Standard Operating Procedures for GBV Interventions in Humanitarian Settings

GBV SOPs Resource Package (2023)

ACKNOWLEDGEMENTS

This GBV SOPs resource package replaces *Establishing gender-based violence standard operating procedures (GBV SOPs) for multisectoral and inter-organizational prevention and response to gender-based violence in humanitarian settings,* dated May 2008 and the UNHCR *Standard operating procedures for SGBV prevention and response* dated July 2006. The GBV SOPs development process was coordinated in partnership between UNHCR and the gender-based violence area of responsibility (GBV AoR).

This resource is the product of inter-agency collaboration and consultation with multiple actors at local, regional and global levels. The changes and additions made to the 2023 GBV SOPs Resource Package reflect the evolution of GBV programming over more than a decade, the outcomes of a survey and direct consultations with country-level, regional and headquarters staff and pilots in four settings involving refugees, internally displaced (IDPs) and stateless persons in Moldova, Columbia, Poland and Yemen. Draft versions of this guide were reviewed by GBV and other thematic technical experts from UN agencies as well as local, national and international NGOs and civil society organizations (CSOs). Collecting feedback from GBV practitioners from different operations was critical to making the resource an inclusive, operation-informed tool, based on established or emerging best practices. The resource also benefited from contributions from GBV sub-cluster /sub-sector coordinators and regional GBV advisors and specialists working with UNHCR and the GBV AoR.

The drafting of the revised GBV SOPs was supported by Inbal Sansani under joint overall management and support from Amel Amirali and Kathryn McCallister (UNHCR) and Tamah Murfet and Stefanie Lorin (GBV AoR).

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GBV SOPs Resource Package

Part 1: GBV SOPs Development Guide: includes an overview of the SOPs development and revision processes. It discusses process initiation, coordination and contextualization in diverse contexts.

Part 2: GBV SOPs template: the SOPs template is the core document to be completed in a specific physical setting.

Part 3: GBV SOPs Annexes: should be completed, revised, or omitted as needed.

Standard Operating Procedures for GBV Interventions in Humanitarian Settings

GBV SOPs Resource Package

Part 1: GBV SOPs Development Guide

Table of Contents: GBV SOPs – Part I

1 Introduction

The purpose of this GBV SOPs resource package is to support the development of standard operating procedures (SOPs) for gender-based violence (GBV) interventions in humanitarian settings.

Why develop inter-agency SOPs?

When multiple organizations are providing GBV prevention and response services in humanitarian settings, it is crucial to adopt a coordinated approach. GBV SOPs are specific procedures that are agreed among organizations in a particular context, outlining the roles and responsibilities of each actor in preventing, mitigating the risks, and responding to GBV. GBV SOPs support GBV and other humanitarian actors to coordinate and implement safe and accessible GBV response, risk mitigation and prevention interventions. GBV SOPs can be a powerful tool for creating shared ownership among local, national, and international actors, agreeing on ethical standards and legal frameworks and outlining the specific accountability of each actor.

GBV actors in a setting come together to develop single national or sub-national GBV SOPs. Sub-national GBV SOPs for a specific physical setting or location should be based on the main national SOPs document.

Individual organizations providing case management services complement the inter-agency SOPs with agency internal GBV case management SOPs. However, it is important to ensure that there is only one inter-agency SOPs document in each setting that defines the procedures around multisectoral GBV services, including GBV case management services.

This GBV SOPs resource package reflects the increasingly multisectoral nature of GBV interventions and addresses linkages among sectors that go beyond the basics of GBV response and toward comprehensive GBV programming.

Table 1: Overview of GBV SOPs

What	Standard Operating Procedures (SOPs) for GBV interventions (GBV SOPs)
Who	GBV coordinators, GBV coordination group members and non-GBV actors and sectors. See section 3.3 for a full list of actors that can participate in the GBV SOPs development process.
When	As soon as possible in an emergency setting; as standard on-going practice in all humanitarian settings; as context changes in development settings; as part of preparedness planning if possible.
Why	Coordinated efforts are essential for promoting safe and accessible GBV services, preventing and mitigating the risk of GBV.
Where	In all humanitarian contexts in which GBV programming is implemented, including in refugee, internally displaced, migrant and mixed settings. In nexus and development contexts, where existing frameworks, action plans and procedures do not adequately cover the needs of survivors and those at risk of GBV among affected people. In this case, existing processes and procedures should be identified first to work toward alignment and avoid duplication.

What is new in the updated GBV SOPs resource package?

- This GBV SOPs resource package is intended for use in a variety of humanitarian response settings, including those **supporting refugees, internally displaced (IDPs) and stateless persons and mixed populations**. Although it focuses on humanitarian settings, the content can be used in contexts where there are both humanitarian and development interventions.
- It includes sections on risk mitigation, preparedness, and coordination. These are included to outline the expectations and commitments of different actors. The GBV SOPs development process is an opportunity to ensure that all actors and stakeholders are aware of coordination mechanisms, available resources, and responsibilities.

The GBV SOPs resource package is not a ''how-to" manual for all GBV programming. Rather, it should be used alongside complementary existing technical resources. Each section of the template includes references to relevant technical resources.

To keep the GBV SOPs accessible and user-friendly, the information in the document should be kept to a minimum. For example, if the GBV coordination group has completed terms of reference and workplans, it is better to provide a link to these documents in the GBV SOPs rather than including the full text.

The GBV SOPs put women and girls at the centre, in response to structural and systemic gender inequality and discrimination that lead to their higher risk of experiencing GBV and their lack of safe and equitable access to humanitarian assistance. For this reason, the GBV SOPs use female pronouns except in sections that apply specifically to men and boys.

2 How to use the GBV SOPs resource package

This GBV SOPs resource package has three parts:

Part 1, the **GBV SOPs development guide**, includes an overview of the GBV SOPs development or revision process and essential aspects to consider for each phase of development.

Part 2 is the **GBV SOPs template**. This is the main document to be completed and contextualized in the relevant context.

Part 3, the **Annexes**, includes forms and guidance to support both the development of GBV SOPs and GBV programming. These should be completed (e.g. the GBV SOPs workplan), adapted (e.g. the forms) or omitted as relevant.

3 How to develop inter-agency GBV SOPs

The development of GBV SOPs involves collaboration, coordination, inter-organizational and cross-sectoral exchange, as well as community participation and negotiation. The purpose of a collaborative process is to increase all participants' understanding of how to respond to, mitigate and prevent GBV in a particular setting, agree on common procedures and create ownership. The **process** for developing the SOPs is hence an important intervention.

3.1 Leadership and coordination of GBV SOPs development

The GBV coordinator(s) (or person(s) covering this function) are responsible for initiating GBV SOPs development on behalf of the GBV coordination mechanism and its members, for managing negotiations and revisions for the GBV SOPs and for monitoring its functioning over time.

UNFPA is the lead agency of the GBV AoR, within the global protection cluster led by UNHCR, under the IASC coordination structure. UNHCR is the lead on implementation of the refugee coordination model in refugee settings together with national authorities (see also section 9 in the SOPs template). Coordination arrangements for mixed settings are set out in the Joint Note on Mixed Situations.

If there is no operational GBV coordination system in the setting, GBV actors can initiate the GBV SOPs development process. A group of agencies and/or organizations focused on GBV service provision may form before a GBV "coordination body" is formally designated, particularly at the start of an emergency.

Where there is a national coordination mechanism with decentralized local structures, consider developing one set of national GBV SOPs and then contextualizing the local referral pathways in each sub-national location. In this case, it is important that GBV coordinators involve decentralized structures and local humanitarian and development actors when developing

national GBV SOPs. In some cases, sub-national contexts may be different enough to require their own GBV SOPs.

3.1.1 Coordination with governments

It is important to engage relevant government actors early in the development or revision of GBV SOPs. If the government is not leading the GBV coordination, involvement in SOPs drafting can vary from setting to another, ranging from active participation in the drafting process to endorsing the final document. It is important to share information with the relevant government actors to promote understanding of the importance of SOPs, the implications for different actors and support for implementation.

In contexts where national authorities do not adhere to humanitarian principles and obstruct protection or perpetuate abuse, it may be difficult or harmful to engage authorities in SOPs development. The approach to working with government actors is decided on a case-by-case basis, based on an in-depth understanding of the context, to ensure that assistance is provided in line with both humanitarian principles and a "do-no-harm" approach.

Highlight: Alternative SOPs title

In some contexts, the use of GBV standard operating procedures as a title can create confusion or pushback from government counterparts, particularly where GBV-related terminology and interventions are less accepted. In such situations, different titles have been used to promote acceptance, for example "Guidance for Humanitarian Actors" rather than SOPs.

3.1.2 Coordination of GBV SOPs development process in mixed settings

In "mixed settings" – i.e. where there are different categories or affected populations (e.g. both refugees and IDPs or migrants and host community members) – it is recommended to develop one set of GBV SOPs to cover all populations.

Where more than one coordination structure is operational, the relevant coordination bodies decide together who is best placed to (co)-lead the development of GBV SOPs. This decision should be informed by each actor's mandate and capacity (including technical capacity, funding, staff, etc.) and ensure equal and safe access for all populations. Where possible, joint coordination and leadership of this process should be considered.

3.2 GBV SOPs development process phases

The GBV SOPs are developed in consultation with a diverse group of actors and agencies (see section 3.3 Participants in GBV SOPs development process). The SOPs development process can be led by GBV coordinators in the context or delegated to an organization member of the GBV coordination group. This section outlines a phased approach to the development of GBV SOPs.

Step 1: Prepare for GBV SOPs development

In preparation for the SOPs development process, GBV coordinators[1]:

- Gather any existing SOPs, guidance, national strategies or action plans that address GBV prevention, risk mitigation or response in the given context.
- In contexts where collaboration with national authorities is possible, safe and ethical, and where GBV national strategy, action plan or other documents exist:
    - Initiate discussions with authorities on SOPs development or review as early as feasible.
    - Clarify differences and similarities between existing GBV documents and this resource package.
    - Determine the extent to which the existing GBV SOPs or other documents are aligned with GBV minimum standards, accurately reflect the current context and capacities and include different aspects of response services.
    - Determine whether to revise, adapt or build on existing SOPs or documents, including addressing barriers to equal access and inclusion, such as for forcibly displaced and stateless persons.
    - If the revision of existing documents requires long-term investment in terms of resources, time and negotiation, discuss with authorities the possibility of developing practical interim GBV SOPs based on this resource package.

Step 2: Convene a GBV SOPs reference group and develop a workplan

GBV coordinators convene a small core group – the GBV SOPs reference group – to facilitate the development of GBV SOPs and keep it moving forward.

GBV coordinators convene a group of diverse participants based on the actors' roles and profiles and assess how to maximize safe participation by community organizations and representatives. The GBV SOPs reference group should include approximately 5-10 people.

The reference group (RG) drafts a work plan[2] and identifies who should be involved in the development of GBV SOPs (see section 3.3 for guidance on who to engage during the different steps). The workplan should include a training for GBV and non-GBV actors on basic GBV concepts, including using the GBV guiding principles, GBV minimum standards (2019) and IASC GBV Guidelines (IASC 2015),[3] as necessary.

The reference group coordinates with all identified relevant stakeholders and advises on the upcoming GBV SOPs development or revision and the importance of their participation.

Step 3: Conduct situational analysis and/or service mapping

[1] Lead of GBV SOPs development process can be delegated to a specific organization, GBV coordinator used here for brevity.
[2] It is good practice to integrate or link the SOPS workplan with existing GBV coordination group workplans.
[3] The key resources for such training include the Inter-Agency Minimum Standards for GBV in Emergencies for GBV actors and the IASC GBV Guidelines (2015) for non-GBV actors.

GBV coordinators review available research and documentation to gather information about GBV needs, risks, available resources, services and gaps.

This may include:

- Information from inter-agency and agency-specific assessment reports (e.g. multisector initial rapid assessment, data from the GBV information management system (GBVIMS), safety audits and focus-group discussions).
- Service mapping, situational analysis or secondary data review.

If sufficient information is not available, GBV coordinators oversee rapid situational analysis including, if needed and possible, safety audits and focus-group discussions.

Step 4: Share the workplan, situational analysis and service mapping.

GBV coordinators invite other key actors involved in GBV response, mitigation and prevention efforts to a meeting or workshop to review and provide input to the reference group's draft plan for developing the GBV SOPs.

GBV coordinators share the situational analysis and this SOPs resource package (guide, template and annexes) with the actors who will be involved in developing the GBV SOPs. GBV coordinators or reference group initiate individual or group discussions to engage actors and encourage participation.

Step 5: Facilitate GBV SOPs template review and revision meetings

GBV coordinators facilitate a series of meetings to go through the GBV SOPs template by section. This must be inclusive, participatory and transparent to build relationships and commitment among actors.

These discussions must be carefully facilitated to stay on track and maintain balance between ensuring timely development of GBV SOPs and adequate engagement of all relevant actors. Meetings and process have to be results-oriented and engaging to ensure sustained participation.

At this stage, GBV coordinators share information about the development of GBV SOPs with relevant clusters/sectors, in particular health and child protection, to ensure alignment of procedures across actors.

The use of technology may increase access to the GBV SOPs development process and make it more inclusive, for example through remote or virtual discussions online or by phone. The GBV coordinators should pay attention to any stakeholders who may not have access to technology and use multiple communication and meeting methods to expand participation. It may also be necessary to support those with less access to technology, for example by allowing them to use the office of an organization or agency with internet or phone access.

The reference group or a designated member, summarizes and documents key decisions and revises the GBV SOPs template after each meeting to reflect decisions and agreed procedures.

Case Study: Engagement of local actors in the SOPs development process

In Libya, the GBV sub-cluster (GBV SC) designed a participatory consultation/data collection exercise to complement available information on GBV services and clarify mandatory reporting and clinical management of rape (CMR) practices and regulations to inform GBV SOPs development. Local GBV actors providing GBV response services in Libya were part of the GBV SOPs task force. With the objective of strengthening meaningful participation of key GBV stakeholders and leveraging the operational footprint and contextual knowledge of actors on the ground, the GBV SOPs task force jointly developed several questionnaires to inform different sections of the GBV SOPs and appointed local sub-cluster members as focal points to undertake data collection. Focal points consulted key stakeholders, such as officials of relevant line ministries, CSOs and international non-governmental organizations (INGOs) and presented findings back to the sub-cluster during a validation workshop, which brought together all relevant stakeholders. This participatory approach helped clarify procedures amongst sub-cluster members and enhance engagement of external stakeholders. It increased ownership of the SOPs amongst GBV sub-cluster members and created leadership opportunities for local actors.

Step 6: Finalize the GBV SOPs

The reference group completes the GBV SOPs based on all discussions and feedback. When all sections are complete, GBV coordinators distribute the draft version to all participating actors and invite them to a final meeting to review the draft.

Step 7: Sign the GBV SOPs

GBV coordinators ensure that appropriate and inclusive procedures for signing the SOPs are in place, depending on the context. This might include a reception or other event where the heads of agencies and organizations sign the document on behalf of their agency/organization to demonstrate their commitment to the GBV SOPs.

Step 8: Share the GBV SOPs

GBV coordinators present and share the final GBV SOPs with GBV coordination group members. Each signatory agency presents and disseminates the GBV SOPs with their staff to support that agency's role in upholding the procedures outlined in the GBV SOPs.

As part of the dissemination process, GBV coordinators should:

- Facilitate orientation sessions or training for GBV and other actors in the setting on the GBV SOPs, including referral pathways.
- Organize periodic trainings to respond to emerging needs and priorities among service providers and any other actors whose agencies are signatories to the GBV SOPs.
- Share the final GBV SOPs with humanitarian actors, including humanitarian leadership and relevant cluster/sector leads.
- Share the final GBV SOPs or key elements as relevant, with community representatives, women-led organizations (WLOs) and women's rights organizations (WROs) and with youth-led organizations in the format most relevant to the audience.

- Share information on accessing GBV services through community outreach activities (see section 3.7).

Step 9: Conduct periodic updates of GBV SOPs

GBV coordinators initiate regular reviews of the GBV SOPs, including service mapping and referral pathways as needed to ensure these remain updated, accurate and comprehensive.

GBV coordinators review the GBV SOPs between six and nine months after they are first developed. After that, reviews are usually done annually or on ad hod basis in case of significant changes in the context or capacity of actors to respond (e.g. new emergency, large decrease in funding, influx of new actors). These reviews broadly follow the steps outlined above. However, they may be less extensive if there are no significant changes in the context and response.

GBV referral pathway should be regularly updated (based on updated service mapping) to reflect changes in service availability or to improve usability, separately from reviewing the rest of the GBV SOPs. Feedback from communities, particularly women and girls, should be included in this process, as well as feedback on the accessibility and effectiveness of the referral pathway.

3.3 Participants in the GBV SOPs development process

GBV SOPs are developed through a consultative process that should include a diverse group of actors and agencies, ranging from those who provide direct services to survivors or organizations that represent diverse groups of people to actors focused on risk mitigation or prevention activities.

Some meetings involve all actors; for example, during discussions on GBV case management, referral pathways and coordination mechanisms. Other meetings focus on sector-specific groups and/or participants involved in certain response, risk mitigation or prevention-related activities. However, information on the process should be shared regularly with all participants to ensure transparency.

The GBV SOPs development process should include the following types of actors:

Type of Actor	Purpose of engagement	Example	Suggested part of RG (Y/N)	Notes
GBV specialized actors	Service provision to survivors of GBV and targeted GBV prevention activities (beyond risk mitigation).	Case management, psychosocial, safety and security, legal aid, CMR in health sector, actors implementing GBV prevention activities.	Y	These actors have the most direct input into SOPs development process; one representative of each type of GBV response service participates in

				the reference group.
Organizations and/or agencies that provide representation, services and/or advocacy for groups who face increased barriers to accessing services.	Representation, inclusion, advocacy.	Organizations of persons with disabilities (OPD), organizations supporting people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC)and organizations supporting older persons, UNHCR refugee case processing GBV focal points.	N	These actors are consulted to ensure that the needs and priorities of all groups are represented and that barriers to access are identified and addressed.
Representatives of other sectors.	Responsibility to integrate GBV risk mitigation into sectoral interventions (e.g. camp coordination and management (CCCM); water, sanitation and hygiene (WASH); food security, education and shelter and non-food items (SNFI), among others.		N	These representatives should be consulted to improve coordination and preparedness and further risk mitigation and other prevention-related efforts in the setting and ensure that the GBV SOPs are aligned with other policies and procedures.

Focal points from agencies, organizations or coordination structures with cross-cutting roles.	Areas intersecting with GBV for service provision and coordination that need to be aligned	Child protection, mental health and psychosocial support, (MHPSS), protection from sexual exploitation and abuse (PSEA)and anti-trafficking and gender in humanitarian action (GiHA).	Y	Consult these focal points when developing the GBV SOPs to ensure they are aligned with other policies and procedures and avoid duplication. Inclusion of these focal points may vary depending on the context.
Local organizations.	Various GBV responsibilities, including service provision, advocacy and capacity development.	WLOs and WROs, civil society organizations, women's activists, youth-led organizations, organizations led by displaced and stateless persons and other organizations representing at-risk groups.	Y	GBV coordinators and SOPs reference group promote the inclusion and participation of WLOs and WROs in the GBV SOPs development process by supporting potential participants with access needs (e.g. transportation, childcare, internet access, etc.).
Communities.	Consult when developing the GBV SOPs and share the final document with them	Community leaders and members representing	N	Support or establish inclusive channels to consult with

	(especially referral pathways, access points and feedback mechanisms).	diverse groups of people.		affected people, building on preferred and trusted communication channels.
Local and/or national government representatives.	Government representatives who are (co-) leading a coordination group, play the role of GBV coordinators outlined in the steps above. Otherwise, they should be consulted in SOPs development.	Relevant line ministry representatives.	Y	Ideally GBV, gender or "women's" focal points. Consider the safety of all GBV actors when engaging with government counterparts.

3.3.1 Participation by women and girls

Women and girls should be engaged as active partners and leaders in influencing the humanitarian sector to mitigate and prevent GBV and support survivor access to quality services.[4]

Participation by women and girls through regular feedback or accountability mechanisms is a mean of monitoring unintended harmful consequences of humanitarian programming.

Effectively engaging women and girls in the SOPs development process can take different forms. Depending on the context and available resources, women and girls can be included through:

- Consultancy: women and youth can be hired from the community to work on the drafting of the SOPs.
- Consultation: before and after the development of the SOPs to get their ideas for the development process and feedback/validation afterward.
- Regular review sessions with women and girls to monitor and evaluate SOPs. Where feasible, incorporate community involvement in the monitoring and evaluation of SOPs implementation.
- Inclusion of women-led organizations, in particular those from affected people where applicable, throughout the development process.

Information gathered by consulting with women and girls from the affected people informs the GBV SOPs and all GBV programming and supports access to services and GBV prevention and

[4] Inter-Agency Minimum Standards for GBV in Emergencies (2019), p.19.

risk mitigation. The participation of women and girls, including through finding ways to ensure that those who are marginalized can share their voices safely, helps to improve the accuracy of monitoring and assessment data for a more effective, contextualized response.[5]

Consultations and collection of information should be done in a safe and ethical manner,[6] based on the ways in which women and girls prefer to communicate and engage. It may be necessary to establish different ways of engaging community stakeholders to ensure access and inclusion and to mitigate risk.

Highlight: Overcoming constraints to participation by women and girls[7]

When scheduling meetings or activities during SOPs development, consideration should be given to the time and location to ensure women and girls can participate safely and easily. To overcome constraints to the participation of women and girls, it is necessary to consider a number of factors:

- Time and location of meetings and activities and how these are determined and communicated.
- Travel required (Is it safe? Is transportation available and accessible? How can the GBV programme actor support safe travel? Do arrangements have to be made so that adolescent girls, older women or women and girls with disabilities do not have to travel alone?).
- Mobility (Are women and girls free to move around and leave their homes/shelter? Should mobile units be created rather than expecting women and girls to move?).
- Compensation for time (i.e. in-kind compensation, such as food/drink or non-food items).
- Involvement of "gatekeepers" (e.g. community and religious leaders or others who may inhibit or enable access for women and girls) to facilitate the participation of women and girls.
- Safety, security and community acceptability of venues.
- Outreach strategies to ensure participation by women and girls (e.g. involving volunteers from target communities and providing childcare facilities); and
- Facilitation (Which groups of women and girls feel safe speaking with which facilitators and other group members?).

[5] Ibid, p. 10. See also pp. 13-14 for considerations on overcoming constraints on participation by women and girls.
[6] See, WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies, (2007).
[7] Inter-Agency Minimum Standards for GBV in Emergencies (2020), p.19 and 33.

4 GBV SOPs development in acute emergencies

In an acute emergency, the first priority is to map services and establish a referral pathway to ensure access for survivors to GBV-specialized services as soon as possible. Where information on services or services themselves, are limited, the referral pathway that is first developed may not include all services.

In such situations, it is not realistic to develop comprehensive GBV SOPs quickly enough to meet immediate needs. Some sections in the GBV SOPs template require negotiation and discussion, which may not be possible or appropriate in the early stages of an emergency.

In this case, **preliminary GBV SOPs** that cover the most relevant and immediately needed sections of the GBV SOPs template should be developed (initiated within the first two months). These should be developed by health, psychosocial, case management and any other protection actors who will be providing services (e.g. safety/security and legal aid/access to justice actors).

The existence of clear GBV SOPs is more important than how comprehensive they are.

At minimum, preliminary GBV SOPs should include the following sections:

- GBV terms (section 1).
- GBV guiding principles (section 2).
- Key considerations for response services, including consent, disclosure and mandatory reporting (section 3).
- Safety audit and service mapping in the setting (section 4).
- A referral pathway (section 5).

In situations where GBV SOPs already exist for a state or country-level response, it may only be necessary to develop a referral pathway at a specific emergency or new response location to contextualize the broader state or national SOPs. For further guidance on SOPs development where national GBV strategies/ documents exist see section 3.2 GBV SOPs development process phases – step 1.

5 GBV SOPs development in refugee settings

In refugee contexts, additional services related to refugee case processing will be in place. Refugee case processing, whether conducted by governments or UNHCR, covers registration, refugee status determination (RSD) and identification of durable solutions for refugee and asylum seekers.

The various components of refugee case processing have their own standards, objectives, good practices and guidelines. During the GBV case management process, a survivor might seek support to be referred to one of the refugee case processing components. In preparation for the development of SOPs in refugee settings, it is important to be aware of existing SOPs for these processes and ensure the identification and inclusion of focal points responsible for the services. This will ensure that the referral criteria and processes are adequately outlined in the GBV SOPs. This is important so that all actors are aware of the specific protection needs of and services

available to asylum seekers and refugees so they will be able to give survivors a clear explanation of the services and processes during the informed consent process.

6 Groups who face increased discrimination and barriers to access

In any setting, there are groups of individuals who are at increased risk and face additional and/or greater barriers to access response services than other members of the population. This includes forcibly displaced and stateless women and girls, women and girls with disabilities, adolescent girls, older women, women, girls and others who menstruate, women and girls living with HIV and AIDS, sex workers, women and girls with mental health conditions, substance abuse issues and women and girls from ethnic and religious minorities. Other forms of discrimination that lead to increased risk of GBV include those related to diverse sexual orientations and gender identities, socioeconomic status, birth country and legal status, including statelessness and asylum status, religion and ethnicity – these intersect with gender-based discrimination to increase risk of GBV.

Efforts to address GBV should be alert to and promote the rights and needs of these groups. Targeted work with specific at-risk groups should be undertaken in collaboration with agencies or organizations that have expertise in identifying additional barriers and addressing the needs of these marginalized groups.

When developing the GBV SOPs:

- Relevant sections will need to include specific operational guidance[8] on how to address the needs of these specific groups. Prompts are included in the template where this information should be included. The GBV SOPs template does not list every possible barrier, risk or potential discrimination to people we serve in each setting. Part of the GBV SOPs development process is to consider the specific barriers and risks in the setting to certain groups and all exacerbating factors.
- The GBV SOPs development process should include representatives of groups who are at increased risk of GBV and the organizations that support them (see section 3). It is important to engage with community members, particularly diverse women and girls, from the onset of a crisis, to identify, analyse and determine strategies to address intersecting forms of oppression that exacerbate the risk of GBV and create barriers to accessing GBV response services and meaningful and safe inclusion and participation.

Some of the groups that commonly face increased risk and barriers to access include but are not limited to:

6.1 Adolescent girls

Adolescent girls are especially vulnerable to GBV. They experience elevated risks of restrictions posed by cultural practices, sexual violence, exploitation and forced marriage, but are often not specifically considered for provision of sexual and reproductive health care. Given their age, the

[8] See, e.g. IASC Guidelines, Inclusion of persons with disabilities in humanitarian action (2019).

risks of early pregnancy, lack of decision-making power, denial of resources and limited access to information and services – including education and health care – special attention must be given to removing barriers and facilitating their access to services. GBV specialized actors should commit to providing compassionate care and services that are accessible, acceptable and appropriate to younger and older adolescent girls.

6.2 Women and girls with disabilities

Approximately 15 percent of any community may be persons with disabilities; this rises in humanitarian contexts where conflict and/or natural disasters result in new impairments from injuries and limited access to health care.[9] Rates of violence in developed countries are 4 to 10 times greater among persons with disabilities than persons with no disabilities. This has significant implications for protection of women and girls in humanitarian settings.

Women and girls with intellectual disabilities are particularly vulnerable to sexual violence. Those with intellectual, psychosocial or physical disabilities who are isolated in their homes report rape and domestic and intimate partner violence. In addition, women and adolescent girls who disproportionately assume caregiving roles in households with persons with disabilities may be exposed to harassment and exploitation when seeking assistance or accessing income. Attitudes of families, GBV service providers and community members can be the biggest barriers or the greatest facilitators for persons with disabilities to access safe and effective services and assistance. Additional barriers that should be identified and mitigated include physical obstacles in accessing GBV services and inaccessibility and absence of alternative ways of facilitating information and communication (e.g. lack of trained sign language interpreters).

6.3 Forcibly displaced and stateless women and girls

Over 43 million forcibly displaced and stateless women and girls are at heightened risk of gender-based violence[10] due to challenges arising from conflict and displacement, legal status or lack of thereof, lack of documentation, language barriers and intersecting forms of discrimination.

Those challenges also hamper access by forcibly displaced women and girls to life-saving services for GBV survivors and other essential services such as education and livelihoods, creating additional barriers that can increase their vulnerability to violence, abuse and exploitation through riskier livelihood options.

Forcibly displaced and stateless women and girls also hesitate to disclose GBV incidents if reporting requires the involvement of authorities for fear of arrest, deportation, detention, discrimination and/or further ill-treatment.

6.4 Individuals with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC)

Individuals with diverse SOGIESC may be among the most isolated and at-risk individuals in a community due to discrimination and threats of family and community rejection and harm. In all

[9] Inter-Agency Minimum Standards for GBV in Emergencies (2020) , p. 27.
[10] UNHCR, Global Trends (2022) (accessed 27 June 2023).

humanitarian settings, those who do not conform to proscribed heteronormative gender roles are at risk of persecution, discrimination and violence as a result of their real or perceived sexual orientation, gender identity or gender expression. Caregivers may abuse children who display non-conforming sexual orientation and gender identities and force them into heterosexual marriages.

6.5 Older women[11]

GBV against older women is widespread yet mostly hidden. Worldwide, almost half of older women live alone due to being widowed, divorced or never married. Older women isolated from friends, family and community have a threefold risk of exploitation and often limited access to services or support. GBV against older women occurs in multiple, often intersecting forms by perpetrators who may include intimate partners, family members (including female and male adult children), caregivers or members of the wider community. For older women and survivors of sexual assault, the health consequences and resulting injuries are often more severe. Age can impact women's health-seeking behaviour and access to services, which in turn means that the harmful health consequences for GBV can go untreated and may worsen and that GBV continues and increases in frequency and severity.

6.6 Adolescent boys and adult men survivors of sexual violence[12]

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

6.7 Children survivors of GBV

Children are more vulnerable than adults to abuse due to their mental, psychological and physical development and limited participation in decision-making. In emergencies, systems that protect children, including family and community structures, often break down. Children may be separated

[11] International Rescue Committee, Inclusion of diverse women and girls, Guidance note, 2020; See also GBV AoR Whole of Syria, Gender-based violence prevention and response to older women in the whole of Syria, 2020.
[12] GBV AoR. Guidance to gender-based violence coordinators addressing the needs of male survivors of sexual violence in GBV coordination ; see also Women's Refugee Commission, various resources and guidance on "Sexual Violence against Men and Boys", available at www.womensrefugeecommission.org/focus-areas/sexual-gender-based-violence/sexual-violence-against-men-and-boys (accessed 27 June 2023).

from their families, placing them at even greater risk. Specific measures should be implemented to protect children from the risk of GBV at home, school, online and in the community.[13]

For additional information on at-risk groups, please refer to the table "Key considerations for at-risk groups" pp. 21-23 of the IASC GBV Guidelines.

7 Technical guidance

This section lists essential GBV resources and materials to inform the content of the GBV SOPs and also support capacity strengthening. In addition, the GBV SOPs template itself includes specific suggestions for additional technical guidance and resources in relevant sections.

- GBV area of responsibility. Handbook for coordinating gender-based violence interventions in emergencies (2019).
- UNFPA. *The inter-agency minimum standards for gender-based violence in emergencies Programming (GBV minimum standards) (2019)*.
- Although the GBV minimum standards are the common reference document for emergency settings, the Essential services package for women and girls subject to violence (UN Women, UNFPA, WHO, UNDP and UNODC, 2021) is often used in more stable development contexts and should be used as a reference where applicable.
- IASC. *IASC guidelines for integrating gender-based violence interventions in humanitarian action (IASC GBV Guidelines) (2015).*
- World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR). Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings(2019).
- WHO. *WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*(2007).

[13] See International Rescue Committee and UNICEF, Caring for Child Survivors of Sexual Abuse Guidelines for health and psychosocial service providers in humanitarian settings, 2014 (accessed 27 June 2023).

Standard Operating Procedures for GBV Interventions in Humanitarian Settings

GBV SOPs Resource Package

Part 2: GBV SOPs Template

PART 2 Using the GBV SOPs template:

The GBV SOPs template in part 2 includes all of the sections recommended for comprehensive GBV SOPs. The GBV SOPs development process is the process of completing the template with information from the operating context.

Text boxes throughout the template, titled “Essential issues to consider”, provides background and other essential information to guide actors as they consider the specific actions, interventions and procedures to be agreed upon and established in their specific setting.

These text boxes may be removed once the template is completed. They are included for informational purposes and are not intended to form part of the final GBV SOPs. The reference group can choose to delete or to keep some or all of the text boxes. The template includes guidance and recommendations as well as links to relevant resources if additional information is needed.

Throughout the GBV SOPs template, blue text indicates information that needs to be discussed and updated or completed based on the specific context for which the GBV SOPs are being developed. For each section and detail completed, please change the blue text to black text; the final GBV SOPs document should eliminate all blue text as those items should be either filled in or deleted.

The GBV SOPs reference group[14] may create its own GBV SOPs document using the GBV SOPs template as a guide – with modifications as needed based on the context – or it may edit the GBV SOPs template with information relevant to the specific setting for which the GBV SOPs are being developed.

With the exception of section 2, Guiding principles for GBV programming, which are non-negotiable, all other sections of the GBV SOPs template must be contextualized based on the actual services and interventions in place.

[14] The GBV SOPs reference group represents key actors and organizations and includes women-led organizations (WLOs) and women’s rights organizations (WROs), local, national and international NGOs, government, other clusters/sectors and UN agencies. This core group will facilitate the GBV SOPs development process and keep it moving forward.

STANDARD OPERATING PROCEDURES

FOR GBV INTERVENTIONS IN HUMANITARIAN SETTINGS[15]

[Name of Location]

[Country]

Developed collaboratively among:

[List the names and roles of all[16] agencies, organizations and other actors involved in developing these GBV SOPs]

Role in GBV response, risk mitigation and/or prevention	Name of actor
Health	
Psychosocial Support	
Case Management	
Protection	
Legal Support	
Security/Safety Support	

Date of completion: _____

Next revision planned: _____

Revision completed: _____

[15] Although this GBV SOPs resource package focuses on humanitarian settings, the content is flexible enough to be used in contexts where there are both humanitarian and development interventions.

[16] Please add other sectoral actors to the table based on the actors and persons we work with and also based on who participated in the GBV SOPs development process.

Table of Contents

Acronyms

[To be filled in when SOPs are completed.]

Definitions

[To be filled in when SOPs are completed.]

DEFINITIONS

Common terms and definitions used in this document are defined below and listed in alphabetical order.[17] These terms and definitions are not legal definitions, nor are they intended as such. The definitions of many of the types of violence provided here are based on commonly accepted global 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. When developing the SOPs, the list of definitions should be revised and aligned with terminology used in context.

Actor(s): Refers to individuals, groups, organizations and institutions involved in responding to, mitigating and preventing gender-based violence. Actors may be refugees/internally displaced persons, stateless persons, local populations, employees or volunteers of UN and all other agencies and organizations, NGOs, host government institutions, donors and other members of the international community.

Adolescence: Defined as the period between ages 10 and 19 years old. It is a continuum of development in a person's physical, cognitive, behavioural and psychosocial spheres.

Adolescent: Any person between the ages of 10-19 years old. Adolescence can be broken down into the following sub-group: pre-adolescence (9–10), early adolescence (10–14), middle adolescence (15–17) and late adolescence (18–19).[18]

Adult: Any person 18 years and older.

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 with a view to changing attitudes, power relations, social relations and institutional functioning to improve the situation for groups of individuals who share similar problems.[19]

Affected people: For UNHCR, the terms affected people and affected populations, common in inter-agency settings, generally refer to persons of concern to UNHCR, in line with the organization's mandate for refugees, asylum-seekers, refugee returnees, stateless people and

[17] In an effort to ensure consistency, to the extent possible, some definitions have been taken directly from the IASC GBV Guidelines (2015) (accessed 27 June 2023) and from Caring for Child Survivors of Sexual Abuse (2014) (accessed 27 June 2023).

[18] Age 18 is the legal age for a person to be responsible for their actions. The same person can be a "late adolescent" in terms of development and an "adult" according to international guidance.

[19] IASC GBV Guidelines (2015), p. 324, note 1.

the internally displaced. In many situations, affected people may also refer to communities hosting persons of concern to UNHCR.[20]

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. In humanitarian settings, NGOs and United Nations agencies often carry out assessments to identify community needs and gaps in coordination and then use this information to design effective interventions.[21]

Asylum seekers: An individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which the claim is submitted. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee was initially an asylum-seeker.[22]

Case action plan: The case document that outlines the main needs of the survivor and goals and strategies for meeting their needs and improving their current condition.[23]

Case conference (or meeting): Case conferences are meetings with the survivor, concerned support people in the survivor's life as appropriate and service providers involved in the survivor's care when the survivor's needs are not being met in a timely or appropriate manner. The survivor should be invited but is not required to participate. The purpose of the case conference is to identify or clarify ongoing issues regarding her care. Case conferences provide an opportunity to review activities, including progress and barriers towards goals; map roles and responsibilities; resolve conflicts or strategize solutions and adjust action plans.[24]

Case documentation: This is information related to the provision of case management services. Generally, this information includes dates of services; the specific service provider; a brief description of the situation and the person's responses to the subject matter; relevant action plans and follow-up appointment information. Case documentation also includes dates and reasons for closing the person's case.[25]

Caseworker: This term describes an individual working within a service-providing agency who is responsible for providing case management services to clients. This means that caseworkers are trained appropriately on client-centred case management; they are supervised by senior programme staff and adhere to a specific set of systems and guiding principles designed to promote health, hope and healing for their clients. Caseworkers are also commonly referred to as social workers and case managers, among other terms.[26]

[20] UNHCR, Master Glossary of Terms (accessed 27 June 2023).
[21] IASC GBV Guidelines (2015), p. 338.
[22] UNHCR, Master glossary of terms (accessed 27 June 2023).
[23] Inter-Agency GBV Case Management Guidelines (2017), p.243
[24] Ibid, p. 243.
[25] Ibid, p. 243.
[26] Ibid, p. 244.

Child: Every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier.[27]

Denial of resources, opportunities or services: Denial of rightful access to economic resources/assets or livelihoods 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.[28]

Disclosure: The process of revealing information. Disclosure in the context of this document refers to a survivor voluntarily sharing with someone that she has experienced or is experiencing gender-based violence.[29]

Disability: An evolving concept that results from the interactions between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.[30]

Domestic violence (DV): Although DV and intimate partner violence (IPV) are sometimes used interchangeably, there are important distinctions between them. "Domestic violence" is a term used to describe violence that takes place within the home or family between intimate partners as well as between other family members.[31] "Intimate partner violence" applies specifically to violence occurring between intimate partners (married, cohabiting, boyfriend/girlfriend or other close relationships) 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. This type of violence may also include the denial of resources, opportunities or services. See definition of intimate partner violence.

Disaster: A serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses that exceed the ability of the affected community or society to cope using its own resources. Disasters can be slow-onset (such as drought or socio-economic decline) or sudden-onset (such as earthquakes, floods or sudden conflict situations).[32]

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.[33]

[27] United Nations Convention on the Rights of the Child, Art.1.
[28] IASC GBV Guidelines (2015), p. 335.
[29] Inter-Agency GBV Case Management Guidelines (2017), p. 244.
[30] Convention on the rights of persons with disabilities, Preamble.
[31] The Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) Art.3.
[32] UNDRR, Sendai Framework Terminology on Disaster Risk Reduction (accessed 27 June 2023)
[33] IASC GBV Guidelines (2015), p. 321.

Emergency: An event or series of events that represents a critical threat to the health, safety, security or wellbeing of a community or other large group of people, usually over a wide area.[34]

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.[35]

Empowerment of women and girls: The empowerment of women and girls concerns women and girls 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 that reinforce and perpetuate gender discrimination and inequality.[36]

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.[37]

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.[38]

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. Even though some countries permit marriage under the age of 18, international human rights standards classify these as forced marriages because those under age 18 are unable to give informed consent for these actions. Therefore, child marriage is a form of forced marriage as children are not legally competent to agree to such unions.[39]

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- and 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

[34] Humanitarian Coalition. What is a humanitarian-emergency (accessed 27 June 2023).
[35] IASC GBV Guidelines (2015), p. 321.
[36] UNWOMEN, Gender Equality Glossary (accessed 27 June 2023).
[37] IASC GBV Guidelines (2015) , p.321.
[38] Ibid, p.321.
[39] Ibid, p. 321.

resources, as well as decision-making opportunities and power relations. Gender is part of the broader socio-cultural context.[40]

Gender-based violence (GBV): 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.[41]

As agreed in the *Declaration on the Elimination of Violence against Women* (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 some forms of sexual violence against males and /or targeted violence against people, especially women and girls, with diverse sexual orientations and gender identities (see SOGIESC definition, below), in these cases when referencing violence related to gender-inequitable norms of masculinity and/or norms of gender identity.

Gender-based violence (GBV) case management: GBV case management, which is based on social work case management, is a structured method for providing help to a survivor.[42] It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way and providing the survivor with emotional support throughout the process. GBV case management services require specialized intervention from a range of service providers to meet a survivor's immediate needs and support long-term recovery. Effective GBV case management ensures adherence to the GBV Guiding Principles. Case management for child survivors will be guided by the best interests of the child.

GBV coordination group: An umbrella term to describe a group of actors implementing or involved in supporting GBV programming. Examples include sub-cluster, sub-sector, area of responsibility or working group.

GBV specialized service providers: Refers to all actors, including UN, NGO and governmental actors and local organizations providing GBV specialized services.

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 are the same but that women's and men's rights, responsibilities and opportunities do 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.

[40] Ibid, p. 325.
[41] Ibid, p. 322.
[42] Inter-Agency GBV Case Management Guidelines (2017), p. 243.

Equality between women and men is seen both as a human rights issue and as a precondition for and indicator of sustainable people-centred development.[43]

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.[44]

Gender mainstreaming: A strategy that 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. 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.[45]

Gender roles: A set of social and behavioural 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. 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.[46]

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.[47]

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 and girls. These harmful traditional practices may include female genital mutilation/cutting (FGM/C); forced feeding of women; child marriage; the various taboos or practices that 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. Other harmful traditional practices include binding, scarring, burning, branding, violent initiation rites, fattening, forced marriage, killings in the name of honour, dowry-related violence, exorcism or "witchcraft".[48]

Host community: A community that hosts large populations of refugees or internally displaced persons, whether in camps, integrated into households or independently.[49]

[43] IASC GBV Guidelines (2015), p. 325.
[44] Ibid, p. 325.
[45] Ibid, p. 325.
[46] Ibid, p. 325.
[47] Ibid, p. 325.
[48] Ibid, p. 322.
[49] UNHCR, Master Glossary of Terms (accessed 27 June 2023).

Incident monitoring: Monitoring of data derived from reported incidents of GBV. Incident data always represents only a small percentage of the number of incidents of GBV in a specific population at a particular time point or over a specified period of time (known as prevalence). Data on reported incidents of GBV are not representative of the prevalence of GBV in any community, as trends are based solely on incidents reported by survivors to GBV actors and using the specific data collection tool. Hence, it is not advisable to use findings of any reported incident data as a proxy of the prevalence of GBV in any setting or to use it in isolation to monitor the quality of programmatic interventions. "Incident data" should not be confused with the term "incidence" which refers to the number of individuals who experience a specific event during a particular time period (such as a month or year).

Individual, non-identifiable data: Data about an individual survivor that cannot be used to identify the survivor. This means that the data does not include any information such as the name or address of the survivor or any other information that may allow identification.

Informed assent: Willingness to participate in services expressed by younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services. [50] Consent from parents/ guardians is not necessary where it is not in the best interests of the child to share information with their parents/guardians or where the parents/guardians are not reachable. The information provided and the way in which consent/assent is expressed must be appropriate to the age and capacity of the child and to the particular circumstances in which it is given.[51]

Informed consent: The voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent individuals must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. To ensure consent is "informed", service providers must provide the following information to the survivor:

- Provide all the possible information and options available to the person so she/he can make choices.
- Inform the person that she/he may need to share his/her information with others who can provide additional services.
- Explain to the person what will happen as you work with her/him. Explain the benefits and risks of services to the person.
- Explain to the person that she/he has the right to decline or refuse any part of services.
- Explain limits to confidentiality.

Inter-agency GBV standard operating procedures (GBV SOPs): Specific procedures and agreements among organizations in a particular context that reinforce the GBV Guiding Principles and standards for ethical, safe and coordinated multisectoral service delivery and outline the roles and responsibilities of each actor in the response to risk mitigation and prevention of GBV.

[50] Inter-Agency GBV Case Management Guidelines p. 245.
[51] UNHCR Best interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child (2021), p 13.

Internally displaced people (IDP): Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters and who have not crossed an internationally recognized state border. "Internally displaced persons" is an interchangeable term.[52]

Intimate partner violence (IPV): Although IPV and domestic violence (DV) are sometimes used interchangeably, there are important distinctions between them. "Intimate partner violence" applies specifically to violence occurring between intimate partners (married, cohabiting, boyfriend/girlfriend or other close relationships)[53] 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. This type of violence may also include the denial of resources, opportunities or services. "Domestic violence" is a term used to describe violence that takes place within the home or family between intimate partners as well as between other family members. See definition of domestic violence.

Local integration: A durable solution for refugees that involves their permanent settlement in a host country. Local integration is a complex and gradual process, comprising three distinct but interrelated dimensions: legal, economic and socio-cultural. The process is often concluded with the naturalization of the refugee.

Mandatory reporting: This refers to state laws and policies that mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected forms of interpersonal violence (e.g. physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).[54] 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.

Menstrual health and hygiene (MHH): Menstrual health and hygiene (MHH) encompasses both menstrual hygiene management (MHM) and the broader systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment and rights.[55] These systematic factors have been summarized by UNICEF as accurate and timely knowledge, available, safe and affordable materials, informed and comfortable professionals, referral and access to health services, sanitation and washing facilities, positive social norms, safe and hygienic disposal and advocacy and policy.

Menstrual materials: Purpose-made products (e.g. pads, tampons or cups) or other materials (e.g. cloth or self-made solutions) used to collect or absorb menstrual fluid.

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[52] Policy on UNHCR's Engagement in Situations of Forced Displacement (2019), p.10.
[53] IASC GBV Guidelines (2015), p 321.
[54] Inter-Agency GBV Case Management Guidelines, p 246.
[55] Global Water Security and Sanitation Partnership, Menstrual Health and Hygiene Resource Package, Tools and Resources for Task Teams (2021), p 13.

Menstrual supplies: Additional products required to manage menstruation, including but not limited to underwear, bathing soap for personal hygiene, washing detergent for cleaning clothing or reusable menstrual products.

Mental health and psychosocial support (MHPSS): A composite term used in these guidelines 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.[56] 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.

Migrants: There is no universally accepted definition of the term migrant and the term is not defined by international law. Traditionally, the word migrant (or, more accurately, international migrant) has been used to refer to people who choose to move across international borders, not because of a direct threat of persecution, serious harm or death, but exclusively for other reasons, such as to improve their conditions by pursuing work or education opportunities or to reunite with family. Migrants in this sense of the word – unlike refugees – continue in principle to enjoy the protection of their own government, even when they are abroad. If they return, they will continue to receive that protection. Nevertheless, the word migrant is used by some actors as an umbrella term to refer to any person who moves within a country or across a border, temporarily or permanently and for a variety of reasons. In this sense, the term covers legally defined categories such as migrant workers and smuggled migrants, as well as others whose status or means of movement is not specifically defined under international law, such as international students. UNHCR recommends that – except in very specific contexts (notably statistical: see below) – the word migrant should not be used as a catchall term to refer to refugees or to people who are likely to be in need of international protection, such as asylum-seekers. To do so risks undermining access to the specific legal protections that States are obliged to provide to refugees.[57]

Mixed setting: A physical setting or location that includes different groups of affected populations (e.g. a mixed setting of migrants and refugees).

Nexus: A "nexus approach", "nexus programming" or "the nexus" is shorthand for the concept of a "humanitarian-development nexus" or a "humanitarian-development-peace nexus". It focuses on the work needed to coherently address people's vulnerability before, during and after crises. It is an approach or framework that takes into account both the immediate and long-term needs of affected populations and enhances opportunities for peace. Other understandings of the nexus go further, to include a full range of diplomatic and security measures.[58]

Perpetrator: Person, group or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will.[59]

[56] IASC Guidelines on mental health and psychosocial support in emergency settings, 2007. p. 1.
[57] UNHCR, Master Glossary of Terms (accessed 27 June 2023).
[58] Oxfam, The Humanitarian-Development Nexus: What does it mean for multi-mandated organizations? (2019).
[59] Inter-Agency GBV Case Management Guidelines (2017), p. 246.

Physical assault: An act of physical violence that is not sexual in nature.[60] Examples 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.

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.).[61]

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 United Nations, NGO and inter-governmental (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.[62]

Psychosocial: A term used to emphasize the interaction between the psychological aspects of human beings and their environment or social surroundings. Psychological aspects are related to our functioning, such as our thoughts, emotions and behaviour. Social surroundings concern a person's relationships, family and community networks, cultural traditions and economic status, including life tasks such as school or work.[63]

Rape:[64] Physically forced or otherwise coerced penetration, even if slight, of the vagina, anus or mouth with a penis or other body part. It also includes penetration of the vagina or anus with an object. Rape includes marital rape and anal rape/sodomy. The attempt to do so is known as attempted rape.[65] Rape of a person by two or more perpetrators is known as gang rape.[66]

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 or because of conflict, generalized violence or other circumstances that have seriously disturbed public order, is outside the country of her or his nationality and is unable to or, owing to such fear, is unwilling to avail herself or himself of the protection of that country. This person, as a result, requires international protection.[67]

Resettlement: The selection and transfer of refugees from a State in which they have sought treaty protection to a third State that has agreed to admit them – as refugees – with permanent

[60] IASC GBV Guidelines (2015), p.346.
[61] Ibid, p.11.
[62] Ibid, p. 326.
[63] Inter-Agency GBV Case Management Guidelines , p. 246.
[64] This definition of rape is consistent with the IASC GBV Guidelines (2015). The GBV Information Management System (GBVIMS), however, defines rape as "non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object." These are the two definitions used by GBV specialized actors, whereas health actors might use a World Health Organization definition. Please see section 1.3.2.1 for the GBVIMS Incident Type definitions.
[65] In the GBV Information Management System (GBVIMS), attempted rape is included under "sexual assault".
[66] IASC GBV Guidelines (2015) , p. 322.
[67] UNHCR, Master Glossary of Terms (accessed 27 June 2023).

residence status. The status provided ensures protection against refoulement and provides resettled refugees and their dependents with access to rights similar to those enjoyed by nationals. Resettlement also carries with it the opportunity to eventually become a naturalized citizen of the resettlement country. As such, resettlement is a mechanism for refugee protection, a durable solution and an example of international burden and responsibility sharing.[68]

Response: Response refers to immediate interventions that address survivors' physical safety, health concerns, psychosocial needs and access to justice, in line with the survivor-centred approach and the GBV Guiding Principles.[69] The provision of multisectoral services and assistance to all GBV survivors contributes to ensuring people's safety, improving physical, mental, sexual and reproductive health and facilitating access to justice. All GBV survivors, including survivors of sexual exploitation and abuse (SEA) perpetrated by humanitarian workers, have the right to immediate life-saving protection and GBV services. Survivors of SEA should be treated equally as survivors of other forms of GBV. Working with perpetrators of GBV is not the responsibility of GBV response programming.

Returnee: A former refugee or IDP who has returned to their country of origin but has not yet been fully (re)integrated.[70]

Risk mitigation: Refers to a process and specific interventions to mitigate risks in all phases of humanitarian programming. It includes actions that are taken in each humanitarian sector and area of work to reduce risks and exposure to GBV and improve safety as part of an agency-wide mainstreaming approach. Cross-sectoral coordination is essential to ensure a comprehensive approach.[71]

Safeguarding: A set of policies, procedures and practices employed to actively prevent harm, abuse and distress.[72] Broadly, it means preventing harm to people – and the environment – in the delivery of development and humanitarian assistance, including taking all reasonable steps to prevent sexual exploitation, abuse and harassment from occurring; to protect people, especially vulnerable adults and children, from that harm; and to respond appropriately when harm does occur.[73]

Sexual abuse: The actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.[74]

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.

[68] UNHCR Integration Handbook (accessed 27 June 2023).
[69] The Inter-Agency Minimum Standards for GBV in Emergencies (2019), p.16.
[70] UNHCR, Master Glossary of Terms (accessed 27 June 2023).
[71] UNHCR Policy on GBV Prevention, Risk Mitigation and Response (2020), p.9 (accessed on 27 June 2023)
[72] Save the Children. Safeguarding Children (accessed 27 June 2023).
[73] Resource & Support Hub. What is Safeguarding (accessed 27 June 2023).
[74] IASC GBV Guidelines (2015), p.344.

Sexual exploitation: 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.[75]

Sexual exploitation and abuse (SEA): A common acronym in the humanitarian world referring to acts of sexual exploitation and sexual abuse committed by United Nations, NGO and inter-government (IGO) personnel against the affected population.[76]

Sexual harassment: Unwelcome sexual advances, requests for sexual favours and other verbal or physical conduct of a sexual nature.[77]

Sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC): Umbrella term for all people whose sexual orientations, gender identities, gender expressions and/or sex characteristics place them outside culturally mainstream categories. Sometimes used interchangeably with "LGBTIQ+".[78]

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 of the relationship to the victim, in any setting, including but not limited to home and work". Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse and forced abortion.[79]

Standard operating procedures (SOPs) reference group: This small group represents key actors and organizations participating in the GBV SOPs development process. This core group will facilitate the GBV SOPs development process and keep it moving forward.

Stateless Person: Someone who is "not considered as a national by any State under the operation of its law"[80] and is thus someone without any nationality or citizenship anywhere.[81]

Survivor (see also "Victim"): 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.[82]

Trafficking in persons is "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

[75] Ibid, p. 344.
[76] Ibid, p. 344.
[77] Ibid, p. 344.
[78] IOM, Full Glossary of Terms (accessed 27 June 2023).
[79] IASC GBV Guidelines (2015), p.344.
[80] As defined in article 1(1) of the 1954 Convention relating to the Status of Stateless Persons, a definition considered by the International Law Commission to form part of customary international law.
[81] Guidance Note of the Secretary General, The United Nations and Statelessness (2011), (accessed 27 June 2023).
[82] IASC GBV Guidelines (2015), p.348.

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."[83]

Victim (see also "Survivor"): 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 and in the context of trafficking in persons as the term "victim of trafficking" is linked to a legal definition. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency.[84]

Violence against women and girls (VAWG): Article 1 of 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 2 continues: "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."[85]

The 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.[86]

Voluntary repatriation: The free and informed return of refugees to their country of origin in safety and dignity. Voluntary repatriation may be organized (i.e. when it takes place under the auspices of the States concerned and/or UNHCR) or spontaneous (i.e. when refugees repatriate by their own means with little or no direct involvement from government authorities or UNHCR).

[83] Ibid, p. 323, citing United Nations (2000), Protocol to prevent, suppress and punish trafficking in persons, especially women and children (accessed 27 June 2023).
[84] Ibid, p.348.
[85] Ibid, p. 323, citing United Nations General Assembly. December 1993. "Declaration on the Elimination of Violence against Women , (accessed 27 June 2023).
[86] Ibid, p. 323, citing United Nations Secretary-General. 2006. The secretary-general's in-depth study on all forms of violence against women, (accessed 27 June 2023).

8 SECTION 1: INTRODUCTION

These GBV Standard Operating Procedures (GBV SOPs) have been developed to facilitate collaborative action to address GBV in *[insert setting here].*

These GBV SOPs will be updated *[annually]* to reflect changes in the context and needs. If preliminary GBV SOPs have been developed, it is important to expand the GBV SOPs to be comprehensive.

8.1 Purpose

These GBV SOPs, developed by representatives of the organizations listed on the cover, describe the procedures, roles and responsibilities for each actor involved in the response to and mitigation and prevention of GBV. They are designed for actors to be able to hold each other accountable for addressing the needs of GBV survivors, to be used together with established guidelines and other good practice materials related to the response to and mitigation and prevention of GBV.

8.2 Context

[Insert general contextual information on the setting and GBV in the setting. If available, draw on a secondary data review[87] conducted for the setting or similar contextual analysis, including a brief summary of:

- *the drivers of the current crisis (e.g. natural disaster, displacement).*
- *an overview of the in-crisis situation (people in need, GBV protection needs, including information on legal practices that criminalize survivors of GBV, if applicable).*
- *key priorities and most critical areas for intervention.*
- *key geographic areas (e.g. any areas where the situation is worse than others e.g. north of the camp vs. south, governorate X vs. Y, etc.).*
- *key vulnerable groups (were any groups particularly affected? E.g. displaced women and girls, women over 60 years old, girls with disabilities or women from minority group X).]*

8.3 Settings and affected populations

These GBV SOPs have been developed for use in the following settings:

Location	**Type of Setting**	**Affected populations**
Name of the camp, settlement, village, town or city.	Specify whether it is camp, settlement, urban, etc.	Specify refugees (and include country of origin), IDPs, returnees, migrants or host community members.

[87] A template for conducting a secondary data review is available on the GBV AoR website (accessed 27 June 2023).

8.4 Terms

8.4.1 General terms

An extensive but non-exhaustive list of general terms is included in the Definitions section above. The list of definitions must be revised and aligned with terminology used in context.

8.4.2 Gender-based violence terms

Gender-based violence[88] is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (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. Many – but not all – forms of GBV are illegal and criminal acts in national laws and policies.

Around the world, GBV has a greater impact on women and girls than on men and boys. The term "gender-based violence" is often used interchangeably with the term "violence against women and girls". The term "gender-based violence" highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased risk to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, especially sexual violence.

The nature and extent of specific types of GBV vary across cultures, countries and regions. Examples of GBV include but are not limited to sexual violence, including sexual exploitation and abuse, intimate partner violence, trafficking in persons, forced marriage, harmful traditional practices such as female genital mutilation, widow inheritance and others.

The term "GBV" is most commonly used to underscore how systemic inequality between male and female persons, 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 term "gender-based violence" also includes sexual violence committed with the explicit purpose of reinforcing gender-inequitable norms of masculinity and femininity.

8.4.2.1 GBV incident type definitions

Gender-based violence encompasses many different types of violence. When each GBV actor has a different understanding of how a type of GBV is defined, challenges in communication and analysis can result. Differing definitions may cause inaccurate information to be reported about

[88] This definition of gender-based violence is used widely by the GBV area of responsibility and various UN agencies.

the scope and impact of GBV risks. To address this issue, the GBV Information Management System (GBVIMS) developed an incident classification system that helps to define and standardize different types of GBV for documentation and trend analysis.

The incident types/case definitions listed below reflect the current recommended good practice for classifying GBV incidents by the GBVIMS. Please see Annex 4 for the GBVIMS classification tool.

Note: Incident type definitions used in the context of GBV programming are not necessarily the legal definitions used in national laws and policies. Many forms of GBV may not be considered crimes in certain places and legal definitions and terms vary greatly across countries and regions. If GBV incidents are defined differently in the setting, please outline the differences in definitions between the international humanitarian GBVIMS definitions and the local or national definitions.

The six core GBV types were created for data collection and statistical analysis of GBV.[89] They should be used only in reference to GBV incidents, even though some of the definitions may be applicable to other forms of violence that are not gender-based.

- **Rape:**[90] non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.
- **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. FGM/C is an act of violence that impacts sexual organs and as such should be classified as sexual assault. This incident type does not include rape, i.e. where penetration has occurred.
- **Physical Assault**: an act of physical violence that is not sexual in nature. Examples 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. This incident type does not include FGM/C.
- **Forced Marriage**: the marriage of an individual against her or his will.
- **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

[89] GBVIMS data is collected by GBV case management organizations as a means to improve planning and delivery of care to survivors. Hence, collected data represents reported incidences associated with data sharing protocols. IMS data, when available, should not be confused as reflecting prevalence. See Inter-Agency Minimum Standards for GBV in Emergencies (2019), Standard 14: Collection and Use of GBV Survivor Data.

[90] Rape is defined in the IASC GBV Guidelines (2015) (p. 336) as: "Physically forced or otherwise coerced penetration, even if slight, of the vagina, anus or mouth with a penis or other body part. It also includes penetration of the vagina or anus with an object. Rape includes marital rape and anal rape/sodomy. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape."

contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.

- **Psychological / Emotional Abuse**: infliction of mental or emotional pain or injury. Examples include threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

[List and define the forms of GBV that are relevant in this setting.]

9 SECTION 2: GUIDING PRINCIPLES FOR GBV PROGRAMMING

9.1 GBV Guiding Principles and Approaches

All humanitarian aid programming, including GBV interventions, must adhere to these core principles:

- **Humanitarian principles:** The humanitarian principles of humanity, impartiality, independence and neutrality are essential to maintaining access to affected populations and ensuring an effective humanitarian response.[91]
- **"Do no harm" approach:** A "do no harm" approach involves taking all measures necessary to avoid exposing people to further harm as a result of the actions of humanitarian actors.[92]
- **Accountability to affected populations**[93] (AAP) refers to the "commitments and mechanisms that humanitarian agencies have put in place to ensure that communities are meaningfully and continuously involved in decisions that directly impact their lives". Humanitarian actors have a duty to make sure that assistance generates the best possible outcomes for all groups who are affected by a crisis, including those who may be less visible.[94]

The guiding principles and approaches outlined in the following section apply to all GBV programming:

- **Survivor-centred approach:** A survivor-centred approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured

[91] See, e.g. www.unocha.org/sites/unocha/files/OOM_Humanitarian%20Principles_Eng.pdf (accessed 27 June 2023).
[92] See, e.g. Inter-Agency Minimum Standards for GBV in Emergencies (2019).
[93] The 'P' in AAP may also refer to 'People'.
[94] AAP focuses on the rights, dignity and protection of an affected community in its entirety. AAP is about meaningful engagement, working with communities and actively seeking and putting forward the voices of the most vulnerable. It requires humanitarian actors to identify and address the needs and vulnerabilities of members of affected communities and it equally requires them to recognize and harness the capacities, knowledge and aspirations of those communities. Community members must be engaged and empowered throughout all stages of the humanitarian programme cycle, not only to be a part of decision-making but to be equal partners helping to drive the process. Humanitarian actors aim to achieve this by taking account, giving account and being held to account.

and they are treated with dignity and respect. A survivor-centred approach is based on the following guiding principles:

a. **Safety:** The safety and security of survivors and their children are the primary considerations.

b. **Confidentiality:** Survivors have the right to choose to whom they will or will not tell their story and any information about them should only be shared with their informed consent.[95]

c. **Respect:** All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.

d. **Non-discrimination:** Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or any other characteristic.

- **Rights-based approach:** A rights-based approach seeks to analyse and address the root causes of discrimination and inequality to ensure that everyone has the right to live with freedom and dignity, safe from violence, exploitation and abuse, in accordance with principles of human rights law.
- **Community-based approach:** A community-based approach ensures that affected populations are engaged actively as partners in developing strategies related to their protection and the provision of humanitarian assistance. This approach involves direct involvement of women, girls and other at-risk groups at all stages in the humanitarian response to identify protection risks and solutions and build on existing community-based protection mechanisms.
- **Age, gender, diversity (AGD)**:[96] Age, gender and diversity factors influence how forced displacement and statelessness impact people; understanding and analysing how these factors impact people's experience is necessary for an effective response.
- **Child-centred approach**: A child-centred approach creates a supportive environment in which children are involved in all matters that affect them, including building on their capacities/strengths, and they are part of the decision-making process. A child-centred approach ensures programmes that are adjusted and tailored towards the child's unique needs and capacities. Child-centred and child-focused are terms used interchangeably.
- **Best interests of the child**: In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.[97] The best interest of the child is one element of the child-centred approach. The best

[95] There are some limitations to confidentiality, including when there are concerns about the immediate physical safety of survivors or risk to others, or in the case of mandatory reporting requirements. See section 3.3.3 on mandatory reporting for more information.
[96] UNHCR Age, Gender and Diversity Policy (2018), 2018, pp. 5-6.
[97] Convention on right of the Child, Art.3.

interest of children and adolescent survivors of GBV should be of primary consideration in all decisions affecting them.

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

It is important to emphasize that:

- GBV encompasses a wide range of human rights violations. Preventing and mitigating GBV involves promoting gender equality and beliefs and norms that are respectful and non-violent.
- Safety, respect, confidentiality and non-discrimination in relation to survivors and those at risk are vital considerations at all times.

10 SECTION 3: GBV RESPONSE PROGRAMMING

Safe access to GBV services (see SOPs development guide for groups facing barriers to access)

All GBV service providers must reduce barriers to accessing GBV services. Women, girls and other persons at risk face various barriers to accessing services, including but not limited to:

- Location of the services.
- Lack of mobility without male supervision.
- Language barriers.
- Perception/stigma of the service in the community.
- Lack of wash facilities and/or menstrual materials and supplies at the service location.

GBV survivors may need various types of care and support to help them recover, heal and be safe from further violence. GBV survivors have the right to access quality, confidential, age-appropriate and compassionate services. All services should be delivered in a non-judgmental and non-discriminatory manner that considers the survivor's sex, age and specific needs.

Across all contexts and types of GBV incidents, health care for GBV survivors is a priority service. Adequate health services are vital to ensuring life-saving care for women, girls and other at-risk groups. Health care providers are often the first and sometimes only point of contact for GBV survivors.

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

All GBV service providers should create a safe, supportive, confidential environment that allows survivors and/or their caregivers to disclose violence should they choose to do so. It often takes time to build trust for the survivor to disclose that they have experienced violence.

Entry points to services for GBV survivors need to be accessible, safe, private, confidential and trustworthy. The suggested help-seeking and referral pathway for GBV response is illustrated in section 3.3; information sharing for service provision and consent are described in sections 4.2 and 3.3.2 respectively.

Case/incident documentation and information sharing for coordination and trend analysis are discussed in section 9.1.

10.1 Overview of GBV response services[98]

Essential issues to consider

This section of the GBV SOPs template should outline the GBV specialized services available for GBV survivors in the setting.

It is necessary that women, adolescent girls, women-led organizations and representatives of groups of persons who experience discrimination (e.g. women and girls with disabilities, older women, etc.) participate in the GBV SOPs development process to support risk assessment for each of the services listed below. Access to, and safety and effectiveness of, GBV services depends on women's and adolescent girls' input.

It is necessary to involve all operational GBV service providers in the GBV SOPs development process to ensure accurate descriptions of the services available.

GBV SOPs and referral pathways among health, protection and other safety and security actors and GBV programme actors must uphold a survivor's right to choose where and when to disclose and facilitate timely access to health care and other services.

GBV response services include:

- **Medical treatment and health care** to address the immediate and long-term physical and mental health effects of GBV, including but not limited to initial examination and treatment, follow-up medical care and health-related legal services, such as preparation of documentation.
- **Psychosocial care and support** to assist with healing and recovery from emotional, psychological and social effects, including but not limited to crisis care, longer term emotional and practical support, and information and advocacy.
- **GBV case management** services, including information, referrals, advocacy and other practical support.
- **Options for safety and protection** for survivors and their families who are at risk of further violence and who wish to be protected through safe shelters, police or community security and relocation.
- **Legal (informal and formal) and law enforcement services** that can promote or help survivors to claim their legal rights and protections, including but not limited to legal aid services.

Survivors might also be referred to other services on a case by case basis when those can contribute to survivor's protection and well-being, including:

- **Education, economic assistance and livelihood opportunities** to support survivors and their families to live independently and in safety and with dignity, including but not

[98] All programme sections in the GBV SOPs are based on Inter-Agency Minimum Standards for GBV in Emergencies (2019) unless otherwise noted. Additional information on each service and how it should be delivered is available in the GBV minimum standards and other resources referenced (e.g. Inter-Agency GBV Case Management Guidelines).

limited to referrals for existing livelihood and education programmes, and targeted economic interventions that can mitigate risks of GBV and foster healing and empowerment.

- **Other protection services, including cash and voucher assistance, orientation to all available services and durable solutions for displaced populations** Documentation and entitlement services (e.g. separate ration cards) as well as planning for durable solutions, including resettlement, local integration and voluntary repatriation, can contribute significantly to a survivor's safety.[99]

Referral pathways should be comprehensive and include services to all survivors regardless of their age, gender and diverse characteristics, including male survivors. However, there is a need to maintain female-only spaces and services to support women and girl survivors of GBV. Many services developed for women and girls will not be appropriate for male survivors. Further, providing support for male survivors through some GBV services will make them less safe and accessible for women and girls and could act as a deterrent for both female and male survivors in accessing care. Hence, it is important that services and referrals for male survivors are included in GBV referral pathways and detailed in standard operating procedures and that information on this is shared with all relevant actors.[100]

10.2 Risk analysis to promote safe implementation of GBV response programming

Essential issues to consider

During the SOPs development process, the coordination leads and coordination partners should confirm that service providers have considered risks in the design and implementation of GBV response services. If there is no evidence that risks have been considered, it may be useful for the GBV coordination mechanism to undertake programmatic risk analysis as part of determining whether the service should be included in the SOPs referral pathway. The programmatic risk analysis can also assist GBV partners to understand potential safety and ethical issues in

the wider community that must be collectively addressed to support survivor-centred care.

A programmatic risk assessment can also be a useful tool to "spot-check" safety issues in programming on a periodic basis.

All GBV-related services and interventions should be based on *programmatic risk analysis,* which examines whether certain safety and ethical considerations are currently in place. While the primary focus of programmatic risk assessment is survivor safety, it is also important to consider the safety of those delivering services. This includes understanding the risks of backlash and

[99] Inter-Agency GBV Case Management Guidelines, p.24.

[100] GBV AoR, Guidance to gender-based violence coordinators addressing the needs of male survivors of sexual violence in GBV coordination, p.10.

intimidation; targeting of staff at the workplace as well as to and from work; potential pressure from community and family to stop doing the work; and other contextual risk factors for GBV programme staff and volunteers.

All existing or planned programmes should be assessed for the risk they may carry for women in terms of violence and intimidation and safety must be continuously monitored. Plans must be put in place to avert risk and respond to threats. It is important to conduct on-going monitoring for adverse outcomes, including through regular consultations with women, girls and women's groups to ensure any protection concerns are highlighted and addressed. The financial and human resources necessary to assess and respond to the risks of violence against women and girls must be dedicated in programmes from the outset. See Annex 6 for a risk analysis checklist.

10.3 Referral system

This section describes how to support GBV survivors after a GBV incident is disclosed.

10.3.1 Disclosure

Disclosure refers to survivors voluntarily sharing with someone that they have experienced or are experiencing GBV.

Survivors have the freedom and right to disclose a GBV incident to anyone. They may disclose their experience to a trusted family member or friend, seek help from a trusted individual or organization in the community or make an official report to a local, national or international humanitarian actor.

Anyone survivors tell about their experience has a responsibility to give honest and complete information about the response services available and to accompany and support them based on their request.

Survivors' wishes must always be respected as to where or with whom to seek help. They should not be urged into a particular course of action. Survivors information must be kept confidential at all times and can only be shared with the consent of survivors and/or their caregivers and on a need-to-know basis.

Disclosure could be direct, when survivors disclose their experience directly – and in these cases referral can be made with the survivor's consent – or indirect, when someone else discloses experience of GBV by others, in which case the survivor cannot be referenced as the survivor is not present to consent.

Special considerations for children

All actors and stakeholders, including community members, should not attempt to actively identify survivors of GBV as this can lead to stigma and put survivors and staff/volunteers at risk.

However, in the case of young children, a more active identification approach is required. This approach should be discussed and agreed between GBV and child protection actors and align with child protection minimum standards.

See section 3.4.3.2 on child protection.

10.3.1.1 Disclosure to non-GBV specialized service providers

- If a survivor discloses a GBV incident to a non-GBV specialized actor, the actor should refer the survivor safely and appropriately, based on a solid understanding of the referral system available services and mandatory reporting policies.
- Ensure frontline staff and volunteers are trained on (1) how to support a survivor safely and ethically in the event of a disclosure, including through psychological first aid (PFA);[101] and (2) how to relay information on available GBV services, including remote modalities, such as hotlines, if necessary.
- Non-specialized actors should ask for the survivor's informed consent[102] to contact a primary focal point on the GBV referral pathway and facilitate contact between service provider and survivor.
- For cases involving child survivors, non-specialized actors should take into consideration informed assent/consent from child survivors (depending on their age and level of maturity) and the informed consent of caregivers (where relevant and not against the child's best interest).

10.3.2 Informed consent and assent[103]

Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent (age 18+). Consent should be obtained before a disclosure is made, if possible. Consent is obtained again for every new action or referral. Consent to one action or referral by a service provider does not constitute consent for any other actions. Survivors have the right to revoke consent at any time. Consent should be written if possible; if it is not possible, survivors can give verbal consent, which is recorded by the service provider.

Survivors should be given honest and complete information about possible referrals for services. If survivors agree and request referrals, they must give their informed consent before any information is shared with others. They are made aware of any risks or implications of sharing information about their situation. They have the right to place limitations on the type(s) of information to be shared and to specify which organizations can and cannot be given the information. Survivors must also understand and consent to the sharing of non-identifying data about their case for data collection purposes (see section 9.1 on information management).

To provide informed consent, individuals must have the capacity and maturity to understand the services being offered, be legally able to give their consent and have the relevant information to understand the implications of the decision they make.

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[101] IASC GBV pocket guide (2015) (accessed 27 June 2023).
[102] Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent (age 18+). It is a term that is widely used in health and social services and is intended to protect the rights of the survivor and ensure that they are fully aware of the limitations, risks (and benefits) of receiving services.
[103] See Inter-Agency GBV Case Management Guidelines (2017) , section 2.2, Engaging the survivor in services (accessed 27 June 2023).

To ensure consent is "informed", service providers must:

- Provide all possible information and options available to the person.
- Inform the person that the service provider may need to share the survivor's information with others who can provide additional services.
- Explain to the survivor what will happen as part of service provision.
- Explain the benefits and risks of services to the survivor.
- Explain to survivors that they have the right to decline or refuse any part of services.
- Explain limits to confidentiality (e.g. mandatory reporting; see section 3.3.3).
- Check that survivors understand the case management process by asking them to share their understanding of the purpose, what they have agreed to and what the risks might be.
- If needed, rephrase the information shared as many times as required to ensure the survivor understands.

There is no consent when agreement is obtained through:

- The use of threats, force or other forms of coercion, abduction, fraud, manipulation, deception or misrepresentation.
- The use of a threat to withhold a benefit to which the person is already entitled; or
- A promise made to the person to provide a benefit.

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

Children must be consulted and given all the information needed to make an informed decision using child-friendly techniques that encourage them to express themselves. Their ability to provide assent on the use of the information and the credibility of the information will depend on their age, maturity and ability to express themselves freely. (See also the GBV guiding principles in section 2.1 and *Caring for child survivors of sexual abuse*).

The best interest of the child should be taken into consideration in the decision to refer to services when the child's and caregivers' assent/consent are not obtained.

A sample Consent for release of information form,[104] *Consent for service form*[105] *and the GBVIMS standard intake and assessment form can be found in Annex 6*.

[Describe the process for obtaining informed consent and the form(s) to be used in your setting. Refer to or include here information about how any mandatory reporting requirements will be managed, as these impact the consent process (see section 3.3.3).

[104] This form requires survivors to give their authorization for any of their information to be shared with other agencies or organizations. It is intended to ensure that the rights of the survivors to control their incident data are maintained and protected. This form is also available in the Inter-Agency GBV Case Management Guidelines (2017), pp. 227-228.

[105] Inter-Agency GBV Case Management Guidelines (2017), p. 179.

Outline how information sharing related to service provision (i.e. sharing survivor personal data for the purpose of making a referral) will occur. Information should only be shared based on the referral pathway and a "need to know" basis.

Include copies of the consent form(s) in an annex to the final GBV SOPs.]

10.3.3 Mandatory reporting

***Essential issues to consider**:*

Many countries have laws that require service providers to report to police or other authorities any acts that are believed to be criminal offences. In such situations, legal requirements override the survivor's consent. Survivors (and caregivers) should be made aware of these legal requirements as part of the informed consent process (see section 3.3.2).

Although mandatory reporting is often intended to protect survivors (particularly children), in some situations, following mandatory reporting procedures conflicts with the GBV guiding principles. It can also result in actions that are not in the best interests of the survivor. For example, mandatory reporting of cases of sexual violence or intimate partner violence to the police can put the survivor at greater risk of harm from the perpetrator, family members or community members, particularly where certain forms of GBV are criminalized (for survivors).

*Given the risks of mandatory reporting, **these GBV SOPs must include at least the following**:*

- *A common strategy for addressing issues relating to mandatory reporting that could arise in the setting and/or the requirement for each individual actor to develop their own mandatory reporting strategy.*
- *The requirement for service providers to inform survivors about mandatory reporting policies. This must be included as part of the consent process at the beginning of services, as described in section 3.3.2.*

It is against best practice to require survivors to report to the police before accessing health care. It is strongly recommended that GBV and health care actors coordinate with the police to ensure survivors can access health care first and then choose whether to report GBV incidents to the police.

Mandatory reporting procedures that require survivors to first report to the police delay or obstruct survivors from seeking potentially life-saving medical care. Health care services are the first priority and must be provided regardless of the reporting circumstances.

GBV standing operating procedures and referral pathways among health, police and GBV programme actors must uphold a survivor's right to choose where and when to report and facilitate timely access to health care.

Inter-agency GBV minimum standards, p. 28.

Survivors must be informed as soon as possible about any mandatory reporting procedures that are in place, including what information must be disclosed and what they can expect after the report is made. Service providers should not promise confidentiality when it cannot be maintained.

Each service provider must have documented procedures for handling mandatory reporting requirements and train staff to:

- Inform survivors about the staff's duty to report certain incidents in accordance with laws or policies.
- Explain the reporting mechanism to the survivor; and
- Explain what the survivor can expect after the report is made.

Procedures for mandatory reporting requirements differ; therefore, it is important that each organization outline its mandatory reporting procedures. For signatories to the GBV SOPs, each actor's mandatory reporting procedures should include detailed guidance on:

- How mandatory reporting policies are explained to survivors.
- When the caseworker should inform a supervisor of the mandatory reporting disclosure.
- The responsibility of the supervisor to review the case and agree on the reporting.
- To whom the mandatory report will be made; and
- What information will be needed if a mandatory report to an external entity is necessary.

In some countries there are mandatory reporting requirements for cases of trafficking in persons. Service providers who believe that a GBV survivor has been subjected to trafficking in person should, with the survivor's consent, consult with experts and/or refer the case to specialized anti-trafficking protection actors to determine whether the case falls under the anti-trafficking mandatory reporting laws.[106]

Reporting requirements related to SEA

In humanitarian settings, all organizations are mandated to have protocols in place for responding to sexual exploitation and abuse by humanitarian workers (see also section 5 on protection from sexual exploitation and abuse). Organizations need to be clear on the inter-agency protocol and inform the survivor about limitations of confidentiality, such as to whom the case will be reported, what information will be shared and what the expectations will be regarding the survivor's involvement.

[Insert information here about relevant mandatory reporting laws, policies, protocols and any other requirements in the setting, including reporting mechanisms and investigation procedures. This includes reporting suspected sexual exploitation or abuse perpetrated by any humanitarian workers (see section 5).]

[106] See section 3 of the GPC anti-trafficking task team's An introductory guide to anti-trafficking action in internal displacement contexts (2020) (accessed 27 June 2023). Note also that assistance to survivors of trafficking should not be conditional on the initiation of criminal proceedings and that state signatories to the Palermo Protocol should respect the non-punishment principle.

10.3.4 Referral pathway

Essential issues to consider

How to establish and update referral pathways

- *Draw on coordinated mapping and/or assessment of available services and capacity in each location to establish the referral pathway. This includes understanding the capacity of each actor that may be included in the referral system.*
- *Consult with women, girls and other community members about where and with what organization(s) the "entry point(s)" for GBV response services should be located and what might make these entry points safer and more accessible.*
- *Establish a clear referral system in each setting so that survivors of an incident know to whom they should disclose and what sort of assistance survivors can expect to receive from the health, psychosocial, case management and other sectors.*
- *Include easy-to-understand terms explaining what to do and where to go for immediate service delivery. The people who are most likely to refer survivors to services need to understand the referral pathway.*
- *Document the quality of services and monitor this over time to ensure they are functional and meet minimum standards of care in line with GBV guiding principles.*[107]
- *Update referral pathways when service providers change. Agree amongst service providers how to share the referral pathway so that it reaches key community members.*

Key information and accessibility considerations

- *In settings where it is safe to include more detailed information about entry points, the referral pathway should include both (1) the name of the organization and (2) its GBV focal point, with the contact phone number and/or address.*
- *Involve representatives and members of groups who face barriers to access in the development of the GBV SOPS and referral pathway to ensure appropriate adaptations and increase marginalized groups' safe access to services.*
- *Implement specific access adaptations to the referral pathway for groups of persons who face additional barriers to access, including survivors with disabilities and older women.*

See Annex 10 for sample referral pathways and a sample description of referral methods in a specific location.

A referral system is a flexible mechanism that safely links survivors to services such as health, psychosocial support, case management, safety/security and justice and legal aid. A functional referral system of survivor-centred, multisectoral service providers supports survivors' health, healing and empowerment. A referral system should include all GBV specialized services that are available in the setting.

[107] See Barrier to care analysis and planning tool, and Service gap analysis and planning tool, annex 5.

A referral pathway documents the referral system that is in place, describing the GBV and other service providers in a context, how survivors can access these services and how referrals are made between service providers.

Referral system

- A referral is made only with the informed consent and/or assent of the survivor and/or caregiver. A survivor should not be urged or forced to take a particular course of action. The wishes of the survivor must always be respected.
- If the survivor does not want to access services, provide them with details of service providers in your area in case they want to use them in future.
- If the survivor agrees to access services, contact the primary focal point on the GBV referral pathway for your location and facilitate contact between service providers and survivors to arrange for follow-up care. Follow the information given in the referral pathway [on Page 52].
- Ask survivors if they would like to be accompanied to the agency to which they are being referred and talk through potential safety concerns.
- Information about referrals should be kept to a minimum; do not discuss sensitive information with anyone but the recipient of the referral, including other staff from your organization.
- Use the coded inter-agency GBV Referral Form that does not include the name, address or any other information that might identify the survivor.
- Avoid sending referral forms by email, if possible. If needed, ensure that the referral form is password-protected and only selected focal points know the passwords.[108]
- A referral is only complete once survivors have received the service to which they were referred. In other words, merely referring survivors to another service provider does not constitute a "referral".[109]
- No referrals can be made if a service provider/non-specialized actor receives a report about a GBV incident affecting a third party (e.g. the sister of a beneficiary or a neighbour etc.) or if they suspect a case of GBV based on their own observations because the direct consent of the survivor is necessary. Frontline workers should limit themselves to providing accurate information about services available and contact details of service providers and encourage the beneficiary to pass this information along to GBV survivors or women/girls at risk and support them in their decision to seek help. This limitation can be frustrating in urgent cases but referrals made without the consent of the person directly affected can cause further harm and stigma.
- *[Complete this list with any setting-specific guidance on referrals.]*

[108] If there are inter-agency digital case management systems in place that allow for digital referral, indicate here a method for those users and indicate the method to be used by those not using it.
[109] See Inter-Agency Minimum Standards for GBV in Emergencies (2019), standard 7: Referral systems.

Referral pathway

The following page displays agreed entry points for receiving disclosure of GBV incidents and pathway for referrals and follow-up. This is summary information only; details and procedures on specialized services are described in section 3.4.

[Complete with information from the setting, add the existing referral pathway to this template or provide links to electronic referral pathways if relevant. Ensure that the referral pathway lists specific information about each service, including but not limited to:

- *How to access the service.*
- *The service delivery focal points.*
- *The hours of operation and service availability.*
- *If the service costs money and how much.*
- *Any specific approaches or needs to ensure access for particular groups, including in what language/s the service is available.*

Illustrate the entry points and include basic information about reporting and referrals in the local and relevant language(s) and/or as a pictorial presentation.

Describe any other referral methods available in the setting (e.g. GBVIMS+,/Primero, proGres /Electronic referral pathways).

Explain how you will seek feedback on the referral pathway to ensure it is understandable, accessible and available in the main languages of the population(s) of concern.]

Disseminating referral pathways

- *Conduct targeted outreach campaigns to disseminate information on referral pathways and GBV response service entry points to diverse community members so that as many people as possible are aware of where to go for help and what to expect.*
- *Balance protection risks to survivors and service providers with accessibility. For example, in certain contexts, a referral pathway that contains contact information could pose risks to service providers if the information is publicly shared.*
- *Proceed with extreme caution in settings where public discussion about the establishment or existence of GBV services poses security risks. In these cases, a referral pathway with accompanying basic protocols for survivors may be distributed only to those who fully understand the GBV guiding principles.*
- *In some contexts, it may be possible to use electronic systems to document and disseminate referral pathways.*

See also section 3.7 on raising awareness.

10.4 Specialized GBV service providers

The following sections will explain the role, function and services provided by each GBV specialized service provider in the setting's referral pathway.

10.4.1 Health care for GBV survivors

Access to quality, confidential, age-appropriate and compassionate health care services is a critical component of a multisectoral response to GBV in emergencies. Adequate health services are not only vital to ensuring life-saving care for women, girls and other at-risk groups, they are also essential for a society to overcome the devastation of a humanitarian emergency. Health service delivery systems should be equipped to ensure clinical management of rape, intimate partner violence and the consequences of other forms of GBV.[110]

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

Male survivors have specific needs regarding treatment and care that should be addressed by health care providers who are trained to identify indications of sexual violence in men and boys and offer care that is survivor-centred, non-stigmatizing and non-discriminatory.

[Include here specific information about available health care services for GBV survivors in the setting, including but not limited to:

- *A list of names of health care organizations providing services for GBV survivors, specifying the types of services provided by each health care provider.*
- *Additional information about specific entry points to health care for GBV survivors, including making referrals and organizing transport for hospital care, surgery, etc.*
- *Any limitations to accessing health care including requirements to have police reports and strategies to address these limitations.*
- *Who the services are for (i.e. if limited to specific populations).]*

10.4.2 Psychosocial support

The term “psychosocial” emphasizes how “psychological” and “social” aspects influence one another and recognizes that individual human beings are influenced and impacted by the environments in which they live. GBV psychosocial support includes programming geared towards all women and girls and specific services for GBV survivors. Quality psychosocial support (PSS) services are survivor-centred, age-appropriate, build individual and community resilience and support positive coping mechanisms. They include opportunities for social networking and

[110] This includes first-line support/psychological first aid, the provision of emergency contraception, HIV post-exposure prophylaxis, treatment of sexually transmitted infections, Hepatitis B immunization, identification and care of survivors of intimate partner violence (including assessing the risk of continued and more serious violence, treatment of injuries and other physical care needs) and assessment and management of mental health conditions such as depression, suicidal thoughts or attempts and post-traumatic stress disorder. Health-care providers and messaging should include menstrual hygiene management. See Inter-Agency Minimum Standards for GBV in Emergencies (2019), p. 29.

solidarity-building among women and girls. It is important that psychosocial support for women and girls is informed by an understanding of their experiences of violence and discrimination.[111]

PSS includes a variety of approaches delivered by different types of organizations, including community-based and women-led organizations. GBV case management is considered a form of PSS, as well as a means of ensuring access to other services and support.

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

[List all organizations providing psychosocial support including information about community-based support provided by women-led organizations and indicate the types of services available for GBV survivors.]

10.4.3 Case management (see also section 4 on documentation considerations for case management providers)

GBV case management involves a trained psychosocial support or social services actor who: (1) ensures that survivors are informed of all the options available to them and referring them to relevant services based on consent; (2) identifies and follows up on issues that survivors (and their families, if relevant) are facing in a coordinated way; and (3) provides the survivor with emotional support throughout the process. Refer to the Inter-Agency GBV case management guidelines for more information on the steps of GBV case management.

GBV case management[112] has become the primary entry point for GBV survivors to receive crisis and longer-term psychosocial support because of the lack of more established health and social support service providers in humanitarian settings.[113]

[List the organization(s) providing GBV case management services in your setting.]

10.4.3.1 Remote GBV case management[114]

Remote case management is the provision of case management services at a distance, usually by phone or internet. Remote case management is an adaptation of in-person case management services so that survivors can access and receive safe and confidential services. Remote case management services also support the health and wellbeing of GBV case workers.

In some instances, service providers may suddenly have restricted access (e.g. due to armed conflict, contact restrictions during a health pandemic) and need to adapt in-person services to remote services. Two key considerations must be taken into account before moving forward: Is it

[111] For more information, see Inter-Agency Minimum Standards for GBV in Emergencies (2019), p. 36.
[112] Inter-Agency GBV case management guidelines (2017).
[113] Ibid; see also Inter-Agency Minimum Standards for GBV in Emergencies (2019).
[114] For additional technical information on remote case management, see, for example GBVIMS. COVID-19 guidance on remote GBV services focusing on phone-based case management and hotlines (accessed 27 June 2023).

possible to enable access to technology and a phone network and to ensure the safety and privacy of the survivor?[115]

[Conduct risk analysis and describe mitigation measures related to this service provision when adapting case management services to remote modalities.[116]

List the organization(s) providing remote case management services in your setting, including by telephone or internet.]

10.4.3.2 Inter-agency case conferences

A case conference is a planned, structured meeting convened by the caseworker to discuss a particular case with other service providers involved in the survivor's care and treatment. Case conferences allow you to: (1) review activities, including progress and barriers towards goals; (2) map roles and responsibilities; (3) resolve conflicts and strategize solutions; (4) adjust current action plans.[117] Case conferences can be effective venues for addressing any problems with services not being provided in a timely way or to get clarity on who is doing what to avoid duplication of efforts in complex cases involving many actors. Consent from the survivor before holding a case conference should always be obtained. Case conferencing is done on an ad hoc basis and is distinct from ongoing service coordination and other coordination forums.

Information is shared on a need-to-know basis in case conferences and information that is not relevant to the work of a particular service provider is not shared with them. For example, a health care provider does not need to know perpetrator details or how the case is being handled. To ensure that this principle is respected, specific service providers attend only that part of the case conference where issues related to their work are discussed.[118]

- For children, consent/assent should be provided before sharing information with participants in a case conference (see section 3.3.2). In some circumstances, if it is in the best interests of the child, information may be shared on a need-to-know basis without the consent of the child or their caregiver.[119]
- All meeting participants are responsible for ensuring that the dignity and confidentiality of survivors are maintained and that the information discussed is limited to that which is needed to resolve problems and coordinate actions.

It is the responsibility of the relevant caseworkers to discuss any plans with the survivor (and concerned support people in the person's life as appropriate, i.e. if the survivor is a child) in advance and ensure that all survivors have given consent for information related to their case to be shared, as well as to update them about the discussion.

[List here any information about how and by whom case conferences can be convened.]

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[115] GBV AoR. COVID-19 guidance on remote GBV services focusing on phone-based case management and hotlines (2021) (accessed 27 June 2023).
[116] For a draft rapid assessment tool see GBV AOR, rapid assessment remote service mapping tool (2020) and related webinar (accessed 27 June 2023).
[117] Inter-Agency GBV Case Management Guidelines (2017), p. 243.
[118] Ibid, p. 84.
[119] Include here Best Interests procedure, if these are relevant to the context.

10.4.3.3 Coordination with child protection actor(s)

Essential issues to consider

Child protection (CP) and GBV caseworkers work together closely to ensure that young and adolescent girl and boy survivors of GBV receive appropriate gender- and age-sensitive case management support. Both types of actors implement Caring for child survivors of sexual abuse: Guidelines for health and psychosocial service providers in humanitarian settings and invest in joint training and ongoing mentoring and supervision to increase the quality of case management support to child survivors.

In contexts with both child protection and GBV programme actors providing case management services, it is recommended that service-level coordination agreements are established between organizations. When both child protection and GBV response services are equipped to meet the needs of child survivors of GBV, children benefit from increased access to age- and gender-sensitive case management support services.

Engaging in joint coordination and mapping of response services, joint referral pathways and clear criteria for offering specialized support to children are key actions for child protection and GBV response actors. See the Gender-based violence and child protection field cooperation framework (2021) to support work to address service provision gaps and promote complementarity in humanitarian settings.

GBV and CP actors jointly develop the content of the section on child survivors in the respective SOPs. Content should be developed by actors who are trained to handle the special needs of child survivors of GBV and who are familiar with national laws and policies relating to the protection of children.

See Annex 1 for resources on GBV and child protection collaboration.

[Describe here the procedures for supporting child survivors. At a minimum, be sure to include:

- *Procedure and any special forms for obtaining informed consent or assent with child survivors and their non-harmful parents/care givers.*
- *Procedures on what to do when informed assent/ consent is not obtained, including best interest procedure for refugee children.*
- *Action to be taken if there are suspicions that the perpetrator is a family or household member.*
- *Any mandatory reporting laws relevant to acts of GBV against children and procedures that will be taken with regard to those laws.*
- *List specific organizations skilled in working with child survivors of GBV and provide information on how to make referrals to those organizations.*
- *A clear coordination agreement between the GBV and child protection programmes in the setting on referrals and other aspects of service delivery.]*

10.4.4 Women's and girls' safe spaces

Women's and girls' safe spaces[120] (WGSS) are a critical part of GBV programming.[121] WGSS serve as an entry point for women and girls to report protection concerns, express their needs, receive services, engage in empowerment activities and connect with the community.

A WGSS is "a structured place where women and girls' physical and emotional safety is respected and where women and girls are supported through processes of empowerment to seek, share and obtain information, access services, express themselves, enhance psychosocial wellbeing and more fully realize their rights."[122] Safe spaces may also be a venue for sexual and reproductive health information and materials (e.g. as part of menstrual health and hygiene management), laundering of menstrual materials and access to justice services. See Advancing Women's and Girls' Empowerment in Humanitarian Settings: A Global Toolkit for Women's and Girls' Safe Spaces[123] for additional information on WGSS, including the five standard objectives.

List WGSS in the setting and any specific services or activities provided there. Describe considerations for safety and security of WGSS and any coordination with child-friendly spaces or other similar initiatives within other sectoral programming.

10.4.5 Security and safety[124]

This section focuses on actors in the setting who contribute to women's, girls' and other GBV survivors' safety and security in the setting. All service providers prioritize the safety and security of survivors and their families as well as that of staff providing care to survivors. A safety and security assessment is part of GBV case management and service delivery. GBV caseworkers, service providers and survivors assess security risks and conduct safety planning.[125]

10.4.5.1 Security actors

Security actors include police, other law enforcement personnel, community security groups and humanitarian protection staff, among others. Respecting and upholding the rights of women and girls is central to all security efforts. Focusing on the survivor also requires that security personnel and policies reflect an awareness of the immediate and ongoing threats facing women and girls who have experienced gender-based violence. Certain forms of GBV require particular safety measures (e.g. facilitating access to safe houses or shelters for those at risk of so-called "honour-based" crimes).

Law enforcement and other security personnel often lack the knowledge and capacity to respond adequately to survivors. They may also share the societal values that condone violence against women and girls, leading to survivor-blaming or discriminatory attitudes and decisions. Thus, in

[120] The terms women-friendly space and adolescent girls' safe spaces also refer to WGSS.
[121] A "safe space" is a women-and-girls-only space; this is important because public spaces in most cultures are inhabited largely by men. Safe spaces provide a critical space where women and girls can be free from harm and harassment and can access opportunities to exercise their rights and promote their own safety and decision-making.
[122] IRC and International Medical Corps (2019). Advancing women's and girls' empowerment in humanitarian settings: a global toolkit for women's and girls' safe spaces (accessed 27 June 2023).
[123] Ibid.
[124] See, for example Handbook on gender-responsive police services for women and girls subject to violence and From evidence to action: Tackling gender-based violence against migrant women and girls (accessed 27 June 2023).
[125] See IASC GBV Case Management Guidelines, section 1.2.3 on Planning for safety, pp. 101-102.

addition to establishing clear responses to violence against women and girls and specialized support services for survivors, it is crucial to support ongoing training and awareness-raising interventions for security personnel at all levels. For police, training focuses on clear protocols for responding to reports of violence, emphasizing women's legal right to protection.

GBV specialized actors should be aware of the potential risks to GBV survivors in engaging with security actors.

[List all safety and security actors [specify, e.g. police or protection officers] and include specific information about roles, procedures, limitations, benefits and risks of all available security options, including how to access security services.]

10.4.5.2 Safe houses/emergency shelter

Safe houses/shelters are places that provide immediate security, temporary refuge and support to survivors who are escaping violent or abusive situations. This service is made available to women and girl survivors of GBV who are in imminent danger. Ideally, a safe shelter or house is accredited and staffed by professionals. Admission is contingent on specific criteria and strict standard operating procedures. It is rarely possible for safe houses and shelters to be operated safely within a camp setting due to the need for their location to be confidential.[126]

In cases where safe houses/shelters are not available, emergency accommodation may be provided in the form of rented private houses or apartments, hotels or commercial venues, rooms in specialized facilities (e.g. hospitals or medical centres), places of worship (e.g. churches, mosques, temples, etc.) or a community-based system.[127]

[Include any information about safe houses/shelters/community-based systems, supporting organizations, modalities of operation and entry criteria (including for children of survivors). In contexts where this information cannot safely be included in the main document, describe how this information can be confidentially obtained.]

10.4.6 Justice and legal aid[128]

GBV specialized actors should be aware of the risks to GBV survivors that are inherent to

justice systems and any specific additional risks in the setting. Legal actors clearly and honestly inform the survivor of the procedures, limitations, benefits and risks of all existing legal options. This includes:

- Information about available security measures that can prevent further harm by the alleged perpetrator.
- Information about procedures, timelines and any inadequacies or problems in national or informal justice solutions (i.e. justice mechanisms that do not meet international legal standards).

[126] Inter-Agency Minimum Standards for GBV in Emergencies (2019), p. 64.
[127] For examples of alternative safe shelter, see ''Safe haven: sheltering displaced persons from sexual and gender-based violence'' (accessed 27 June 2023).
[128] UN Women, 2018, A practitioner's toolkit on women's access to justice programming (accessed 27 June 2023).

- Information about available support if formal legal proceedings or remedies through alternative justice systems are initiated.
- Information about other civil/non-criminal services or procedures that help survivors access their rights (e.g. ration card division, asylum hearings, etc.).

[List here the organizations that provide legal and administrative advice and counselling for survivors and specify the roles and responsibilities of each.

Specify what services are available in this setting e.g. transportation and accompaniment to court, legal advice and support through the process, other legal information and counselling related to civil or administrative procedures (e.g. access to asylum status hearings, ration card division, inheritance claims, etc.).]

10.4.6.1 Police procedures for reports of GBV-related crimes

In most cases, referrals will be made to national justice systems by the police only if victims/survivors have given their informed consent (see section 3.3.2).

[Describe the procedure for reporting a GBV incident to the police e.g., make a complaint to the police at the local police post or make a complaint to the local police family support unit. Be sure to include any requirement for medical forms/forensic medical evidence.]

10.4.6.2 Informal justice and alternative dispute mechanisms

GBV specialized actors should be aware of the risks to GBV survivors that are inherent to

informal justice mechanisms and any specific additional risks in the setting. They should clearly communicate those risks to survivors while being non-judgmental and honouring survivors' wishes for a justice outcome.

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

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

[List interventions to be undertaken with the informal justice and alternative dispute mechanisms and specify which organizations will do this work.]

10.4.7 Dignity kits

Essential issues to consider

Dignity kit content is based on the input and preferences of women and girls in the community and include context-specific items (e.g. headscarves in settings where women cannot appear in public without them). Consult with women and girls to inform dignity kit content, including women and girls' practices related to menstruation and their preference for menstrual products and whether these are to be provided in-kind or through cash and voucher assistance (see following section).

Dignity kit distribution is also an opportunity to reach women and girls and other survivors at risk with information about GBV risks and entry points to GBV services.

To identify relevant, appropriate content for dignity kits, organizations consider the following basic parameters: relevance of the items, cultural sensitivity, context, environment, quantity, frequency of distribution and price.

Dignity kits may be procured and distributed by WASH or shelter, settlement and recovery actors. GBV programme actors coordinate with other sectors to ensure dignity kits are responsive to the needs of women and girls, maximize the distribution potential of all items and avoid gaps or unnecessary duplication of efforts. (IASC GBV Guidelines, 2015, p. 292.) Whenever possible, questions are integrated into other assessments (e.g. sexual and reproductive health, WASH) to minimize duplication and avoid overburdening women and girls.

Women and girls need basic items to interact comfortably in public and maintain personal hygiene, particularly menstrual hygiene. Without access to culturally appropriate clothing and hygiene products, women and adolescent girls are at greater risk of GBV, their health is compromised, their mobility is restricted and they may become increasingly isolated.

Humanitarian actors often distribute dignity kits that typically contain menstrual hygiene materials, soap, underwear and information on available GBV services, including where and how to access those services. Dignity kits may also include items that may help mitigate GBV risks such as radios, whistles and lights.[129]

To reduce risk of GBV and other violence, dignity kit distribution outside of GBV specialized services includes multiple categories of women (e.g. women heads of households, women with disabilities) and does not target GBV survivors only.

It is important to conduct post-distribution monitoring to assess the distribution results, whether the right beneficiaries received the kits or any risks resulted from the distribution.[130] For further information see section 6.1 on menstrual hygiene management.

[129] Global Protection Cluster, Dignity Kits Guidance Note (accessed 27 June 2023).
[130] Post-distribution monitoring is done through focus group discussions (FGDs) with women and girls 1-3 months after distribution to assess whether the kits achieved the intended result. It is important to ensure women and girls who receive kits are involved in post-distribution FGDs.

[List organizations that distribute dignity kits or any other non-food items. Describe any agreed standardized contents of kits, pre-positioning of kits and agreements on consultations (either conducted or agreed processes for these to take place) and post-distribution monitoring feedback mechanisms.

List agreements between sectors (e.g. GBV and WASH) on coordination of dignity kit contents and distribution, including but not limited to the items distributed, the intended beneficiaries of distributions, referrals of survivors between sectors and the sharing of distribution data.]

10.4.8 Cash & voucher assistance[131] (see also section 6.3)

Essential issues to consider

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

Cash is (1) a way to mitigate GBV risks and/or (2) a component of survivor centred GBV case management services. Cash can be lifesaving; for example, it can help a survivor meet the costs (e.g. rent, temporary shelter, transportation, food, clothing) associated with fleeing an abusive relationship. In situations where core GBV response services (e.g. health, safe shelter or legal services) have associated costs and/or are not available free of charge, cash transfers facilitate access and support recovery.

This section describes CVA as part of GBV case management services. For more information on CVA as part of GBV risk mitigation, see section 6.3.

GBV case management should assess any financial needs that a survivor might have (for example that may hinder service access) and refer the client for cash assistance (whether the service is provided directly by the case management actor or other actors providing cash support). Cash works best when it complements rather than replaces other types of assistance and services within GBV case management. It should be viewed as one option among GBV response services and wider prevention and empowerment efforts.

GBV programme actors in humanitarian settings must establish clear internal or inter-agency protocols to outline the roles and responsibilities of cash and GBV programme actors to ensure the availability of quality services and timely and accessible care for survivors.

[131] UNHCR, Cash assistance and gender; UNHCR, Guide for protection in cash-based interventions; Cash and voucher assistance for GBV cases: standard operating procedures, Turkey Cross-border/Northwest Syria; IASC GBV Guidelines: Cash & voucher assistance and GBV compendium: Practical guidance for humanitarian practitioners; Women's Refugee Commission, Resources for mainstreaming gender-based violence (GBV) considerations in cash and voucher assistance (CVA) and utilizing CVA in GBV prevention and response (accessed 27 June 2023).

Coordination between cash and GBV programme actors is essential to prioritizing clients and developing systems and procedures that effectively meet the specific needs of diverse populations, including women and girls at increased risk of GBV, while preserving confidentiality and safety.

[List here any organizations that distribute cash to women, girls or survivors of GBV and reference any inter-agency protocols, SOPs or action plans between cash and GBV programme actors.]

Case study: Establishing a cash working group and gender-based violence sub-cluster task force[132]

In Northwest Syria, the Cash Working Group and the GBV Sub-Cluster established a task force to build bridges between GBV and CVA actors. The task force has focused on strengthening partner capacities to enable systematic referrals from GBV case management to CVA to transition GBV survivors from relief to recovery. Task force members are all active GBV Sub-Cluster and Cash Working Group members working in GBV response and programming with CVA. The task force engagement with other clusters has widened the scope of implementing partners to help GBV survivors gain access to livelihood opportunities, safe shelter and other forms of assistance. The task force and its objectives have buy-in from Cash Working Group and GBV Sub-Cluster partners alike. Key learnings so far relate to establishing collaboration between GBV and CVA actors and to recognize how they – and not least rights holders – can benefit from the collaboration. CVA is recognized as a resource to access services and meet priority needs for GBV survivors and women and girls at risk. However, use of the modalities has to be designed and implemented safely. This requires continuous collaboration between GBV and CVA actors and specialists.

10.5 Economic empowerment and livelihoods

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

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

[List here any livelihood actors or programmes in which survivors of GBV and marginalized women and girls may be integrated.]

[132] IASC GBV Guidelines (2015).

10.5.1 Additional support services

Survivors may need basic assistance in order to ensure their immediate wellbeing, safety and security. Material assistance, such as emergency food and non-food items (NFI), shelter and other assistance can be provided through referrals. **Assistance should never stigmatize GBV survivors by identifying them as survivors in the specific services they receive or at the locations in which services are provided.**

[Please complete the table below and add additional rows as needed:

Service	***Agency / Organization***	***Criteria for Inclusion***
Nutrition & Food Assistance		
Non-Food Items, including Dignity or Hygiene Kits		
Non-formal Education		
Education		

10.6 Refugee case processing

In refugee contexts survivors might need access to additional services such as documentation and durable solutions that are not applicable in other contexts. These services are related to their status as asylum seekers or refugees or might be available due to this status. When developing service mappings and referral pathways in refugee contexts it is important to be aware of the following services and integrate them as appropriate into referral pathways and identify GBV focal points within the relevant services and include them in development of the SOPs.

10.6.1 Registration

Registration gives access to documentation and legal protection which reduces the risk of GBV and provides access to services, including income-generating activities and assistance provided by humanitarian actors. Registration procedures usually give priority access to vulnerable asylum seekers at heightened risk, including women and girls at risk and GBV survivors, especially in contexts where high number of applications are received and waiting periods are long. Procedures for safe and confidential referral to registration should be followed by GBV actors if the need for registration has been expressed by the survivor.

10.6.2 Refugee status determination

Refugee Status Determination (RSD) is conducted by national authorities or UNHCR depending on contexts and agreement between host country and UNHCR. The purpose of RSD is to permit UNHCR to determine whether asylum seekers fall within the criteria for international refugee protection. The determination of refugee status has potentially profound implications for the life and security of the individuals concerned. RSD procedures give priority access to asylum seekers at heightened risk, including women and girls at risk and GBV survivors, especially in contexts where high number of applications are received and waiting periods are long. Procedures for safe and confidential referral to RSD should be followed by GBV actors if the need for RSD has been expressed by survivors.

10.6.3 Durable solutions

Identification of durable solutions for refugees is part of UNHCR's mandate. Local integration, resettlement and voluntary repatriation are means of providing international protection and durable solutions to refugees. While local integration and voluntary repatriation depend on a favourable environment in the country of asylum and country of origin respectively, resettlement is part of UNHCR's ongoing protection and assistance activities. Women and girls, including GBV survivors, are given priority for resettlement as means of protection when they are at risk in the country of asylum or have specific protection needs or vulnerabilities for which resettlement is assessed as the most appropriate protection and durable protection solution. Procedures for safe and confidential referral to resettlement or other durable solution should be followed by GBV actors.

[Please complete the table below. Include relevant services, focal points and explain any agreement on referrals of GBV survivors to refugee case processing services and inclusion criteria.]

Service	***Agency / Focal Point***	***Criteria for Inclusion***	***Referral Process***
Registration			
RSD			
Durable Solutions			
RST Hotlines			

[Link any existent SOPs and guidance documents (if they exist) for relevant refugee case processing in your context.]

10.7 Community outreach for awareness raising[133]

Community outreach for the purpose of awareness-raising serves to increase timely and safe access to services and to mitigate risks of GBV.

Community outreach methods vary based on the context and should always use preferred and trusted communication channels. Some ideas include loudspeakers; sharing of information, education, communication materials (IEC) (e.g. posters, pamphlets); meetings or small-group discussions; sharing information at distributions of materials or food; social media and websites.

Safety is an essential element to consider when designing community outreach information and methods. It is important to assess how certain information may be viewed by different members of the community or armed groups and what this may mean for staff and women and girls. The means of sharing information with communities must also be weighed, for example in some contexts, men will not allow women to meet together or mobilize. All GBV outreach should be led by or coordinated with GBV specialized actors.

Key attributes of effective community outreach messages on GBV include:

- Clarity: Keep the wording and meaning of the message simple.
- Easy to read/hear/understand: Images should be clear and culturally appropriate using common words which have been tested for comprehension with community members.
- Action-oriented: Consider how the information conveyed helps the community, women and girls, and GBV survivors know what to do to help themselves.
- Specific: Include instructive details.
- Positive: Illustrate positive action and attitudes; do not patronize, shame or depict people in negative ways. Images of violence against women and girls should not be used in community outreach messaging as this can normalize violence and be a harmful trigger for survivors.
- Inclusive: Messages should be as inclusive as possible by ensuring that different groups of women and girls – including all age groups, relevant ethnicities and those with different disabilities – are reflected in community outreach images. Design messages to reach the most people possible, for example, taking into account the literacy rate and/or internet access.

When deciding when and how to share information, consider the barriers that women and girls may face in accessing information. It is important to use multiple channels to share information and consider how women and girls prefer to access information.

All outreach on GBV must include information on how survivors can access support. **Do not conduct outreach activities on GBV in locations where response services are not available.**

[List here key information to share with the community to increase timely and safe access to services and mitigate risks of GBV. List safe and appropriate community outreach methods or include these in an annex.]

[133] For additional information on community outreach, see Inter-Agency Minimum Standards for GBV in Emergencies (2019), p. 57.

11 SECTION 4: DOCUMENTATION CONSIDERATIONS FOR CASE MANAGEMENT PROVIDERS

Quality GBV case management services require a survivor-centred approach that includes the GBV guiding principles and supports survivors to meet their needs through a series of steps (see also section 3.4.3). In addition to direct interaction with survivors, other key activities are necessary to ensure the quality and safety of services. Effective GBV coordination is necessary for quality GBV case management by ensuring that relevant actors know their roles and work according to minimum standards for compassionate and competent care as well as existing service mapping. How information is collected during the case management process is integral to providing quality care and ensuring safety.

Case documentation[134] refers to the documentation of information (either on paper or digitally) relating to an individual survivor's case management service provision by a case management organization. Generally, case documentation information includes dates of services and summaries of discussions, a brief description of the incident and the survivor's situation, relevant action plans and follow-up appointment information. Case documentation also includes the date and reason for closing the survivor's case.

Although documentation supports the quality of service provision to survivors and promotes accountability, it is not required to provide quality case management services and might be inappropriate under certain conditions. Setting up a system to document individual case information is appropriate only if a service is offered and paper or digital records can be securely stored. Any type of survivor information should only be collected in line with the GBV guiding principles, on a need-to-know basis and as part of direct service provision. It is not appropriate, for example, to seek out or record identifiable information about survivors solely for the purpose of protection or human rights monitoring.

It is important to be cautious in all contexts when deciding if and when to begin documenting and maintaining survivor case files because of the security risks to survivors, their families and staff. The decision of whether to collect survivor data depends on an organization's capacity to ensure safe, confidential storage of all information. All documentation containing information about survivors should be collected and stored in adherence to international standards that prioritize survivors' confidentiality, safety and security. In the absence of secure storage for information, it should be assumed that data is not secure and may be subject to unauthorized access and dissemination.

4.1 Case management forms and case files[135]

If it is safe to establish a system for case management documentation, consent form and standard GBV intake and assessment form should be developed and used. Other forms that can be part

[134] See Inter-Agency GBV Case Management Guidelines (2017) for additional guidance, including the range of case management forms. For forms, see also Annex 9.

[135] See Inter-Agency GBV Case Management Guidelines (2017) and gbvims.com for all case management forms (accessed 27 June 2023). The standardized forms that are available are hyperlinked in the main text. See Annex 9 for all forms.

of case documentation include case action plan[136], written safety plan, referral form, case follow-up form[137] and case closure form[138] (see the case management guidelines).[139] These can be added as your case management system becomes more developed. If case management services existed prior to the emergency, consultation should take place with these service providers about the tools they use to determine whether they are standardized and usable across agencies.

Each survivor should have a separate case file that includes all relevant completed case management forms. A code should be assigned to and marked on the front of each case file. To protect confidentiality, a list linking the case file codes to the survivors' names should be stored in a different location, stored electronically through a password-protected file or in a secure digital case management platform. Consent forms, which contain identifiable information about the survivor, should be stored separately to the case file.

Information collected about survivors as part of GBV service provision belongs to them. To ensure their meaningful participation in the process, they must have access to it at any time.

[List here the agreements of the coordination group around case documentation and forms to be used, including whether these will be paper, electronic, digital or a platform like GBVIMS+/Primero or proGres.[140] List the forms used for case management and referral (and include these as annexes).]

4.2 Refugee case processing documentation and information sharing

It is important when referring individuals for refugee case processing services that best practices around data security and information sharing are adhered to. Referrals for services such as resettlement can require more abstract informed consent discussions with survivors around information sharing for potential and future services. It is therefore important that the processes for referring to these services are clearly described above (see section 3.5, refugee case processing). Additionally, the sharing of personal data to facilitate these referrals should always be in line with best practices outlined in the *Technical Note on Sharing Personal Protection Data.*[141]

[136] Inter-Agency GBV Case Management Guidelines (2017), p. 180.
[137] Ibid. p. 181.
[138] Ibid. p. 183.
[139] Ibid. p. 34.
[140] Additional resources on good practices for GBV data management are available on the GBVIMS website: http://gbvims.com (accessed 27 June 2023).
[141] UNHCR, Technical Note on Sharing Personal Protection Data (2022)

12 SECTION 5: PROTECTION FROM SEXUAL EXPLOITATION AND ABUSE

Essential issues to consider

GBV actors and the GBV coordination group are not responsible for the implementation of PSEA prevention and response interventions; this is the responsibility of the PSEA network coordinator and ultimately humanitarian leadership. However, GBV actors and coordinators play an important role in:

- Ensuring that GBV services and referral pathways reflect the needs of SEA survivors and that the support is streamlined (i.e. that no parallel referral pathway is created).
- Sharing information on referral pathways with the PSEA coordinator and focal points.
- Supporting training for PSEA focal points and network members on GBV SOPs and referral pathways.
- Promoting PSEA training and codes of conduct for GBV actors.
- Supporting the development of PSEA SOPs to ensure the integration of GBV guiding principles and survivor-centred approach.
- Promoting the establishment or support of community accountability and feedback mechanisms.

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

As outlined in the UN Secretary-General's bulletin for protection from sexual exploitation and abuse,[142] sexual exploitation and abuse violates universally recognized international legal norms and standards and is prohibited conduct for humanitarian aid personnel. It harms those whom humanitarian actors are mandated to protect.

All humanitarian aid organizations are required to adapt or develop, fund and implement effective and comprehensive systems for prevention and response to SEA. Protection from sexual exploitation and abuse is the responsibility of entire organizations, including management, operations, human resources and programme staff.

Although GBV programme staff can play a role in advocating for PSEA measures, implementation of internal measures and the coordination of inter-agency processes to address sexual exploitation and abuse are outside the purview of the GBV coordination group. They are the responsibility of the UN country team assigned PSEA focal points. This is important to ensure the independence, integrity and confidentiality of mandatory reporting mechanisms and investigation processes.

Limits to confidentiality

[142] United Nations Secretary-General, 2003. Secretary-General's Bulletin: special measures for protection from sexual exploitation and sexual abuse, ST/ SGB/2003/13. (accessed 27 June 2023).

There are mandatory reporting policies for cases of sexual exploitation and abuse that involve humanitarian workers. In these situations, organizations need to be clear on the inter-agency protocol and inform the survivor about to whom the case will be reported, what information will be shared, and what the expectations will be regarding the survivor's involvement (e.g. will the survivor have to file a report and, if so, to whom?).

Harmonized service provision

Survivors of sexual exploitation and abuse are survivors of GBV and are referred to existing GBV services; no parallel referral pathway should be established.

The GBV response system is the appropriate referral system for women and girls to access support if they experience sexual exploitation and abuse perpetrated by humanitarian actors or other duty bearers.

Inter-agency GBV minimum standards, p. 23.

5.1 Prevention

All programme staff must design and implement interventions in a way that minimizes risks of sexual exploitation and abuse. Managers and human resource staff are responsible for ensuring that all staff and partners are trained on PSEA and have signed a code of conduct.

5.2 Reporting and response

The GBV response system is the appropriate referral system for women and girls to access support if they experience sexual exploitation and abuse perpetrated by humanitarian actors or other duty bearers.[143]

Each organization is responsible for ensuring that their staff understand their individual responsibilities to report any suspected incidents and know the mechanisms in place for mandatory reporting (see section 3.3.3). They must also establish reporting mechanisms if these are not already in place.

In particular, GBV response service providers should be aware of community-based reporting mechanisms and investigation processes to ensure these can be clearly explained for informed consent when supporting survivors of SEA (see section 3.3.2 on consent and section 3.4.3 on case management).

Reporting of sexual exploitation and abuse is mandatory for all United Nations staff and partners. All reporting must be confidential and be made through the in-country PSEA focal point, who is assigned by the Head of Mission within each UN country team/humanitarian country team.

[Describe how the GBV coordination group interacts with the PSEA network (e.g. are focal points established from each group to attend the other group's meetings, are trainings jointly facilitated,

[143] See also UNFPA, Tip sheet: defining linkages to better assist survivors of sexual exploitation and abuse (2022) (accessed 27 June 2023).

etc.). Insert the locally established PSEA protocols and procedures for receiving reports of suspected SEA perpetrated by humanitarian staff and investigating reports.]

13 SECTION 6: RISK MITIGATION

Essential issues to consider

In emergencies, women and girls face a wide range of GBV risks that increase during displacement and conflict, including sexual exploitation and abuse perpetrated by male humanitarian actors. Humanitarian agencies may unintentionally increase these risks without properly identifying and addressing the needs of women and girls and the potential obstacles they may face in accessing services safely.

Humanitarian actors can both mitigate risks in advance (e.g. through code of conduct training) and quickly address many of these once they arise. Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations. Inaction and/or poorly designed programmes can cause further harm.

Risk mitigation strategies must be led by the relevant sector, with technical support from GBV specialists if needed and community involvement.

All humanitarian sectors and actors are responsible for promoting women's and girls' safety and reducing their risk of GBV. The IASC GBV Guidelines state clearly and prominently: "All humanitarian actors must be aware of the risks of GBV and – acting collectively to ensure a comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation." (p. 14). Protecting women and girls from GBV stems from all national and international actors' essential duty to protect those affected by crises.

Integration of GBV risk mitigation actions in humanitarian response is the process of ensuring that humanitarian interventions across all clusters/sectors: (1) do not cause or increase the likelihood of GBV; (2) proactively seek to identify and take action to mitigate GBV risks in the environment and in programme design and implementation; and (3) proactively facilitate and monitor vulnerable groups' safe access to services. GBV integration is distinct from, but complementary to, GBV specialized programming, which includes response services for GBV survivors and longer-term prevention interventions (see section 7).

Risk mitigation focuses on reducing the risks of GBV, including sexual exploitation and abuse, that women and girls face and protecting those who have already experienced violence from further harm. Reducing risk by implementing GBV mitigation strategies across all areas of humanitarian response, from the pre-emergency to the recovery stages, is necessary to maximise protection and save lives.

GBV specialized actors must be aware of risks to women and girls to inform advocacy with the sectors responsible for mitigating these risks. GBV specialized actors' role is to facilitate support to non-GBV sectors and actors to analyse the GBV risks safely and ethically in their environment, using available information and data from an age, gender and diversity perspective; and to provide technical inputs to other sectors' coordination and programming actions on GBV risk mitigation. This encompasses how to consult safely with affected communities, especially women and girls,

on barriers to accessing services as well as safety concerns they may have, including sexual exploitation and abuse perpetrated by humanitarian actors.[144]

Although community outreach activities (see section 3.7) are an essential part of GBV risk mitigation efforts, they are not enough to change norms, attitudes and behaviours around GBV. This requires more structured, targeted and long-term interventions (as described in section 7). GBV specialized actors must advise and inform other sectors' messaging and also align outreach and messaging with other sectors, including but not limited to health and water, sanitation and hygiene (WASH).

[List interventions by both GBV specialists and non-GBV actors designed to mitigate risks of GBV.]

GBV specialized actors' commitments to advise[145] other humanitarian sectors on efforts to reduce risk of GBV in the setting include but are not limited to:	**Non-GBV actors'** commitments to mitigate risk of GBV, including but not limited to the following:

[144] Inter-Agency Minimum Standards for GBV in Emergencies (2017), pp. 72-73.

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

- Providing accurate and accessible information on available GBV services and referral processes. - Supporting non-GBV actors to analyse the GBV risks safely and ethically in their environment. - Providing technical inputs to other sectors' coordination and programming actions on GBV risk mitigation, including how to consult safely with affected communities, especially women and girls, on barriers to accessing services as well as safety concerns they may have, including sexual exploitation and abuse perpetrated by humanitarian actors; 1. Supporting or providing training about gender-based violence, the Inter-agency GBV minimum standards, IASC GBV Guidelines, these GBV SOPs and other relevant materials	- Require code of conduct commitments by all staff and create accountability mechanisms for staff about sexual exploitation and abuse. - Identify an active GBV focal point per sector. - Include GBV risk mitigation interventions in all humanitarian response plans and refugee response plans. - Conduct and track safety audits.[146] - Set up functional community-based feedback and complaint mechanisms that can respond to sexual exploitation and abuse, including complaint referral forms. - Ensure that all staff: 1. Have at least a basic understanding of gender-based violence, the GBV minimum standards and the IASC GBV Guidelines. 2. Are trained on safe response to disclosure and know how and where to refer a survivor for support and assistance (using a psychological first aid approach, in line with the GBV pocket guide).

6.1 Menstrual hygiene management

Lack of access to quality menstrual materials and supplies (i.e. soap or underwear) and limited access to WASH facilities prevent women and girls from managing their menstruation safely, hygienically and with dignity. In addition, stigma, taboo and cultural practices poses additional risk by hindering women's and girls' advocacy around their menstruation-related needs, placing restrictions on women and girls, limiting their mobility, access to education, ability to engage in daily life and, in some cases, signalling a girl's readiness to have children or get married.

[146] UNHCR, Safety audit toolkit. Safety Audit Toolkit (2021).

All WASH facilities (including disposal mechanisms) should be assessed for their safety and accessibility for girls, women and others who menstruate to assure daytime and night time access. These can be sites of particular risk of violence and/or hinder the usage of such facilities by those who menstruate if they perceive them to be unsafe.

Risks can also be mitigated through dignity kit assembly and distribution or cash and voucher assistance, based on discussions with women and girls (see section 3.4.7).

Access to menstrual products can also be provided through CVA. Key considerations include availability of a variety of quality items and barriers to access, including specific barriers for adolescent girls.[147]

Women's and girls' safe spaces (WGSS) (see section 3.4.4) and dignity kit distribution – particularly when complemented by information/awareness sessions – can be important entry points for women and girls to access information about menstruation and receive MHM materials.

GBV actors can contribute to menstrual hygiene management in collaboration with other actors through activities focused on:

- **Product**: Although WASH actors have the primary responsibility for providing menstrual materials and supplies, GBV actors can target specific populations with dignity kits as part of broader GBV programming. The types of menstrual products to include should be determined based on consultations with women and girls and should meet global quality specifications (i.e. disposable pads, reusable pads and menstrual cups). See section 3.4.7 for more about dignity kits.
- **Facilities**: To ensure GBV programming is accessible to women and girls who are menstruating, it is crucial that WGSS are equipped with toilets to change, wash and clean used menstrual products. Guidance on menstruation-friendly toilets.
- **Information**: To overcome challenges around managing menstruation, information should be provided in a culturally sensitive way around the materials being distributed and their usage and disposal options. In addition, providing information and education on menstruation is important to address stigma and taboos that result in restrictions placed on those who menstruate. GBV actors can partner with health care actors and education actors to conduct joint programming on menstruation as part of GBV health care and education integrated programming.

[Describe interventions to assess and support access to MHM such as any joint SOPs or action plan with other agencies and/or sectors.]

[147] For a full list of considerations see annex 20 CVA programming for menstrual product in Market-based programming in WASH

6.2 Cash and voucher assistance[148]

Cash and voucher assistance (CVA) refers to all initiatives through which cash transfers or vouchers for goods or services are provided directly to individual, household or community recipients. CVA is also a modality other sectors use to meet women's and girls' needs.

Cash can be both a way to mitigate risks and a part of survivor centred GBV case management services in humanitarian settings. This section describes the use of CVA to mitigate risks related to financial issues. See section 3.4.8 for further information on cash and voucher assistance as part of case management.

[Describe interventions to assess and address risks using CVA delivered by other sectors, for example, any joint SOPs or action plan with other agencies and/or sectors.[149]]

[148] IASC GBV Guidelines, Cash & voucher assistance and GBV compendium: Practical guidance for humanitarian practitioners (2019) (accessed 27 June 2023).
[149] There are countries where CVA & GBV SOPs are used for case management purposes (i.e. cash is a tool in case management; see for example Cash and voucher assistance for GBV cases: standard operating procedures (accessed 27 June 2023), Turkey cross-border/northwest Syria) and other countries where the GBV and CVA sectors develop a joint action plan or workplan with regard to risk mitigation or use of sectoral cash for GBV programming.

14 SECTION 7: GBV PREVENTION

Essential issues to consider

As for GBV response services, all prevention interventions should be based on *risk analysis* to assess whether certain safety and ethical considerations are currently in place or can be put in place, as part of programme design and implementation. Risk analysis focuses specifically on risks to survivors (or other women and girls in the community) that may be exacerbated in the process of programme delivery. See Annex 6 for a programmatic risk analysis checklist.

GBV prevention programming aims to address the root causes of GBV and promote the safety and equality of women and girls.

GBV prevention programming requires working along a spectrum ranging from immediate risk mitigation in an acute emergency (see section 6) to longer term social norms and systemic change. GBV prevention approaches can be divided into four categories:[150]

1. **Risk mitigation**: Risk mitigation aims to reduce the risk of exposure to GBV through all aspects of service provision. Risk mitigation focuses primarily on addressing "contributing factors" to GBV that might expose women and girls to increased risk of violence.
2. **Primary prevention or "tackling the root cause"**: Primary prevention includes strategies that focus on preventing GBV before it occurs by tackling its root cause – gender inequality. These approaches focus on behaviour modification and attitudinal change and require long-term resources.
3. **Secondary prevention**: Secondary prevention includes strategies that focus on response for survivors and consequences for perpetrators. This includes addressing the consequences of various forms of violence, mitigating the harm this violence can cause and taking steps to prevent the violence from happening again.
4. **Tertiary prevention**: Tertiary prevention includes actions that focus on the long-term impact of violence when untreated, such as community reintegration and acceptance, addressing trauma and the long-term medical and psychosocial needs a survivor may have.

Because prevention programming often seeks to change social norms, it can inadvertently cause backlash or resistance when not implemented carefully. This backlash may not only be targeted to women and girls who are a part of the prevention programming, but also to other women and girls in the community where the programming is taking place. It is important to anticipate and mitigate this backlash in programming. Some of the core strategies for effectively dealing with backlash include:

Recognizing and identifying potential forms of resistance that can occur during an intervention and see them as resistance and not just "challenges";

[150] See Inter-Agency Minimum Standards for GBV in Emergencies (2019), pp. 101-102.

Integrating gender and power analyses into project conceptualization and design, as well as risk mitigation covering resistance in particular.

Building partnerships where possible with women's and other community-based organizations or community members to better leverage each other's complementary skills, capacities and approaches and to build a more resilient civil society.

Creating spaces for dialogue and sharing with communities – i.e. adopting inclusive and intersectional approaches rather than defensive positions when facing opposition or questions on the prevention work – is a pathway to reaching agreement on an ultimate goal (e.g. ending VAWG).[151]

The International Rescue Committee has also identified several core principles for undertaking prevention programming in emergencies. These are as follows:

1. Prioritize the safety of women and girls.
2. Use an intersectional gender-power analysis.
3. Start with ourselves.
4. Centre the voices, power and agency of women and girls.
5. Recognize, engage and be accountable to women and girls experiencing multiple forms of discrimination.
6. Reflect the specific context.
7. Work in solidarity with women's rights organization, activists and leaders.
8. Engage communities in ways that are meaningful, creative and dynamic, asking questions rather than giving messages.[152]

Prevention programming may encourage women and girls to speak out on violence and seek assistance. **As such, it is critical to remember that it is unethical for prevention programmes to stimulate attention on GBV in communities without first ensuring there are services in place for survivors**.[153]

This section describes primary prevention interventions (outreach activities – also essential to but not sufficient for primary prevention efforts – are described in section 6.1.)

[List the primary prevention-related interventions (interventions that aim to address gender and social norms that underpin GBV) and responsible organizations in the setting.]

[151] Adapted from Viswanathan, R. (2021), *Learning from Practice: Resistance and Backlash to Preventing Violence against Women and Girls* (New York, United Nations trust fund to end violence against women). https://untf.unwomen.org/sites/default/files/Field%20Office%20UNTF/Publications/2021/Prevention%20briefs/Resistance%20and%20backlash/Synthesis%20Review%207%20-%20resistance%20and%20backlash_v2_compressed.pdf (accessed 27 June 2023).

[152] See International Rescue, EMPOWER: Preventing violence against women and girls in acute emergencies (2021) (accessed 27 June 2023).

[153] These and other potential risks and concerns are identified in the prevention programming risk analysis checklist in Annex 6. See also Inter-Agency Minimum Standards for GBV in Emergencies (2019), standard 13: Transforming systems and social norms.

15 SECTION 8: PREPAREDNESS

Essential issues to consider

A core function of GBV coordination partners should be to build national and local capacity in preparedness and contingency planning to combat GBV when an emergency occurs. The GBV minimum standards outline the steps to take to address possible GBV concerns in preparedness plans, including working with local actors to assess the capacity of institutions to handle GBV procedures and prepositioning relevant supplies, such as dignity kits, in areas that may be exposed to disasters. The IASC GBV Guidelines also contain guidance on how non-sector specialists can undertake risk mitigation measures as part of preparedness planning.

GBV sub-clusters/sectors play a significant role in ensuring that appropriate arrangements are in place for immediate provision of GBV services and that risk mitigation measures are in place across other sectors of humanitarian response. Contingency planning is also an opportunity for GBV coordination bodies to draft templates or pre-proposals for their response. When undertaking preparedness and contingency planning for disasters, it is important to assess the variety of risk factors within the setting.

GBV SOPs can be developed in preparation for a new crisis or additional or cyclical crises.

Preparedness is a continuous process, so preparedness activities can take place in contexts where an emergency is already active. For example, preparedness activities may be initiated for drought-prone areas that are also armed conflict areas.

"Preparedness" is any action, measure or capacity development that is introduced before an emergency to improve the overall effectiveness, efficiency and timeliness of response and recovery. Contingency plans describe an initial response strategy and create operational plans that can be implemented at the onset of an emergency. They are usually developed in anticipation of a particular crisis.

This section lays out key actions, strategies and approaches agreed to support preparedness and contingency planning.

[List here all relevant preparedness actions or commitments, including:

- *Preparatory mapping of GBV response structures and capacities (including mobile and static) either on a regular basis as part of general preparedness or as part of contingency planning for an identified crisis.*
- *Prepositioning of dignity kits, post-rape kits (in collaboration with the health care sector), IEC materials, emergency fuel supplies or cooking stoves with food security or shelter/non-food items (NFI) clusters and other relevant response materials or supports.*
- *Preparation of a communication plan with alternative contact modalities [attach in annex if available].*
- *Plans for safeguarding documentation relating to case management or other service provision in case of evacuation [attach in annex if available].*

- *Training of first responders (focusing on those most likely to respond in the first 48 hours to two weeks of a crisis).*
- *Identification of first responder personnel with appropriate training, through a "roster" or other form of rapid response mechanism.*
- *Operational guidance/procedures for key areas of GBV prevention or risk mitigation or commitments to develop such documents (e.g. one-pagers on actions to implement in the first 72 hours of a crisis to mitigate GBV risk for internally displaced persons and refugees during food distribution or in transit areas).]*

16 SECTION 9: COORDINATION

16.1 Coordination among GBV specialized actors and other service providers

This section outlines the importance and function of GBV coordination and lists the key responsibilities of GBV coordinators. If the relevant GBV coordination groups' way of working has been established and described in other documents, insert and/or refer to that information in the GBV SOPs.

Essential issues to consider

Because governments hold primary responsibility for the well-being of their own citizens and forcibly displaced persons as per their international commitments, coordination groups should engage national authorities when working with the government does not pose security risks.

In refugee contexts, UNHCR is the lead on the implementation of the refugee coordination model together with national authorities. A GBV coordination mechanism may be established under the Protection Working Group.

Under the IASC clusters, the Global Protection Cluster includes four specialized coordination bodies called Areas of Responsibility (AoRs), which may be replicated at field level as required. UNFPA is the lead agency of the GBV AoR and functions as an integral part of the protection cluster, contributing to commonly defined goals and outcomes and fulfilling equivalent responsibilities as the cluster in its specialised area. UNHCR is a core member of the global GBV AoR and the GPC operations cell has observer status. UNFPA and the GBV AoR are members of the GPC Strategic Advisory Group (SAG).

Coordination of refugee GBV in mixed situations is informed by the agreed coordination arrangements between UNHCR and OCHA. Where the IASC cluster system is utilized, leadership arrangements should be implemented according to the joint note on coordination. UNFPA and UNHCR are accountable to ensure that the needs and coordination arrangements for all population groups are catered for according to existing agreements and also in line with operational realities. Coordination mechanisms offer a space to raise critical issues – for example, if organizations are not responding to the needs of women and girls, if geographic coverage is insufficient or if there are service delivery or other gaps that need to be filled.

Under international and other instruments, governments hold primary responsibility for the well-being of their own citizens and displaced and stateless persons.

The core functions listed below can be applied to GBV coordination mechanisms in refugee settings. Examples of activities relating to each of the core functions can be found in the GBV coordination handbook[154] and standard 14 in the GBV minimum standards.

Coordination systems help plan interventions and strategies, manage information, mobilize resources, uphold accountability, fill gaps and avoid duplication. Coordination is also important in

[154] See GBV AOR coordination handbook (2019) (accessed 27 June 2023).

ensuring capacity gaps are addressed, including by supporting governments on preparedness and contingency planning.

The primary goals of GBV coordination are to:

1. Ensure accessible, safe, quality services are prioritized and available to survivors through strategic planning.
2. Promote appropriate attention to prevention of GBV (including risk mitigation) across sectors and actors in line with the IASC GBV Guidelines; and
3. Secure sufficient funding to support GBV specialized programming.

These goals are achieved through a set of deliverables organized around the **six core functions** of coordination, namely:

1. **To support service delivery by:**
    - Providing a platform that ensures service delivery is driven by the humanitarian/refugee response plan and strategic priorities.
    - Developing mechanisms to eliminate duplication of service delivery.
2. **To inform the humanitarian coordinator/humanitarian country team/refugee coordinator's strategic decision-making by:**
    - Preparing needs assessments and analysis of gaps to inform priority-setting.
    - Identifying and finding solutions for (emerging) gaps, obstacles, duplication and cross-cutting issues.
    - Formulating priorities based on analysis.
3. **To plan and implement the sub-cluster/sector strategy by:**
    - Developing a GBV sectoral plan, objectives and indicators that directly support realization of the overall response's strategic objectives.
    - Applying and adhering to common standards and guidelines.
    - Clarifying funding requirements, helping to set priorities and agreeing on sub-cluster/sector contributions to the humanitarian coordinator/humanitarian country team/refugee coordinator's overall humanitarian funding proposals.
4. **To monitor and evaluate performance by:**
    - Monitoring and reporting on activities and needs.
    - Measuring progress against the sub-cluster/sector strategy and agreed results.
    - Recommending corrective action where necessary.
5. **To build national capacity in preparedness and contingency planning**
6. **To support robust advocacy by:**
    - Identifying concerns and contributing key information and messages to the

humanitarian coordinator and humanitarian country team messaging and action.

- Undertaking advocacy on behalf of the cluster/sector, cluster/sector members and affected people.

This section outlines the GBV coordination group's ways of working for *[insert setting]*.

[Describe the coordination group's ways of working at national and sub-national levels, including the following elements:

- *Location, frequency and modality of meetings.*
- *Criteria for participation.*
- *Leadership of the coordination group, including any co-chairing arrangements.*
- *Any sub-groups or task forces within the coordination group (e.g. strategic advisory group, case management task force or GBVIMS task force) and/or in collaboration with other sectors/clusters (e.g. cash and voucher assistance task force/working group), focal point systems in other sectors/clusters.*
- *Processes for updating relevant coordination documents including service mapping, referral pathways and these GBV SOPs; and*
- *Priorities and/or strategies for advocacy.]*

16.1.1 Information management for coordination purposes

Information management is an essential function of GBV coordination, supporting GBV actors to better understand, visualize and respond to needs, priorities and service gaps. This section describes the collection, compilation, analysis and use of different kinds of information to inform coordination. This section includes assessments, service mapping and response monitoring data, as well as the use of aggregated, non-identifiable GBV incident data for the purposes of trend analysis to inform service provision (see section 9.1.1.1). See section 4.1 for information on identifiable survivor data collected as part of case management. This type of case information should never be shared for the purposes of trend analysis.

GBV-related data should never be sought from survivors for any purposes besides direct service provision. For example, needs assessments should not seek to collect data on survivors' experiences of GBV and should not be conducted if essential GBV response services are not in place. All parties to these GBV SOPs agree to uphold the principles of confidentiality (e.g. no information is shared that could be used to identify the survivor, the alleged perpetrator, the family or the community of the survivor) and of informed consent (survivors' control over their data must be respected at all times).

It is inappropriate to share a survivor's de-identified data (even in aggregate form) unless proper and agreed information-sharing protocols are in place and informed consent conversations with survivors make clear how their data will be used, by whom and for what purposes and that they consent to share their data under those conditions.

16.1.1.1 Incident monitoring: using aggregated GBV incident data to inform service provision

GBV incident data is extremely sensitive, and its collection, storage and sharing can pose serious safety risks to survivors, their families and communities as well as to caseworkers and their organizations. It is critical to carry out a risk analysis prior to initiating data collection and sharing survivor data.

For the purpose of inter-agency trend analysis and coordination, GBV incident data can be compiled from multiple service providers into reports for analysis at inter-agency level; however, the sharing of data and reporting should always be limited to non-identifiable, aggregate-level data. Data sharing at this level should only happen if the service provision organizations are collecting a standardized dataset, preferably as part of the same information management system (e.g. GBVIMS) and have an information-sharing protocol in place with agreed rules on how data should be shared and used, as well as training on safety and ethics in GBV data management. Because multiple providers often operate in the same area and provide services to the same population, the ability to produce high-quality GBV incident data that can be safely shared and analysed at the inter-agency level is a critical step towards understanding trends in reported cases and ensuring a coordinated response.

In insecure environments, contingency plans should be in place at inter-agency level to ensure that data evacuation and destruction protocols are clear and agreed upon.

Inter-agency GBV information-sharing protocols must take into account (1) what information is being shared, (2) how it will be used, (3) at what levels (within an organization, among signatories to the information-sharing protocol, external to protocol signatories and geographic levels of sharing).[155]

In order to develop such agreements, organizations collecting survivor data through service provision should agree on using the same information management system, such as one based on the GBVIMS to allow for standardized data. Signatories to these protocols are limited to organizations providing direct service provision for GBV survivors (usually GBV case management services) and collecting data as part of that service provision and those agencies supporting the implementation of the information management system.

In the first weeks and months of a rapid onset emergency or in contexts where a limited amount of documentation and data sharing is possible, a simplified version of standardized tools and information-sharing protocols is available.[156] This can be used to assist response coordination and mitigate the risk of any unsafe data collection and information sharing. The simplified system should only be used as an interim solution until more comprehensive system (such as the GBVIMS) are able to be established. This is only a solution if all of the minimum criteria for data protection and security and other established best practices around GBV data collection can be met.

[157] For more information on information-sharing protocols, including format, contents and development, and acute emergency toolkit see www.gbvims.com (accessed 27 June 2023).

[Summarize here any systems that are in place for collecting, analysing and sharing any aggregated data related to GBV incidents (e.g. GBVIMS+/Primero or ProGres). State whether an information-sharing protocol is in place or describe the process to establish one.]

16.1.1.2 Management of other GBV-related information

All parties to these GBV SOPs agree to share relevant information to inform and support the analysis of service needs and gaps and improvement of GBV prevention and response interventions.

[List here the types of (non-GBV incident-related) information to be shared in the setting, by whom and how often. This may include:

- *Frequency of updating service mapping and relevant tools (e.g. 3/4/5 Ws templates) [attach in annex];*
- *Harmonized needs assessment questions, tools or processes, including safety audits;*
- *Tools or processes for response monitoring; and*
- *Locations or processes for sharing public data related to GBV interventions, including response dashboards or publications.]*

9.2 Coordination with other sectors

This section describes coordination with other clusters or sectors in relation to risk mitigation and GBV response, including areas such as CVA, MHM, PSEA and others unless these are already described under the relevant sections above.

[Describe here any agreements related to:

- *Designating focal points for GBV among other sectors/clusters or sector/cluster focal points among GBV actors.*
- *Cross-participation in coordination meetings.*
- *Collaboration on assessments.*
- *Any other areas of coordination.]*

Signature page for participating actors

[All participating agencies and organizations mentioned in the document demonstrate, with a signature, their full commitment to the GBV SOPs.]

We, the undersigned, as representatives of our respective organizations, agree and commit to:

- Abide by the procedures and guidelines contained in this document.
- Fulfil our roles and responsibilities to respond to, mitigate and prevent GBV.
- Provide copies of this document to all incoming staff in our organizations with responsibilities for action to address GBV so that these procedures will continue beyond the contract term of any individual staff member.

[List here all of the organizations/groups who participated in the process of developing these GBV SOPs:]

Organization / Agency Name	**Date**	**Signature**

Standard Operating Procedures for GBV Interventions in Humanitarian Settings

GBV SOPs Resource Package

Part 3: GBV SOPs Annexes

Table of Contents

7. Technical guidance for developing GBV SOPs

a. Annex 1: Technical resources for developing GBV SOPs

This annex lists essential GBV resources and materials for the GBV SOPs development process and content, capacity strengthening and GBV programming in general. See also below for thematic resources.

i. General

1. Handbook for Coordinating Gender-based Violence Interventions in Emergencies (2019);
2. *The Inter-agency minimum standards for Gender-Based Violence Programming in Emergencies (GBV minimum standards) (2019);*
3. IASC, Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery *(IASC GBV Guidelines) (2015);*
4. UNHCR Policy on the Prevention of, Risk Mitigation and Response to Gender-Based Violence (2020);
5. WHO. *WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*. Geneva, World Health Organization, 2007.
6. UN Women, UNFPA, WHO, UNDP and UNODC 2021, Essential Services Package for Women and Girls Subject to Violence.

ii. Risk Assessment

1. Interaction. Module 1: GBV Risk Analysis. (Note that this Module is part of a broader package on evaluating GBV prevention work; however, this introductory module is useful in performing a GBV risk analysis.)
2. UNICEF. (2019). *Availability, accessibility, acceptability and quality framework*. https://gbvguidelines.org/wp/wp-content/uploads/2019/11/AAAQ-framework-Nov-2019-WEB.pdf.
3. El-Tahrawi, A. (2017). Readiness and GBV response plan in times of emergency: Analysis of main risks, vulnerabilities and capacity to respond to disaster/emergencies. www.alianzaporlasolidaridad.org/axs2020/wp-content/uploads/CEPRP-Final_EN.pdf.

iii. COVID-19 & GBV

- GBV AoR. (2020-a). *COVID-19 contingency planning guidance for gender-based violence (GBV) coordination groups.* https://gbvaor.net/sites/default/files/2020-03/COVID%20Contingency%20Planning_GBV%20AoR%20Guidance%20for%20GBV%20Coordination%20Groups.pdf.

- GBV AoR. (2020-b). template: Contingency planning for a COVID-19 outbreak. https://gbvaor.net/sites/default/files/2020-03/GBV AoR template for COVID-19 Contingency Planning.docx.

iv. Healthcare

1. World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR). Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: WHO; 2019.
2. GBV AoR. (n.d.). *Tip sheet: Addressing gender-based violence (GBV) in health assessments and initial programme design.* www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/GBV%20Tip%20Sheet%20Health%20FINAL.pdf.
3. Bell, E. and Butcher, K. (2015) DFID Guidance Note on Addressing Violence Against Women and Girls (VAWG) in Health Programmes – Part B, London: VAWG Helpdesk. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/446114/Health-guidance-note-partB_3_.pdf.
4. WHO (2017a). Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers. www.who.int/reproductivehealth/publications/violence/vaw-health-systemsmanual/en/.
5. WHO (2017b). Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva. http://ccsas.iawg.net/wp-content/uploads/2017/12/9789241550147-eng.pdf.

v. Prevention

1. International Rescue Committee (2021). EMPOWER: Preventing violence against women and girls in acute emergencies. https://gbvresponders.org/wp-content/uploads/2022/02/Empower-EN.pdf
2. UN Women. (2020). Respect women: Strengthening the enabling environment for VAW prevention. www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/RESPECT-implementation-guide-Strengthening-the-enabling-environment-for-VAW-prevention-en.pdf
3. UNICEF & Criterion Institute. (2020). Mitigating the risks of gender-based violence: A due diligence guide for investing. www.unicef.org/sites/default/files/2020-06/Covid-19-Diligence-Tool-UNICEF-Criterion.pdf.
4. Lockett, K. & Bishop, K. (2012). Guidance Note 2: A practical guide on community programming on violence against women and girls. *UK Department for International Development (DFID).* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/67335/How-to-note-VAWG-2-community-prog.pdf.

5. Alexander-Scott, M., Holden, J., & Bell, E. (2016). Shifting social norms to tackle violence against women and girls (VAWG). *UK Department for International Development (DFID).* Violence Against Women and Girls Helpdesk. www.oecd.org/dac/gender-development/VAWG%20HELPDESK_DFID%20GUIDANCE%20NOTE_SOCIAL%20NORMS_JAN%202016.pdf.
6. Viswanathan, R. (2021), *Learning from Practice: Resistance and Backlash to Preventing Violence against Women and Girls* (New York, United Nations Trust Fund to End Violence against Women). https://untf.unwomen.org/sites/default/files/Field%20Office%20UNTF/Publications/2021/Prevention%20briefs/Resistance%20and%20backlash/Synthesis%20Review%207%20-%20resistance%20and%20backlash_v2_compressed.pdf

vi. Case Management (including Remote Case Management)

1. GBVIMS Steering Committee. 2017. Inter-agency GBV Case Management guidelines: Providing Care and Case Management Services to Gender-Based Violence Survivors in Humanitarian Settings.
2. IRC & UNICEF. *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*
3. International Rescue Committee. 2018. Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery.
4. GBV AoR (2021). COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines.

vii. Child Protection

1. Gender-Based Violence and Child Protection Field Cooperation Framework (2021).
2. The Alliance for Child Protection in Humanitarian Action (2019). Minimum Standards for Child Protection in Humanitarian Action.
3. Global Child Protection Working Group. (2014). Inter-agency guidelines for Case Management & Child Protection.
4. UN High Commissioner for Refugees (UNHCR), 2021 UNHCR Best Interests Procedure guidelines: Assessing and Determining the Best Interests of the Child, May 2021,available at: *www.refworld.org/docid/5c18d7254.html* [accessed 14 March 2022]

viii. Psychosocial Support

1. IASC 2007. IASC guidelines on Mental Health and Psychosocial Support in Emergency Settings.
2. IASC 2022. Minimum Service Package Mental Health and Psychosocial Support
3. UNFPA. Guidelines for the provision of remote psychosocial support services for GBV survivors.
4. IASC 2015. IASC GBV Pocket Guide.

5. IFRC. (2015). *Rapid assessment guide for psychosocial support and violence prevention in emergencies and recovery.* https://pscentre.org/wp-content/uploads/2018/03/PSS-and-VP-Rapid-Assessment-Tool-Emergencies-and-Recovery-2015.pdf.
6. IRC and University of California Los Angeles (UCLA) (2014). Competent, Compassionate and Confidential Clinical Care for Sexual Assault Survivors (CCSAS) Multimedia Learning Tool. Available from: https://iawg.net.

ix. Women's and Girls' Safe Spaces

1. IRC and International Medical Corps (2019). Advancing Women's and Girls" Empowerment in Humanitarian Settings: A Global Toolkit for Women's and Girls" Safe Spaces.
2. UNFPA & IRC. (2017). Safe Spaces for Women and Girls (SSWG) Standardization and Technical Guidance – How to set up a SSWG in practice. https://reliefweb.int/sites/reliefweb.int/files/resources/sswg_technical_toolkit_oct_2017_final_2.pdf.

x. Legal & Justice

1. GBV AoR. (2020-c). Strengthening access to justice for gender-based violence survivors in emergencies. Available at: https://gbvaor.net/node/911.
2. Skinnider, E. (2019). Handbook for the judiciary on effective criminal justice responses to gender-based violence against women and girls. UNODC. Available at: www.unodc.org/pdf/criminal_justice/HB_for_the_Judiciary_on_Effective_Criminal_Justice_Women_and_Girls_E_ebook.pdf.

xi. Safety and Security

1. UN Women. Handbook on Gender-Responsive Police Services for Women and Girls Subject to Violence
2. Kerr-Wilson, A., Hilker, L. M., Mitra, S., Busiello, F., Maguire, S. & Jennings, M. (2011). Working with the security sector to end violence against women and girls. Social Development Direct and UN Women. www.endvawnow.org/uploads/modules/pdf/1326476671.pdf.
3. Esplen, E., Moosa, Z., Hilker, L. M., & Khan, S. (2013). Addressing violence against women and girls through security and justice (S&J) programming. DFID. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/267720/AVAW-security-justice-progA.pdf.
4. UN Women (2021). Handbook on gender-responsive police services for women and girls subject to violence. www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2021/Handbook-on-gender-responsive-police-services-en.pdf.

xii. Cash and Voucher Assistance

1. UNHCR, Cash Assistance and Gender
2. UNHCR, Guide for Protection in Cash-based Interventions
3. Cash and Voucher Assistance for GBV Cases: Standard Operating Procedures, Turkey Cross-border/Northwest Syria
4. IASC GBV Guidelines, Cash & Voucher Assistance and GBV Compendium: Practical Guidance for Humanitarian Practitioners (2019)
5. Women's Refugee Commission, Resources for Mainstreaming Gender-Based Violence (GBV) Considerations in Cash and Voucher Assistance (CVA) and Utilizing CVA in GBV Prevention and Response.

xiii. Menstrual Health and Hygiene

1. Columbia Public Health. MHM in Emergencies Toolkit.
2. Columbia University & International Rescue Committee. 2020. A Compendium: Menstrual Disposal, Waste Management & Laundering in Emergencies.
3. MHM Operational 2-pager for GBV
4. FGD Guide for Menstruation related preferences, English, French, Arabic, Spanish
5. Checklist for MHM Friendly latrines, English, French, Arabic, Spanish
6. Market Based Programming for WASH Guidance on the provision of menstrual materials through CVA.
7. https://syria.unfpa.org/sites/default/files/pub-pdf/mhm_report_-_english_-_f3_0.pdf

xiv. Protection from Sexual Exploitation and Abuse

1. Tip Sheet: Defining Linkages to Better Assist Survivors of Sexual Exploitation and Abuse

8. Tools and templates for SOPs development process

a. Annex 2: GBV SOPs workplan

Workplan_GBV SOPs Development_Template.xlsx - Google Sheets

b. Annex 3: Sample terms of reference for GBV SOPs reference group

Reference group for the process of updating the GBV standard operating procedures

GBV sub-cluster, Aden, Yemen (draft)

Terms of reference

The reference group (RG)

1. Purpose and specific tasks

The GBV SOPs RG is an ad hoc body of the GBV sub-cluster (GBV SC) in Aden focused on leading the process of updating the GBV SOPs. More specifically, the RG:

a) Creates a workplan, with activities and roles specified, as well as a timeline for updating the SOPs.

b) Identifies actors and other relevant stakeholders to participate in the SOPs updating process.

c) Leads the revision/development of specific parts of the SOPs (as will be agreed in the RG's first meeting), collects feedback from other stakeholders and shares any inputs with the GBV sub-cluster coordinator in Aden.

d) Provides support with final reviews of the (updated) SOPs.

e) Sets up a plan for and supports the roll-out of the updated SOPs in order to ensure their application and efficiency.

2. Members of the RG (and their selection): Number and profile of members

2.1. Members of the RG are organizations, agencies, institutions, etc. that are involved in GBV response, i.e. providing directly specialized services to survivors of GBV in Yemen and are active members of the GBV SC. Direct services can be case management, mental health and psychosocial services, health services (especially if providing CMR), protection and legal services.

2.2. The reference group represents the authorities (1-2), INGOs (3), NNGOs (3) and UN agencies (2-3) engaged in GBV response in the given geographical area. The number of members does not exceed nine persons.

2.3. The members of the RG are identified based on their engagement in the GBV SC and service provision – both the services they provide and also active membership and participation in the coordination initiatives.

3. The process of selecting RG members

3.1. The GBV SC coordinator in Aden proposes a list of organizations based on a review of the activities as recorded through meetings and regularity of information sharing and also on the acknowledged GBV expertise of the organization nationally or internationally.

3.2. This list is verified and approved by the GBV SC coordinators in south Yemen and the GBV SC coordinator at national level. If any of the proposed members rejects their engagement for any

reason, the Aden GBV SC coordinator will suggest a new member who will be approached subject to agreement of the above-mentioned coordinators.

3.3. Representation of national NGOs, international NGOs, UN and the government is ensured to the extent possible.

3.4. Role of the GBV SC coordinator (Aden)

The GBV SC coordinator leads all the processes and ensures the activities are implemented and the timeline is respected. The GBV SC also carries out all communications and organizes workshops and meetings for updating purposes as agreed by the RG. Where needed, the national GBV SC coordinator will provide support.

4. The principles of work

In its work the RG adopts the principles of neutrality and impartiality and carries out a process that is reasonably transparent and open to all active members of the GBV sub-cluster. If and when engaged in revision or review of the SOPs, the members will at all times be guided by the do-no-harm principle, the promotion of survivor-centred approach and other principles that contribute to efficiency in the protection of survivors and those at risk from GBV.

5. Finalization of ToR

These terms of reference (ToR) of the RG are reviewed and finalized in the first meeting of the RG on (date), at which members may suggest any edits or additions to the ToR.

c. Annex 4: Items for budget considerations

This annex describes potential costs involved in developing SOPs. These are not exhaustive and must be adapted for each context.

General

- Phone credit / internet access
- Printing (for hard copies)
- Translation of documents into relevant languages

- In-person workshops
  - Meeting room rental
  - Audio-visual equipment rental
  - Paper copies
  - Refreshments
  - Transportation
  - Interpreting (language, sign language interpretation as needed)
- Remote workshops (note that these are costs for making the SOPs process more inclusive and accessible)
  - SIM cards
  - Payment for internet/Wi-Fi access
  - Accessibility features
  - Interpreting

Please consider additional approaches and related costs that might increase access to participation in the GBV SOPs development process for women-led and other local and national organizations.

d. Annex 5: GBV assessment tools

1. Global GBV AoR 3-4-5W template
2. GBV Service Mapping Tool
3. Service Gap Analysis and Planning Tool
4. Barriers to Care Analysis and Planning Tool
5. UNICEF. GBV in Emergencies. Programme Resource Pack: Assessment Tools for GBV in Emergencies. Programme Resource Pack: Assessment Tools.
6. UNHCR (2021). Safety Audit Toolkit.
7. "GBV assessment and situation analysis tools" (2012). *Managing gender-based violence programmes in emergencies.* Phase II Workshop, Nairobi, Kenya. www.refworld.org/pdfid/5c3465c64.pdf. Situation analysis form p. 20 ff.
8. CARE. (n.d.). *Gender and protection audit.* Rapid gender analysis assessment tools. https://insights.careinternational.org.uk/images/in-practice/RGA-and-measurement/6._gender_and_protection_audit.doc.

9. Tools and templates to accompany the SOPs template

a. Annex 6: Risk analysis

1. **Programmatic risk analysis for response services (Checklist)**
2. **Programmatic risk analysis for GBV prevention interventions (Checklist)**

b. Annex 7: GBV classification tool

1. GBVIMS classification tool

c. Annex 8: PSEA

1. United Nations Secretary-General, 2003. Secretary-General's Bulletin: Special Measures for Protection from Sexual Exploitation and Sexual Abuse, ST/ SGB/2003/13.
2. UNFPA. 2022. Tip Sheet: Defining Linkages to Better Assist Survivors of Sexual Exploitation and Abuse.

d. Annex 9: Inter-agency case management forms

1. Sample consent for services form
2. Standard GBV intake and initial assessment form
3. Sample Consent for release of information form
4. Sample case action plan
5. Sample case follow-up form
6. Sample case closure form
7. Sample client feedback survey
8. Sample safety planning
9. Sample suicide safety agreement

e. Annex 10: Referral pathway

1. Referral Protocol from Inter-Agency Case Management Guidelines
2. Referral pathway form for refugee settings

f. Annex 11: Referral Form

1. Sample referral form