strategies that promote the safety and well-being of those at risk of GBV, and to long-term efforts to reduce specific types of GBV (*e.g. integrating GBV risk-reduction strategies into national and local policies, such as standardizing partitions into pre-positioned tent supplies; developing strategies for cyclical natural disasters in which women-, adolescent- and child-friendly spaces and safe shelters are considered from the onset of an emergency; etc.*)?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

C. PROJECT DESCRIPTION

- ▶ Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for integrating GBV-related work?
- ▶ Do the proposed activities illustrate linkages with other humanitarian actors/ sectors in order to maximize resources and work in strategic ways?
- ▶ Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as SS&R staff and in community-based SS&R-related committees?





KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some common GBV-related considerations when implementing SS&R programming in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

Integrating GBV Risk Reduction into: SS&R PROGRAMMING

- 1. Involve women and other at-risk groups as staff and leaders in the design and implementation of SS&R programming (with due caution in situations where this poses a potential security risk or increases the risk of GBV).**
 - ▶ Strive for 50% representation of females within SS&R programme staff. Provide them with formal and on-the-job training in the construction, operation and maintenance of shelter facilities, as well as targeted support to assume leadership and training positions.
 - ▶ Ensure women (and where appropriate, adolescent girls) are actively involved in community-based SS&R committees and management groups. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.
 - ▶ Employ persons from at-risk groups in SS&R staff, leadership and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.



ESSENTIAL TO KNOW

LGBTI Persons

Lesbian, gay, bisexual, transgender and intersex (LGBTI) persons face unique difficulties during displacement. In most areas of the world, they are at significant risk of harassment, discrimination, and physical or sexual assault. SS&R strategies or guidelines should be inclusive of the rights and needs of LGBTI persons and address specific safety concerns, especially in contexts where there is widespread prejudice against LGBTI persons. With the assistance of LGBTI specialists, SS&R programmers should consult with local LGBTI organizations and consider culturally-sensitive strategies to address the needs of LGBTI persons. For example:

- Where appropriate and without putting them at greater risk, encourage the representation of LGBTI persons on SS&R committees and ensure they are consulted on the safe design of shelters.
- Consider that scattered-site housing mechanisms work better in certain contexts than communal “safe houses” for LGBTI persons.
- Allow transgender persons to choose the housing option that they believe is safest for them. For example, where shelters are sex-segregated, persons identifying as men should be housed with men and those identifying as women should be housed with women, unless they indicate other preferences based on safety.
- Consider allowing transgender residents the ability to sleep near safe and well-trained night staff to lower the risk of assault and harassment.

(Information provided by Duncan Breen, Human Rights First, Personal Communication, May 20, 2013)

2. Prioritize GBV risk reduction in allocation of shelter materials and shelter construction.

- ▶ Implement clear, consistent and transparent criteria for qualifying for shelter assistance. Ensure these criteria do not discriminate against GBV survivors or women seeking accommodation without a male relative.



- ▶ Ensure personal accommodation is available for women, girls and at-risk groups. Provide temporary separate housing for unaccompanied children until a foster care situation can be arranged. Where possible, position this housing away from high-trafficked areas such as distribution points.
- ▶ Implement Sphere standards for space and density to avoid overcrowded living arrangements. Consider that overcrowding can add to family stress and can in turn increase intimate partner violence and other forms of domestic violence.
- ▶ Strive to build shelters no more than 500 metres from water points (in accordance with Sphere standards) so that women, girls and other at-risk groups do not have to venture far for their household's WASH needs.
- ▶ Improve safety and privacy within sleeping areas and protect against attack by providing strong and non-transparent building materials; doors and windows that lock; and (where age-, gender-, and culturally-appropriate) family and sex-segregated partitions.
- ▶ Where lighting is a responsibility of the SS&R sector, prioritize the installation of appropriate lighting in and around shelters, particularly in areas deemed at high risk of GBV. Distribute torches and/or solar powered lights for individual use.
- ▶ Establish a system for the community to provide feedback about shelter-related safety issues relating to GBV.



LESSON LEARNED

Following two earthquakes in El Salvador in 2001, single women participating in the shelter response demanded that the sheeting provided for temporary shelters be strong and opaque. Translucent materials that had been provided previously made it easy for outsiders to see through the walls and identify isolated women. The material could also easily be cut and as a result many women had been sexually assaulted.

(Excerpted from **Active Learning Network for Accountability and Performance in Humanitarian Action. 2003. Participation by Crisis-Affected Populations in Humanitarian Action. A Handbook for Practitioners.** London. Overseas Development Institute, p.299. www.alnap.org/pool/files/gs_handbook.pdf)

3. Ensure equal and impartial distribution of SS&R-related non-food items (NFIs).

- ▶ As a matter of priority, determine which NFIs are the responsibility of the SS&R sector. Identify ways of mitigating the risk of GBV through adequate and sustained distribution of these NFIs, which can include:
 - Cooking and heating fuel and fuel alternatives.
 - Building materials for shelter.
 - Hygiene and dignity kits.
 - Lighting for personal use.
- ▶ In consultation with the affected community, ensure women, girls and other at-risk groups (particularly women- and



PROMISING PRACTICE

In Somalia, UNICEF's Child Protection, WASH and Education sections came together to conduct a survey on menstrual hygiene management to increase the retention of school attendance for girls and to mitigate the risks of child and/or forced marriage. While the main focus in the survey was on menstrual hygiene management (type of sanitary towels, type of underwear, soap, access to water, etc.), UNICEF used the opportunity to also survey participants on items to include in dignity kits. The UNICEF partners therefore involved the SS&R sector in the development of the survey since it was the main provider of dignity kits. This led to further cooperation between sectors for the benefit of the affected population.

(Information provided by UNICEF Somalia Child Protection Section, Personal Communication, August 2014)



child-headed households, single women, young girls, older persons, persons with disabilities, and other at-risk groups) have access to age-, gender-, and culturally-appropriate NFIs.

- Promptly address inequities in distribution among women and men.
 - Consider additional needs while distributing shelter materials to women and other at-risk groups (e.g. directly delivering materials to designated sites).
 - Ensure that NFI distributions consider the needs of persons with disabilities and GBV survivors isolated or confined in the home. These persons may require additional items (e.g. soap, cloth, incontinence pads, containers for water storage, etc.) to ensure their safety and dignity.
- In non-camp settings, consider cash-for-rent, cash-for-work or voucher assistance to reduce risks of GBV associated with lack of appropriate shelter.
- Establish clear, consistent and transparent distribution systems that are known by all members of the community. Regularly communicate information about distribution to women, girls, boys and men.



PROMISING PRACTICE

Cash transfers have the potential to respond to the disadvantage, discrimination and abuse of women and children. According to reports, 55% 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 (especially boys, who were vulnerable to wage exploitation and were more willing to work under dangerous conditions), and forced and/or coerced prostitution. The risk of intimate partner violence and other forms of domestic violence also likely increased as economic pressures caused frustrations and feelings of helplessness among household members. A 2012 survey conducted by the International Rescue Committee (IRC) reported that cash transfers through the means of pre-paid ATM cards were the most appropriate means of support because they provided refugees with an increased sense of independence and dignity.

(Adapted from **IRC. 2012. Assessment Report: Cash Transfer Program to Syrian Refugees in Jordan.** <http://data.unhcr.org/syrianrefugees/download.php?id=1176>)

4. **Distribute cooking sets and design cooking facilities that reduce consumption of cooking fuel, which in turn reduces the need to seek fuel in unsafe areas.**
- Where SS&R actors are responsible for distributing cooking and heating fuel, link with GBV specialists to monitor whether women and girls are selling firewood or charcoal as a source of income, and whether this livelihoods activity is putting them at risk of sexual assault and exploitation.
 - Whenever possible, provide fuel-efficient stoves and cash assistance/vouchers for fuel. Consult women about their preferred type of fuel-efficient stoves and the distribution of cooking and heating fuel. Train women and men in the use of these stoves and ensure ongoing availability of a sustainable, safe and appropriate energy source.

Integrating GBV Risk Reduction into: SS&R POLICIES

- 1. Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of SS&R programmes.**
 - ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in SS&R activities. These can include, among others:
 - Policies regarding childcare for SS&R staff.
 - Standards for equal employment of females.
 - Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.
 - ▶ Circulate these widely among SS&R staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).
- 2. Advocate for the integration of GBV risk-reduction strategies into national and local policies and plans related to SS&R, and allocate funding for sustainability.**
 - ▶ Support governments, customary/traditional leaders, and other stakeholders in the review and reform of policies and plans to address discriminatory practices hindering women, girls and other at-risk groups from safe participation (as staff and leaders) in the SS&R sector.
 - ▶ Ensure national SS&R policies include GBV-related safety measures (e.g. consider standardizing the inclusion of partitions into pre-positioned tent supplies; consider the construction of women-, adolescent- and child-friendly spaces and safe shelter from the onset of an emergency; ensure that policies for reconstruction integrate GBV risk reduction measures related to space and density; etc.).
 - ▶ Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. Undertake awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.

Integrating GBV Risk Reduction into: SS&R COMMUNICATIONS and INFORMATION SHARING

- 1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure SS&R staff has the basic skills to provide them with information on where they can obtain support.**
 - ▶ Ensure all SS&R personnel who engage with affected populations have written information about where to refer survivors for care and support. Regularly update information about survivor services.

! ESSENTIAL TO KNOW

Referral pathways

A “referral pathway” is flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.



- ▶ Train all SS&R personnel who engage with affected populations in gender, GBV, women's/human rights and psychological first aid (e.g. how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).

2. Ensure that SS&R programmes sharing information about reports of GBV within the SS&R sector or with partners in the larger humanitarian community abide by safety and ethical standards.
 - ▶ Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community.

3. Incorporate GBV messages into SS&R-related community outreach and awareness-raising activities.

- ▶ Work with GBV specialists to integrate community awareness-raising on GBV into SS&R outreach initiatives (e.g. community dialogues; workshops; meetings with community leaders; GBV messaging; etc.).
 - Ensure this awareness-raising includes information on prevention, survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.
 - Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).
 - Engage (separately when necessary), women, girls, men and boys in the development of messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.
- ▶ Engage males, particularly leaders in the community, as agents of change in SS&R outreach activities related to the prevention of GBV.
- ▶ Consider the barriers faced by women, girls and other at-risk groups to their safe participation in community discussion forums (e.g. transportation; meeting times and locations; risk of backlash related to participation; need for childcare; accessibility for persons with disabilities; etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.) so that participants feel safe to raise GBV issues.
- ▶ Provide community members with information about existing codes of conduct for SS&R personnel, as well as where to report sexual exploitation and abuse committed by SS&R personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.



ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. **When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**





KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, SS&R programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist SS&R actors to:

- ▶ Design and conduct SS&R assessments that examine the risks of GBV related to SS&R programming, and strategize with SS&R actors about ways these risks can be mitigated.
- ▶ Provide trainings for SS&R staff on issues of gender, GBV and women's/human rights, and how to respectfully and supportively engage with survivors.
- ▶ Identify where survivors who may report instances of GBV exposure to SS&R staff can receive safe, confidential and appropriate care, and provide SS&R staff with the basic skills and information to respond supportively to survivors.
- ▶ Provide training and awareness-raising for the affected community on issues of gender, GBV and women's/human rights as they relate to SS&R.
- ▶ Provide advice regarding women-, adolescent- and child-friendly spaces and safe shelter to make sure that the location and physical structures are secure and safe.

In addition, SS&R programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, SS&R actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.



PROMISING PRACTICE

To ensure that GBV prevention was prioritized in the planning of the Azraq camp for Syrian refugees in Jordan, a task force of the SGBV sub-working group (SGBV SWG) was established. The task force included UNHCR, UNFPA, UNICEF, IMC and IRC. In 2013, the task force organized a visit by UNHCR in coordination with UNFPA and UNICEF to the planned site and followed up with recommendations to shelter actors, site planners and other sector colleagues. As a result, plans for the camp were modified and adapted to include:

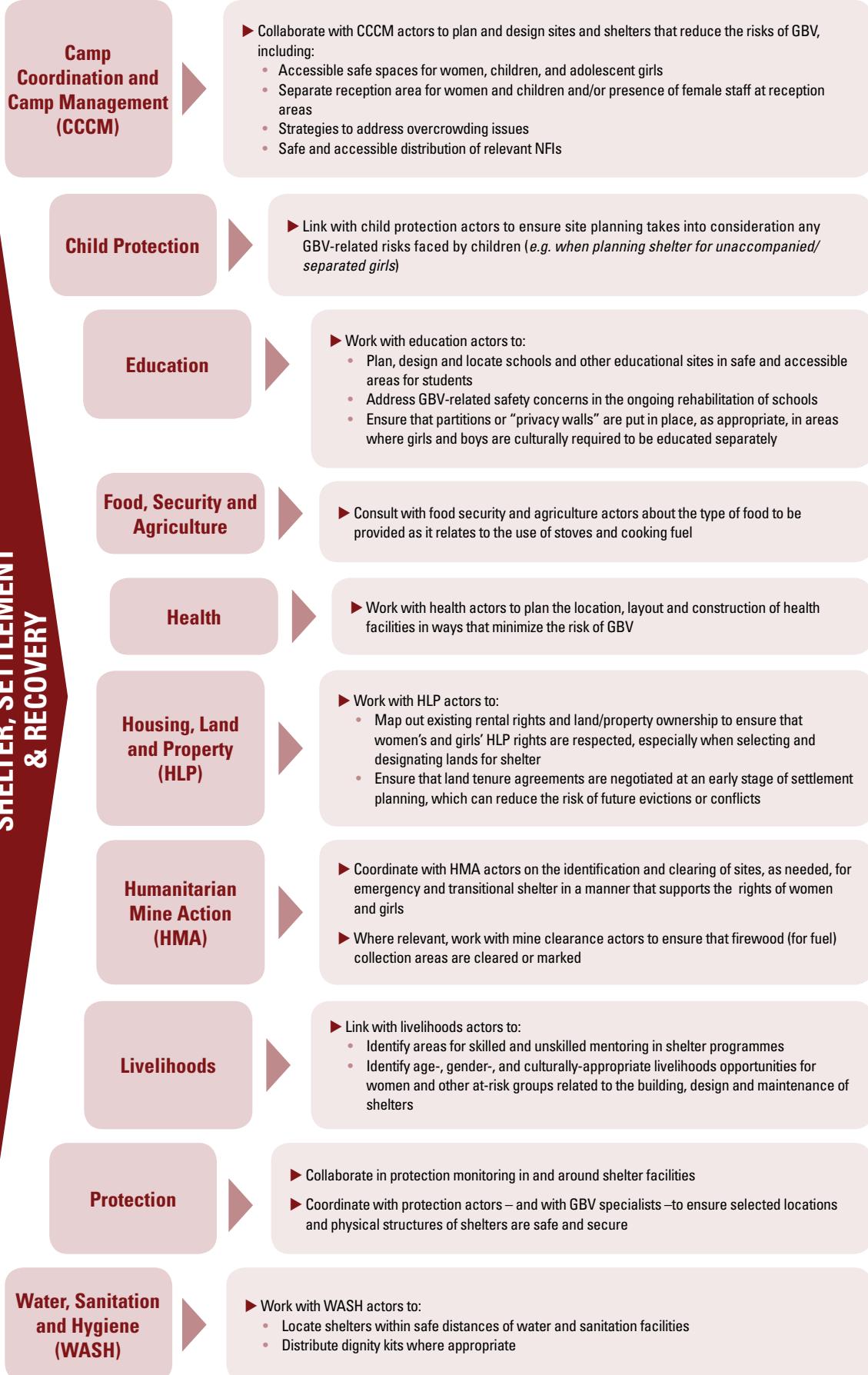
- A separate reception area for vulnerable refugee women and their children.
- Safe spaces for women and girls and other community services for each area of the camp (1/20,000 refugees)

In addition, the task force coordinated with shelter actors and community service providers to prevent the most at-risk refugees (such as women- and child-headed households, single women, unaccompanied children, elderly persons and persons with disabilities) from becoming dependent on others to build transitional shelters, which in turn would increase their risk of sexual exploitation. It was agreed that 'T-shelters' would be pre-built and allocated to families upon the arrival of refugees. These T-shelters would include a wiring system that allowed separators to be added for privacy. As refugees continued to arrive, some refugees were involved in the construction of new shelters as part of a cash-for-work programme. The SGBV SWG maintains ongoing discussions on the prevention of GBV with the camp management sector and all other sectors, each of which have been very receptive to implementing further protection recommendations.

(Information provided by UNFPA and UNHCR in Jordan, Personal Communication, October 7, 2014)



SHELTER, SETTLEMENT & RECOVERY





KEY GBV CONSIDERATIONS FOR: MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in Shelter, Settlement and Recovery sector (SS&R) assessments ³	# of SS&R assessment that include GBV-related questions* from the GBV Guidelines x 100 _____ # of SS&R assessment	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	# of assessment respondents who are female x 100 _____ # of assessment respondents and # of assessment team members who are female x 100 _____ # of assessment team members	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

³ Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Consultations with the affected population on GBV risk factors in shelters	<i>Quantitative:</i> # of specified geographic locations assessed through consultations with the affected population on GBV risk factors in and around shelters x 100	Organizational records, focus group discussion (FGD), key informant interview (KII), assessment reports	100%			
<i>Disaggregate consultations by sex and age</i>	# of specified geographic locations <i>Qualitative:</i> What types of GBV-related risk factors do affected persons experience in and around shelters?			✓	✓	
Female participation prior to the design of shelter facilities⁴	<i>Quantitative:</i> # of affected persons consulted before designing a shelter facilities who are female x 100 # of affected persons consulted before designing shelter facilities <i>Qualitative:</i> How do women and girls perceive their level of participation in the design of shelter facilities? What enhances women and girls' participation in the design process? What are barriers to female participation in these processes?	Organizational records, FGD, KII	Determine in the field			✓
Staff knowledge of referral pathway for GBV survivors	# of SS&R staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors x 100 # of surveyed SS&R staff	Survey	100%	✓		✓
RESOURCE MOBILIZATION						
Inclusion of GBV risk reduction in SS&R funding proposals or strategies	# of SS&R funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines x 100 # of SS&R funding proposals or strategies	Proposal review (at agency or sector level)	100%	✓	✓	
Stock availability of pre-positioned supplies for GBV risk mitigation	# of GBV risk reduction supplies that have stock levels below minimum levels x 100 # of GBV risk reduction supplies <small>* See page 212 for list of supplies</small>	Planning or procurement records, forecasting records	0%	✓	✓	
Training of SS&R staff on the GBV Guidelines	# of SS&R staff who participated in a training on the GBV Guidelines x 100 # of SS&R staff	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	

(continued)

⁴ United Nations Office for the Coordination of Humanitarian Affairs. Humanitarian Indicator Registry. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION									
► Programming									
Risk factors of GBV in and around shelters	<p><i>Quantitative:</i></p> <p># of affected persons who report concerns about experiencing GBV when asked about areas in and around shelters x 100</p> <hr/> <p># of affected persons asked about areas in and around shelters</p> <p><i>Qualitative:</i></p> <p>Do affected persons feel safe from GBV in and around shelters? What types of safety concerns does the affected population describe in and around shelters?</p>	Survey, FGD, KII, participatory community mapping	100%						
Coverage of non-food items (NFIs)⁴	<p># of households in need of NFIs* and who received NFIs x 100</p> <hr/> <p># of surveyed households in need of NFIs</p> <p>* NFIs can include hygiene and dignity kits, lighting for personal use, cooking and heating fuel, and transitional shelter materials</p>	Survey, W matrix	Determine in the field						
Knowledge of distribution location and time for SS&R-related materials	<p># of heads of households who, in response to a prompted question, correctly say the time and location of the next SS&R-related materials distribution x 100</p> <hr/> <p># of surveyed heads of households</p>	Survey, FGD	Determine in the field						
Risk factors of GBV in collecting cooking fuel/firewood	<p># of affected persons who report risk factors of GBV when asked about collecting cooking fuel or firewood x 100</p> <hr/> <p># of affected persons asked</p>	Survey, FGD, KII	100%						
► Policies									
Inclusion of GBV prevention and mitigation strategies in SS&R policies, guidelines or standards	<p># of SS&R policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines x 100</p> <hr/> <p># of SS&R policies, guidelines or standards</p>	Desk review (at agency, sector, national or global level)	Determine in the field						
► Communications and Information Sharing									
Staff knowledge of standards for confidential sharing of GBV reports	<p># of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100</p> <hr/> <p># of surveyed staff</p>	Survey (at agency or programme level)	100%						
Inclusion of GBV referral information in SS&R community outreach activities	<p># of SS&R community outreach activities programmes that include information on where to report risk and access care for GBV survivors x 100</p> <hr/> <p># of SS&R community outreach activities</p>	Desk review, KII, survey (at agency or sector level)	Determine in the field						

(continued)



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
COORDINATION						
Coordination of GBV risk reduction activities with other sectors	# of non-SS&R sectors consulted with to address GBV risk reduction activities* x 100 # of existing non-SS&R sectors in a given humanitarian response <small>* See page X for list of sectors and GBV risk reduction activities</small>	KII, meeting minutes (at agency or sector level)	Determine in the field	✓	✓	

RESOURCES

Key Resources

- For a checklist to assess gender equality programming in site selection, design, construction, and/or shelter allocation, see the **Inter-Agency Standing Committee (IASC). 2006. Gender Handbook in Humanitarian Action**, [http://www.humanitarianinfo.org/iasc/documents/subsidiary/gender/IASC%20Gender%20Handbook%20\(Feb%202007\).pdf](http://www.humanitarianinfo.org/iasc/documents/subsidiary/gender/IASC%20Gender%20Handbook%20(Feb%202007).pdf)
- **Norwegian Refugee Council. 2008. Camp Management Toolkit.** "Chapter 10: Prevention of and Response to Gender-Based Violence," p. 319-323, http://www.nrc.no/arch/_img/9178016.pdf. These pages of NRC's toolkit focus on protection-sensitive shelter and site planning, along with community protection systems.
- **Norwegian Refugee Council (NRC) and the International Federation of Red Cross and Red Crescent Societies (IFRC). 2013. Security of Tenure in Humanitarian Shelter Operations,** <http://www.ifrc.org/Global/Documents/Secretariat/201406/NRC%20IFRC%20Security%20of%20Tenure.pdf>
- **United Nations High Commissioner for Refugees (UNHCR) and International Organization for Migration (IOM). 2010. Collective Centre Guidelines.** These guidelines provide suggestions for programme planning around collective centres, including risk factors for gender-based violence and strategies to address them. http://www.sheltercentre.org/sites/default/files/Collective_Centre_Guidelines_2010_small.pdf
- **The National Center for Transgender Equality. 2011. "Making Shelters Safe for Transgender Evacuees,"** <http://transgenderequality.wordpress.com/2011/08/26/hurricane-irene-is-coming-guide-to-making-shelters-safe-for-transgender-evacuees>. Considering the unique difficulties transgender evacuees encounter, NCTE, Lambda Legal, and the National Gay and Lesbian Task Force have issued these simple guidelines to assist shelters in making their spaces safe for transgender persons.
- **Global Shelter Cluster. 2013. Guidance on Mainstreaming the Prevention of and Response to Sexual and Gender Based Violence in Emergency Shelter Programmes,** <https://www.sheltercluster.org/Global/Working%20Groups%202012%20Documents/Shelter%20-%20SGBV%20tipsheet%20IC13%20120625.doc>
- **Global Shelter Cluster. 2013. Guidance on Mainstreaming Protection in Shelter Programmes,** https://www.sheltercluster.org/Global/Working%20Groups%202012%20Documents/Protection%20Matrix_v4%2020120924.doc
- **Jones, A., Bretherton, J., Bowles, R. and Croucher, K. 2010. "Sanctuary Schemes for Households at Risk of Domestic Violence."** Communities and Local Government, <http://www.communities.gov.uk/publications/housing/sanctuarieschemesguide>
- **International Federation of Red Cross and Red Crescent Societies (IFRC). 2012. Assisting Host Families and Communities After Crises and Natural Disaster: A Step-by Step Guide.** Geneva: IFRC, <https://www.ifrc.org/PageFiles/95186/ASSISTING%20HOST%20FAMILIES%20AND%20COMMUNITIES%20-%20IFRC%202012%20.pdf>
- **United Nations, Department for International Development (DFID) and Shelter Centre. 2010. Shelter after disaster: strategies for transitional settlement and reconstruction,** <http://sheltercentre.org/node/12873>
- **Sphere Project. 2011. Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response,** <http://www.sphereshandbook.org>. The Sphere Handbook is the most widely known and recognized set of common principles and universal minimum standards for humanitarian response.
- **House, S., Mahon, T., & Cavill, S. 2012. Menstrual hygiene matters. A resource for improving menstrual hygiene around the world,** <http://www.wateraid.org/what-we-do/our-approach/research-and-publications/view-publication?id=02309d73-8e41-4d04-b2ef-6641f6616a4f>
- **Médecins Sans Frontières / Doctors Without Borders.** "Learn more about Shelter", http://webpal.org/SAFE/aaareconstruction/immediate/refugee_camp#provision



WATER, SANITATION AND HYGIENE



THIS SECTION APPLIES TO:

- Water, sanitation and hygiene (WASH) coordination mechanisms
- WASH actors (staff and leadership): NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and UN agencies
- Local committees and community-based groups (i.e. groups for women, adolescents/youth, older persons, etc.) related to WASH
- Other WASH stakeholders, including national and local governments, community leaders, and civil society groups

Why Addressing Gender-based Violence is a Critical Concern of the Water, Sanitation and Hygiene Sector

Armed conflict, natural disasters, and other humanitarian emergencies can significantly alter a community's traditional water, sanitation, and hygiene (WASH) practices. During an emergency, well-designed WASH programmes and facilities can help to keep affected populations safe from violence. Conversely, WASH programming that is poorly planned and insensitive to gender dynamics in a given social and cultural context can exacerbate risk of exposure to sexual and other forms of gender-based violence (GBV). This is particularly true for women, girls, and other at-risk groups¹, who may be disproportionately affected by WASH issues. For example:

- ▶ Women, girls, and other at-risk groups face an increased risk of sexual assault and violence while traveling to WASH facilities (including water points, cooking facilities and sanitation facilities) that are limited in number, located far from homes, or placed in isolated locations. In some emergencies, women and girls must travel through unsafe areas or after nightfall to relieve themselves.
- ▶ If there is insufficient water (i.e. during drought), they may be punished for returning home empty-handed or for returning home late after waiting in line for hours.
- ▶ School-age girls who must spend a long time collecting water are at a higher risk of missing and/or not attending school, which limits their future opportunities. This, in turn, may place them at a higher risk of GBV in the future (for more information, see the **Education Section**).

¹ For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



PART 3: GUIDANCE

WASH

INTRODUCTION

Essential Actions for Reducing Risk, Promoting Resilience and Aiding Recovery throughout

ASSESSMENT, ANALYSIS AND PLANNING

- Promote the active participation of women, girls and other at-risk groups in all WASH assessment processes (especially assessments focusing on the location and design of WASH facilities)
- Investigate community norms and practices related to WASH that may increase the risk of GBV (e.g. responsibilities of women and girls for water collection and maintenance of WASH facilities; etc.)
- Assess the level of participation and leadership of women, adolescent girls and other at-risk groups in the design, construction and monitoring of WASH facilities (e.g. water committees; etc.)
- Analyse physical safety of and access to WASH facilities to identify associated risks of GBV (e.g. travel to/from WASH facilities; sex-segregated toilets; accessibility features for persons with disabilities; etc.)
- Assess awareness of WASH staff on basic issues related to gender, GBV and women's/human rights (including knowledge of where survivors can report risk and access services)
- Review existing/proposed community outreach material related to WASH to ensure it includes basic information about GBV risk reduction (including where survivors can report risk and access services)

RESOURCE MOBILIZATION

- Identify and pre-position age-, gender-, and culturally-appropriate supplies for WASH that can mitigate risks of GBV (e.g. sanitary supplies for menstruating women; hand pumps and water containers that are women- and girl-friendly; accessibility features for persons with disabilities; etc.)
- Develop proposals for WASH programmes that reflect awareness of GBV risks for the affected population and strategies for reducing these risks
- Prepare and provide trainings for government, WASH staff and community WASH groups on the safe design and construction of WASH facilities that mitigate GBV risks
- Target women for job skills training on operation and maintenance of water supply and sanitation, particularly in technical and managerial roles to ensure they are able to respond to GBV risks

IMPLEMENTATION

► Programming

- Involve women and other at-risk groups as staff and leaders in the siting, design, construction and maintenance of water and sanitation facilities and in hygiene promotion activities (which increases the risk of GBV)
- Implement strategies that increase the availability and accessibility of water for women, girls and other at-risk groups (e.g. follow Sphere standards for placement of WASH facilities; work with receptor/host communities to reduce tension over shared water resources; etc.)
- Implement strategies that maximize the safety, privacy and dignity of WASH facilities (e.g. location of facilities; safety patrols along paths; adequate lighting and signage; accessible facilities for persons with disabilities; etc.)
- Ensure dignified access to hygiene-related materials (e.g. sanitary supplies for women and girls of reproductive age; washing facilities that allow laundry and menstrual waste disposal)

► Policies

- Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of WASH programmes (e.g. standards for equal employment opportunities; policies about GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse; etc.)
- Advocate for the integration of GBV risk-reduction strategies into national and local policies and plans related to WASH, and allocate funding for sustainability (e.g. through the WASH sector)

► Communications and Information Sharing

- Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure WASH staff has the capacity to respond to GBV incidents
- Ensure that WASH programmes sharing information about reports of GBV within the WASH sector or with partners in the larger humanitarian community do not pose a security risk to individual survivors, their families or the broader community
- Incorporate GBV messages (including where to report risk and how to access care) into hygiene promotion and other WASH-related community outreach activities

COORDINATION

- Undertake coordination with other sectors to address GBV risks and ensure protection for women, girls and other at-risk groups

Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a WASH focal point to regularly participate in GBV coordination meetings

MONITORING AND EVALUATION

- Identify, collect and analyze a core set of indicators—disaggregated by sex, age, disability, and other relevant vulnerability factors—to monitor GBV risk-reduction activities
- Evaluate GBV risk-reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making and adaptation

NOTE: The essential actions above are organized in chronological order according to an ideal model for programming. The actions that are in bold are the **suggested minimum commitments** for WASH actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Thematic Area Guidance**.

at the Programme Cycle

Stage of Emergency Applicable to Each Action

	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
cation and design of water points, toilets, laundry, kitchen and bathing facilities)	✓	✓	✓	✓
n, water storage, waste disposal, cleaning, and taking care of children's hygiene; management	✓	✓	✓	✓
cilities (e.g. ratio of male/female WASH staff; participation in water management groups and	✓	✓	✓	✓
equate lighting and privacy; accessibility features for persons with disabilities; etc.)	✓	✓	✓	✓
access care; linkages between WASH programming and GBV risk reduction; etc.)	✓	✓	✓	✓
e to report risk and how to access care)	✓	✓	✓	✓

on; sturdy locks for toilets and bathing facilities; lights for toilets, laundry, kitchen and bathing	✓	✓		
	✓	✓	✓	✓
ate the risk of GBV	✓	✓	✓	✓
their presence in decision-making processes	✓	✓	✓	✓

ene promotion activities (with due caution where this poses a potential security risk or	✓	✓	✓	✓
ment of water points; establish ration schedules in collaboration with women, girls and other		✓	✓	✓
d privacy; sturdy internal locks; sex-segregated facilities; sufficient numbers of facilities based		✓	✓	✓
f menstrual cloth; proper disposal of sanitary napkins; etc.)	✓	✓	✓	✓
payment of females; procedures and protocols for sharing protected or confidential information	✓	✓	✓	✓
address discriminatory practices hindering women and other at-risk groups from safe participation	✓		✓	✓

he basic skills to provide them with information on where they can obtain support	✓	✓	✓	✓
abide by safety and ethical standards (e.g. shared information does not reveal the identity of		✓	✓	✓
ies		✓	✓	✓

ination meetings	✓	✓	✓	✓
	✓	✓	✓	✓

duction activities throughout the programme cycle	✓	✓	✓	✓
nd ensure accountability		✓	✓	✓

- ▶ Schools that are not equipped with hygiene supplies for girls may discourage girls from attending and staying in school, especially adolescent girls who are menstruating.
- ▶ Lack of lighting, locks, privacy, and/or sex-segregated sanitation facilities can increase the risk of harassment or assault against women and girls. Inadequate building materials (such as weak plastic sheeting) and poor design (such as open roofs in sites where there is an embankment located above) can also increase this risk.
- ▶ In situations of displacement, tensions with receptor/host communities over water resources can lead to violence against IDPs/refugees, especially women and girls who are most often responsible for collecting water.
- ▶ Women, girls and other at-risk groups may face exploitation at the hands of WASH staff in return for soap, sanitary materials, water, or other WASH supplies.

Crucial to the design of any WASH intervention is a thorough analysis of the differing rights, needs and roles of those at risk of GBV related to WASH. It is critical to engage women, girls and other at-risk groups in the design and delivery of WASH programming—as both employees in the WASH sector and as community-based advisers. This engagement not only helps to ensure effective response to life-saving needs, but also contributes to long-term gains in gender equality and the reduction of GBV. Actions taken by the WASH sector to prevent and mitigate the risk of GBV should be done in coordination with GBV specialists and actors working in other humanitarian sectors. WASH actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. (See “Coordination” below.)



ESSENTIAL TO KNOW

GBV and WASH

In both urban and rural contexts, girls and women regularly face harassment when going to the toilet. Given the taboos around defecation and menstruation and the frequent lack of privacy, women and girls may prefer to go to the toilet or use bathing units under the cover of darkness. They may even delay drinking and eating in order to wait until nightfall to relieve themselves. However, using WASH facilities after dark puts women, girls, and other vulnerable groups at risk of harassment and sexual assault.

(Adapted from House, S. 2013. *Gender-based violence and sanitation, hygiene and water*, WaterAid, BLOG series by the Institute of Development Studies, <http://www.communityledtotalsanitation.org/blog/gender-based-violence-and-sanitation-hygiene-and-water>)

WHAT THE SPHERE HANDBOOK SAYS:

Programme design and implementation

- ▶ All users are satisfied that the design and implementation of the WASH programme have led to increased security and restoration of dignity.

Communal washing and bathing facilities

- ▶ People require spaces where they can bathe in privacy and with dignity. If this is not possible at the household level, separate central facilities for men and women will be needed...The number, location, design, safety, appropriateness and convenience of facilities should be decided in consultation with the users, particularly women, adolescent girls and persons with disabilities. The location of facilities in central, accessible and well-lit areas with good visibility of the surrounding area can contribute to ensuring the safety of users.

Appropriate and adequate toilet facilities

- ▶ Inappropriate siting of toilets may make women and girls more vulnerable to attack, especially during the night. Ensure that women and girls feel safe when using the toilets provided.

(Excerpted from **Sphere Project. 2011. Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response.** <http://www.spherehandbook.org>)





ESSENTIAL TO KNOW

Survivors, Injuries, and WASH

During an emergency, well-designed WASH programmes and facilities can help survivors of sexual assault to deal with their injuries, as well as minimize the likelihood of stigmatization. Female and male survivors may require exceptional access to WASH facilities as a result of genital and/or rectal traumas that render basic washing and hygiene activities difficult and time-consuming. They may also require additional non-food items (NFIs), such as incontinence pads, which should be dispensed in a confidential and non-stigmatizing fashion.

(Information provided by UNHCR, Personal Communication, September 2014)

Addressing Gender-based Violence Throughout The Programme Cycle



KEY GBV CONSIDERATIONS FOR: ASSESSMENT, ANALYSIS AND PLANNING

The questions listed below are **recommendations for possible areas of inquiry that can be selectively incorporated into various assessments and routine monitoring** undertaken by WASH actors. Wherever possible, assessments should be inter-sectoral and interdisciplinary, with WASH actors working in partnership with other sectors as well as with GBV specialists.

The information generated from these areas of inquiry should be analyzed to inform planning of WASH programmes in ways that prevent and mitigate the risk of GBV. They are linked to the three main types of responsibilities detailed below under “Implementation”: programming, policies and communications and information sharing. The data may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Thematic Area Guidance**.



LESSON LEARNED

In India, women and girls are subject to sexual harassment, assault and abuse in public sanitation service sites, as these are often poorly designed and maintained. Boys and men stare, peep, hang out and harass women and girls in toilet complexes. Women and girls are afraid of collecting at certain waterpoints due to hostile and unsafe environments. Poor drainage and piles of solid waste create narrow paths and lead to increased incidents of boys and men brushing past women and girls when walking by them.

(Adapted from **Women in Cities International, Jagori. 2011. Gender and Essential Services in Low-income Communities, Report findings of the action research project: Women's Rights and Access to Water and Sanitation in Asian Cities**, <http://www.idrc.ca/Documents/105524-Gender-and-Essential-Services-in-Low-Income-Communities-Final-Technical-Report.pdf>)



KEY ASSESSMENT TARGET GROUPS

- Key stakeholders in WASH: governments; local WASH committees; local leaders; humanitarian workers; GBV, gender and diversity specialists
- Affected populations and communities
- In IDP/refugee settings, members of receptor/host communities

POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)

Areas related to WASH PROGRAMMING

Participation and Leadership

- a) What is the ratio of male to female WASH staff, including in positions of leadership?
- Are systems in place for training and retaining female staff?
 - Are there any cultural or security issues related to their employment that may increase their risk of GBV?
- b) Are women and other at-risk groups actively involved in community activities related to WASH (*e.g. community water management and sanitation committees, etc.*)? Are they in leadership roles when possible?
- c) Are the lead actors in WASH response aware of international standards (including these Guidelines) for mainstreaming GBV prevention and mitigation strategies into their activities?

Cultural and Community Norms and Practices

- d) What are the gender- and age-related responsibilities related to WASH (*e.g. water collection, storage and treatment; waste disposal; general cleaning; taking care of children's hygiene; laundry; maintenance and management of WASH facilities; etc.*)?
- What are the different uses for water, especially by women and girls (*e.g. drinking, cooking, sanitation, gardening, livestock, etc.*)?
 - What are the patterns of water allocation among family and community members (*including sharing, quantity and quality*)?
 - How are decisions made about the use of water? Who makes these decisions?
- e) What are the preferences and cultural habits to consider before determining the type of toilets, bathing facilities, laundry, kitchens, and water points to be constructed?
- What are the relevant cultural, ethnic, and gender differences related to WASH practices in the affected community (*e.g. different anal cleansing practices; washing facilities close to prayer rooms; etc.*)?
 - What water and sanitation practices were the population accustomed to before the emergency?
 - Are there recommendations for how certain roles related to WASH practices should or could change in the emergency?
- f) How does the crisis impact the access of women, girls and other at-risk groups to WASH facilities?
- How does it affect their personal hygiene practices as compared to before the emergency?
 - What are the barriers that keep women, girls and other at-risk groups from using toilets, bathing, or collecting water (*e.g. lack of privacy; fear of harassment; unsafe times of day or night; etc.*)?
 - Has the crisis created new or additional WASH needs—particularly arising from physical injuries and trauma?

Infrastructure

- g) What is the current source of water? Is it adequate—in terms of both quality and quantity—as per humanitarian standards?
- h) How often do women, girls and other at-risk groups collect water or use other WASH facilities?
- What time of day?
 - How many hours per day are spent traveling to and from WASH facilities?
 - In what way(s) do these factors exacerbate risk of exposure to GBV?
 - Are children, especially girls, prevented from attending school as a result of WASH-related responsibilities (*such as collecting water*)?

(continued)



POSSIBLE AREAS OF INQUIRY

(Note: This list is not exhaustive)

- i) In situations where water is rationed or pumped at given times:
 - Are times set that are convenient and safe for those who are responsible for collecting water?
 - Are there enough water points available to prevent fighting at the pumps and/or waiting for long periods in order to get water?
 - What means of transporting water are available, and who is given access to these means (e.g. *do men have priority access to bicycles, donkeys or motorbikes; are smaller water containers available for children and elderly people; etc.*)?
- j) If trucking water, are the drop-off points convenient and safe?
- k) What is the distance to water points, toilets, and other WASH facilities?
 - Is the route to be travelled safe?
 - Is there a system of safety patrolling or a community surveillance system of potentially insecure areas?
- l) Are WASH facilities secure?
 - Is there sufficient lighting (*alternative lighting for periods with no power; adequate lightbulbs; etc.*)?
 - Do they provide adequate privacy?
 - Are bathrooms and bathing facilities equipped with doors that lock from the inside?
 - Are facilities designed and built based on universal design and/or reasonable accommodation² to ensure accessibility for all persons, including those with disabilities (*e.g. physical disabilities; injuries; visual or other sensory impairments; etc.*)?
 - Are they adequate in number to meet the rights and needs of the affected population (*e.g. using the approximate ratio of 3 female cubicles for every 1 male cubicle, according to Sphere standards*)?
 - Are there family latrines?
 - If latrines are communally shared, are there separate facilities for males and females that are clearly marked, private and appropriate distances apart?
- m) What types of sanitary supplies and hygiene materials are appropriate to distribute to women and girls, especially related to menstruation?
 - Are these materials available, re-supplied and distributed regularly?
 - Does the timing and process of distribution put women and girls at higher risk of GBV?
 - Are there adequate and private mechanisms for cleaning or disposing of sanitary supplies?
- n) What types of sanitary supplies and hygiene materials are required by female and male survivors of sexual assault with injuries? Are mechanisms in place to ensure that they can be accessed and distributed in a confidential and non-stigmatizing manner?

Areas related to WASH POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of WASH programming?
 - Are women, girls and other at-risk groups meaningfully engaged in the development of WASH policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Are these policies, standards and guidelines communicated to women, girls, boys and men (separately when necessary)?
 - Is WASH staff properly trained and equipped with the necessary skills to implement these policies?
- b) Do national/local sector policies address discriminatory practices hindering women and other at risk groups from safe participation (as staff, in community-based groups, etc.) in the WASH sector?
- c) Do national and local WASH sector policies and plans integrate GBV-related risk reduction strategies? Do they allocate funding for sustainability of these strategies?
 - In situations of cyclical natural disasters, is there a policy provision for a GBV specialist to advise the government on WASH-related GBV risk-reduction?

(continued)

² For more information regarding universal design and/or reasonable accommodation, see definitions in Annex 4.



POSSIBLE AREAS OF INQUIRY (Note: This list is not exhaustive)**Areas related to WASH COMMUNICATIONS and INFORMATION SHARING**

- a) Has training been provided to WASH staff on:
 - Issues of gender, GBV, and women's/human rights?
 - How to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care?
- b) Do WASH-related community outreach activities raise awareness within the community about general safety and GBV risk reduction?
 - Does this awareness-raising include information on survivor rights (including confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV?
 - Is this information provided in age-, gender- and culturally-appropriate ways?
 - Are males, particularly leaders in the community, engaged in these community mobilization activities as agents of change?
- c) Are discussion forums on hygiene and sanitation age-, gender-, and culturally-sensitive? Are they accessible to women, girls and other at-risk groups (*e.g. confidential, with females as facilitators of women's and girls' discussion groups, etc.*) so that participants feel safe to raise GBV issues?

**LESSON LEARNED**

In Haiti, the assessment for water and sanitation needs largely overlooked the gender and cultural dimensions of the population. No specific questions in the Phase I and II rapid assessments addressed gender or GBV. The Assessment Capacities Project (ACAPS) had a Gender Focal Point for Haiti write up a concise report on gender issues to help inform the analyses of the assessment findings. In her report, the Gender Focal Point looked at the full rapid assessment report for WASH and found that, outside of Port au Prince, 83% of the latrines were not divided by sex, and 84% were not adequately lit. However, in the final Rapid Initial Needs Assessment report, much of this gender-sensitive data was not included to inform programming. As a result, the Gender Focal Point deemed the WASH intervention to be inefficient and ineffective. Key concerns were that latrines were not separated by sex; were not sufficiently private; were too far away from dwellings; were not lit; lacked locks; and were culturally inappropriate (i.e. people could not sit down). These factors all increased the risk of sexual harassment and assault when using the latrines. Key protection issues emerged as sexual assault was reported in 29% (6 our of 21) of the sites.

(Adapted from **Mazurana, Benelli, Gupta and Walker. August 2011. "Sex and Age Matter: Improving Humanitarian Response in Emergencies."** Feinstein International Center, Tufts University, p 79-80. <http://www.care.org/sites/default/files/documents/sex-and-age-disag-data.pdf>)

**PROMISING PRACTICE**

In Somalia, UNICEF's WASH, child protection, and education sectors came together to conduct a survey on menstrual hygiene management. Their aim was to mitigate child marriage, ensure girls remained in school, and provide dignity to women and girls. While the main focus of the survey was on menstrual hygiene management (e.g. types of sanitary towels, types of underwear, access to water, etc.), they used the opportunity to also survey participants on what kinds of items upheld dignity and could be included in a "dignity kit". The UNICEF sections involved the shelter cluster in developing the survey to ensure that the main providers of dignity kits were participating. All sectors were pleased with the outcome and the level of coordination between sectors.

(Information provided by UNICEF Somalia Child Protection Section, Personal Communication, August 2014)





KEY GBV CONSIDERATIONS FOR: RESOURCE MOBILIZATION

The information below highlights important considerations for mobilizing GBV-related resources when drafting proposals for WASH programming. Whether requesting pre-/emergency funding or accessing post-emergency and recovery/development funding, proposals will be strengthened when they reflect knowledge of the particular risks of GBV and propose strategies for addressing those risks.



ESSENTIAL TO KNOW

Beyond Accessing Funds

Resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment. For more general considerations about resource mobilization, see **Part Two: Background to Thematic Area Guidance**. Some additional strategies for resource mobilization through collaboration with other humanitarian sectors/partners are listed under “Coordination” below.



A.

HUMANITARIAN NEEDS OVERVIEW

- ▶ Does the proposal articulate the GBV-related safety risks, protection needs and rights of the affected population as they relate to the provision of WASH services?
- ▶ Are WASH responsibilities in the home and in the wider community understood and disaggregated by sex, age, disability, and other relevant vulnerability factors? Are the related risk factors of women, girls and other at-risk groups recognized and described?
- ▶ Are risks for specific forms of GBV (*such as sexual assault, sexual exploitation, harassment, intimate partner violence and other forms of domestic violence, etc.*) described and analysed, rather than a broader reference to "GBV"?

B.

PROJECT RATIONALE/ JUSTIFICATION

- ▶ When drafting a proposal for emergency preparedness:
 - Is there an anticipation of the types of age-, gender-, and culturally-appropriate supplies that should be pre-positioned in order to facilitate a rapid WASH response that mitigates the risk of GBV (*e.g. sanitary supplies for menstruation; sturdy locks for toilets and bathing facilities; lights for toilets, laundry, kitchen and bathing facilities; solid doors and privacy fencing; hand pumps and water containers that are women- and girl-friendly; features to improve accessibility for persons with disabilities; etc.*)?
 - Is there a strategy for preparing and providing trainings for government, WASH staff and community WASH groups on the safe design and construction of WASH facilities that mitigates the risk of GBV?
 - Are additional costs required to ensure any GBV-related community outreach materials will be available in multiple formats and languages (*e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.*)?
- ▶ When drafting a proposal for emergency response:
 - Is there a clear description of how the WASH programme will mitigate exposure to GBV (for example, in terms of the location and design of facilities)?
 - Do strategies meet standards promoted in the Sphere Handbook?
 - Are additional costs required to ensure the safety and effective working environments for female staff in the WASH sector (*e.g. supporting more than one female staff member to undertake any assignments involving travel, or funding a male family member to travel with the female staff member*)?
- ▶ When drafting a proposal for post-emergency and recovery:
 - Is there an explanation of how the WASH project will contribute to sustainable strategies that promote the safety and well-being of those at risk of GBV, and to long-term efforts to reduce specific types of GBV?
 - Does the proposal reflect a commitment to working with the community to ensure sustainability?

C.

PROJECT DESCRIPTION

- ▶ Do the proposed activities reflect guiding principles and key approaches (*human rights-based, survivor-centered, community-based and systems-based*) for integrating GBV-related work?
- ▶ Do the proposed activities illustrate linkages with other humanitarian actors/ sectors in order to maximize resources and work in strategic ways?
- ▶ Does the project promote/support the participation and empowerment of women, girls and other at-risk groups—including as WASH staff and in local WASH committees?





KEY GBV CONSIDERATIONS FOR: IMPLEMENTATION

The following are some common GBV-related considerations when implementing WASH programming in humanitarian settings. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.

Integrating GBV Risk Reduction into: WASH PROGRAMMING

1. Involve women and other at-risk groups as staff and leaders in the siting, design, construction and maintenance of water and sanitation facilities and in hygiene promotion activities (with due caution in situations where this poses a potential security risk and/or increases the risk of GBV).

- ▶ Strive for 50% representation of females within WASH programme staff. Provide women with formal and on-the-job training in the construction, operation and maintenance of safe WASH facilities, as well as targeted support to assume leadership and training positions.
- ▶ Ensure women (and where appropriate, adolescent girls) are actively involved in community-based WASH committees and management groups. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.
- ▶ Employ persons from at-risk groups in WASH staff, leadership, and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.

2. Implement strategies that increase the availability and accessibility of water for women, girls and other at-risk groups.

- ▶ Strive to place water points no more than 500 metres from households, in accordance with Sphere standards. When water cannot be made available in kitchens, design kitchens that are no more than 500 metres from water points.
- ▶ Ensure hand pumps and water containers are women- and girl-friendly, and are designed in ways that minimize the time spent collecting water.
- ▶ In situations where water is rationed or pumped at given times, work with affected communities to plan schedules. Times should be set that are convenient and safe for women, girls, and other at-risk groups, and users should be fully informed of when and where water is available.



PROMISING PRACTICE

In Morocco, the Rural Water Supply and Sanitation Project of the World Bank aimed to reduce the “burden of girls who were traditionally involved in fetching water”. In the six provinces where the project was based, the time spent collecting water by women and young girls reduced by 50 to 90 percent. Due in part to more convenient access to water, girls’ school attendance increased by 20% in four years.

(Adapted from **World Bank, 2003**. Report No. 25917. http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2003/06/17/000090341_20030617084733/Rendered/PDF/259171MA1Rural1ly010Sanitation01ICR.pdf)





ESSENTIAL TO KNOW

Persons with Disabilities

Persons with disabilities and older persons face additional challenges when trying to safely access WASH facilities in humanitarian emergencies. Girls and women (including older women) with disabilities are especially impacted by both their vulnerability as females and the risks associated with their limited ability. For older persons and persons with disabilities, access to WASH facilities should be promoted through physical accessibility, as well as community outreach which encourages them to use these facilities. Information and education (IEC) materials for sanitation or hygiene should be adapted so that they are accessible for older people and people with disabilities (e.g. audio materials for people with sight impairments, etc.). Regular meetings should be held with older persons and persons with disabilities within the community to monitor safety and access issues. Accessibility measures (in both design and utilisation) should be considered for water points and distribution; water pump design; water containers; and latrine and bathing/shower unit design (e.g. with ramps at entry; more space inside the cubicle; latrine seats and handrails; etc.).

(Information provided by Handicap International, Personal Communication, February 7, 2013. For more information on making WASH facilities accessible, see Handicap International's "Disability Checklist for Emergency Response": http://www.handicap-international.de/fileadmin/redaktion/pdf/disability_checklist_booklet_01.pdf)

- ▶ In IDP/refugee settings, work with receptor/host communities to reduce tension over shared water resources, as this tension can exacerbate the risk of attacks against those collecting water (often women and girls).
- ▶ Implement water distribution patterns that support the sustainable and long-term supply of water. This helps to prevent future water shortages that can place women, girls and other at-risk groups at risk of GBV.
 - Limit the overdraining of ground water resources.
 - Encourage water-saving measures among camp residents.
 - Support the development of community-based drought preparedness plans for refugee/IDP camps with vulnerable water resources (e.g. the construction of rainwater harvesting projects in rural areas).

3. Implement strategies that maximise the safety, privacy and dignity of WASH facilities.

- ▶ Build upon indigenous knowledge and practices to construct age-, gender-, and culturally-sensitive WASH facilities (including toilets, laundry, kitchen and bathing facilities). Take into account cultural norms and practices related to sanitation and hygiene (for example, noting who is responsible for cleaning toilets; noting whether women would feel comfortable using a toilet cleaned by a man; etc.).
- ▶ In consultation with affected communities, locate WASH facilities in safe locations and within safe distances from homes (e.g. toilets no more than 50 metres from homes with a maximum of 20 people using each toilet, in accordance with Sphere standards). Ensure they are accessible to persons with disabilities.



PROMISING PRACTICE

During Oxfam's 2007 Solomon Islands tsunami response, female community mobilisers learned that women were concerned about lack of privacy at wash points. This information was sent to management, and with further consultation with the concerned women, screens were built to provide privacy and a feeling of security.

(Adapted from **Oxfam. 2011. Gender Equality and Women's Rights in Emergencies**, p 57)



- ▶ Ensure adequate lighting both inside and outside WASH facilities. Identify strategies to ensure lighting even without electricity. For example:
 - Provide temporary lighting or solar lighting in early emergencies.
 - Explore and implement electricity alternatives in times of flooding or other natural disaster.
 - Provide families/individuals with torches.
- ▶ Construct culturally-appropriate toilets and bathing facilities that are family-based or sex-segregated. Clearly label these facilities with pictures as well as text, and equip them with doors, sturdy internal locks, privacy fencing, and other safety measures. Use sex-disaggregated data to plan the ratio of female to male cubicles (using the approximate ratio of 3:1, in accordance with Sphere standards).
- ▶ In settings where affected populations must travel some distance to reach WASH facilities, develop strategies to enhance safety along these routes (e.g. safety patrols along paths; escort systems; community surveillance systems; etc.). Work with communities, security personnel, peacekeepers (where appropriate) and other relevant sectors (such as livelihoods, CCCM, and protection) to develop these strategies.
- ▶ In situations where women, girls, and other at-risk groups feel too unsafe to use toilets and other WASH facilities after dark, consider making provisions at the household level (e.g. potties, bucket latrines, etc.).



ESSENTIAL TO KNOW

Transgender Persons

Transgender women are often culturally prohibited from using women's spaces, yet face a high risk of violence and assault in men's spaces. Similarly, transgender men may be excluded from sex-segregated spaces and face increased risk of violence when attempting to use these spaces. When possible, and with the assistance of LGBTI specialists, WASH actors should consult with local transgender organizations to ensure their programmes meet the basic rights and needs of transgender individuals. For instance in Nepal, which has recently recognized a legal third gender category, a third gender-inclusive bathroom was implemented as a means of providing space for those who might not otherwise fit into traditionally sex-segregated spaces. Such strategies, however, are very culture- and context-specific and in some cases might actually increase the risk of GBV against transgender individuals. Therefore, engagement with local communities and local LGBTI experts is essential before implementing any risk-reduction strategies for transgender individuals.

(Information provided by Duncan Breen, Human Rights First, Personal Communication, May 20, 2013; and **Knight, K. 2012.** "Nepal Flushes Out Genderism," http://www.huffingtonpost.com/kyle-knight/nepal-flushes-out-genderism_b_1464279.html)

4. Ensure dignified access to hygiene-related materials.

- ▶ Distribute suitable material for the absorption and disposal of menstrual blood for women and girls of reproductive age.
 - Consult with women and girls to identify the most culturally appropriate materials.
 - Distribute underwear, menstrual hygiene supplies and other sanitary supplies at regular intervals throughout the emergency and to any new arrivals.
 - Support the sustained availability of these supplies post-emergency (for example, undertake a market assessment with livelihoods actors to identify potential opportunities for local production of sanitary supplies as a micro-enterprise).
 - Ensure that the timing and process of distributing these materials does not place women and girls at a higher risk of GBV.



- ▶ Ensure dignified and confidential access to incontinence pads for male and female survivors of sexual assault who have suffered urethral or rectal damage (and may have undergone reconstructive surgery).
- ▶ Include bins for disposable sanitary supplies in female toilets to prevent women, girls, and other at-risk groups from having to dispose of their sanitary supplies in locations or at times that increase their risk of assault or harassment. Include bins in male toilets for disposable incontinence pads to minimize stigmatization of male survivors of sexual assault. Develop sustainable systems for the regular end disposal of sanitary materials. Provide private areas with washing lines for women and girls to wash their undergarments and sanitary supplies.



ESSENTIAL TO KNOW

Hygiene and Dignity Kits

Hygiene kits are often distributed by WASH programmes, Hygiene Promoters, CCCM and protection staff at the onset of emergencies. These kits include items that enhance a person's ability to improve cleanliness (e.g. soap, sanitary materials for women and girls, toothbrushes and toothpaste, etc.). Dignity kits, on the other hand, are often distributed by health or shelter, settlement and recovery (SS&R) actors. They focus on promoting the dignity, respect and safety of women and girls by providing age-, gender-, and culturally-appropriate garments and other items (such as headscarves, shawls, whistles, torches, underwear, and small containers for washing personal items) in addition to sanitary supplies. It is essential that hygiene actors work closely with logisticians, health actors, and SS&R actors to maximize the distribution potential of all of these items and avoid gaps or unnecessary duplication of efforts. Hygiene and dignity kits must also be designed in partnership with the affected community to identify the most appropriate items for inclusion and determine the best timing and process of distribution so as not to increase the risk of GBV against women and girls.

(Adapted from **UNICEF. 2007. WASH related non-food items: A briefing paper. WASH Cluster.** <http://www.unicefemergencies.com/downloads/eresource/docs/WASH/WASH%20Hygiene%20Promotion%20in%20Emergencies.pdf>)

Integrating GBV Risk Reduction into: WASH POLICIES

1. Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of WASH programmes.
 - ▶ Identify and ensure the implementation of programmatic policies that (1) mitigate the risks of GBV and (2) support the participation of women, adolescent girls and other at-risk groups as staff and leaders in WASH activities. These can include, among others:
 - Policies regarding childcare for WASH staff.
 - Standards for equal employment of females.
 - Procedures and protocols for sharing protected or confidential information about GBV incidents.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.
 - ▶ Circulate these widely among WASH staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.).



- 2. Advocate for the integration of GBV risk-reduction strategies into national and local policies and plans related to WASH, and allocate funding for sustainability.**
 - ▶ Support governments, customary/traditional leaders, and other stakeholders in reviewing and reforming policies and plans to address discriminatory practices that hinder women and other at-risk groups from safely participating in the WASH sector (as staff and/or community advisers, in community-based groups, etc.).
 - ▶ Ensure national WASH policies and plans include GBV-related safety measures (e.g. measures regarding safe placement and monitoring of water points and other public WASH facilities).
 - ▶ Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. Undertake awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.

Integrating GBV Risk Reduction into: **WASH COMMUNICATIONS AND INFORMATION SHARING**

- 1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure WASH staff has the basic skills to provide them with information on where they can obtain support.**
 - ▶ Ensure all WASH personnel who engage with affected populations have written information about where to refer survivors for care and support. Regularly update information about survivor services.
 - ▶ Train all WASH personnel who engage with affected populations in gender, GBV, women's/human rights and psychological first aid (e.g. how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).
- 2. Ensure that WASH programmes sharing information about reports of GBV within the WASH sector or with partners in the larger humanitarian community abide by safety and ethical standards.**
 - ▶ Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community.
- 3. Incorporate GBV messages into hygiene promotion and other WASH-related community outreach activities.**
 - ▶ Work with GBV specialists to integrate community awareness-raising on GBV into WASH outreach initiatives (e.g. community dialogues, workshops, meetings with community leaders, GBV messaging, etc.).
 - Ensure this awareness-raising incorporates information on survivor rights (including to confidentiality at the service delivery and community levels), where to report risk and how to access care for GBV.



ESSENTIAL TO KNOW

Referral Pathways

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.



- Use multiple formats and languages to ensure accessibility (e.g. braille; sign language; simplified messaging such as pictograms and pictures; etc.).
- Engage women, girls, men and boys (separately when necessary) in the development of messages and in strategies for their dissemination so they are age-, gender-, and culturally-appropriate.
- ▶ Work with communities to discuss the importance of sex-segregated toilets and bathing facilities, particularly for shared or public facilities. Organize a community-based mechanism to ensure that separate usage is respected.
- ▶ Engage males, particularly leaders in the community, as agents of change in WASH education activities related to the prevention of GBV.
- ▶ Consider the barriers faced by women, girls and other at-risk groups to their safe participation in community discussion forums and educational workshops related to sanitation and hygiene (e.g. transportation; meeting times and locations; risk of backlash related to participation; need for childcare; accessibility for persons with disabilities; lack of access to menstrual hygiene supplies, etc.). Implement strategies to make discussion forums age-, gender-, and culturally-sensitive (e.g. confidential, with females as facilitators of separate women's and girls' discussion groups, etc.) so that participants feel safe to raise GBV issues.
- ▶ Provide community members with information about existing codes of conduct for WASH personnel, as well as where to report sexual exploitation and abuse committed by WASH personnel. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.

! ESSENTIAL TO KNOW

GBV-Specific Messaging

Community outreach initiatives should include dialogue about basic safety concerns and safety measures for the affected population, including those related to GBV. **When undertaking GBV-specific messaging, non GBV-specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**





KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, WASH programmers should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to assist WASH actors to:

- ▶ Design and conduct WASH assessments that examine the risks of GBV related to WASH programming, and strategize with WASH actors about way to mitigate these risks.
- ▶ Provide trainings for WASH staff on issues of gender, GBV and women's/human rights, and how to respectfully and supportively engage with survivors.
- ▶ Identify where survivors who may report instances of GBV to WASH staff can receive safe, confidential and appropriate care, and provide WASH staff with the basic skills and information necessary to respond supportively to survivors.
- ▶ Provide training and awareness raising for the affected community on gender, GBV, and women's/human rights as they relate to WASH.

In addition, WASH programmers should link with other humanitarian sectors to further reduce the risk of GBV. Some recommendations for coordination with other sectors are indicated below (to be considered according to the sectors that are mobilized in a given humanitarian response). While not included in the table, WASH actors should also coordinate with—where they exist—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.



PROMISING PRACTICE

In 2009-2010, a programme in North Kivu Province in the Democratic Republic of the Congo (DRC) linked WASH, protection and health in the prevention of GBV. Links between sanitation and GBV became apparent due to lack of private latrines: women faced no choice but to find private places to defecate, often at night and at a considerable distance away from their homes, increasing their risk to sexual assault. Women also faced violence—including rape—when collecting water from springs outside of the village.

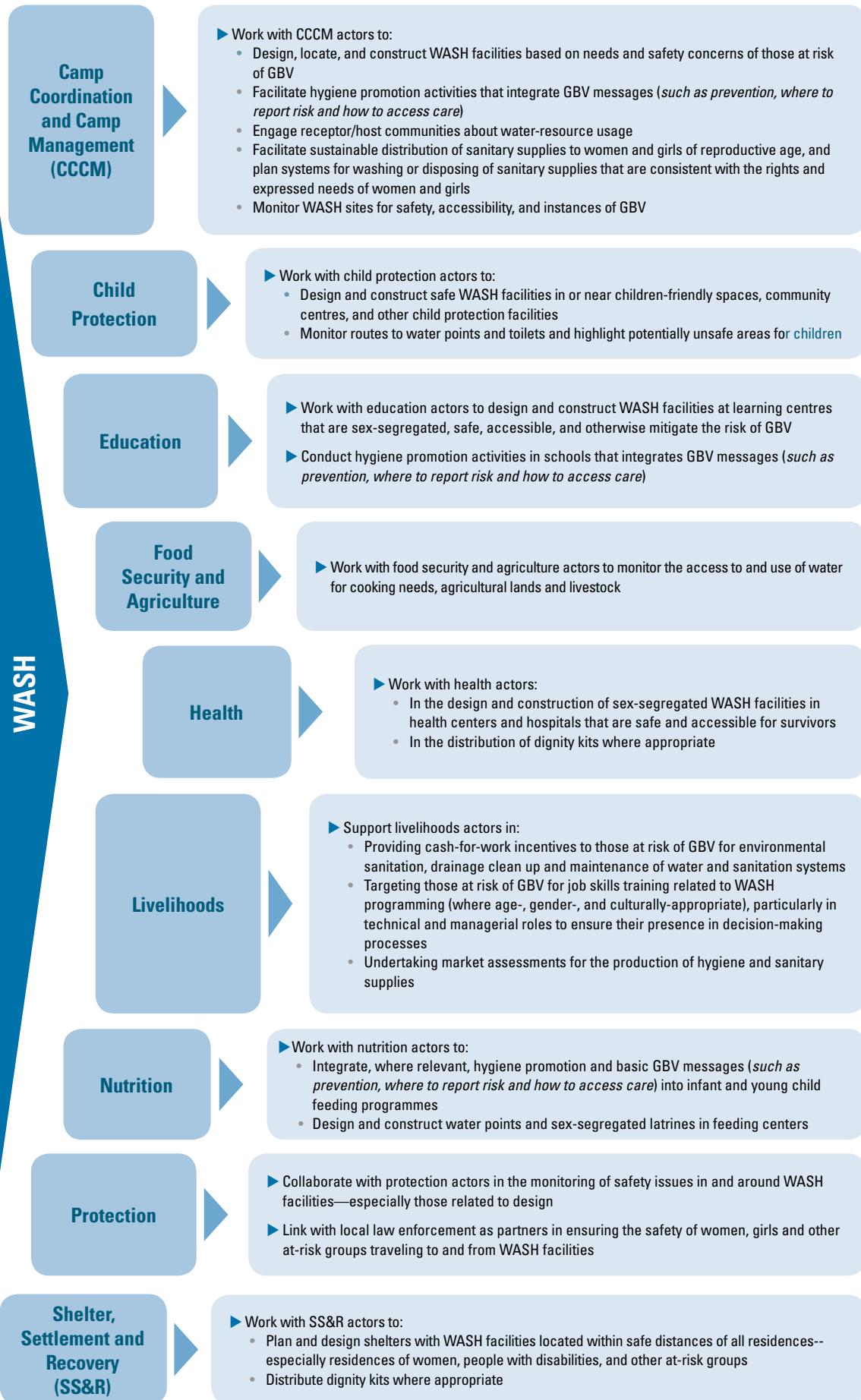
The programme included three areas of focus: health, WASH, and protection. WASH focused on construction of basic WASH facilities in public places (such as schools, hospitals, health centres, markets); promotion of household sanitation, accompanied by health promotion; careful design and maintenance of waterpoints (e.g. clearing pathways, building fencing around waterpoints to make areas safer, ensuring a good flow of water, etc.); and appropriate siting of latrines relative to houses.

In addition, protection committees were established involving men, women, a community leader, church members, a representative from the local authority and the police. Their aim was to raise awareness on sexual violence and its impacts in the community; connect GBV and HIV; denounce any abuses of human rights; and share knowledge on how people could protect themselves. They monitored facilities and pathways to waterpoints and formed the first point of contact in the community for rape allegations, assisting survivors in getting medical and psychological help.

Women were involved as a fundamental part of all processes, including as members of waterpoint and protection committees and in the siting and design of household latrines. The programme found that integrating WASH, protection and health programmes can have a range of positive impacts, and this approach has now been replicated in other areas.

(Adapted from **House, S, Ferron, S, Sommer, M. and Cavill, S. Violence, Gender and WASH: A Practitioner's Toolkit – Making Water, Sanitation and Hygiene Safer through Improved Programming and Services**, WaterAid/SHARE, <http://violence-wash.lboro.ac.uk/>)







KEY GBV CONSIDERATIONS FOR:

MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in WASH assessments ³	$\# \text{ of WASH assessment that include GBV-related questions* from the GBV Guidelines} \times 100$ $\# \text{ of WASH assessment}$ <small>* See page 225 for GBV areas of inquiry that can be adapted to questions in assessments</small>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	$\# \text{ of assessment respondents who are female} \times 100$ $\# \text{ of assessment respondents and}$ $\# \text{ of assessment team members who are female} \times 100$ $\# \text{ of assessment team members}$	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

³ Inter-Agency Standing Committee. November 30, 2012. Reference Module for Cluster Coordination at the Country Level - IASC Transformative Agenda Reference Document. http://www.humanitarianresponse.info/system/files/documents/files/iasc-coordination-reference%20module-en_0.pdf



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Consultations with the affected population on GBV risk factors in and around WASH facilities⁴	$\frac{\# \text{ of WASH facility sites assessed through consultations with the affected population on GBV risk factors in and around WASH facilities} \times 100}{\# \text{ of WASH facility sites}}$	Organizational records, focus group discussion (FGD), key informant interview (KII)	100%		✓	✓
<i>Disaggregate consultations by sex and age</i>						
Female participation prior to WASH facility siting and design⁴	<p><i>Quantitative:</i></p> $\frac{\# \text{ of affected persons consulted before to WASH facility siting and design who are female} \times 100}{\# \text{ of affected persons consulted before to WASH facility siting and design}}$ <p><i>Qualitative:</i></p> <p>How do women and girls perceive their level of participation in WASH facility siting and design? What enhances women and girls' participation in the design process? What are barriers to female participation in these processes?</p>	Organizational records, FGD, KII	Determine in the field		✓	
Staff knowledge of referral pathway for GBV survivors	$\frac{\# \text{ of WASH staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors} \times 100}{\# \text{ of surveyed WASH staff}}$	Survey	100%	✓		✓
RESOURCE MOBILIZATION						
Inclusion of GBV risk reduction in WASH funding proposals or strategies	$\frac{\# \text{ of WASH funding proposals or strategies that include at least one GBV risk reduction objective, activity or indicator from the GBV Guidelines} \times 100}{\# \text{ of WASH funding proposals or strategies}}$	Proposal review (at agency or sector level)	100%	✓	✓	
Stock availability of pre-positioned supplies for GBV risk mitigation	$\frac{\# \text{ of GBV risk reduction supplies* that have stock levels below minimum levels} \times 100}{\# \text{ of GBV risk reduction supplies}}$ <p>* See page 228 for list of supplies</p>	Planning or procurement records, forecasting records	0%	✓	✓	
Training of WASH staff on the GBV Guidelines	$\frac{\# \text{ of WASH staff who participated in a training on the GBV Guidelines} \times 100}{\# \text{ of WASH staff}}$	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	

(continued)

⁴ United Nations Office for the Coordination of Humanitarian Affairs. *Humanitarian Indicator Registry*. <http://www.humanitarianresponse.info/applications/ir/indicators>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme					
				BASE-LINE	OUT-PUT	OUT-COME			
IMPLEMENTATION									
► Programming									
Female participation in WASH community-based committees⁴	<p><i>Quantitative:</i></p> $\frac{\text{\# of affected persons who participate in WASH community-based committees who are female}}{\text{\# of affected persons who participate in WASH community-based committees}} \times 100$ <p><i>Qualitative:</i> How do women and girls perceive their level of participation in WASH community-based committees? What enhances and what are barriers to female participation in WASH committees?</p>	Site management reports, Displacement Tracking Matrix (DTM), FGD, KII	50%		✓	✓			
Female staff in WASH programmes	$\frac{\text{\# of staff in WASH programmes who are female}}{\text{\# of staff in WASH programmes}} \times 100$	Organizational records	50%		✓	✓			
Risk factors of GBV in and around WASH facilities <i>Disaggregate WASH facilities by: water point, bathing and sanitation; time of day; and geographic locations</i>	<p><i>Quantitative:</i></p> $\frac{\text{\# of affected persons who report concerns about experiencing GBV when asked about access to WASH facilities}}{\text{\# of affected persons asked about access to WASH facilities}} \times 100$ <p><i>Qualitative:</i> Do affected persons feel safe from GBV when accessing WASH facilities? What types of safety concerns do persons describe in and around WASH facilities?</p>	Survey, FGD, KII, participatory community mapping	100%		✓	✓			
Access to water point within 500 meters of household⁵	$\frac{\text{\# of affected persons living within 500 meters of water point}}{\text{\# of affected persons}} \times 100$	Direct observation	Determine in the field		✓	✓			
Existence of lockable, sex-segregated WASH facilities in affected areas⁴	$\frac{\text{\# of specified affected areas that have sex-segregated (for shared facilities) and lockable WASH facilities}}{\text{\# of specified in affected areas}} \times 100$	DTM, needs assessment, safety audit	100%		✓	✓			
Presence of functional lighting at WASH facilities	$\frac{\text{\# of WASH facilities with a functional lighting}}{\text{\# of WASH facilities}} \times 100$	Direct observation, safety audit	Determine in the field		✓	✓			
Distribution of culturally-appropriate sanitary materials for females of reproductive age⁴	$\frac{\text{\# of females receiving culturally appropriate sanitary materials for menstruation in a specified time}}{\text{\# of female affected persons of reproductive age in a specified time}} \times 100$	Survey, FGD	Determine in the field		✓	✓			

(continued)

⁵ Sphere Project. 2011. *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*. <http://www.spherehandbook.org>



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme															
				BASE-LINE	OUT-PUT	OUT-COME													
IMPLEMENTATION (continued)																			
<p>► Policies</p> <table border="1"> <tr> <td>Inclusion of GBV prevention and mitigation strategies in WASH policies, guidelines or standards</td> <td> $\# \text{ of WASH policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines} \times 100$ $\# \text{ of WASH policies, guidelines or standards}$ </td> <td>Desk review (at agency, sector, national or global level)</td> <td>Determine in the field</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> </tr> </table>						Inclusion of GBV prevention and mitigation strategies in WASH policies, guidelines or standards	$\# \text{ of WASH policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines} \times 100$ $\# \text{ of WASH policies, guidelines or standards}$	Desk review (at agency, sector, national or global level)	Determine in the field	✓	✓	✓							
Inclusion of GBV prevention and mitigation strategies in WASH policies, guidelines or standards	$\# \text{ of WASH policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines} \times 100$ $\# \text{ of WASH policies, guidelines or standards}$	Desk review (at agency, sector, national or global level)	Determine in the field	✓	✓	✓													
<p>► Communications and Information Sharing</p> <table border="1"> <tr> <td>Staff knowledge of standards for confidential sharing of GBV reports</td> <td> $\# \text{ of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors} \times 100$ $\# \text{ of surveyed staff}$ </td> <td>Survey (at agency or programme level)</td> <td>100%</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Inclusion of GBV referral information in WASH community outreach activities</td> <td> $\# \text{ of WASH community outreach activities programmes that include information on where to report risk and access care for GBV survivors} \times 100$ $\# \text{ of WASH community outreach activities}$ </td> <td>Desk review, KII, survey (at agency or sector level)</td> <td>Determine in the field</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> <td style="text-align: center;">✓</td> </tr> </table>						Staff knowledge of standards for confidential sharing of GBV reports	$\# \text{ of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors} \times 100$ $\# \text{ of surveyed staff}$	Survey (at agency or programme level)	100%	✓	✓	✓	Inclusion of GBV referral information in WASH community outreach activities	$\# \text{ of WASH community outreach activities programmes that include information on where to report risk and access care for GBV survivors} \times 100$ $\# \text{ of WASH community outreach activities}$	Desk review, KII, survey (at agency or sector level)	Determine in the field	✓	✓	✓
Staff knowledge of standards for confidential sharing of GBV reports	$\# \text{ of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors} \times 100$ $\# \text{ of surveyed staff}$	Survey (at agency or programme level)	100%	✓	✓	✓													
Inclusion of GBV referral information in WASH community outreach activities	$\# \text{ of WASH community outreach activities programmes that include information on where to report risk and access care for GBV survivors} \times 100$ $\# \text{ of WASH community outreach activities}$	Desk review, KII, survey (at agency or sector level)	Determine in the field	✓	✓	✓													
COORDINATION																			
Coordination of GBV risk reduction activities with other sectors	$\# \text{ of non-WASH sectors consulted with to address GBV risk reduction activities}^* \times 100$ $\# \text{ of existing non-WASH sectors in a given humanitarian response}$ <small>* See page X for list of sectors and GBV risk reduction activities</small>	KII, meeting minutes (at agency or sector level)	Determine in the field	✓	✓	✓													



RESOURCES

Key Resources

- For a checklist for ensuring gender-equitable programming in the WASH sector, see **Inter-Agency Standing Committee (IASC). 2006. Gender Handbook in Humanitarian Action**, [http://www.humanitarianinfo.org/iasc/documents/subsidiary/gender/IASC%20Gender%20Handbook%20\(Feb%202007\).pdf](http://www.humanitarianinfo.org/iasc/documents/subsidiary/gender/IASC%20Gender%20Handbook%20(Feb%202007).pdf)
- **UNWater. 2006.** "Gender, Water and Sanitation: A Policy Brief." Developed by the InterAgency Task Force on Gender and Water (GWTF). <http://www.unwater.org/downloads/unwpolbrief230606.pdf>
- **House, S., Ferron, S., Sommer, M., and Cavill, S. 2014.** *Violence, Gender and WASH: A Practitioner's Toolkit – Making Water, Sanitation and Hygiene Safer through Improved Programming and Services*, WaterAid/SHARE. <http://violence-wash.lboro.ac.uk/>
- **Global WASH Cluster. 2009.** *WASH Accountability Resources: Ask, Listen, Communicate booklet*. New York, USA: Global Protection Cluster, <http://www.hapinternational.org/pool/files/wash-accountability-handbook.pdf>
- **Handicap International. 2008.** "Disability Checklist for Emergency Response." http://www.handicap-international.de/fileadmin/redaktion/pdf/disability_checklist_booklet_01.pdf. Other equity and inclusion guidance including WASH for persons with disabilities can be accessed through: <https://wecd-knowledge.lboro.ac.uk/collections/equityinclusion/>
- **Sphere Project. 2011.** *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*, <http://www.spherehandbook.org>
- **Oxfam. 2010.** *Ideas that Work: preventing violence against women through water and sanitation interventions in early emergency response*. <http://policy-practice.oxfam.org.uk/publications/Ideas-That-Work-A-gender-WASH-and-emergencies-toolkit-334900>

Additional Resources

- **Global WASH Cluster** - The Global WASH Cluster provides an open and formal platform for humanitarian WASH actors to work together to address key weaknesses in the WASH sector as a whole. A range of resources can be accessed through <http://www.washcluster.info/>
- **Mercy Corps. 2008-2009.** *Water, Sanitation and Hygiene Guidelines*, <http://www.mercycorps.org/sites/default/files/WASH%20Guidelines.pdf>
- **Oxfam. 2013.** *Minimum Requirements for WASH Programmes*, <http://policy-practice.oxfam.org.uk/publications/oxfam-minimum-requirements-for-wash-programmes-mr-wash-300134>
- **OHCHR Special Rapporteur Website:** <http://www.ohchr.org/EN-Issues/WaterAndSanitation/SRWATER/Pages/SRWATERIndex.aspx>
- **WaterAid** is an international non-governmental organisation whose mission is to transform lives by improving access to safe water, improved hygiene and sanitation in the world's poorest communities. For more information see: http://www.wateraid.org/uk/what_we_do/the_need/206.asp. For a slideshow by WaterAid, see: http://www.wateraid.org/uk/what_we_do/how_we_work/equity_and_inclusion/8323.asp
 - For a slideshow by WaterAid on considering equity and inclusion in WASH projects, see: http://www.wateraid.org/uk/what_we_do/how_we_work/equity_and_inclusion/8323.asp
- **The Interagency Task Force on Gender and Water (GWTF).** The Task Force's objectives are to promote gender mainstreaming in the implementation of the Millennium Development Goals (MDGs) related to water and sanitation and the Johannesburg Plan of Implementation (JPOI) at the global, regional, national, local and utility levels. It also promotes coherence and coordination of activities by UN Water members and partners in this area. Task Force activities reflect a long-term strategy and ongoing process of gender mainstreaming, which informs the design and implementation of national planning documents. For more information, see <http://www.unwater.org/TFgender.html>
- **Office of the Special Adviser on Gender Issues and Advancement of Women. 2006.** *Gender, Water and Sanitation: case studies on best practices*. New York, United Nations. http://www.un.org/waterforlifedecade/pdf/un_gender_water_and_sanitation_case_studies_on_best_practices_2006.pdf
- For information on Dignity Kits, see [https://ochanet.unocha.org/p/Documents/Dignity%20Kit%20\(Final\).pdf](https://ochanet.unocha.org/p/Documents/Dignity%20Kit%20(Final).pdf)



- For information on Hygiene Kits, see **UNICEF. 2007. WASH related non-food items: A briefing paper.** WASH Cluster HP project. <http://www.unicefemergencies.com/downloads/eresource/docs/WASH/WASH%20Hygiene%20Promotion%20in%20Emergencies.pdf>
- **Mehrotra, S.T. 2010. A Handbook on Women's Safety Audits in Low-income Urban Neighbourhoods: A focus on essential services.** New Delhi, India: Jagori and Women in Cities International. <http://jagori.org/wp-content/uploads/2006/01/Handbook1.pdf>
- **Water, Engineering and Development Centre,** Barrier analysis and accessibility and safety audit tools: <https://wecd-knowledge.lboro.ac.uk/collections/equity-inclusion/general.html>
- **UNESCO. 2014.** "Puberty Education & Menstrual Hygiene Management, Good Policy and Practice in Health Education, Booklet 9," UNESCO, France. <http://unesdoc.unesco.org/images/0022/002267/226792e.pdf>
- **UNICEF. 2011.** "Water, Sanitation and Hygiene for Schoolchildren in Emergencies: A Guidebook for teachers," UNICEF, USA. http://www.unicef.org/wash/files/WASH_in_Schools_in_Emergencies_Guidebook_for_teachers_.pdf
- **Halcrow, G., C. Rowland, J. Willetts, J. Crawford and N. Carrard. 2010.** "Resource Guide: Working effectively with women and men in water, sanitation and hygiene programmes." Sydney, Australia. http://www.inclusivewash.org.au/_literature_68164/Working_effectively_with_women_and_men_in_water_and_sanitation_programs



HUMANITARIAN OPERATIONS' SUPPORT SECTORS FOCUSING ON LOGISTICS AND TELECOMMUNICATIONS



THIS SECTION APPLIES TO:

- Humanitarian actors (staff and leadership) working in the logistics and telecommunications sectors (whose work is primarily or exclusively to assist other humanitarian actors in carrying out operations)
- Support sector coordination mechanisms

Why Addressing Gender-based Violence is a Critical Concern of Humanitarian Operations' Support Sectors

While most humanitarian actors in emergencies work directly with affected populations, some sectors work to ensure that an uninterrupted supply of life-saving relief items reaches women, girls, men and boys who have been exposed to a humanitarian emergency. **Even if these sector actors have limited interaction with affected populations, they can play an important role in supporting efforts to prevent and mitigate GBV.**

Logistics (including Procurement): The Logistics sector is critical to ensuring the rapid procurement, storage, installation and distribution of essential and life-saving supplies, including supplies that can mitigate the risk of GBV.¹ Logistics departments may be responsible for establishing contracts for constructions, rentals, and casual labours. They may also determine the location and scheduling of distribution points, all of which can influence the risks of GBV.

Emergency Telecommunications: While telecommunications personnel primarily focus on supporting other humanitarian operations, the field of telecommunications and new technologies is continuously evolving. Where infrastructure allows, the use of telecommunications and technology can expand humanitarian actors' capacity to help affected populations. In particular, the field of telecommunications offers exciting opportunities to prevent and mitigate GBV. Although opportunities are generally led by GBV specialists, telecommunications personnel can work with GBV specialists on new

¹ Such supplies can include, among others: food; medicines and medical drugs; post-exposure prophylaxis [PEP] kits; privacy screens for medical examinations; sturdy locks for toilets and bathing facilities; school uniforms or other appropriate clothing; partitions for shelters; ramps and other accessibility features for persons with disabilities; sanitary supplies for women and girls of reproductive age; etc.

technologies to ensure they are developed and used in an ethical and secure manner, so that the benefits of these new strategies outweigh any potential risks (e.g. risks associated with particular messages as well as access and use of technology by males and females). Emerging possibilities for assisting GBV survivors and those at risk through the strategic use of information and communication technologies (ICTs) include:

- ▶ Using mobile phones to disseminate information about GBV services and promote messages related to GBV prevention.
- ▶ Using mobile phones to enable GBV survivors to reach GBV helplines or other venues for reporting violence, or to receive money/cash vouchers.
- ▶ Mapping safe and unsafe areas through Global Positioning Systems (GPS), codifying and confidentially sharing this information with GBV specialists to better inform policy and programming.



KEY ACTIONS FOR HUMANITARIAN OPERATIONS' SUPPORT SECTORS

The following are some of the common GBV-related actions that can be implemented by logistics and telecommunications support sectors operating in humanitarian settings.

1. **Work with GBV specialists to improve the capacity of humanitarian operations' support sector actors (staff, contractors, volunteers) to prevent and mitigate GBV.**
 - ▶ Solicit support from GBV specialists to:
 - Conduct research on the links between the support sector and GBV (e.g. when, why and how GBV-related safety issues arise at the field level; how the sector can be involved in mitigative or supportive actions; how to ensure that women are meaningfully involved in support sectors; how to minimize the potential risks of new technological strategies; etc.).
 - Provide training to all support sector actors about these potential risk factors.
 - ▶ Provide guidance to procurement personnel on the specifications for commonly purchased articles that facilitate prevention of and response to GBV. Link with GBV specialists and other relevant sector actors as needed.
 - ▶ Put in place a mechanism that allows support sector actors to report (e.g. to a supervisor or an identified focal point within a contracting agency) any GBV-related concerns they may observe while carrying out their responsibilities (for example, observing women, girls and other at-risk groups walking in isolated places or being threatened by others in the community).
 - ▶ In cases where support sector actors work with affected populations, provide community members with information about existing codes of conduct for support sector actors, as well as where to report sexual exploitation and abuse committed by support sector actors. Ensure appropriate training is provided for staff and partners on the prevention of sexual exploitation and abuse.



- 2. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure support sector actors have the basic skills to provide them with information on where they can obtain support.**
- ▶ Ensure all actors (staff, contractors, volunteers, etc.) have written information about where to refer survivors for care and support, including who to contact at both the country and global/headquarter levels to refer this information. Regularly update information about survivor services.
 - ▶ Train all actors in issues of gender, GBV, women's/human rights and psychological first aid (e.g., how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).
- 3. Involve women and other at-risk groups² in all aspects of humanitarian operations' support sector activities (with due caution in situations where this poses a potential security risk and/or increases the risk of GBV).**
- ▶ Where appropriate, strive to increase the representation of females as staff and volunteers in support sectors activities.
 - Provide women with formal and on-the-job training as well a targeted support to assume leadership and training positions.
 - Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.
 - ▶ Employ persons from at-risk groups in support sector staff, leadership, and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.
- 4. Incorporate GBV prevention and mitigation strategies into the policies, standards and guidelines of support sectors.**
- ▶ Review and revise sector policies to ensure they integrate GBV prevention and mitigation strategies. These can include, among others:
 - Policies regarding childcare for staff.
 - Standards for equal employment of females, and policies to prevent discrimination in hiring practices.
 - Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse, including immediate termination of a contract where a case is confirmed.
 - Policies to prevent children from working.
 - Policies on age-, gender- and culturally-appropriate and safe housing for staff.

ESSENTIAL TO KNOW**Referral Pathways**

A “referral pathway” is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance, and legal/justice support.

² For the purposes of these Guidelines, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; and separated or unaccompanied children and orphans, including children associated with armed forces/groups. For a summary of the protection rights and needs of each of these groups, see page XXX of these Guidelines.





KEY GBV CONSIDERATIONS FOR: COORDINATION WITH OTHER HUMANITARIAN SECTORS

As a first step in coordination, logistics and telecommunications support sectors operating in humanitarian settings should seek out the GBV coordination mechanism to identify where GBV expertise is available in-country. GBV specialists can be enlisted to:

- ▶ Provide trainings for support sector actors (staff, contractors, and volunteers) on issues of gender, GBV, and women's/human rights.
- ▶ Support research on the links between the support sector and GBV.
- ▶ Review existing (or develop new) sector policies to integrate GBV prevention and mitigation strategies.
- ▶ Identify where survivors who may report instances of GBV exposure to support sector staff can receive safe, confidential and appropriate care, and provide staff who interact with affected populations with the basic skills and information to respond supportively to survivors.

In addition, support sector programmers should link with other humanitarian sectors to meet GBV-related risk-reduction priorities. These include—where they exist and as appropriate—partners addressing gender, mental health and psychosocial support (MHPSS), HIV, age, and environment. For more general information on GBV-related coordination responsibilities, see **Part Two: Background to Thematic Area Guidance**.





KEY GBV CONSIDERATIONS FOR:

MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

The indicators listed below are non-exhaustive suggestions based on the recommendations contained in this thematic area. Indicators can be used to measure the progress and outcomes of activities undertaken across the programme cycle, with the ultimate aim of maintaining effective programmes and improving accountability to affected populations. The '*Indicator Definition*' describes the information needed to measure the indicator; '*Possible Data Source*' suggests existing sources where a sector or agency can gather the necessary information; '*Target*' represents a benchmark for success in implementation; '*Baseline*' indicators are collected prior to or at the earliest stage of a programme to be used as a reference point for subsequent measurements; '*Output*' monitors a tangible and immediate product of an activity; and '*Outcome*' measures a change in progress in social, behavioural or environmental conditions. Targets should be set prior to the start of an activity and adjusted as the project progresses based on the project duration, available resources and contextual concerns to ensure they are appropriate for the setting.

The indicators should be collected and reported by the sector represented in this thematic area. Several indicators have been taken from the sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Thematic Area Guidance** for more information on monitoring and evaluation.

To the extent possible, indicators should be disaggregated by sex, age, disability and other vulnerability factors. See **Part One: Introduction** for more information on vulnerability factors for at-risk groups.

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
Training of support sector staff on the GBV Guidelines	# of support sector* staff who participated in a training on the GBV Guidelines x 100 # of support sector staff <small>* Support sector includes logistics, procurement and telecommunications</small>	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	
Staff knowledge of standards for confidential sharing of GBV reports	# of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors x 100 # of surveyed staff	Survey (at agency or programme level)	100%	✓		✓
Staff knowledge of referral pathway for GBV survivors	# of support sector staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors x 100 # of surveyed support sector staff	Survey	100%	✓		✓
Female staff in support sector positions	# of staff in support sector positions who are female x 100 # of staff in support sector positions	Organizational records	50%	✓	✓	



RESOURCES

Key Resources

- The United Nations Development Programme (UNDP) has identified a variety of ways through which information about GBV services can be deployed. For more information, see **UNDP. 2008. Gender Responsive E-governance: Exploring the Transformative Potential**, http://www.undp.org/content/dam/aplaws/publication/en/publications/womens-empowerment/primers-in-gender-and-democratic-governance-4/f_GenderGovPr_eG_Web.pdf
- **Smith, G., MacAuslan, I., Butters, S., and M. Tromm  , for the Cash Learning Partnership (CaLP). 2012. New Technologies in Cash Transfer Programming and Humanitarian Assistance**, <http://www.cashlearning.org/resources/library/272-new-technologies-in-cash-transfer-programming-and-humanitarian-assistance>
- **OCHA. March 2013. Humanitarianism in the Network Age**, <https://docs.unocha.org/sites/dms/Documents/WEB%20Humanitarianism%20in%20the%20Network%20Age%20vF%20single.pdf>. See <http://irevolution.net/2013/04/09/humanitarianism-network-age/> for a summary of the report.



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KEY GENDER-BASED VIOLENCE RESOURCES

A. Key GBV-Related Coordination Structures

Coordinated action is a cornerstone of effective GBV interventions. Some key coordination partners with a GBV focus and expertise are listed below. Humanitarian actors should access these structures at the global level and locally when seeking assistance in designing and implementing GBV-related prevention and mitigation strategies.

Coordination Structure	Description
GBV Area of Responsibility (GBV AoR)	The GBV AoR is one of five ‘functional components’ of the Protection Cluster. It is the first globally standardized mechanism for facilitating a multi-sectoral approach to GBV prevention and response in humanitarian settings. The responsibilities of the AoRs are comparable to the work of any of the humanitarian clusters. At the global level the work of the GBV AoR is led jointly by UNFPA and UNICEF. At the field level the GBV AoR may alternatively be known as the GBV Sub-Cluster or GBV Working Group. In some settings coordination partners may opt to name the coordination structure something more contextually appropriate, such as Women’s Protection. For more information see: www.gbvaoor.net
Global Health Cluster	At the global level the Health Cluster, led by WHO, aims to strengthen individual and collective capacities to respond better and faster to health issues in humanitarian settings. At country level, health partners work to jointly assess and analyse information, prioritize interventions, build an evidence-based strategy and action plan, monitor the health situation and the health sector response, adapt/re-plan as necessary, mobilize resources and advocate for humanitarian health action. The Health Cluster is tasked to assign a lead agency within the Cluster to support, promote, advocate and lead actions in the area of reproductive health (through an RH working group). This includes the Minimal Initial Service Package (MISP), which addresses prevention and response to sexual violence and more comprehensive reproductive health, including broader GBV as the emergency situation stabilizes. For more information see: http://www.who.int/hac/global_health_cluster/about/en/
UN High Commissioner for Refugees (UNHCR)	In refugee and some displacement contexts, UNHCR has the primary responsibility for the protection of affected populations and their work incorporates action against sexual and gender-based violence as an urgent, core protection issue. They often lead GBV coordination in these contexts. For more information see: http://www.unhcr.org/cgi-bin/texis/vtx/home
United Nations Action Against Sexual Violence in Conflict (UN Action)	UN Action Against Sexual Violence in Conflict (UN Action) is a network of 13 UN entities launched in March 2007. The network aims to amplify UN system-wide efforts to combat conflict-related sexual violence and is cited by the Security Council in all relevant resolutions as a critical coordination platform. UN entities, including field Missions and Country Teams, can request technical and strategic support from UN Action to enhance coordination and cohesion on the ground, for instance through the design of Comprehensive Strategies to combat sexual violence or the deployment of dedicated coordination expertise, and to assist with advocacy and knowledge-building, including through the roll-out and dissemination of practical tools aimed to enhance collective efforts to prevent, report and respond to sexual violence during or in the wake of war. For more information see: http://www.stoprapenow.org
UN Peacekeeping Missions	In multi-dimensional UN peacekeeping operations, the UN has adopted an integrated approach for all parts of the UN system that are active in that country. This means the UN peacekeeping operations and UN Country Team work towards the same strategic vision. A Deputy Special Representative of the Secretary-General (DSRSG) – who is sometimes the Humanitarian Coordinator and the Resident Coordinator of the UN Country Team – ensures effective coordination and integration of efforts. Since the adoption of Security Council Resolutions 1820 and 1888, and with the appointments of a Special Representative to the Secretary-General on Sexual Violence in Conflict, the Department of Peacekeeping Operations (DPKO) is putting in place a more standardized structure to coordinate mission activities in addressing sexual violence, including the deployment of women protection advisors in some peacekeeping missions. For more information see: http://www.un.org/en/peacekeeping/

B. Key GBV Resources

In each thematic area section of **Part Three**, there is a resource list of specific GBV-related tools for that particular sector. The information below offers additional resources for those seeking to increase their general knowledge about GBV and related issues. Also included are IASC documents that reinforce the humanitarian communities' responsibilities to address GBV. Additional information and resources can be accessed through the GBV AoR website: www.gbvaor.net

1. WEBSITES

Topic	Resource	Description
Comprehensive GBV Guidelines and Tools	<i>The Virtual Knowledge Centre to End Violence against Women and Girls</i> http://www.endvawnow.org/en/	An online resource in English, French and Spanish, designed to encourage and support evidence-based programming to more efficiently and effectively design, implement, monitor and evaluate initiatives to prevent and respond to violence against women and girls. To achieve this, the Global Virtual Knowledge Centre offers a 'one stop' service to users by making available the leading tools and evidence on what works to address violence against women and girls. The VKC includes a programming module on conflict/post-conflict.
General GBV Bibliography	<i>Reproductive Health Response in Conflict (RHRC) Consortium GBV Bibliography</i> http://www.rhrc.org/resources/index.cfm?sector=gbv	Comprehensive bibliography of GBV-related resources.
Data	<i>The United Nations Secretary General's Database on Violence Against Women</i> http://sgdatabase.unwomen.org/home.action	The database was developed in response to United Nations General Assembly resolution 61/143 which called for an intensification of efforts to eliminate all forms of violence against women, and requested the Secretary-General to create a coordinated database on violence against women.
Data Collection and Data Management	<i>GBV Information Management System (GBVIMS)</i> http://www.gbvims.com	Provides information about and links to key tools for implementing the GBVIMS. Includes a standardized template for classifying the incidence of GBV, a Standard Intake / Initial Assessment form for standardized data collection (to be used in the context of service delivery), an Excel "incident recorder" for compiling and analyzing reported incident data, and guidelines for developing protocols to facilitate safe information-sharing between agencies.
LGBTI	<i>LGBTI Refugee Portal Project</i> http://portal.oraminternational.org/	Aims to help official bodies and NGOs share approaches to protecting LGBTI refugees and to adopt best practices in the face of rising persecution of LGBTI people globally. This portal showcases projects and approaches that enhance the protection of LGBTI forced migrants in the areas of refugee status determination, policy development and research, practical protection measures and staff development.
Natural Disasters	<i>Gender and Disaster Sourcebook</i> www.gdnonline.org/sourcebook	Hosted by the Gender and Disaster Network, the Sourcebook is a virtual library for all those interested in gender mainstreaming in disaster risk reduction (DRR) and post-disaster management. With information categorised under the following headings: Gender Equality and DRR; Planning and Practice Tools; Good Practices; Communication; Cross Cutting Issues; Training and Education; Case Studies and Analyses; Photo Gallery; and Glossary and Acronyms, the Sourcebook holds a huge number of resources.
Sexual Violence in Conflict and Post-Conflict	<i>Sexual Violence Research Initiative</i> http://www.svri.org/emergencies.htm	This online bibliography and web portal to resources related to sexual violence includes a conflict/post-conflict section, structured according to the priorities identified by WHO, UN Action, SVRI and MRC to disseminate findings which may inform policy and programmes and build knowledge in the area of addressing sexual violence in conflict.
Protection from Sexual Exploitation and Abuse Committed by Humanitarian Actors	<i>Accountability to Affected Populations (AAP) and Protection from Sexual Exploitation and Abuse (PSEA) Task Force</i> http://pseataskforce.org/en/tools	This site has a wide range of resources on the subject of protection from sexual exploitation and abuse (PSEA) committed by personnel of the United Nations (UN), non-governmental organizations (NGOs) and other international organizations and local implementing partners.

(continued)

2. GUIDELINES

Topic	Resource	Description
Child Survivors	Caring for Child Survivors (IRC & UNICEF, 2012) http://www.gbvresponders.org/node/1542	Aims to equip humanitarian field staff working with children and families affected by sexual abuse with core knowledge and competencies for providing care and support. These “how-to” guidelines outline how to communicate, engage, and interview children who have experienced sexual abuse; implement step-by-step case management for cases of child sexual abuse; and provide psychosocial care interventions for child survivors of sexual abuse. In addition, these guidelines contain specific recommendations for how GBV, child protection, and other actors can most effectively coordinate care for a child.
Clinical Care for Intimate Partner Violence and Sexual Violence	Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook (WHO/RHR/14.26, Field testing version, September 2014) http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/index.html	This handbook is based on the World Health Organization (WHO) guideline <i>Responding to Intimate Partner Violence and Sexual Violence Against Women</i> (2013). The handbook offers easy steps and suggestions for health care providers, including: 1. Awareness about violence against women; 2. First-line support for women subjected to violence; 3. Additional clinical care after sexual assault; 4. Additional support for mental health.
Clinical Management of Rape	Clinical management of survivors of rape: developing protocols for use with refugees and internally displaced persons (WHO/UNHCR, 2004) http://www.who.int/reproductivehealth/publications/emergencies/924159263X/en/	Describes best practices in the clinical management of people who have been raped in emergency situations. It is intended for adaptation to each situation, taking into account national policies and practices, and availability of resources, materials and drugs. It can also be used in planning care services and in training health care providers. Includes detailed guidance on the clinical management of women, men and children who have been raped.
Coordination	Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings (GBV AOR, provisional edition 2010; finalized edition 2015) http://gbvaor.net	Intended as a quick reference tool for all individuals and agencies involved in GBV programming and coordination. Practical guidance on leadership roles, key responsibilities and specific actions to be taken when establishing and maintaining GBV coordination mechanisms in a humanitarian setting. The handbook can also be used as an education and advocacy tool about basic protection responsibilities related to GBV coordination, prevention and response.
Data Collection (also see GBVIMS website, above)	WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies (WHO, 2007) http://www.who.int/gender/documents/violence/9789241595681/en/	The ethical and safety guidelines (or recommendations) in this document are meant to complement existing internationally-agreed ethical guidelines for research and to inform ethics review processes. The recommendations apply to all forms of inquiry about sexual violence in emergencies, including research, human rights documentation, and GBV programme monitoring and evaluation.
	Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries: Do's and Don'ts (UN Action, 2008) http://www.stoprapenow.org/uploads/advocacyresources/1282164733.pdf	This Note is intended to assist staff from UN Country Teams and Integrated Missions to improve data collection, analysis and reporting on sexual violence in conflict. Any data collected on sexual violence must respect established ethical and safety principles, such as security, confidentiality, anonymity, informed consent, safety and protection from retribution, and protection of the data itself.
	Gender-based Violence Tools Manual: For Assessment, Program Design, Monitoring and Evaluation in Conflict-Affected Settings (RHRC, 2004) http://www.rhrc.org/resources/gbv/gbv_tools/manual_toc.html	The tools in this manual have been formulated according to a multi-sectoral model of GBV programming that promotes action within and coordination between the constituent community, health and social services, and the legal and security sectors. The manual is meant to be used by humanitarian professionals who have experience with and are committed to GBV prevention and response.
	International Protocol on the Investigation and Documentation of Sexual Violence in Conflict (Foreign and Commonwealth Office, 2014) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319054/PSVI_protocol_web.pdf	Launched in June 2014 as part of the <i>UN Declaration of Commitment to End Sexual Violence in Conflict</i> , the objective of these protocols is to act as a consistent set of guidelines that are used by first responders to ensure that survivors of sexual violence receive consistent and sympathetic responses, and also to ensure that information collected from survivors (physical and testimony) is taken and stored in a way that assists future prosecutions or other justice mechanisms.

(continued)

2. GUIDELINES (continued)

Topic	Resource	Description
Disability	<p>Disability Inclusion: Translating Policy into Practice in Humanitarian Action (WRC, 2014)</p> <p>http://womensrefugeecommission.org/programs/disabilities/disability-inclusion</p>	Documents positive practices and ongoing challenges to promote disability inclusion across UNHCR's and its partners' work in multiple countries and multiple displacement contexts. The report provides lessons and recommendations for other organizations and the wider humanitarian community on engaging persons with disabilities at all levels of humanitarian work, including work related to GBV.
Emergency Response	<p>GBV Emergency Toolkit (IRC, updated 2014)</p> <p>http://www.gbvresponders.org/emergency-toolkit#ER</p>	The IRC Women's Protection & Empowerment (WPE) Unit developed the <i>GBV Emergency ToolKit</i> based on years of experience responding to GBV in emergencies. The ToolKit, designed to strengthen our global response and preparedness, includes ready-to-use tools and templates, as well as guidelines and examples of best practice.
Engaging Men and Boys	<p>Engaging Men through Accountable Practice (IRC, 2014)</p> <p>For more information contact: Abby Erikson at Abigail.Erikson@rescue.org</p>	Aims to build the knowledge and skills of practitioners designing, implementing, and/or providing oversight to GBV programmes and/or GBV prevention activities in humanitarian/post-conflict settings. The resources package introduces an evidence-based curriculum and field tested approach to engaging men in weekly discussion groups that foster opportunities to challenge belief systems, learn through reflection and group discussion, and make individual-level changes. Includes a guidance package for accountable practice with men in post-conflict settings; an activity guide containing weekly lessons for working with men and women in single-sex groups, facilitator guidance and monitoring tools; and a training guide.
General Prevention and Response	<p>Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response (UNHCR, 2003)</p> <p>http://www.unhcr.org/3f696bcc4.html</p>	These Guidelines offer practical advice on how to design strategies and carry out activities aimed at preventing and responding to sexual and gender-based violence. They also contain information on basic health, legal, security and human rights issues relevant to those strategies and activities. They are intended for use by UNHCR staff and operational partners involved in protection and assistance activities for refugees and the internally displaced.
Monitoring and Evaluation	<p>Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators (Measure Evaluation, University of North Carolina at Chapel Hill, 2008)</p> <p>http://www.cpc.unc.edu/measure/tools/gender/violence-against-women-and-girls-compendium-of-indicators</p> <p>Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions Along the Relief to Development Continuum (USAID, 2014)</p> <p>http://www.usaid.gov/gbv/monitoring-evaluating-toolkit</p>	<p>A compendium of monitoring and evaluation indicators focused on violence against women and girls. Organised by topic/sector of action, any of the indicators may be appropriate in humanitarian settings; there is also a specific Humanitarian Settings chapter with more targeted indicators for these settings.</p> <p>USAID developed this toolkit to support the implementation of the U.S. Strategy to Prevent and Respond to Gender-based Violence Globally. The toolkit is designed to help users to:</p> <ul style="list-style-type: none"> Determine the effectiveness of GBV programmes by adapting and applying tested M&E practices and tools to collect GBV data and analyze evidence of GBV results. Design and implement an M&E plan for GBV interventions along the RDC. Use M&E information to realign, adjust, improve and institutionalize GBV programmes. Coordinate the GBV M&E actions of humanitarian assistance and development actors.

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2. GUIDELINES (continued)

Topic	Resource	Description
Natural Disasters	<p>Secretary General's Report on Gender Equality and the Empowerment of Women in Natural Disasters (UNSG, 2014)</p> <p>http://un.org.au/2014/01/29/secretary-general-report-gender-equality-and-the-empowerment-of-women-in-natural-disasters/</p>	Suggests how to address gender equality and women's empowerment in natural disasters within the existing United Nations framework. Outlines developments in inter-governmental and intra-agency strategies and policies, as well as actions taken by Member States, the UN and humanitarian agencies related to GBV prevention and response. Calls for recommendations for monitoring and accountability.
Prevention	<p>SASA! Activist Kit for Preventing Violence against Women and HIV (Raising Voices, 2008)</p> <p>http://raisingvoices.org/sasa/#tabs-419-0-1</p>	<i>SASA!</i> is a comprehensive approach to community mobilization to prevent violence against women and HIV, documented in a user-friendly programme tool. The <i>SASA!</i> Toolkit includes practical resources, activities and monitoring and assessment tools for local activism, media and advocacy, communication materials and training that organizations working on violence or HIV/AIDS can use to incorporate these cross-cutting issues into their work.
	<p>Communities Care: Transforming Lives and Preventing Violence (UNICEF, 2014)</p> <p>For more information, contact Mandy Marsh: mmarsh@unicef.org</p>	The <i>Communities Care: Transforming Lives and Preventing Violence Programme</i> (CC Programme) is a pilot initiative that aims to prevent sexual violence against women and girls in communities affected by conflict by working with communities to transform harmful social norms that promote sexual violence into norms that promote non-violence and that uphold women's and girl's equality, safety and dignity. The programme also aims to build capacity within communities to provide good quality care and support to survivors and their families.
Protection of Women and Girls	<p>UNHCR Handbook for the Protection of Women and Girls (UNHCR, 2008)</p> <p>http://www.refworld.org/docid/47fcf2962.html</p>	Describes some of the protection challenges faced by women and girls and outlines various strategies to tackle these challenges. It sets out the legal standards and principles that guide work to protect women and girls and outlines the different roles and responsibilities of States and other actors. Suggestions for actions by UNHCR and partners to support women's and girls' enjoyment of their rights are also included. Examples of innovative practices from the field illustrate how these principles can be applied.
Protection of Other Groups	<p>UNHCR Need to Know Guidance Series (UNHCR, 2011-2013)</p> <p>http://www.globalprotectioncluster.org/en/tools-and-guidance/essential-protection-guidance-and-tools/age-gender-diversity-essential-guidance-and-tools.html</p>	Aims to provide field practitioners with an essential introduction to, and action-oriented advice on, a range of protection issues. Includes key considerations for working with persons with disabilities; LGBTI persons; national or ethnic, religious and linguistic minorities and indigenous people; older persons; and men and boys survivors of sexual violence.
Psychological First Aid	<p>Psychological First Aid: Guide for Field Workers (WHO, War Trauma Foundation and World Vision International, 2011)</p> <p>http://www.who.int/mental_health/publications/guide_field_workers/en/</p>	This guide covers psychological first aid which involves humane, supportive and practical help to fellow human beings suffering serious crisis events. It is written for people in a position to help others who have experienced an extremely distressing event. It gives a framework for supporting people in ways that respect their dignity, culture and abilities. Endorsed by many international agencies, the guide reflects the emerging science and international consensus on how to support people in the immediate aftermath of extremely stressful events.
Reproductive Health/Minimum Initial Service Package (MISP)	<p>Inter-agency Field Manual on Reproductive Health in Humanitarian Settings (IAWG, 2010)</p> <p>http://www.iawg.net/resources/field_manual.html</p> <p>For specific information on MISP, see: http://www.iawg.net/resources/MISP%20cheat%20sheet%202012%2017%2009_FINAL.pdf</p>	Guidelines for health providers on comprehensive reproductive health including: Maternal and newborn health care, Family Planning, Comprehensive Abortion Care, Gender-based Violence, Sexually Transmitted Infections, HIV, Adolescent Reproductive Health. Provides guidance on: <ul style="list-style-type: none"> • Protecting women and girls from sexual violence and ensuring that survivors have access to medical care from the very onset of an emergency. • How to implement the Minimum Initial Service Package (MISP), a minimum standard of care and coordinated set of priority activities which includes preventing and managing the consequences of sexual violence in humanitarian response.

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2. GUIDELINES (continued)

Topic	Resource	Description
Standard Operating Procedures	Establishing GBV Standard Operating Procedures (IASC Sub-working Group on Gender and Humanitarian Action, 2008) http://gbvar.net/resource/gbv-standard-operating-procedures-training-workshop-2008-english/	The SOP Guide provides clear and concrete information and a step by step process for working with an interagency multi-sectoral team to develop well coordinated prevention and response to GBV. Includes a fill-in and adaptable template for creating SOPs.

3. TRAINING TOOLS

Topic	Resource	Description
Advocacy , face to face training	GBV Emergency Response and Preparedness in Emergencies: Participant Handbook, "Module 5: Advocating in Emergencies" (IRC, 2011) http://gbvresponders.org/resources/	This module, part of a larger training package on emergency response and preparedness, focuses on issues related to conducting advocacy on GBV in humanitarian contexts, including where to target advocacy efforts, and considerations for undertaking advocacy in insecure settings.
Caring for Survivors , face to face training	Caring for Survivors of Sexual Violence in Emergencies Training Guide (IASC Gender Sub-Working Group and GBV AoR, 2010) http://www.unicefemergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf	The training pack provides information and skills development in various aspects related to communication and engagement with sexual violence survivors in conflict-affected countries or complex emergencies. It also focuses on medical care for survivors. The training manual is designed for professional health care providers, members of the legal profession, police, women's groups and other concerned community members, such as community workers, teachers and religious workers.
Clinical Management , E-learning (online or download)	Clinical Management of Rape e-learning Programme (WHO, UNHCR & UNFPA, 2009) http://www.who.int/hac/techguidance/pht/womenshealth/en/index.html	Aimed at giving health care providers (nurses, midwives & physicians) an opportunity to learn about how to provide an appropriate and integrated package of care to rape survivors in humanitarian settings. Based on the content of the WHO/UNHCR guidance on <i>Clinical Management of Rape Survivors</i> and training materials used by UNHCR and UNFPA.
Clinical Management , face to face training	Clinical Care for Assault: A Multimedia Tool (IRC and University of California Los Angeles, 2009, revised 2014) http://www.iawg.net/ccsas	The goal of this training tool is to improve the clinical care of sexual assault survivors in low resource settings by encouraging compassionate, competent, and confidential care in keeping with international standards. It is intended for all clinic workers who interact with sexual assault survivors, with a separate section specifically for non-medical staff. This is a group training with a facilitator and is not intended as a self-teaching tool. It is designed for all levels of clinic staff from cleaners to nurses and physicians.
Communication Skills with Survivors , face to face training	Communication Skills in Working with Survivors of GBV: A Five-Day Training of Trainers Workshop (FHI, IRC, & RHRC, 2002) http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html	This is a 5-day training guide, beginning with an overview of GBV and then covering areas including: engagement strategies for working with GBV survivors; methods to support the service provider; service provider responsibilities; and community referrals facilitation. Includes skills overview, training review, and evaluation.
	Mental health and gender-based violence: Helping survivors of sexual violence in conflict – a training manual (Sveaass, N., Drews, D., Salvesen, K., Christie, H., Dahl S., With, A. & Langdal, E., 2014) http://hhri-gbv-manual.org	This training material has been written for individuals who provide assistance and support to women who survive gender-based violence (GBV) and sexual trauma during disasters, wars and conflicts. The goal of this manual is to provide information on the effects of GBV on mental health, and how to use this knowledge when engaging with survivors of GBV. This training has been developed for use in situations where helpers have limited or no access to specialised health services, and where humanitarian workers must deal with severe human loss, sorrow and distress in the midst of insecurity, conflict and war.

(continued)

3. TRAINING TOOLS (continued)

Topic	Resource	Description
Coordination, face to face training	<p><i>Coordination of Multi-Sectoral Response to GBV in Humanitarian Settings</i> (developed by UNFPA and ICRH, publication pending)</p> <p>To be posted at: http://gbvaor.net</p>	Designed to train field-based GBV programme managers and related practitioners to coordinate multi-sectoral interventions to address GBV in humanitarian settings. Objectives are to improve knowledge, understanding and communication skills to effectively prevent and respond to GBV and to build technical capacity in the coordination of a multi-sectoral response to GBV. Offered annually in Belgium since 2007, the curriculum will be finalized and the aim is for the course to be rolled out in regional locations.
Coordination, Focusing on Child Protection and GBV linkages, face to face training	<p><i>Protecting Women and Child Survivors through Improved Coordination: A Training Curriculum</i> (IRC, UNICEF, 2011)</p> <p>For more information contact Mandy Marsh: mmarsh@unicef.org</p>	The content of the curriculum is designed to complement existing training materials, guidelines and resources developed to address violence against women and girls. The IRC-UNICEF collaboration is unique, however, in its attention to the coordination of specialized services for child survivors, and its focus on links between GBV and child protection coordinating bodies.
Design and Management of GBV Programmes, multi-phased learning programme, E-learning, face to face training	<p><i>Managing GBV Programmes in Emergencies</i> (developed by UNFPA for the GBV AOR, 2012)</p> <p>E-learning: https://extranet.unfpa.org/Apps/GBVinEmergencies/index.html</p> <p>Companion Guide: http://www.unfpa.org/public/home/publications/pid/10495</p> <p>Face-to-Face Training Manual: Contact Erin Kenny: ekenny@unfpa.org</p>	Aims to build professional competencies to design and manage GBV programmes. E-learning is an overview of GBV in humanitarian settings and the fundamentals of how to address it. Face to face course focuses on day-to-day responsibilities of designing and managing GBV programmes; building skills for assessment, participatory methods, programme design, case management, etc. Follow up and continued learning/networking will include meetings and online methods.
Domestic Violence Prevention, face to face training	<p><i>Rethinking Domestic Violence: A Training Process for Community Activists</i> (Raising Voices, 2004)</p> <p>http://raisingvoices.org/innovation/creating-methodologies/rethinking-domestic-violence/</p>	This is a tool for strengthening the capacity of a wide range of community members to prevent domestic violence. It is a series of training sessions that can be used individually or as a part of a longer process. It can help participants think about, discuss, and take action to prevent domestic violence. It is a practical tool for trainers and activists who want to begin a process of change in their community.
Emergency Response, face to face training	<p><i>GBV Emergency Response & Preparedness</i> (IRC, 2011)</p> <p>http://www.gbvresponders.org/</p>	Aims to equip a cadre of field-based practitioners with the skills and knowledge necessary to effectively and rapidly launch a response to GBV in emergencies. The curriculum is designed to complement existing training materials and resources developed by other agencies and experts, and operationalize key guidelines.
Engaging Boys and Men, face to face training	<p><i>Engaging Boys and Men in GBV Prevention and Reproductive Health in Conflict and Emergency Response – A Workshop Module</i> (Engender Health and CARE, 2008)</p> <p>http://www.engenderhealth.org/files/pubs/gender/map/ConflictManual.pdf</p>	This curriculum is designed to build the skills of participants working to engage boys and men in the prevention of GBV and in the promotion of reproductive health in conflict and other emergency-response settings. The two-day participatory module provides a framework for discussing strategies for male engagement, based on the phases of prevention and response in conflict and displacement. Specific audiences are NGO project managers, field staff, health sector coordinators, health promoters, donor representatives, local ministry of health representatives, and community liaisons working for UN agencies.
Multi-sectoral, inter-agency Introduction to GBV Prevention and Response, face to face training	<p><i>Training Manual - Multi-sectoral & Interagency Prevention and Response to GBV in Populations Affected Armed Conflict</i> (RHRC, 2004)</p> <p>http://www.rhrc.org/resources/gbv/gbv_manual/full.pdf</p>	This curriculum outlines a 2-3 day training and planning workshop for multi-sectoral GBV teams. The purpose is to support GBV teams to develop or strengthen plans for multi-sectoral prevention and response. Curriculum covers basic information/definitions, causes, consequences, and outlines prevention and response strategies including coordination and planning.

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3. TRAINING TOOLS (continued)

Topic	Resource	Description
Natural Disasters, face to face training	Oxfam Gender and Disaster Risk Reduction Training Pack (Oxfam GB, 2011) http://policy-practice.oxfam.org.uk/publications/gender-and-disaster-risk-reduction-training-pack-136105	Unequal power relations between women and men mean that, despite the resilience and capacity for survival that women often display when coping with disaster, they also experience a range of gender-specific vulnerabilities during disasters. The pack - which was designed for Oxfam programme staff, partner organisations, and agencies working in disaster risk reduction (DRR) - aims to provide a 'gender lens' through which DRR workers can plan, implement, and evaluate their work. The pack seeks to develop participants' skills and competencies in addressing gender issues throughout the project cycle, and provides a self-contained set of modules, case studies, and exercises to be used in training workshops, all written in accessible language, and assuming no prior knowledge of gender issues.
Protection, face to face training	Protection Mainstreaming Training Package (Global Protection Cluster, 2014) http://www.globalprotectioncluster.org/en/areas-of-responsibility/protection-mainstreaming.html	The IASC Principals Statement on the Centrality of Protection in Humanitarian Action (2013) recognises the role of the protection cluster to support protection strategies, including mainstreaming protection throughout all sectors. To support the realisation of this, the Global Protection Cluster has committed to providing support and tools to other clusters, both at the global and field level, to help strengthen their capacity for protection mainstreaming. This training package is a key tool for field clusters to make protection mainstreaming a concrete reality.
Psychological First Aid, face to face training	Psychological First Aid: Facilitators Manual for Orienting Field Workers (WHO, War Trauma Foundation and World Vision International, 2011) http://apps.who.int/iris/bitstream/10665/102380/1/9789241548618_eng.pdf	This manual is designed to orient helpers to offer psychological first aid (PFA) to people following a serious crisis event. PFA involves humane, supportive and practical assistance for people who are distressed, in ways that respect their dignity, culture and abilities. This facilitator's manual is to be used together with the <i>Psychological first aid: Guide for field workers</i> (World Health Organization, War Trauma Foundation, World Vision International, 2011).
Sexual Exploitation & Abuse, face to face training	Interagency Training for Focal Points on Protection from Sexual Exploitation and Abuse (ECHA-ECPS PSEA Taskforce, 2010) http://pseataskforce.org/en/	A three-day Interagency Training for Focal Points on Protection from Sexual Exploitation and Abuse: a "four pillar" framework for addressing SEA; responsibilities of senior managers, focal points, and in-country networks; victim assistance, etc. Also includes a one-day "learning event" for senior Managers.
Standard Operating Procedures, face to face training	SOP Workshop Package (GBV AOR, 2010) http://gbvaor.net	Training package for developing new or improving existing SOPs. Includes detailed orientation to the contents of the SOP Guide and best practices for the process of developing SOPs. Includes a "report card" for reviewing existing SOPs and developing plans for strengthening and improving this tool and its use in field sites.

4. INTER-AGENCY STANDING COMMITTEE (IASC) TOOLS

Tool	What it is	How it relates to GBV
Women, Girls, Boys & Men. Different Needs – Equal Opportunities (IASC Gender Handbook for Humanitarian Action, 2006) http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-products-products&productcatid=3	Provides standards for the integration of gender issues from the outset of a new complex emergency or disaster, so that humanitarian services provided neither exacerbate nor inadvertently put people at risk; reach their target audience; and have maximum positive impact.	<ul style="list-style-type: none"> Gender and GBV programming are complementary—they are not interchangeable. Mainstreaming gender into humanitarian interventions does not, on its own, prevent or ensure an adequate response to GBV. Yet gender-equality programming is critical to any long-term efforts to address GBV and should be initiated from the start of any humanitarian intervention. Gender actors—such as the GenCap Advisors, gender theme groups and gender focal points in agencies and organizations—are responsible for ensuring the broader responsibilities of gender mainstreaming.

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4. INTER-AGENCY STANDING COMMITTEE (IASC) TOOLS (continued)

Tool	What it is	How it relates to GBV
IASC Gender E-Learning Course (2010) http://www.interaction.org/iasc-gender-elearning	This online course provides the basic steps a humanitarian worker must take to ensure gender equality in programming. The course includes information on the core issues of gender and how it relates to other aspects of humanitarian response. The three hour, self-paced course provides information and scenarios which enable you to practice developing gender-sensitive programming.	<ul style="list-style-type: none"> This training is based on, and supplements, the IASC Gender Handbook and related IASC guidelines, including the Guidelines for Gender-based Violence Interventions in Humanitarian Settings and others. It covers 8 clusters (CCCM, Education, Food Issues, Health, Livelihoods, NFIs, Shelter, WASH) so that humanitarian actors can gain cross-cutting skills in developing gender-sensitive programming.
IASC Gender Marker https://www.humanitarianresponse.info/topics/gender/page/iasc-gender-marker	The IASC Gender Marker is a tool that codes, on a 0 – 2 scale, whether or not a humanitarian project is designed well enough to ensure that women/girls and men/boys will benefit equally from it or that it will advance gender equality in another way.	<ul style="list-style-type: none"> If a project has the potential to contribute to gender equality, the gender marker predicts whether the results are likely to be limited or significant. This webpage also provides links to more information on the GenCap Project and the IASC Gender Reference Group (RG), as well as guidance for implementing the Gender Marker and Gender Marker Cluster-specific tipsheets.
IASC Policy Statement on Gender Equality in Humanitarian Action (2008) http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-common-default&sb=1	Sets out actions to be taken by the IASC to ensure gender equality, including through women's empowerment, is fully incorporated in all IASC work towards more effective and coherent humanitarian action.	<ul style="list-style-type: none"> Gender equality include gender mainstreaming, gender analysis, prevention and response to GBV and SEA, promotion and protection of human rights, empowerment of women and girls, and gender balance in the workplace.
IASC Guidelines for Addressing HIV in Humanitarian Settings (2010) http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-products-products&productcatid=9	<ul style="list-style-type: none"> Aims to assist humanitarian and AIDS organizations to plan the delivery of a minimum set of HIV prevention, treatment, care and support services to people affected by humanitarian crises. Provides background information on HIV and humanitarian crises. Provides information on the sectoral response to HIV in humanitarian settings for nine key sectors. 	<ul style="list-style-type: none"> Describes the links between HIV and GBV. Provides minimum and expanded actions for protecting populations from GBV, particularly for the Health and Protection sectors.
IASC Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings (2007) http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_mhps-default	Enables humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergencies. These guidelines are currently being updated.	<ul style="list-style-type: none"> GBV is a known risk factor for mental health and psychosocial wellbeing, including fear, sadness, anger, self-blame, shame, sadness or guilt, anxiety disorders (such as post-traumatic stress disorder), mood disorders and substance abuse issues. The MHPSS Guidelines describe key links, such as providing psychological first aid and basic mental health care by primary health care workers, and adherence to the guiding principles.

ANNEX 2

GLOSSARY OF SEXUAL ORIENTATION AND GENDER-IDENTITY (SOGI) RELATED TERMS*

Term	Definition/Description
Bisexual	An individual who is physically, romantically and/or emotionally attracted to both men and women. Bisexuals need not have had equal sexual experience with both men and women. In fact, they need not have had any sexual experience at all to identify as bisexual.
Cisgender	An umbrella term for people whose gender identity and/or gender expression corresponds with the sex they were assigned at birth.
Closeted	A term used to describe a person who is not open about his or her sexual orientation and/or gender identity
Cross-dressing	To occasionally wear clothes traditionally associated with people of the other sex. Cross-dressers are usually comfortable with the sex they were assigned at birth and do not wish to change it. Cross-dressing is a form of gender expression and is not necessarily tied to erotic activity. A cross-dresser is sometimes referred to as a transvestite.
Coming out	A lifelong process of self-acceptance. People forge a lesbian, gay, bisexual or transgender identity first to themselves and then may reveal it to others. Publicly identifying one's sexual orientation may or may not be part of coming out.
Gay	Used to describe people whose enduring physical, romantic and/or emotional attractions are to people of the same sex (e.g., gay man, gay people). Often used to describe a man who is sexually attracted to other men, but may be used to describe lesbians as well.
Gender Expression	The external manifestation of one's gender identity, usually expressed through "masculine," "feminine" or gender-variant behavior, clothing, haircut, voice or body characteristics. Typically, transgender people seek to make their gender expression match their gender identity, rather than their birth-assigned sex.
Gender Identity	Refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms.
Heterosexual	A person whose enduring physical, romantic and/or emotional attraction is to people of the opposite sex; also referred to as being straight
Homosexual	A clinical term defining a person attracted primarily to people of the same sex. It may be considered derogatory and offensive by some gay people, and gay and/or lesbian is often a preferred term.
Homophobia	Fear, hatred or intolerance of lesbians and gay men.
Intersex	Refers to a condition of having sexual anatomy that is not considered "standard" for a male or female. Intersex can be used as an umbrella term covering differences of sexual development, which can consist of diagnosable congenital conditions in which development of chromosomal, gonadal or anatomic sex is atypical. The term intersex is not interchangeable or a synonym for transgender.
Lesbian	A woman whose enduring physical, romantic and/or emotional attraction is to other women. Some women prefer to be referred to as gay or gay women.
LGBT or LGBTI	An acronym for "lesbian, gay, bisexual and transgender" persons. Sometimes, persons with intersex conditions are also included, in which case the acronym becomes LGBTI.
Outing	The act of publicly declaring (sometimes based on rumor and/or speculation) or revealing another person's sexual orientation without his or her consent.
Queer	Traditionally a pejorative term, queer has been reclaimed by some LGBT people as a term to describe themselves

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*The Glossary is adapted from Annex 1 in UNHCR. 2010. *The Protection Of Lesbian, Gay, Bisexual, Transgender And Intersex Asylum-Seekers And Refugees. A Discussion Paper*, <http://www.refworld.org/pdfid/4cff9a8f2.pdf>. The terminology itself was adapted from the following sources: Gay & Lesbian Alliance Against Defamation (GLAAD). 2010. *Media Reference Guide, 8th edition*, Glossary of Terms, <http://www.glaad.org/document.doc?id=99>; Human Rights Watch. 2009. "They Want Us Exterminated": Murder, Torture, Sexual Orientation and Gender in Iraq, Glossary, <http://www.hrw.org/node/85050>; and The Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity. 2007. http://www.yogyakartaprinciples.org/principles_en.pdf

Term	Definition
Sex	The biological classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics including: chromosomes, hormones, internal reproductive organs, and genitals.
Sexual Orientation	Refers to each person's capacity for profound emotional, affectational and sexual attraction to, and intimate relations with, individuals of a different gender or the same gender or more than one gender.
Sexual Minorities	An umbrella term used to describe persons subject to discrimination and abuse due to their non-conformance with prevailing gender norms. Sometimes used in place of LGBT, or LGBTI.
Sodomy Laws	Laws that were historically used to selectively punish gay men, lesbians and bisexuals. These laws have been struck down in many countries.
Transgender	An umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. The term may include but is not limited to: transsexuals, cross-dressers, and other gender-variant people. Transgender people may identify as female-to-male (FTM), male-to-female (MTF), or other genders altogether. Transgender people may or may not decide to alter their bodies hormonally and/or surgically.
Transsexual	An older term that originated in the medical and psychological communities. Unlike the term transgender, the word transsexual has a precise medical definition and is considered narrower in scope than transgender.
Transition	A term for the process of altering one's birth sex. This is a complex process that occurs over a long period of time. Transition includes some or all of the following personal, legal and medical adjustments: telling one's family, friends or co-workers; changing one's name and/or sex on legal documents; hormone therapy; and possibly (but not always) one or more forms of surgery.
Transphobia	Fear, hatred or intolerance of transsexual or transgender persons, which can lead to discrimination, prejudice or violence.

ANNEX 3

COMMON TYPES OF GENDER-BASED VIOLENCE

The forms of violence listed below may not always constitute gender-based violence (e.g. child sexual abuse, particularly against boys, may be more driven by paedophilia than the desire to emasculate a boy child). Acts of violence may be considered GBV when they reflect or reinforce unequal power relations between males and females. The term GBV is also increasingly used by some actors to describe violence committed with the explicit purpose of reinforcing prevailing norms of masculinity and/or gender identity—for example, when referencing some forms of sexual violence against males or targeted violence against LGBTI populations.

Type of Violence	Definition/Description*
Child Sexual Abuse	The term child sexual abuse generally is used to refer to any sexual activity between a child and closely related family member (incest) or between a child and an adult or older child from outside the family. It involves either explicit force or coercion or, in cases where consent cannot be given by the victim because of his or her young age, implied force. ¹
Conflict-Related Sexual Violence	'Conflict-related sexual violence refers to incidents or (for SCR 1960 listing purposes) patterns of sexual violence, that is rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity, against women, men, girls or boys. Such incidents or patterns occur in conflict or post-conflict settings or other situations of concern (e.g., political strife). They also have a direct or indirect nexus with the conflict or political strife itself, i.e. a temporal, geographical and/or causal link. In addition to the international character of the suspected crimes (that can, depending on the circumstances, constitute war crimes, crimes against humanity, acts of torture or genocide), the link with conflict may be evident in the profile and motivations of the perpetrator(s), the profile of the victim(s), the climate of impunity/weakened State capacity, cross-border dimensions and/or the fact that it violates the terms of a ceasefire agreement'. ²
Denial of Resources, Opportunities or Services	Denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. "Economic abuse" is included in this category. Some acts of confinement may also fall under this category. ³
Domestic Violence (DV); also referred to as Intimate Partner Violence (IPV)	Domestic Violence is a term used to describe violence that takes place between intimate partners (spouses, boyfriend/girlfriend) as well as between other family members. Intimate partner violence applies specifically to violence occurring between intimate partners, and is defined by WHO as behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours. ⁴ This type of violence may also include the denial of resources, opportunities or services. ⁵
Economic Abuse	An aspect of abuse where abusers control victims' finances to prevent them from accessing resources, working or maintaining control of earnings, achieving self-sufficiency, and gaining financial independence. ⁶
Emotional Abuse (also referred to as Psychological Abuse)	Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, social exclusion, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc. "Sexual harassment" is included in this category of GBV. ⁷
Female Genital Mutilation/Cutting (FGM/C)	Refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. ⁸
Female Infanticide and Sex Selective Abortion	Sex selection can take place before a pregnancy is established, during pregnancy through prenatal sex detection and selective abortion, or following birth through infanticide (the killing of a baby) or child neglect. Sex selection is sometimes used for family balancing purposes but far more typically occurs because of a systematic preference for boys. ⁹
Forced Marriage and Child (also referred to as Early) Marriage	Forced marriage is the marriage of an individual against her or his will. Child marriage is a formal marriage or informal union before age 18. ¹⁰ Even though some countries permit marriage before age 18, international human rights standards classify these as child marriages, reasoning that those under age 18 are unable to give informed consent. Therefore, child marriage is a form of forced marriage as children are not legally competent to agree to such unions. ¹¹

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* Please note: the definitions of many of the types of violence provided here are based on commonly accepted international standards. Local and national legal systems may define these terms differently and/or may have other legally-recognized forms of GBV that are not universally accepted as GBV.

Type of GBV	Definition/Description*
Gender-Based Violence	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. The term gender-based violence is primarily used to underscore the fact that structural, gender-based power differentials between males and females around the world place females at risk for multiple forms of violence. As agreed in the <i>Declaration on the Elimination of Violence Against Women</i> (1993), this includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life. The term is also used by some actors to describe violence against males and LGBTI populations, in these cases when referencing violence related to norms of masculinity and/or gender identity.
Harmful Traditional Practices	Cultural, social and religious customs and traditions that can be harmful to a person's mental or physical health. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. These harmful traditional practices include female genital mutilation (FGM); forced feeding of women; child marriage; the various taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price. ¹² Other harmful traditional practices affecting children include binding, scarring, burning, branding, violent initiation rites, fattening, forced marriage, so-called "honour" crimes and dowry-related violence, exorcism, or "witchcraft". ¹³
Physical Assault	An act of physical violence that is not sexual in nature. Example include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. ¹⁴
Rape	Physically forced or otherwise coerced penetration—even if slight—of the vagina, anus or mouth with a penis or other body part. ¹⁵ It also includes penetration of the vagina or anus with an object. Rape includes marital rape and anal rape/sodomy. ¹⁶ The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape
Sexual Abuse	The term "sexual abuse" means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. ¹⁷
Sexual Assault	Any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. ¹⁸
Sexual Exploitation	The term "sexual exploitation" means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of forced and/or coerced prostitution can fall under this category. ¹⁹
Sexual Exploitation and Abuse (SEA)	A common acronym in the humanitarian world referring to acts of sexual exploitation and sexual abuse committed by UN, NGO, and inter-governments (IGO) personnel against the affected population. ²⁰
Sexual Harrassment	Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. ²¹
Sexual Violence	For the purposes of these guidelines, sexual violence includes, at least, rape/attempted rape, sexual abuse, and sexual exploitation. Sexual violence is "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless or relationship to the victim, in any setting, including but not limited to home and work" ²² Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse, and forced abortion.
Sexual and Gender-Based Violence (SGBV)	The very earliest humanitarian programming addressing violence against conflict-affected women and girls focused on exposure to sexual violence and was primarily based in refugee settings. In 1996, the International Rescue Committee (IRC), in collaboration with UNHCR, introduced a project entitled the 'Sexual and Gender-Based Violence Program' in refugee camps in Tanzania. The inclusion of the term gender-based violence was reflective of the projects' commitment to address types of violence other than sexual that were evident in the setting, particularly domestic violence and harmful traditional practices. GBV was at the time of IRC's programme an increasingly common international term used to describe a spectrum of abuses to which women and girls are exposed as a result of discrimination against them in male-dominated cultures around the world. In 2005, the IASC officially adopted the term "GBV" in the IASC <i>Guidelines on Gender-based Violence Interventions in Humanitarian Settings</i> . Sexual violence was recognized within these guidelines as one type of GBV. Many of the original global guidelines and resources use the language of SGBV. This term continues to be officially endorsed and used by UNHCR in relation to violence against women, men, girls and boys: "UNHCR consciously uses [SGBV] to emphasise the urgency of protection interventions that address the criminal character and disruptive consequences of sexual violence for victims/ survivors and their families" (<i>Action Against Sexual and Gender-based Violence: An Updated Strategy</i> , UNHCR, 2011, http://www.unhcr.org/4e1d5aba9.pdf).

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Type of GBV	Definition/Description*
Son Preference	"Son preference refers to a whole range of values and attitudes which are manifested in many different practices, the common feature of which is a preference for the male child, often with concomitant daughter neglect. It may mean that a female child is disadvantaged from birth; it may determine the quality and quantity of parental care and the extent of investment in her development; and it may lead to acute discrimination, particularly in settings where resources are scarce. Although neglect is the rule, in extreme cases son preference may lead to selective abortion or female infanticide." ²³
Trafficking in Persons	"...the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs." ²⁴
Violence against Women and Girls (VAWG)	The United Nations Declaration on the Elimination of Violence Against Women (1993) 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, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. (Article 1). Violence against women shall be understood to encompass, but not be limited to, the following: (a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. (Article 2) ²⁵ The UN Secretary General's In-depth Study on all forms of Violence Against Women (2006) highlights that the term "women" is used broadly to cover females of all ages, including girls under the age of 18. ²⁶

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ANNEX 4

ADDITIONAL KEY TERMS

Term	Definition/Description
Advocacy	The deliberate and strategic use of information—initiated by individuals or groups of individuals—to bring about change. Advocacy work includes employing strategies to influence decision-makers and policies, to changing attitudes, power relations, social relations and institutional functioning to improve the situation for groups of individuals who share similar problems. ¹
Assessment	Assessments can be defined as “the set of activities necessary to understand a given situation”. They include “the collection, up-dating and analysis of data pertaining to the population of concern (needs, capacities, resources, etc.), as well as the state of infrastructure and general socio economic conditions in a given location/area.” ² In humanitarian settings, NGOs and UN agencies often carry out assessments to identify community needs and gaps in coordination and then use this information to design effective interventions. ³
Child or Minor	Article 1 of the Convention on the Rights of the Child (CRC) defines a child as ‘every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier.’ ⁴ The Committee on the Rights of the Child, the monitoring body for the Convention, has encouraged States to review the age of majority if it is set below 18 and to increase the level of protection for all children under 18. Minors are considered unable to evaluate and understand the consequences of their choices and give informed consent, especially for sexual acts. ⁵
Children Associated with Armed Forces or Armed Groups	Refers to any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities. ⁶
Children in Contact with the Law	A general term for all children in contact with the justice system. This includes children in conflict with the law (as a result of being suspected, accused or convicted of an offence) and child survivors or witnesses. ⁷
Child Labour	The term “child labour” is often defined as work that deprives children of their childhood, their potential and their dignity, and that is harmful to physical and mental development. It refers to work that: <ul style="list-style-type: none"> • is mentally, physically, socially or morally dangerous and harmful to children; and • interferes with their schooling by: • depriving them of the opportunity to attend school; • obliging them to leave school prematurely; or • requiring them to attempt to combine school attendance with excessively long and heavy work. In its most extreme forms, child labour involves children being enslaved, separated from their families, exposed to serious hazards and illnesses and/or left to fend for themselves on the streets of large cities – often at a very early age. Whether or not particular forms of “work” can be called “child labour” depends on the child’s age, the type and hours of work performed, the conditions under which it is performed and the objectives pursued by individual countries. ⁸
Confidentiality	An ethical principle associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client’s case with their explicit permission. All written information is kept in locked files and only non-identifying information is written down on case files. Maintaining confidentiality about abuse means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children or clients who express intent to harm themselves or someone else. ⁹
Consent/Informed Consent	Refers to approval or assent, particularly and especially after thoughtful consideration. ¹⁰ Free and informed consent is given based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action. In order to give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given and be able to evaluate and understand the consequences of an action. They also must be aware of and have the power to exercise their right to refuse to engage in an action and/or to not be coerced (i.e. being persuaded based on force or threats). Children are generally considered unable to provide informed consent because they do not have the ability and/or experience to anticipate the implications of an action, and they may not understand or be empowered to exercise their right to refuse. There are also instances where consent might not be possible due to cognitive impairments and/or physical, sensory, or intellectual disabilities.
Disaster	A serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources. ¹¹ Disasters can be slow-onset (such as drought or socio-economic decline) or sudden-onset (such as earthquakes, floods or sudden conflict situations). ¹²
Emergency	A term describing a state. It is a managerial term, demanding decision and follow-up in terms of extra-ordinary measures. ¹³ A “state of emergency” demands to “be declared” or imposed by somebody in authority, who, at a certain moment, will also lift it. Thus, it is usually defined in time and space, it requires threshold values to be recognized, and it implies rules of engagement and an exit strategy. ¹⁴
Empowerment of Women	The empowerment of women concerns women gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources and actions to transform the structures and institutions which reinforce and perpetuate gender discrimination and inequality. ¹⁵

(continued)

Term	Definition/Description
Gender	Refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities. Gender is part of the broader socio-cultural context. ¹⁶
Gender-Disaggregated Data	The collection of data on males and females separately in relation to all aspects of their functioning – ethnicity, class, caste, age, location, etc. ¹⁷
Gender Equality	Refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration, recognizing the diversity of different groups of women and men. Gender equality is not a women's issue but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a precondition for, and indicator of, sustainable people-centered development. ¹⁸
Gender Equity	Refers to fairness and justice in the distribution of benefits and responsibilities between women and men, according to their respective needs. It is considered part of the process of achieving gender equality, and may include equal treatment (or treatment that is different but considered equivalent) in terms of rights, benefits, obligations and opportunities. ¹⁹
Gender Mainstreaming	A strategy which aims to bring about gender equality and advance women's rights by building gender capacity and accountability in all aspects of an organization's policies and activities, thereby contributing to a profound organizational transformation. ²⁰ It involves making gender perspectives – what women and men do and the resources and decision-making processes they have access to – more central to all policy development, research, advocacy, development, implementation and monitoring of norms and standards, and planning, implementation and monitoring of projects. ²¹
Gender Roles	A set of social and behavioral expectations or beliefs about how members of a culture should behave according to their biological sex; the distinct roles and responsibilities of men, women, and other genders in a given culture. ²² Gender roles vary among different societies and cultures, classes, ages and during different periods in history. Gender-specific roles and responsibilities are often conditioned by household structure, access to resources, specific impacts of the global economy, and other locally relevant factors such as ecological conditions. ²³
Gender Relations	The ways in which a culture or society defines rights, responsibilities, and the identities of men and women in relation to one another. ²⁴
Mandatory Reporting	Laws and policies which mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse). ²⁵ Mandatory reporting may also be applied in cases where a person is a threat to themselves or another person. Mandatory reporting is a responsibility for humanitarian actors who hear about and/or receive a report of sexual exploitation or abuse committed by a humanitarian actor against a member of the affected population.
Mental Health and Psychosocial Support (MHPSS)	Support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder. ²⁶ An MHPSS approach is a way to engage with and analyse a situation, and provide a response, taking into account both psychological and social elements. This may include support interventions in the health sector, education, community services, protection and other sectors. ²⁷
Natural Disaster	Events brought about by natural hazards (such as earthquakes, volcanic eruptions, landslides, tsunamis, floods and drought) that seriously affect the society, economy and/or infrastructure of a region. Depending on population vulnerability and local response capacity, natural disasters can disrupt the functioning of a community or a society causing widespread human, material, economic or environmental losses, which exceed the ability of the affected community or society to cope by using its own resources. ²⁸ In the 2005 Secretary-General Report "Relief to Development", the expression "natural disasters" was purposely not used, as it conveys the mistaken assumption that disasters occurring as a result of natural hazards are wholly "natural", and therefore inevitable and outside human control. Instead, it is widely recognized that such disasters are the result of the way individuals and societies relate to threats originating from natural hazards. ²⁹
Orphan	UNICEF and global partners define an orphan as a child who has lost one or both parents. This definition contrasts with concepts of orphan in many industrialized countries, where a child must have lost both parents to qualify as an orphan. UNICEF and numerous international organizations adopted the broader definition of orphan in the mid-1990s as the AIDS pandemic began leading to the death of millions of parents worldwide, leaving an ever increasing number of children growing up without one or more parents. So the terminology of a 'single orphan' – the loss of one parent – and a 'double orphan' – the loss of both parents – was born to convey this growing crisis. ³⁰
Perpetrator	Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will.

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Term	Definition/Description
Protection from Sexual Exploitation and Abuse (PSEA)	As highlighted in the Secretary-General's Bulletin on Special measures for protection from sexual exploitation and sexual abuse (ST/SGB/2003/13), PSEA relates specifically to the responsibilities of international humanitarian, development and peacekeeping actors to prevent incidents of sexual exploitation and abuse committed by UN, NGO, and inter-governments (IGO) personnel against the affected population, to set up confidential reporting mechanisms, and to take safe and ethical action as quickly as possible when incidents do occur. ³¹
Reasonable Accommodation	Refers to 'necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.' ³²
Refugee	Any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country. ³³
Separated Child	A child separated from both parents, or from their previous legal or customary primary care-giver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members. ³⁴
Survivor (see also Victim)	A survivor is a person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably. "Victim" is a term often used in the legal and medical sectors. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency. ³⁵
Unaccompanied Child	A child who has been separated from both parents and other relatives and is not being cared for by an adult who, by law or custom, is responsible for doing so. ³⁶ This means that a child may be completely without adult care, or may be cared for by someone not related or known to the child, or not their usual caregiver e.g. a neighbour, another child under 18, or a stranger. ³⁷
Universal design	Refers to 'the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. "Universal design" shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.' ³⁸
Victim (see also Survivor)	A victim is a person who has experienced gender-based violence. The term recognizes that a violation against one's human rights has occurred.. The terms "victim" and "survivor" can be used interchangeably. "Victim" is a term often used in the legal and medical sectors. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency. ³⁹

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ANNEX 5

STATISTICS ON THE SCOPE OF GENDER-BASED VIOLENCE

Multi-Country	
Female Refugees in Complex Humanitarian Settings	A meta-analysis published in 2014 of 19 studies found the prevalence of sexual violence among female refugees and internally displaced persons across 14 countries affected by conflict to be 21.4%. The findings suggest that approximately one in five refugees or displaced women in complex humanitarian settings experienced sexual violence. However, this is likely an underestimation of the true prevalence given the multiple existing barriers associated with disclosure. ¹
Child and/or Forced Marriage	According to the UN Population Fund, if current child marriage rates continue, more than 140 million girls will become child brides between 2011 and 2020. Of these, 50 million will be under the age of 15. Complications from pregnancy and childbirth are the leading causes of death for girls ages 15-19 years in developing countries. ²
Sexual Exploitation and Abuse	A 2002 report by the UN Refugee Agency and Save the Children UK detailed allegations of sexual exploitation and abuse by humanitarian aid workers and peacekeepers in 40 agencies in Guinea, Liberia and Sierra Leone. ³
Africa	
Central African Republic	The NGO 'L'Organisation pour la Compassion et le Développement des Familles en Détresse' that undertakes legal action, income-generation activities and advocacy for survivors registered (as of 2005) 800 cases of female rape, 16 children born of conflict-related rape, and 140 cases of male rape. ⁴
	In only 3 months in 2013, IRC Women's Centres in CAR's capital, Bangui, saw 238 women and girls reporting extreme levels of violence and abuse. 82% of women and girls report experiencing rape, with 73% reporting gang rape. A recent IRC report found women and girls were particularly fearful of rape by armed men in some displacement sites, as well as feeling threatened by the general violence and rising levels of domestic violence. ⁵
	At least 146 pregnancies resulting from conflict-related sexual violence were recorded by United Nations partners during 2013. ⁶
Côte d'Ivoire	The United Nations verified 381 cases of sexual violence between January and December of 2013, including 62 gang rapes. Over 60% of recorded rape survivors were children between the ages of 10 and 18 years; 25% were children aged between 14 months and 10 years. At least 10 women and girls were killed after being raped or died from severe injuries sustained during the assault. In urban areas, the prevalence of small arms and light weapons is linked to insecurity: 63 cases of rape were reported during armed robberies. A total of 24 incidents of sexual violence investigated by the United Nations in 2013 involved elements of the Forces républiques de Côte d'Ivoire (FRCI), the police, the gendarmerie or ex-combatants. ⁷
	A survey conducted in 2008 found that 32.9% of women have experienced sexual violence since the age of 15 years, with most of this sexual violence (24% overall) being perpetrated by their intimate partner, and with 5.9% of women reporting sexual assault by both an intimate partner and other men. Only a small percentage of women (0.3%) reported SV perpetrated by an armed combatant. The reported prevalence of non-partner SV was lower after the crisis period than during or before the crisis period; in contrast, the prevalence of SV by an intimate partner remained high. 5.9% of men reported a lifetime experience of forced or coerced sex from a non-partner. ⁸
Democratic Republic of the Congo	In DRC during 2013, UNICEF and partners assisted 12,247 GBV survivors; 3,827—approximately 30%—were children, of whom 3,748 were girls and 79 were boys. ⁹
	Thousands of Congolese girls and women suffer from tissue tears in the vagina, bladder and rectum, after surviving brutal rapes in which guns and branches were used to violate them. A survey of rape survivors in South Kivu region revealed that 91% suffered from one or several rape-related illnesses. ¹⁰
	According to some statistics, men and boys in the DRC comprise some 4–10% of the total number of survivors of sexual violence who seek medical treatment. ¹¹
	During 2013 the Government of DRC recorded 15,352 incidents of sexual and gender-based violence in eastern DRC. Also with reference to 2013, the United Nations Organization Stabilization Mission in DRC (MONUSCO) investigated and verified 860 cases of sexual violence committed by parties to the conflict. Non-State armed groups were involved in 71% of cases verified by MONUSCO, while national security forces and the national police) were responsible for 29% of cases. Almost half of the documented cases of sexual violence during 2013 were rapes of girls. In addition, the Office of the United Nations High Commissioner for Refugees (UNHCR) recorded 525 incidents of forced marriage in areas affected by armed conflict. ¹²
	An IMAGES study carried out by Sonke Gender Justice in 2012, surveying 1,500 men and women, found that 22% of women were forced to have sex or were raped as part of the conflict and 27% were forced to witness a conflict-related rape. Women who were raped by combatants frequently reported rejection by families and partners. Ten percent of men were forced to have sex or were forced to carry out rape, and 17% were forced to witness a conflict-related rape. In addition, 45% of women reported ever having experienced physical violence from a male intimate partner (IPV), and 49% reported having experienced sexual violence from a male intimate partner. ¹³

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Africa (continued)

Liberia	<p>In 2003, 74% of a sample of 388 Liberian refugee women living in camps in Sierra Leone reported being sexually abused prior to being displaced. 55% experienced sexual violence during displacement.¹⁴</p> <p>A population-based survey conducted in Liberia in 2008 of 1666 adults revealed that 32.6% of male combatants had been exposed to sexual violence, including 16.5% who had been forced into sexual servitude.¹⁵</p> <p>According to a 2004/2005 WHO survey, over 90% of those interviewed, regardless of age, marital status and religion, said they were subjected to one or multiple acts of sexual abuse during the war or subsequently. The social and economic consequences of rape in Liberia include stigmatisation by communities and families, a high divorce rate (25.8 per cent) and unwanted pregnancy (15.1 per cent).¹⁶</p> <p>A 2007 study comprised of randomly selected females in Montserrado and Nimba counties found that, in the previous 18 months, 54.1% and 55.8% of females in Montserrado and Nimba respectively were indicated to have experienced non-sexual domestic abuse; 19.4% and 26.0% of females in Montserrado and Nimba respectively were indicated to have been raped outside of marriage; and 72.3% and 73.8% of married or separated women in Montserrado and Nimba respectively were indicated to have experienced marital rape. Husbands and boyfriends were reported as the perpetrators of the vast majority of reported violence. Strangers were reported to account for less than 2% of the perpetrators of rape in either county.¹⁷</p>
Mali	<p>A 2012 inter-agency assessment in Mali showed that displaced girls often engage in transactional/exploitative sex to provide for their families. Due to the weakened economy, girls also have to spend more time selling in markets or on the street, which increases their risk of sexual exploitation and abuse. With environmental degradation and poor infrastructure, girls have to walk further distances to collect water and fuel for cooking, increasing their GBV risk.¹⁸</p> <p>In June 2013, 28 displaced girls under 17 years of age were reported to have become victims of sexual exploitation and sexual slavery in Mopti, while women and girls displaced by the conflict also reported resorting to prostitution. Of the total number of reported cases of rape during 2013, 25% included the rape of minors and more than one third were reportedly carried out by more than one perpetrator. The majority of survivors were women and girls from economically and socially disadvantaged backgrounds.¹⁹</p> <p>In Mali, daughters of displaced families from the North (where female genital mutilation/cutting [FGM/C] is not traditionally practiced) were living amongst host communities in the South (where FGM/C is common). Many of these girls were ostracized for not having undergone FGM/C; this led families from the North to feel pressured to perform FGM/C on their daughters.²⁰</p>
Rwanda	The vast majority of Tutsi women in Rwanda's 1994 genocide were likely exposed to some form of sexual violence; of those, it is estimated that a quarter to a half million survived rape. ²¹
Sierra Leone	<p>Approximately 50,000 to 64,000 of women who were internally displaced during Sierra Leone's conflict reported histories of war-related assault. (Statistics based on a total IDP population of 1-1.3 million, 55% of whom were female.)²²</p> <p>66.7% of participants in a 1998 Sierra Leone survey on domestic violence had been beaten by an intimate partner.²³</p> <p>According to a 1999 government survey, 37% of Sierra Leone's prostitutes were less than 15 years of age, and more than 80% were unaccompanied or displaced children.²⁴</p>
Somalia	<p>According to the UN Office for the Coordination of Humanitarian Affairs, about 800 cases of sexual and gender-based violence were reported in the first half of 2013 in Mogadishu, the capital of Somalia.²⁵ In Somalia during 2013, up to 35% of survivors of rape receiving services were girls under 18, of which 16% were below 12 years old.²⁶ The latest report of the UN Secretary-General on sexual violence in conflict notes that children accounted for about a third of the approximately 1700 registered rape cases in Mogadishu and surrounding areas of Somalia.²⁷</p> <p>In a 2011 assessment, Somali adolescent girls in the Dadaab complex explained that they were in many ways "under attack" from violence that included verbal and physical harassment, sexual exploitation and abuse in relation to meeting their basic needs, and rape, including in public and by multiple perpetrators. Girls said they were particularly vulnerable to violence while accessing scarce services and resources, such as at water points or while collecting firewood outside the camps.²⁸</p>
South Sudan	Prior to 15 December, 2013, UNMISS registered 73 credible allegations of conflict-related sexual violence. Of the 73 cases, 42 were abductions, of which at least 3 resulted in forced marriage. Rape was reported in 22 of the incidents and other violations reported included 3 gang rapes, forced abortion and sexual humiliation. SPLA members were allegedly responsible for 21 of the 73 incidents; 1 incident was reportedly perpetrated by a state official together with police and military police officers. A total of 47 incidents were reportedly perpetrated by unnamed armed individuals or groups. The Lord's Resistance Army was alleged to be responsible for 4 of the recorded incidents. ²⁹
Uganda	Of 64 women with disabilities interviewed in post-conflict Northern Uganda, one third reported experiencing some form of GBV, and several had children as a result of rape. ³⁰

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Europe/Central Asia	
Azerbaijan	25% of Azeri women surveyed in 2000 by the Centers for Disease Control acknowledged being forced to have sex: those at greatest risk were among Azerbaijan's internally displaced, 23% of whom acknowledged being beaten by a husband. ³¹
Bosnia and Herzegovina	By 1993, the Zenica Centre for the registration of War and Genocide Crime in Bosnia-Herzegovina had documented 40,000 cases of war-related rape. ³²
	In the armed conflict in the former Yugoslavia, it has been reported that, of 6000 concentration camp victims in the Sarajevo Canton, 5000 were men and 80% of them had reportedly been raped. ³³
Kosovo	An estimated 23,000 to 45,000 Kosovar Albanian women were raped between August 1998 and August 1999, the height of the war with Serbia. ³⁴
Central and South America and the Caribbean	
Colombia	Between 2001 and 2009, 489,687 women experienced sexual violence in Colombia in municipalities that had state and non-state fighting forces present. ³⁵
	For the period 2012-2013, the General Attorney's Office reported on the investigation of 86 cases of sexual violence, involving 154 victims, perpetrated in the context of armed conflict. United Nations partners have reported that a range of violations and abuses were committed, including rape, gang rape, the recruitment of women, girls and boys by illegal armed groups for use as sexual slaves, forced pregnancy, forced abortion and forced prostitution. United Nations data on sexual and gender-based violence for 2013 indicate that women and girls of Afro-Colombian descent were disproportionately affected. As of November 2013 the special administrative unit charged with providing support and reparation to victims had registered 3,525 survivors of sexual violence (2,902 of whom were female). ³⁶
	The GBV Information Management System (IMS), initiated in Colombia in 2011 to improve survivor access to care, has collected GBV incident data from 7 municipalities. As of mid-2014, 3,499 females (92.6% 18 years or older) and 437 males (91.8% 18 years or older) were recorded in the GBVIMS, of which over 3,000 received assistance. ³⁷
Nicaragua	In a 1995 survey of post-conflict Nicaragua, 50% of female respondents had been beaten by a husband, and 30% had been forced to have sex. ³⁸
	After Hurricane Mitch in 1998, 27% of female hurricane survivors and 21% of male survivors responded to surveyors that woman battering had increased after the hurricane. ³⁹
Asia Pacific	
Afghanistan	In Afghanistan, a household survey (2008) showed 87.2% of women reported one form of violence in their life time and 62% had experienced multiple forms of violence. ⁴⁰
Burma/Myanmar	Research undertaken by the Human Rights Documentation Unit and the Burmese Women's Union in 2000 concluded that an estimated 40,000 Burmese women are trafficked each year into Thailand's factories and brothels and as domestic workers. ⁴¹
	Domestic violence and sexual violence were widely reported to increase in the aftermath of the 2004 Indian Ocean Tsunami. One NGO reported a three-fold increase in domestic violence cases brought to them. ⁴²
Pakistan	In Pakistan following the 2011 floods, 52% of surveyed communities reported that privacy and safety of women and girls was a key concern. In a 2012 Protection rapid assessment with conflict-affected IDPs, interviewed communities reported that a number of women and girls were facing aggravated domestic violence, forced marriage, early marriages and exchange marriages, in addition to other cases of gender-based violence. ⁴³
Philippines	While the Philippines ranked 5th in the 2013 gender gap index, prevalence of GBV is a national concern. In the areas most affected by Typhoon Yolanda the GBV rates were higher than the national average: female respondents in Western Visayas, Central Visaya and Eastern Visayas, reported rates of exposure to physical violence since the age of 15 as 22%, 28%, and 24%, respectively. ⁴⁴
Middle East	
Palestine	Findings from a 1999 study of Palestinian refugees in Jordan indicated that 44.7% of married women had experienced a beating at least once during their marriage. ⁴⁵
Syria	Of 162 unverified reports of sexual violence in Syria compiled by the Women's Media Center's Women Under Siege project and covering the period from March 2011 to March 2013, 80% involved females (ages 7–46) and, of those, 85% involved rape. ⁴⁶
	According to a 2010 study, as many as 1 in 4 Syrian women are or have been subjected to physical violence by their husbands. In 2009 there were at least 1,300 reported cases of rape. The rate of early marriage among surveyed female Syrian refugees in Jordan was 51.3%. ⁴⁷
	An inter-agency safety audit conducted in September 2013 in Za'atari, the second largest refugee camp in the world, found that 75% of survey respondents perceived their environment to be unsafe. 59% reported a lack of privacy for women and girls, placing them at risk of sexual abuse. ⁴⁸

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ANNEX 6

THE OBLIGATION TO ADDRESS GBV

A. Legal Mandates

GBV encompasses actions that violate norms of international human rights law, international humanitarian law, international criminal law and refugee law.

Legal Mandates	WHAT IT DOES	RELEVANCE TO GBV	KEY INSTRUMENTS*
International Law			
International Humanitarian Law (IHL)	<p>Is a set of conventional and customary norms, which seek, for humanitarian reasons, to limit the effects of armed conflict. IHL protects persons who are not or are no longer actively participating in hostilities and regulates the means and methods of warfare.</p> <p>Legally binds all parties in situations of international or non-international armed conflict, including armed non-state actors, to protect the people and civilian property within their territory and/or control.</p>	<p>The Conventions and Additional Protocols provide “general protections” that apply to equally to men and women without adverse discrimination on the basis, <i>inter alia</i>, of sex. In addition, women are afforded “specific protections” relating primarily to their distinct health, hygiene and physiological needs and role as mothers, including:</p> <ul style="list-style-type: none"> • Protection against sexual assault. • Women deprived of their liberty. • Expectant mothers and maternity cases. • Preservation of family links. 	<p>The key IHL treaties include the 1907 Hague Regulations, four 1949 Geneva Conventions, and their 1977 Additional Protocols.</p> <p>Custodial International Humanitarian Law as it relates to rape and other forms of sexual violence (Rule 93) is outlined in Henckaerts, J. and Doswald-Beck, L. 2006. Custodial International Humanitarian Law (ICRC). http://www.icrc.org/eng/resources/documents/publication/pcustom.htm</p>
International Criminal Law	Prohibits war crimes, crimes against humanity and genocide and seeks to hold the perpetrators of such conduct individually criminally accountable.	Rape and other forms of sexual violence committed against civilians have been recognized as war crimes, crimes against humanity and constitutive acts of genocide (depending on the elements of the offence) through the work of the ad hoc international criminal tribunals for Rwanda and former Yugoslavia, as well as the Special Court for Sierra Leone and the ICC.	Statutes (in particular the 1998 Rome Statute of the ICC) and case law from the International Criminal Court, International Criminal Tribunals and Special Courts.
International Human Rights Law	<p>Reinforces the rights and dignity of all human beings – women, girls, men and boys – without adverse discrimination. Puts forth the concept of State responsibility:</p> <ul style="list-style-type: none"> • States have a duty to uphold human rights AND to prevent and respond to human rights abuses. • States are obliged to prevent and punish rights violations by private actors. 	GBV mainly affects: right to life, right to security of person, right to health, right to non-discrimination, right to equal protection under the law, right to just and favourable work conditions.	<ul style="list-style-type: none"> • Universal Declaration of Human Rights (UNDHR) • International Covenant on Economic, Social and Cultural Rights (ICESCR) • International Covenant on Civil and Political Rights (ICCPR) • International Convention on the Elimination of All Forms of Racial Discrimination • Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), especially GR 19 on violence against women and GR 30 on women in conflict prevention, conflict, and post-conflict situations • Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment • Convention on the Rights of the Child • Convention on the Rights of Persons with Disabilities • International Convention for the Protection of All Persons from Enforced Disappearance

(continued)

* A Convention — also called Treaty and Covenant — is a legally binding agreement for governments that have signed them. Once the UN General Assembly adopts a convention, UN member states can ratify the convention, promising to uphold it. The UN can then censure governments that violate the standards set forth in a convention. Conventions are stronger than Declarations, documents stating agreed upon standards but not legally binding.

Legal Mandates	WHAT IT DOES	RELEVANCE TO GBV	KEY INSTRUMENTS*
International Law (continued)			
International Refugee Law	A set of rules and procedures that aims to protect: (i) persons seeking asylum from persecution, and (ii) those recognized as refugees under the relevant instruments. International Refugee Law overlaps in part with International Human Rights Law and IHL.	The refugee definition, when properly interpreted, covers rape and other forms of gender-related violence (e.g. dowry-related violence, coerced family planning, female genital mutilation, family/domestic violence and trafficking, etc.) whether perpetrated by a State or non- State actor. Asylum claims may also be based on discriminatory acts amounting to persecution (e.g. persecution on account of one's sexual orientation; trafficking for the purposes of forced prostitution or sexual exploitation; individuals refusing to adhere to socially or culturally defined roles and mores; etc.).	<ul style="list-style-type: none"> • 1951 Convention Relating to the Status of Refugees • 1967 Protocol Relating to the Status of Refugees • Customary international law • Regional instruments (e.g. 1969 Organization of African Unity Convention and the 1984 Cartagena Declaration)
Regional Legal Instruments			
	In the absence of effective national protection, or where States are not party to international instruments, may: <ul style="list-style-type: none"> • Clarify the rights and obligations of States, humanitarian actors and affected populations. • Protect persons and specific groups. 	<ul style="list-style-type: none"> • May provide more detailed and/or higher standards than at the national level. • Regional courts may be able to investigate acts of GBV when they occur, to prosecute and punish the perpetrators and to provide redress and relief to GBV survivors. 	<ul style="list-style-type: none"> • Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) • African Charter on the Rights and Welfare of the Child (1990) • African Youth Charter (2 July 2006) • Inter-American Convention on the Prevention Punishment and Eradication of Violence against Women (Convention of Belém do Pará) (1994) • Inter-American Convention on International Traffic in Minors (1994) • Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (1999) • Organization of the Islamic Conference (OIC) Covenant on the Rights of the Child in Islam (June 2005) • Council of Europe Convention on Action against Trafficking in Human Beings (2005) • The International Conference on the Great Lakes Region (ICGLR), Kampala Declaration on Prevention of Gender-based Violence in Africa (2003)
National Law and Policy			
	<ul style="list-style-type: none"> • Should include provisions on non-discrimination, equity and equality for women and men of all ages and backgrounds, and for the protection of human rights including women's rights in both formal and non-formal mechanisms within which GBV is addressed. • Should incorporate principles of international instruments ratified or acceded to by States. 	Particularly relevant to GBV: <ul style="list-style-type: none"> • Criminal laws which address murder, assault, incest, sexual offences, etc. • Civil laws which address assault or sexual harassment at work. • Rules of procedure and evidence, which facilitate the application of the law. • Policies that provide a framework for implementing laws and providing reparations and redress to survivors. 	National laws that might be relevant to different types of GBV, such as sexual violence, trafficking for sexual exploitation and/or forced/ domestic labor, intimate partner violence and other forms of domestic violence, etc.: <ul style="list-style-type: none"> • Constitutions • Violence against Women Act (or equivalent) • Children's Rights Act • Human Rights Code or Commission • Family Violence Act • Education Act National policies that might be relevant to different types of GBV: <ul style="list-style-type: none"> • National Plan of Action on GBV • Education Sector Plan • Teacher's Code of Conduct • Justice Sector Plan • Poverty Reduction Strategy Paper (PRSP) • Peace/ Truth and Reconciliation Strategy or Commission • Access to Justice Policy or Programme • National Action Plan on Women, Peace and Security/ SCR 1325/ 1820

B. United Nations Security Council Resolutions

1. WOMEN, PEACE AND SECURITY

Since 2000, the UN Security Council has taken up women, peace and security as a specific thematic agenda item. This emerged out of its broader agenda on the Protection of Civilians and Children and Armed Conflict following years of conflict in Sierra Leone, Somalia, Rwanda and the former Yugoslavia, where evidence pointed to significant attacks specifically targeting women, including reports of systematic sexual violence. Three resolutions (1325, 1889 and 2212) address women, peace and security broadly (e.g. women's specific experience of conflict and their contribution to conflict prevention, peacekeeping, conflict resolution and peacebuilding); the others (1820, 1888, 1960 and 2106) also reinforce women's participation, but focus more specifically on conflict-related sexual violence. (For a complete list of UN documents related to Women, Peace and Security, see <http://www.securitycouncil-report.org/un-documents/women-peace-and-security/>)

- **UNSCR 1325 (2000)** is binding upon all UN Member States. It is the first resolution on women, peace, and security. It **recognizes the disproportionate and unique impact of armed conflict on women**. It calls for their equal and full participation as active agents in all levels of decision-making in conflict prevention, conflict resolution, peace processes, post-conflict peacebuilding and governance.
- **UNSCR 1820 (2008) explicitly links sexual violence, including as a tactic of war, with the maintenance and restoration of international peace and security.** It condemns the use of rape and other forms of sexual violence in conflict situations, stating that rape can constitute a war crime, a crime against humanity, or a constitutive act with respect to genocide. It calls on all parties to immediately stop all acts of sexual violence during armed conflict.
- **UNSCR 1888 (2009)** strengthens the implementation of SCR 1325 and 1820 by **assigning leadership and establishing mechanisms to prevent and address conflict-related sexual violence**. It requested the Secretary General to appoint a Special Representative to coordinate actions on conflict-related sexual violence, working primarily through the interagency network, UN Action Against Sexual Violence in Conflict. It also established a Team of Experts on the Rule of Law/Sexual Violence in Conflict and the field-based position of Women Protection Advisers (WPAs).
- **UNSCR 1889 (2009)** focuses on the **involvement of women during post-conflict and reconstruction periods**. It addresses obstacles to their participation in peace processes and peacebuilding. The Resolution also called for a set of indicators to track the implementation of UNSCR 1325.
- **UNSCR 1960 (2010)** provides an **accountability system** and called for the establishment of **Monitoring, Analysis and Reporting Arrangements on conflict-related sexual violence** to deepen the evidence base for interventions. It mandates the Secretary-General to list in the annexes to annual reports those parties credibly suspected of committing or being responsible for patterns of sexual violence in situations on the Council's agenda.

ESSENTIAL TO KNOW

On 18 October 2013, the Committee on the Elimination of Discrimination against Women adopted the landmark General Recommendation (GR) 30 on Women in Conflict Prevention, Conflict and Post-Conflict Situations. The GR provides guidance to States and non-state actors on how to protect women's rights before, during and after conflict and makes it clear that the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) applies in all types of conflict and post-conflict settings. The GR addresses issues that women face in these settings and which are directly related to the Security Council's thematic agenda on Women, Peace and Security such as violence and challenges in access to justice and education, employment and health. For example, the Committee recommends that States prevent, investigate and punish gender-based violations such as forced marriages, forced pregnancies, abortions or sterilization of women and girls in conflict-affected areas. The GR also highlights the need for a "concerted and integrated approach" between the Security Council's agenda and human rights.

(For more detailed information see <http://www.ohchr.org/Documents/HRBodies/CEDAW/GComments/CEDAW.C.CG.30.pdf>)

- **UNSCR 2106 (2013)** adds greater operational detail to previous resolutions. It reiterates that all actors, including not only the Security Council and parties to armed conflict but all Member States and UN entities, must do more to implement previous mandates and combat impunity for conflict-related sexual violence. It also **affirms the centrality of gender equality and women's political, social, and economic empowerment to efforts to prevent sexual violence** in armed conflict and post-conflict situations. It also includes explicit reference to men and boys as survivors of sexual violence.
- **UNSCR 2122 (2013)** aims to strengthen women's role in all stages of conflict prevention and resolution by putting in place a roadmap for a more systematic approach to the implementation of commitments on women, peace and security. This resolution is groundbreaking in that it notes the need for **access to the full range of sexual and reproductive health services**, including regarding pregnancies resulting from rape, without discrimination.

2. PROTECTION OF CIVILIANS

The protection of civilians (POC) agenda is a framework for the UN's diplomatic, legal, humanitarian, and human rights activities directed at the protection of populations during armed conflict. The Security Council has included POC as a thematic issue on its agenda since 1999, with a particular focus on the duties of states and the role of the Security Council in addressing the needs of vulnerable populations including refugees, internally displaced persons (IDPs), women and children. The agenda is directed at ensuring that all parties understand their responsibilities for the protection of civilians and how those responsibilities can be translated into action. Specifically, its first two resolutions lay out obligations and commitments around the legal (SCR 1265) and physical (SCR 1296) protection of civilians. SCR 1265 recognizes the disproportionate and unique impact of armed conflict on women and calls for their equal and full participation as active agents in all levels of decision-making in conflict prevention, conflict resolution, peace processes, post-conflict peacebuilding and governance. Subsequent resolutions cover a broad range of general and specific issues including condemning sexual violence in conflict and ensuring that training for military and civilian personnel involved in peacekeeping includes training on GBV. For a complete list of UN documents related to POC, see <http://www.securitycouncilreport.org/un-documents/protection-of-civilians/>.

3. CHILDREN AND ARMED CONFLICT

Since 1999, the Security Council has been seized by issues related to children and armed conflict (CAAC), with each resolution containing progressively more concrete provisions to protect children. For example, the UN Security Council established a monitoring and reporting mechanism (MRM), managed by country-based task forces co-led by UNICEF and the highest UN representative in the country, to provide timely and reliable information on six grave violations against in armed conflict (Resolutions 1612 [2005] and 1882 [2009]):

- Killing or maiming of children.
- Recruitment or use of children by armed forced or armed groups.
- Rape and/or sexual violence against children.
- Attacks against schools or hospitals.
- Abduction of children.
- Denial of humanitarian access for children.

On the basis of the information collected through the MRM, the UN Secretary-General names and shames parties to conflict who recruit, kill or maim children, commit sexual violence and attack schools and hospitals in his annual report. The Security Council Working Group on Children and Armed Conflict regularly reviews the reports stemming from the MRM and makes recommendations on how to better protect children in specific country situations, such as the imposition of sanctions by relevant SC committees.

While relevant to all children, the resolutions on CAAC — and the work of the Special Representative on Children and Armed Conflict (<https://childrenandarmedconflict.un.org>) — focus special attention on children in detention, internally displaced children and the girl child—who, in situations of armed conflict, is at greater risk of becoming a victim of sexual violence and exploitation. For a complete list of UN documents related to CAAC, see <http://www.securitycouncilreport.org/un-documents/children-and-armed-conflict/>.

C. Humanitarian Standards and Guidelines

Various standards and guidelines have been developed and broadly endorsed by humanitarian actors that reinforce the humanitarian responsibility to address GBV in emergencies. Some examples are listed in the table below. Additional sector-specific examples can be found in the thematic area sections.

Standard/Guideline	What it is	How it relates to GBV
Child Protection Working Group (CPWG). 2012. Minimum Standards for Child Protection in Humanitarian Action, http://cpwg.net/minimum-standards/	<ul style="list-style-type: none"> Establishes common principles among those working in child protection to strengthen coordination between them and improve the quality of child protection programming, and its impact for children. Each standard provides key actions, measurements, and guidance notes. 	Makes reference to actions and suggested activities related to GBV protection, including through Standard 8 (physical violence and other harmful practices), Standard 9 (sexual violence), and Principles 3 (protect people from physical and psychological harm arising from violence and coercion).
Humanitarian Accountability Partnership (HAP) and People in Aid. 2014 (draft). Core Humanitarian Standard (CHS), http://www.hapinternational.org/what-we-do/the-core-humanitarian-standard.aspx	<ul style="list-style-type: none"> Outlines 10 key commitments to improve the quality, effectiveness and accountability of humanitarian action at the organisational and operational level. Core requirements, indicators and means of verification accompany each commitment. 	Assists organizations and their staff to identify how they can become more accountable to affected populations and protect their well being and dignity, including through the prevention of sexual exploitation and abuse.
ICRC. 2013. Professional Standards for Protection Work Carried out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence (2nd Edition), http://www.icrc.org/eng/resources/documents/publication/p0999.htm	<ul style="list-style-type: none"> Sets minimum standards that should be respected by all humanitarian and human rights actors involved in protection work. Developed for protection work in armed conflicts and violent situations, but can also apply to protection work in natural disasters. 	Applies to actors integrating or working on GBV as part of their protection work: they can complement other sets of standards used by protection actors.
Inter-Agency Network for Education in Emergencies (INEE). 2011. The Minimum standards for education: preparedness, response, recovery, http://www.ineesite.org/en/minimum-standards	<ul style="list-style-type: none"> Gives guidance on how to prepare for and respond to acute emergencies in ways that reduce risk, improve future preparedness and lay a foundation for quality education. The standards are applicable in a wide range of situations and designed for use during different stages of emergencies. 	Make a number of implicit and explicit references to strategies to prevent GBV in and through education. See Access and Learning Environment Standard 2; Teacher and Learning Standard 3; Teachers and Other Education Personnel Standard 2.
Inter-agency Working Group on Reproductive Health in Crisis (IAWG). 2011. Minimum Initial Service Package (MISP) for Reproductive Health, http://www.iawg.net/resources/field_manual.html	<ul style="list-style-type: none"> A minimum standard of care and coordinated or priority set of life saving activities to be implemented at the onset of every emergency. The MISP can be implemented without an initial needs assessment, data on sexual violence, HIV and other SRH issues. The MISP is a standard in the Sphere Minimum Standards in Disaster Response and is integrated into the Inter-Agency Standing Committee (IASC) Health Cluster tools and guidance. 	<ul style="list-style-type: none"> Establishes a minimum standard of care and coordinated set or priority activities. The MISP forms the starting point for sexual and reproductive health programming and should be sustained and built upon with comprehensive sexual and reproductive health services throughout protracted crises and recovery. Includes prevention and management of the consequences of sexual violence.

(continued)

Standard	What it is	How it relates to GBV
International Committee of the Red Cross (ICRC). 1994. <i>Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief</i>, http://www.icrc.org/eng/resources/documents/publication/p1067.htm	<ul style="list-style-type: none"> The Code of Conduct lays down ten points of principle which all humanitarian actors should adhere to in their disaster response work, and describes the relationships that agencies working in disasters should seek with donor governments, host governments and the UN system. 	<p>The 10th principle of the Code highlights the capacities rather than vulnerabilities of affected populations and insists on the need to respect the affected population: "In our information, publicity and advertising activities, we shall recognize disaster victims as dignified human beings, not hopeless objects."</p>
Sphere Project. 2011. <i>Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response</i>, http://www.spherehandbook.org	<ul style="list-style-type: none"> Establishes the minimum standards that people affected by disasters have a right to expect from humanitarian actors. The standards set out in the Sphere Handbook are designed for use in disaster response but may be applicable in a wide range of situations including natural disasters and armed conflict. 	<p>Each standard recognizes that sexual violence programming and gender are crosscutting issues. Meeting minimum standards is critical to the primary prevention of GBV.</p>
UN Secretariat. 2003. <i>Secretary General's Bulletin on Special Measures for Protection for Sexual Exploitation and Abuse (ST/SGB/2003/13)</i>, http://www.pseataskforce.org/uploads/tools/1327932869.pdf	<ul style="list-style-type: none"> Sets the standards/requirements to be observed by all UN staff and its partners to protect affected populations from sexual exploitation and abuse (SEA). 	<ul style="list-style-type: none"> Sexual exploitation and abuse are forms of gender-based violence that have been reported in humanitarian contexts, specifically relating to humanitarian workers. The Bulletin incorporates six core principles relating to SEA.
PSEA Task Force. 2011. <i>Statement of Commitment on Eliminating Sexual Exploitation and Abuse by UN and Non-UN Personnel</i>, http://pseataskforce.org/en/taskforce	<ul style="list-style-type: none"> Statement affirming the determination of 42 UN Entities and 36 Non-UN Entities to prevent future acts of sexual exploitation and abuse by its personnel. 	<p>Includes a goal of achieving full implementation of 10 stated principles as a matter of urgency to prevent and address SEA.</p>
International Protocol on the Documentation and Investigation of Sexual Violence in Conflict. June 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319054/PSVI_protocol_web.pdf	<ul style="list-style-type: none"> Launched in June 2014 as part of the UK Summit to End Sexual Violence in Conflict, the objective of this Protocol is to help first responders to ensure that information collected from survivors (physical and testimony) is taken and stored in a way that assists future prosecutions or other justice processes. 	<p>This Protocol sets out basic standards of best practice on how to collect information and evidence on sexual violence, whilst protecting survivors and witnesses, in order to increase the rate of convictions and thereby deter future perpetrators.</p>

ANNEX 7

HUMANITARIAN STRATEGIC PLANS AND FUNDING MECHANISMS

A. Humanitarian Programme Cycle

The Humanitarian Programme Cycle (HPC) — which was agreed upon by the IASC Principals in 2013 to improve upon the Consolidated Appeals Process (CAP) — refers to a series of actions to help prepare for, manage and deliver humanitarian response. It consists of five inter-related elements: 1) needs assessment and analysis; 2) strategic response planning; 3) resource mobilization; 4) implementation and monitoring; and 5) operational review and evaluation. One of the aims of the HPC is to increase funding for humanitarian priorities. Coordinated by the Office for the Coordination of Humanitarian Affairs (OCHA), the HPC provides a valuable opportunity to mainstream GBV prevention and response throughout all its elements and across all sectors and clusters. (More information on the specific elements of the HPC can be found at: <https://www.humanitarianresponse.info/programme-cycle/space>. See also the IASC Humanitarian Programme Cycle Reference Module, <http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-template-default&bd=87>).

B. Common Humanitarian Action Plan

The Common Humanitarian Action Plan (CHAP) is the core of a consolidated appeal and outlines humanitarian action in a crisis. A CHAP includes:

- Analysis of the context in which humanitarian action takes place.
- Planning scenarios.
- Analysis of humanitarian needs and a statement of priorities.
- Detailed response plans, including a clear division of labour among participating organizations.
- The link to longer-term objectives and goals.
- A framework for monitoring the strategy and revising it if necessary.

The Inter-Cluster Working Group (ICWG) develops the common outcomes and objectives within the framework of the country's crisis, which becomes the basis of cluster-specific outcomes and objectives. The CHAP process is a useful tool to promote mainstreaming of GBV across clusters, with the ICWG taking a pro-active role to ensure each cluster coordinator follows up on mainstreaming responsibilities.

C. Appeal Projects

The projects in an appeal are the planned actions and funding requests to respond to the needs identified in the common humanitarian action plan (CHAP). Taken together, they signal the overall amount that donors should collectively provide to support humanitarian action in a specific crisis. Donors may use the appeal as a catalogue to select projects to fund, or they may contribute flexibly to an agency or a pooled fund for the appeal.

ESSENTIAL TO KNOW

CHAP and GBV

OCHA ensures through the ICWG that each cluster's needs assessments include GBV-related information, and that each cluster includes GBV-related activities and indicators.

ESSENTIAL TO KNOW

Appeal Projects and GBV

OCHA and the ICWG ensure that the criteria for approval for all appeal projects include GBV-related activities and indicators. The ICWG ensures that all cluster guidance notes on the CAP include mandatory GBV-related activities and indicators.

D. Humanitarian Pooled Funding Mechanisms

OCHA manages and/or administers multiple humanitarian pooled funding mechanisms, such as the Common Humanitarian Funds (CHF), Central Emergency Reserve Fund (CERF) and the Flash appeals.

1. COMMON HUMANITARIAN FUND

The Common Humanitarian Fund (CHF) is the pooled funding mechanism that follows the CAP, and through which appeal projects can receive funds. The CHF Secretariat, which sits with OCHA, manages the CHF funds; the CHF Secretariat also issues guidance notes and requirements on applying for CHF. It is essential that OCHA — as the manager of the funds — ensures that one of the requirements for applicants is the inclusion of GBV-related activities and indicators. Good practice would result in the exclusion of projects that do not include such activities and indicators.

2. EMERGENCY RESPONSE FUND

The Emergency Response Fund (ERF) is a part of the CHF; however while the appeal projects are the grounds for application to the CHF, new emerging crises are the grounds for application to the ERF. The CHF Secretariat, which sits with OCHA, manages the ERF.

3. CENTRAL EMERGENCY RESERVE FUND

The Central Emergency Response Fund (CERF) is a stand-by fund established by the UN to enable more timely and reliable humanitarian assistance to victims of disasters and complex emergencies. The Emergency Relief Coordinator manages the Fund on behalf of the UN Secretary-General. It is intended to complement — not to substitute — existing humanitarian funding mechanisms such as the CAP. CERF provides seed funds to jump-start critical operations and fund life-saving programmes not yet covered by other donors. CERF is divided into two components – rapid response and underfunded window – with the following objectives:

- Promote early action and response to reduce loss of life.
- Enhance response to time-critical requirements;
- Strengthen core elements of humanitarian response in underfunded crises.

CERF emphasizes the importance of ensuring that principles highlighted in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC) and UN Resolution 1325 on Women, Peace and Security are pillars in the implementation of CERF funded programmes and projects.¹

UN agencies, IOM, the Global Cluster Leads, and other partners and field practitioners have agreed on the life-saving criteria, both for rapid response and underfunded window, as follows²:

! ESSENTIAL TO KNOW

CHF, ERF and GBV

OCHA and the GBV coordination mechanism should agree that inclusion of GBV-related activities and indicators are mandatory for accessing CHF or ERF.

! ESSENTIAL TO KNOW

CERF and GBV

Support from the CERF is based on the idea of prioritized “life-saving” assistance to people in need; that is, “actions that within a short time span remedy, mitigate or avert direct loss of life, physical and psychological harm or threats to a population or major portion thereof and/or protect their dignity.”

GBV prevention and response has been identified as one life-saving criterion within the CERF. As manager of the Fund, it remains OCHA’s responsibility to ensure that response to GBV is part of the CERF allocation, and that all countries applying for CERF recognize and include GBV prevention and response as a life-saving criteria in their project proposals.

(For more information on CERF lifesaving criteria, see https://docs.unocha.org/sites/dms/CERF/FINAL_Life-Saving_Criteria_26_Jan_2010_E.pdf)

¹ Central Emergency Response Fund, Life-Saving Criteria, Approved by John Holmes, USG Humanitarian Affairs/ERC, 26 January 2010, https://docs.unocha.org/sites/dms/CERF/FINAL_Life-Saving_Criteria_26_Jan_2010_E.pdf

² For a full list see CERF Life-Saving Criteria, <http://www.unocha.org/cerf/resources/guidance-and-templates>

Sector	Activities	Conditions
Gender-Based Violence	Strengthen and/or deploy GBV personnel to guide implementation of an inter-agency multi-sectoral GBV programme response including ensuring provision of accessible confidential, survivor-centered services to address GBV and to ensuring it is appropriately addressed across all sectors.	In an emergency context and as a first priority, support health service providers with relevant supplies and ensure a range of appropriate psychosocial interventions are in place and accessible.
	Identify high-risk areas and factors driving GBV in the emergency and (working with others) strengthen/set up prevention strategies including safe access to fuel resources (per IASC Task Force SAFE guidelines).	Context of specific emergency response.
	Improve access of survivors of gender based violence to secure and appropriate reporting, follow up and protection, including to police (particularly women police) or other security personnel when available.	Context of specific emergency response.
Child Protection	Identification, registration, referral and follow-up for other extremely vulnerable children, including survivors of GBV and other forms of violence, children with no access to basic service and those requiring special protection measures.	Context of specific emergency response.
Education in Emergencies	Essential life-saving skills and support such as GBV information, Mine/UXO risk education, HIV/AIDS, psychosocial, nutrition, health and hygiene.	Context of specific emergency response.
Health in Emergencies	Medical (including psychological) support to survivors of sexual violence. Activities may include updating health staff on clinical management of sexual violence protocols; supply of drugs and material (including through interagency RH kits).	Context of specific emergency response.
	Priority responses to HIV/AIDS. Activities include HIV/AIDS awareness information dissemination, provision of condoms, PMTCT, PEP, and standard precautions in emergency health care settings; emergency awareness and response interventions for high risk groups; care and treatment for people with HIV whose treatment has been interrupted.	Context of specific emergency response.
	Support the provision of Psychological First Aid — protect and care for people with severe mental disorders (suicidal behavior, psychoses, severe depression and substance abuse) in communities and institutions.	Context of specific emergency response.
Protection and Human Rights	Identification and strengthening/set up of community-based protection mechanisms.	Context of specific emergency response.
	Provision of life saving psychosocial support to person with special needs in particular for older persons.	In close coordination with the health cluster/sector.
	Support measures to ensure access to justice with a special focus on IDPs, women and children. (e.g. assessments of justice and security needs; support to legal advice and paralegal services in conflict affected areas).	Context of specific emergency response.
Water and Sanitation	Hygiene and sanitation supplies (including for women and girls) and awareness raising. Active participation of and accountability to affected populations in the prevention and mitigation of WASH related diseases: Information/Communication; optimize effective use of facilities; mobilization and participation; Essential WASH related non-food items.	Context of specific emergency response.

GBV PREVENTION AND RESPONSE PROJECTS: THE GENDER MARKER TIP SHEET

WHY GENDER EQUALITY MATTERS IN GBV PREVENTION & RESPONSE INTERVENTIONS

Conflicts and natural disasters have different impacts on women, girls, boys and men. Risks, vulnerabilities, capacities, needs and access to services and resources vary across contexts. During a crisis, such as armed conflict or natural disaster, institutions and systems that provide physical and social protection may be weakened or destroyed. Families and communities are often separated, which can result in a further breakdown of existing community support systems and protection mechanisms.

Gender-based violence (GBV) can escalate during and following emergencies. GBV is a term used to describe the vulnerability of women and girls to violence as a result of their subordination to men in systems of patriarchy. The term has also been used to refer to any violence that is related to the socially ascribed roles of men, women, boys and girls, such as violence against men that is informed by norms related to masculinities and/or violence against gay, bisexual, transgender or intersex (LGBTI) individuals and groups that is informed by norms related to sexuality and sexual identity. Regardless of how the language is interpreted, it is generally agreed that GBV primarily affects women and girls. Therefore, the majority of GBV projects in humanitarian settings will focus their efforts on prevention of and response to violence against women and girls. In order to be effective, these projects must address issues of women's and girls' empowerment and gender equality, and must include men and boys as partners in prevention.

How programmers and policy makers define GBV will determine priorities for their GBV work. Some projects will therefore focus GBV prevention and response efforts specifically on the problem of violence against women and girls. Others may include certain types of violence against men and boys and/or LGBTI populations. It is important that projects not lump violence against different groups (e.g. women/girls; men/boys; LGBTI) under one overarching 'gender' or 'GBV' intervention. The role that gender plays in relation to violence against each of these groups is distinct and will require distinct approaches in how projects addressing these groups are designed and implemented. Evaluations of the degree to which projects are gender-responsive should be based on the specific objectives of each project. For example, when evaluating GBV programming that specifically targets the problem of violence against women and girls in terms of its gender-responsiveness, the focus of a gender analysis will be on the extent to which these programs include an understanding of the gender-based inequalities that make women and girls vulnerable to specific types of violence, and that inform women's and girls' ability to access violence-related services as well as their ability to be free from violence. When evaluating 'GBV' programming for LGBTI individuals and groups, the focus of a gender analysis will be on how these programmes understand and link problems of violence to homophobia and social norms related to sexuality and sexual identity.

The IASC Gender Marker is a tool that codes, on a 2 - 0 scale, the extent to which humanitarian projects are designed to ensure that the needs of women, girls, men and boys are being appropriately addressed in humanitarian contexts, so to ensure gender equitable access to services, resources and outcomes for women, girls, men and boys. GBV prevention and response projects that demonstrate sound gender analysis to justify the proposed interventions are coded as 2b (targeted action). Nearly all projects coded as 2b will concentrate specifically on violence against women and girls, so as to acknowledge the need in most humanitarian contexts to centre GBV activities on women and girls and to give these projects greater visibility in terms of donor prioritisation and funding. GBV projects that include a broader focus on violence against men/boys and/or LGBTI individuals should demonstrate a strong justification based on a detailed gender analysis. A full description of the IASC Gender Marker and its application can be found in the Gender Marker Overview Tip Sheet.

NEEDS ASSESSMENTS → ACTIVITIES → OUTCOMES

A NEEDS ASSESSMENT is the essential first step to identify the causes and contributing factors to and impacts of the various types of GBV that projects may seek to address. It provides an understanding of the gender dynamics that might particularly affect the security and well-being of the affected population. This analysis should clearly inform project ACTIVITIES. The project's OUTCOMES should capture the change that is expected for female and/or male beneficiaries. Outcome statements should show whether and how target groups have benefitted from interventions.

GENDER IN GBV PREVENTION AND RESPONSE PROJECT NEEDS ASSESSMENT	
✓ DISAGGREGATE data by sex and age <i>and according to other demographic variables as feasible</i> .	
✓ DEFINE the forms of GBV that are to be addressed by the project.	
✓ DISTINGUISH the risks to and protective factors of the form(s) of GBV to be addressed.	
SAMPLE GENDER IN GBV PREVENTION AND RESPONSE PROJECT ACTIVITIES	
✓ According to the proposed target group focus of the project, organise single-sex, age-segmented (and other demographically sensitive) focus group discussions to illicit perceptions of violence, barriers to accessing care and the kinds of culturally appropriate services that the target group requires/requests.	
✓ Train male and female providers across key health, psychosocial, security, and legal/justice sectors to provide safe, ethical and respectful services (e.g. male and female medical staff in the clinical management of sexual violence, best practices for ethical and safe patient intake and referral, including how to adhere to the guiding principles of safety/security, confidentiality, respect and non-discrimination, and coordination).	
✓ Train humanitarian actors across sectors (e.g. Education, Health, Nutrition, Protection, Shelter, etc.) on how to ensure that actions to prevent and respond to GBV are addressed across their sectoral actions.	
✓ Provide training sessions for clan, traditional, religious and male and female community leaders on human rights, gender, and GBV and its consequences for the whole of the community, and mobilize community leaders in the prevention of GBV and the necessity of supporting survivors rather than stigmatizing them, as well as ensuring that communities know how, why and where to access GBV services once they are in place.	
SAMPLE GENDER IN GBV PREVENTION AND RESPONSE PROJECT OUTCOMES	
✓ Males and females, including youth, older people, disabled, etc. involved in culturally-appropriate prevention activities	
✓ Service providers respond to survivors in safe, ethical, and respectful manner	
✓ Increased numbers of survivors (disaggregated by age and sex) access care and report positive outcomes in terms of quality of care and ability to manage GBV experience	

DESIGNING MINIMUM GENDER COMMITMENTS FOR GBV PREVENTION AND RESPONSE:

In order to translate humanitarian actors' commitments to gender-responsive projects into reality, minimum gender commitments can be developed with the aim of being applied systematically in field-based GBV prevention and response initiatives. The commitments must be phrased in a way that can be understood clearly by all, both in terms of value added to current programming and in terms of the concrete actions, which need to be taken to meet these commitments. They should constitute a short body of core actions and/or approaches to be applied by all partners. They should be practical, realistic and focus on improvement of current approaches rather than on a drastic programme reorientation. Finally, they should be measurable for the follow-up and evaluation of their application.

The commitments should be the product of a dialogue with cluster members and/or within the organisation. A first list of commitments should be identified and then discussed, amended and validated by the national cluster and sub-clusters and/or organisation's staff working in the sector. It is important to note that commitments need to reflect the key priorities identified in a particular setting. *The commitments, activities and indicators below, which are drawn directly from the 'disaggregate – define – distinguish- describe' framework set out above, are provided as samples only:*

1. **Disaggregate data by sex and and according to other demographic variables as much as is possible.** Using evidence-based analysis from pre-crisis information if necessary, specify who among the crisis-affected population is most at-risk to various form(s) of GBV, e.g. females of all ages or of specific age (adolescents, young girls, elderly women), disabled women and girls, lesbian women and girls, indigenous and other minority women and girls, etc. In some cases this analysis might also include and/or specifically focus on boys/men and/or broader categories of LGBTI individuals and groups.

Sample Activity	Sample Indicator
According to the proposed target group focus of the project, organise single-sex, age-segmented (and other demographically sensitive) focus group discussions to illicit perceptions of violence and the kinds of culturally appropriate services that the target group requires/requests, as well as strategies for addressing the underlying gender dimensions of the violence they experience	<p><i>Focus group discussions on the nature, extent, risk and protective factors related to GBV have been conducted with relevant target group(s), such as women, adolescent girls, adolescent boys and men in x and x IDP camp.</i></p> <p><i>Recommendations for how to address the specific gender dimensions of the types of violence have been solicited (e.g. livelihoods, women's participation and leadership, skills building for families and youth).</i></p> <p><i>Analysis for risks and vulnerabilities, as well as protective factors has been undertaken</i></p>

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2. **Define the forms of GBV that are to be addressed by the project**, e.g. rape and other forms of sexual violence, domestic violence, early/forced marriage, trafficking, forced prostitution, , etc.

Sample Activity	Sample Indicator
<i>Conduct a coordinated rapid situational analysis (in accordance with Action Sheet 2.1 of GBV Guidelines)</i>	<i>A coordinated rapid situational analysis involving sex-appropriate assessors and affected persons is conducted by [date] and defines the nature and extent of GBV in [camp/region].</i>

3. **Distinguish the risk factors of the form(s) of GBV to be addressed**. While gender inequality and discrimination are the root causes of GBV against women and girls globally, various other factors determine the type and extent of violence women and girls experience in each setting, such as age, disability, sexual orientation, race, ethnicity, poverty, etc. For men and boys, certain forms violence against them might be the result of masculinities that are imposed, acceded to, or even acclaimed by male victims/survivors as well as by perpetrators. For LGBTI groups, certain forms of violence they experience might be related to social norms regulating sexuality and sexual identity. Be specific about the factors that increase women's, girls', boys' and men's risk of exposure to the form(s) of GBV to be addressed by the project.

Sample Activity	Sample Indicator
<i>Through a series of meetings, liaise with other clusters such as WASH, CCCM, Shelter & NFIs, Protection, Health, etc., to discuss the possible risk factors that may increase exposure to GBV and measures to mitigate them</i>	<i>Meetings have been conducted with each of the clusters to discuss possible factors that could contribute to an unsafe environment for women/girls and/or men/boys in [name of camp/area] and recommended measures to mitigate them..</i>

4. **Describe the type of action(s) proposed – preventative, responsive, environment building.**

Sample Activity	Sample Indicator
<i>Consolidate and analyse data from coordinated rapid situational analysis, single-sex, age-segmented focus discussions, secondary data and reports on GBV in [area], mapping exercises, meetings with other Clusters, etc., and confirm specific focus – prevention, response and/or environment building of the project.</i>	<i>All available data has been consolidated and analysed and a clear strategy confirmed for the focus of the project.</i>

For more information on the **Gender Marker** go to www.oneresponse.info

For the e-learning course on “Increasing Effectiveness of Humanitarian Action for Women, Girls, Boys and Men” see www.iasc-elearning.org

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