Kit M

Minimum GBViE Response Package

M

unicef

for every child

Kit M

Minimum GBViE Response Package

Gender-Based Violence in Emergencies
Programme Resource Pack

Contents

Harar, Ethiopia

Overview of the Minimum Response Package

Introduction

★ See the IASC GBV Guidelines

Sexual violence and other forms of gender-based violence (GBV) are an everyday occurrence for girls and women around the world. The problem is magnified in conflict- and disaster-affected settings because of the multiple risk factors that arise in emergency contexts. Some risk factors are context-specific, such as the presence of armed groups that deliberately target girls and women for sexual violence. Other risk factors are common across different types of emergencies, such as a breakdown in formal and informal community protection mechanisms that prevent violence, or an increased dependency on external sources to meet basic needs.

Over the past two decades, GBV has been globally recognized as a critical human rights issue. States, international actors and national actors have taken significant action in line with international human rights instruments to address GBV before, during and after armed conflict and disasters.[1] Much remains to be done, however, to address this widespread problem in emergency settings and to fulfil the rights of all girls and women to safety, dignity and protection from violence.

UNICEF's efforts to respond to gender-based violence in emergencies (GBViE) lie at the heart of the agency's mission to protect the health and well-being of children and women. UNICEF is mandated to support States and other duty bearers, civil society and communities to prevent GBV against girls and women in emergencies and to ensure appropriate systems and services are available and sensitive to the needs of survivors.[2] UNICEF's response to GBViE is shaped by its humanitarian responsibilities and commitments set out in the *Core Commitments for Children in Humanitarian Action* (CCCs),[3] the Inter-Agency Standing Committee (IASC) *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* (referred to as the '**GBV Guidelines**')[4] and the *Minimum Standards for Child Protection in Humanitarian Action*.[5]

UNICEF's work to address GBV in emergencies focuses on the rights and needs of girls and women, recognizing their systematic exposure to and risk of GBV. **Girls, in particular, face heightened vulnerability to many forms of GBV due to both gender- and age-based power relations.** GBV programming is critical not only as a stand-alone intervention, but also as an essential part of UNICEF's violence against children, health, education and other programming.

While focusing on interventions addressing GBV against girls and women in emergencies, **UNICEF recognizes and seeks to ensure support is available for *all* survivors of sexual violence**. As such, UNICEF's programming to assist and support GBV survivors also aims to ensure that care, support and protection-related services are in place to meet the needs of boys who have experienced sexual violence in emergency settings. Other dimensions of programming to address violence experienced by children are addressed through Child Protection in Emergencies and other violence against children programming.

1 The importance of sustaining global momentum against GBV was reaffirmed at the 57th session of the Commission on the Status of Women, March 2013.
2 While UNICEF's GBV prevention and response programming targets girls and women, UNICEF also meets the care, support and protection needs of boy survivors of sexual violence, as well as boys harmed by intimate partner violence and other forms of GBV perpetrated against their mothers.
3 See <www.unicef.org/publications/files/CCC_042010.pdf>.
4 See <https://gbvguidelines.org>.
5 See <www.unicef.org/iran/Minimum_standards_for_child_protection_in_humanitarian_action.pdf>.

Adone, Lao People's Democratic Republic

Bentiu, South Sudan

Components of the Minimum GBViE Response Package

UNICEF's **Minimum GBViE Response Package** includes essential humanitarian interventions to: put in place coordinated life-saving response services for sexual violence survivors immediately following a crisis; build girls' and women's safety and reduce their vulnerability to GBV; and mitigate GBV risks across sectors immediately following an emergency. The diagram below illustrates the four components of the Minimum Response Package.

Working with partners, including government and civil society, to deliver a minimum set of GBViE services and actions is an essential component of UNICEF's core commitments to GBV as outlined in the CCCs.[6]

In line with the IASC GBV Guidelines, UNICEF's Minimum GBViE Response Package focuses on putting health, psychosocial and safety services in place for sexual violence survivors as an *initial* priority in emergency settings. This initial focus on sexual violence is due to the immediate and potentially life-threatening health consequences of such violence, coupled with the feasibility of managing these consequences through medical care. At the same time, there is a growing recognition that affected populations can experience various forms of GBV during conflict and natural disasters, during displacement, and during and following return. Therefore, establishing response for other forms of GBV should occur as soon as clinical management of rape (CMR) services are in place.

1. Effective Coordination to address GBV between:

- GBV actors
- All humanitarian sectors/clusters
- Other actors

1. Providing Assistance and Support to GBV Survivors through age-appropriate:

- Healthcare
- Psychosocial support
- Safety services

1. Building Safety and Resilience

- Community safety planning
- Dignity kit programming
- Safe space programming

1. Mitigating GBV Risks

Integrating essential GBV risk mitigation actions across UNICEF sectors and clusters

6 United Nations Children's Fund, 'Core Commitments for Children in Humanitarian Action', Child Protection 2.6 Commitment 1, UNICEF, 2010, p. 32. See <www.unicef.org/publications/files/CCC_042010.pdf>.

Resources for supporting implementation of the Minimum Response Package

This GBViE Programme Resource Pack contain guidance and tools for implementing each element of the Minimum Response Package, as well as expanded GBV prevention and response programming. The relevant sections of the Resource Pack from **Kit 2: Assessment** and **Kits 3.1–3.7: Programming** have been brought together into this part, **Kit M: Minimum GBViE Response Package**, for ease of reference. It is recommended to consult other components of the Resource Pack for more detailed information, especially when implementing expanded programming beyond a minimum response.

The Resource Pack also contains a series of Learning Modules to help build UNICEF and partner staff knowledge and capacity to implement the Minimum GBViE Response Package. These include:

- *Overview of the UNICEF Gender-Based Violence in Emergencies Resource Pack* (PowerPoint Presentation)
- *Introduction to Gender-Based Violence in Emergencies*
- *UNICEF's Gender-Based Violence in Emergencies Programming*
- *Values and Principles for Gender-Based Violence in Emergencies Programming*
- *Introduction to Gender-Based Violence in Emergencies Assessments*
- *Responding to Gender-Based Violence Survivors in Emergencies*
- *Programming to Build Girls' and Women's Safety and Resilience*
- *Integrating GBV Risk Mitigation Across UNICEF Sectors and Clusters*

Maiduguri, Nigeria

Sapa, Vietnam

Coordination

UNICEF's role in humanitarian coordination

UNICEF's commitment to coordination in humanitarian action is articulated within the *Core Commitments for Children (CCCs) in Humanitarian Action*[1] (Section 1.12, Inter-agency Humanitarian Reform).

UNICEF is a designated lead agency within the cluster system. Globally, UNICEF is responsible for leading/co-leading **three clusters:** Water, Sanitation and Hygiene (WASH); Nutrition; and Education (which it co-leads with Save the Children). UNICEF is also responsible for leading the Child Protection Area of Responsibility (CP AoR) within the Protection Cluster. UNICEF is accountable to affected populations, to the humanitarian coordinator (HC) and emergency relief coordinator, and to national authorities for effective functioning and performance of these clusters and AoR. Guidance exists to support country office (CO) cluster leadership across all clusters.

★ See the IASC GBV Guidelines

Resources

- **Cluster Coordination Guidance for Country Offices**
  UNICEF (2015)
  <www.unicefinemergencies.com/downloads/eresource/docs/Clusters/Cluster%20Guidance%20Eng%20final%20version.pdf>

GBV coordination in emergencies

Good coordination is particularly important for GBV prevention, mitigation and response in emergencies. This is due to the multi-disciplinary, multi-sector and multi-agency nature of GBV prevention, mitigation and response. For instance:

- **Responding to GBV** requires action from a large variety of actors. Addressing the different needs of survivors requires input and services from health, psychosocial support, social service, community, child protection, law enforcement and justice actors and systems.
- **Mitigating risk of GBV** requires every sector of humanitarian response – programmatic and operational – to implement essential actions as set out in the **IASC Guidelines for Integrating GBV Interventions in Humanitarian Action ('GBV Guidelines')**.[2]
- **Prevention programming** involves engaging with different groups and services, from national government and non-government sectors and from the community, to address the underlying cases and drivers of GBV.
- **In situations of armed conflict**, action to protect civilians from GBV and to monitor and respond to conflict-related sexual violence (CRSV) goes beyond the humanitarian system and involves coordinating with peace and security actors where they have a mandate to protect civilians.

In addition to the multiple sectors involved, addressing GBV requires coordinated partnerships between government, civil society and the community – and, in some settings, with international security forces.

The **core functions** of a GBV sub-cluster or working group are:

1. **Supporting service delivery** to affected communities by providing a platform for agreeing on approaches and eliminating duplication of efforts;
2. **Informing strategic decision-making** of the Humanitarian Coordinator/Humanitarian Country Teams (HC/HCT) through coordination of needs assessment, gap analysis and prioritization;

1 For more information on the CCCs, see <www.unicef.org/publications/files/CCC_042010.pdf>.
2 See <www.gbvguidelines.org>.

3. **Planning and strategy development,** including sectoral plans, adherence to standards and funding needs;
4. **Advocacy to address identified concerns on behalf of cluster participants and the affected population;**
5. **Monitoring and reporting** on the cluster strategy and results, and recommending corrective action where necessary; and
6. **Contingency planning/preparedness/national capacity-building,** where needed and where capacity exists within the cluster.

Resources

- **Handbook for Coordinating Gender-Based Violence Interventions in Humanitarian Settings**
  GBV AoR Working Group (2010)
  <www.refworld.org/docid/52146d634.html>
- **Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery**
  IASC (2015)
  <http://gbvguidelines.org>

★ See the IASC GBV Guidelines

- **Reference Module for Cluster Coordination at the Country Level**
  IASC (2015)
  <www.humanitarianresponse.info/en/coordination/clusters/document/iasc-reference-module-cluster-coordination-country-level-0>
- **Operational Guidance for Cluster Lead Agencies on Working with National Authorities**
  IASC (2011)
  <www.humanitarianresponse.info/system/files/documents/files/IASC%20Guidance%20on%20Working%20with%20National%20Authorities_July2011.pdf>

UNICEF and GBV coordination

UNICEF participates in and leads numerous coordination fora related to GBV. Providing support to GBV coordination in emergency settings at national and sub-national levels is very important for the following reasons:

- Humanitarian coordination mechanisms are the pivotal mechanism for **determining humanitarian priorities** and influencing resource mobilization and allocation.
- UNICEF brings **expertise and capacity** in GBViE prevention, mitigation and response. UNICEF attracts and deploys high-quality professional and experienced GBV and CP personnel who contribute significantly to GBV coordination efforts.
- Participation in GBV coordination helps to **ensure linkages** are established between humanitarian response to GBV and CP. In doing so, UNICEF helps to promote the needs, rights and perspectives of child survivors of GBV and those at high risk.
- Good coordination between GBV actors and other sectors is important for ensuring GBV risk mitigation is integrated across all humanitarian sectors and clusters in line with the IASC GBV Guidelines.
- UNICEF often supports **government-led GBV coordination efforts** at national and sub-national levels.
- Participating in coordination mechanisms provides an opportunity to **build capacity of national and local partners** and civil society actors.
- Coordination enables UNICEF to **foster effective relationships** with other actors with a mandate for preventing, mitigating or responding to GBV – for example, in monitoring and responding to CRSV and integrating GBV into other clusters/sectors for which UNICEF is a lead agency.

GBV coordination arrangements

The senior humanitarian leadership – including government, where relevant – is responsible for ensuring that appropriate GBV coordination structures are in place in each country. There are no standard coordination arrangements because emergencies vary in type, scale and complexity, and approaches to coordination must reflect the needs and realities on the ground. Coordination arrangements also change over time as the situation and response evolves. Coordination leadership, structure, cluster/working group membership and terms of reference may therefore not only vary across settings, but also evolve over time.

Leadership of cluster/sectoral coordination

The following principles generally apply to GBV coordination leadership arrangements in situations *not* led by UNHCR.

In disaster-prone settings and settings with national leadership of humanitarian response, preparedness planning should include working with the government to determine capacity gaps and to support national disaster management agencies and/or other relevant government agencies to assume leadership of GBV coordination.

Where the cluster system is activated and a protection cluster is in place, UNFPA assumes responsibility for GBV coordination at the national level. UNICEF supports UNFPA as an active member of the sub-cluster in national and sub-national GBV coordination. In some contexts, this could include UNICEF leadership of sub-national GBV coordination bodies, depending on operational capacity. Through its role as the lead of the CP AoR, UNICEF promotes linkages between field-level CP Working Groups and GBV Working Groups to improve access to services for child survivors.

A range of other actors is involved in GBV coordination at national and sub-national levels, including relevant international and national non-government organizations (NGOs), International Red Cross/Red Crescent Societies and government actors. Where neither UNFPA nor UNICEF are operational or able to assume leadership at the sub-national level, another UN entity, an international or national NGO, or the government will take a leadership role in GBV coordination. Again, *local leadership should be supported* wherever feasible.

Where the cluster system is not activated and there is no formal humanitarian coordination mechanism in place, UNICEF country offices should engage with UNFPA, relevant entities (including the government, unless it is not appropriate to do so) and other actors identified above to advocate for the establishment of an inter-agency GBV coordination mechanism and seek agreement on leadership.

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

Evidence suggests that *co-lead arrangements* are effective when well-managed. In some settings, government authorities co-lead GBV coordination, while in others, an NGO with GBV expertise may co-lead. Wherever possible and appropriate, UNICEF supports government and civil society actors to lead or co-lead GBV coordination. UNICEF may assume responsibility for coordination leadership at a sub-national level where there is sufficient capacity – for example, a GBV or CP specialist who can 'double-hat' in UNICEF programming and GBV coordination.

Membership of coordination working groups

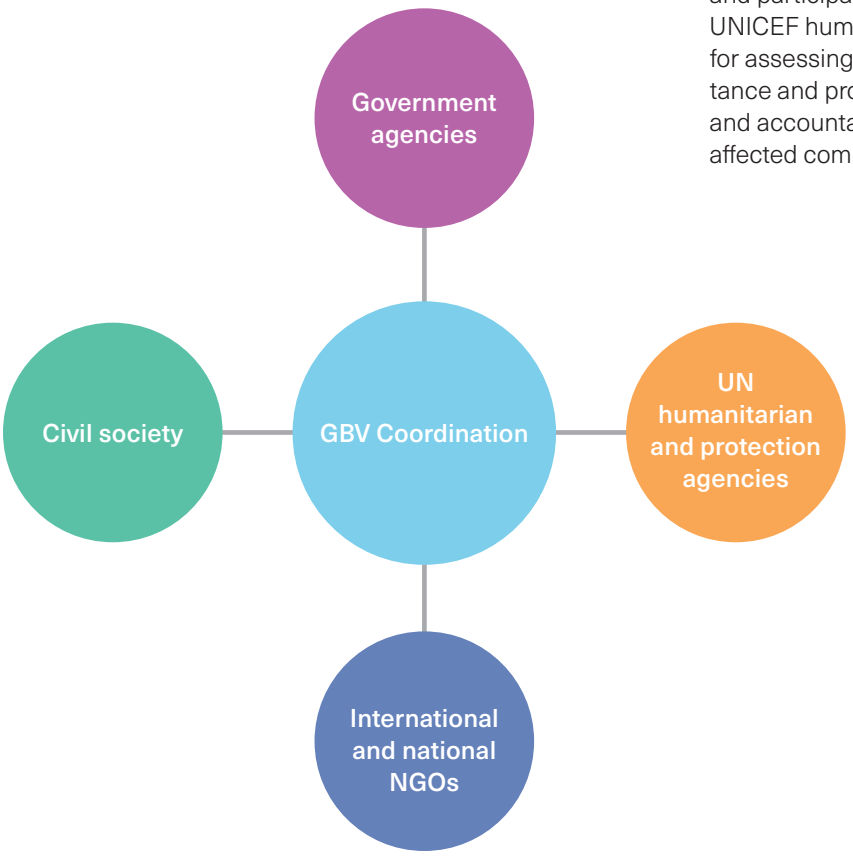
Membership of GBV coordination bodies varies across settings and is determined at the local level. International, national and local actors with a role in GBV assessment, advocacy and programming are all involved. These commonly include government health and social services agencies; UN humanitarian and protection agencies; international and national NGOs; and civil society organizations and groups.

Government agencies include ministries for health, social services, welfare, gender, women and children, and other entities. In conflict-affected settings in which government forces or authorities are implicated in the deliberate use of sexual and other gender-based violence against civilians, government participation in coordination may not be appropriate.

UN humanitarian and protection agencies include UNFPA, UNICEF, UNHCR, UN Women, WHO and OHCHR. The interface between the GBV coordination body and UN political or peace-keeping missions needs to be carefully defined (see below for more information).

International and national NGOs include all NGOs involved in GBV prevention and response programming, such as the International Committee of the Red Cross, which may participate as observers.

Civil society organizations and groups include community-based and other civil society groups. Many local organizations may wish to be involved in GBV coordination and response, even if they are not yet implementing GBV programmes. As well as bringing significant expertise in different areas and in the local context, these groups also bring the critical voices and perspectives of children and women to humanitarian response. Such involvement and participation is a core principle for UNICEF humanitarian action and is essential for assessing whether humanitarian assistance and protection are timely, relevant and accountable to women, girls and other affected community members.



Excluding these actors from GBV coordination is poor practice and should not happen. During the initial or acute phase of an emergency, national-level cluster/GBV coordination group membership may be limited to agencies with the capacity to conduct assessments and deliver immediate services and programmes. However, it is essential that local actors are represented and included in GBV coordination, especially at the sub-national level.

At times, making sure that diverse local and civil society actors are involved and empowered within coordination requires adopting a flexible and creative approach, while also ensuring GBV coordination bodies work quickly to facilitate assessments, prioritize needs and mobilize resources in the early stages of response. In some clusters, the use of a 'strategic group' of humanitarian actors may be delegated by key decision-making in the short term to ensure coordination bodies are inclusive whilst also working quickly. To this end, the simple practice of issuing an agenda in advance of a meeting (outlining any key decisions that need to be made and by whom) has been highlighted as a best practice.[3]

Kathmandu, Nepal

Sub-national GBV working groups are well-positioned to:

- Adapt GBV prevention and response standards to local circumstances;
- Work closely with local authorities and other actors on the ground;
- Engage with and strengthen accountability to affected populations;
- Identify capacity gaps, problems and local solutions; and
- Support other sectors and clusters to integrate GBV risk mitigation within their operations and assistance.

National and sub-national management arrangements

GBV coordination mechanisms are usually established at the national level, with sub-national structures in place as required. Humanitarian operations that employ national and sub-national coordination arrangements have been found to be more effective than ones that coordinate through a single national mechanism.

Sub-national coordination facilitates decentralized decision-making and shortens response time. This type of coordination is critical when emergency responses take place in remote areas or extend over a large geographical area. Different regions may have different needs and – as a result – different strategic objectives and prioritization.

GBV coordination structures should only be established as needed; should build on existing groups or networks; and should be deactivated as soon as those needs are met or transitioned to locally owned and managed groups.

3 Saavedra, L. and P. Knox-Clarke, 'Better together? The benefits and challenges of coordination in the field for effective humanitarian response', Active Learning Network for Accountability and Performance and Overseas Development Institute, London, 2015.

Tips for effective GBV coordination

The following tips complement existing guidance on GBV coordination and cluster coordination. UNICEF COs can help to build and sustain effective GBV coordination by encouraging, and where relevant contributing to, the following:

a) **Support government agencies to prepare for GBV coordination in disaster- and emergency-prone contexts;**

b) **Include and involve all relevant actors in GBV coordination;**

c) **Ensure effective governance arrangements between national and sub-national mechanisms;**

d) **Review and adapt coordination arrangements over time as the situation evolves; and**

e) **Continually assess sub-cluster/working group performance.**

a) Support government agencies to prepare for GBV coordination in disaster- and emergency-prone contexts

- ✔ In disaster-prone settings, work with the government to identify how GBV fits within the national disaster management coordination architecture.
- ✔ Identify GBV coordination roles and responsibilities with relevant government ministries/agencies.
- ✔ Assist relevant government agencies to develop readiness to lead GBV coordination efforts by addressing capacity gaps in line with international standards.

b) Include and involve all relevant actors in GBV coordination

- ✔ Conduct a stakeholder analysis to identify who is and should be involved in GBV coordination. Map existing networks and groups addressing GBV, and consult with them about establishing emergency GBV coordination structures.
- ✔ Make sure national actors, civil society and governments participate, have influence and play an active role in GBV coordination alongside international organizations.
- ✔ Where there are high numbers of local actors wishing to be involved in GBV coordination with limited experience in GBV programming, consider implementing an information-sharing initiative to build knowledge about humanitarian response to GBV, including on ethics and safety.
- ✔ Establish flexible engagement models where there are many agencies wishing to participate in GBV coordination in the early stages of response. For example, establish a strategic decision-making group comprised of organizations implementing large-scale GBV programming for rapid decision-making, and establish smaller technical working groups to address other aspects of GBV response to which local actors can bring their expertise.
- ✔ Identify how to reflect the voices and perspectives of affected girls and women in coordination mechanisms. Consider creative ways of holding humanitarian actors accountable to affected girls and women through surveys, action research, representation and other methods.

c) Ensure effective governance arrangements between national and sub-national mechanisms

- ✔ Establish national GBV sub-cluster/coordination group terms of reference (TORs) and disseminate widely.
- ✔ Base sub-national cluster/sector coordination core functions and TORs on national TORs, making sure there is clarity on roles and responsibilities of national and sub-national groups.

- ✔ Develop clear lines of communication and accountability between national and sub-national working groups.
- ✔ Integrate sub-national working groups into information management and planning processes.
- ✔ Resource sub-national coordination.
- ✔ Hold national-level GBV coordination meetings after sub-national ones so that national meetings are based on and responsive to realities in the field.
- ✔ Produce written record of meetings, and make sure they are shared at both national and sub-national levels.

d) Review and adapt coordination arrangements over time as the situation evolves

- ✔ Review coordination leadership, membership, structure, management, terms of reference and other factors periodically as the situation evolves to adapt coordination arrangements to the changing context, phase of crisis and emerging capacities on the ground.

e) Continually assess sub-cluster/working group performance

- ✔ Conduct regular internal evaluation of GBV sub-cluster working group performance. For example:
  - Routinely ask members for feedback about meeting management, inclusion and other relevant factors at the end of each meeting;
  - Implement a self-assessment process to measure sub-cluster/sector progress against TORs on a quarterly basis; and
  - Put a mechanism in place to solicit feedback from affected communities regarding priorities and performance of humanitarian coordination.

The following is a checklist detailing essential actions for effective GBV coordination.

GBV coordination checklist	
Government readiness to lead GBV coordination is supported by UNICEF and other partners as part of emergency preparedness planning.	○
National and local civil society actors are represented and active in GBV coordination mechanisms, and their expertise is recognized and harnessed.	○
Management arrangements and expectations for national and sub-national GBV coordination are clearly defined and aligned, including TORs, roles, responsibilities and communication lines.	○
GBV coordination arrangements allow for timely decision-making and action, as well as participation of a diverse range of stakeholders.	○
A plan is in place for periodic review of GBV coordination arrangements.	○
Measures are in place to continually assess GBV sub-cluster/working group functioning, performance and accountability to girls and women.	○

Afgoye, Somalia

Coordinating with others

Coordination with other humanitarian clusters/sectors and with actors outside the humanitarian system is essential for preventing, mitigating and responding to GBV in emergencies. There are sometimes multiple overlapping humanitarian and peace and security mechanisms with different but complementary roles or mandates for some aspect of GBViE prevention and response. Therefore, it is vital to create strong linkages between different coordination mechanisms while respecting the mandates of others and upholding humanitarian principles.

There is no 'one size fits all' model for how GBV cluster or sectoral coordination bodies intersect and interact with other humanitarian, military, or peace and security coordination mechanisms. It is critical, however, that the relationships, areas of collaboration and parameters for information-sharing are agreed on and documented, and that all actors understand and respect the mandate and operational concerns of others – such as the imperative for humanitarian actors to maintain the perception of impartiality and neutrality.

The most appropriate framework for inter-agency coordination is best determined at the local level. Country-level coordination arrangements require a pragmatic approach that is flexible; is based on country-specific circumstances; avoids duplication of functions; and prevents overburdening actors and confusion of roles.[4] This entails, among other things, ensuring clarity, principles and procedures for humanitarian and military interaction for information sharing and protection activities.

4 Gender-Based Violence Information Management System and United Nations Action Against Sexual Violence, 'Provisional Guidance Note on the Intersections Between the Gender-Based Violence Information Management System (GBVIMS) and the Monitoring and Analysis Reporting Arrangements (MARA)', 2016.

At minimum, GBV coordination bodies *must* ensure that all other actors with a role in GBV prevention, mitigation and response are familiar with the basic standards for practice – in particular, standards pertaining to ethics, safety, survivors' rights, taking action, and those set out in the **IASC GBV Guidelines**.[5]

★ See the IASC GBV Guidelines

Examples of different inter-agency mechanisms/groups with which GBV sub-clusters/working groups commonly engage are listed below. This list is not exhaustive.

Humanitarian clusters/sectors

All humanitarian clusters/sectors have clearly defined responsibilities and essential actions they must implement to mitigate risk of GBV. Coordination is an integral strategy for implementing the essential actions to mitigate GBV in line with the **IASC GBV Guidelines**. This requires coordination between GBV and other sectoral coordination mechanisms. GBV sub-clusters/working groups play an incredibly important role in providing technical support to other humanitarian sectors, helping them better understand the nature of GBV in the context or advising them on how to implement essential sectoral actions. As a cluster lead agency for numerous clusters, UNICEF plays a key role in making sure effective inter-cluster coordination is taking place. Equally importantly, coordination between sections within UNICEF is vital for the development of integrated programming to reduce GBV risks within all UNICEF humanitarian operations.

Resources

- **Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery**
  IASC (2015)
  <http://gbvguidelines.org>

PSEA networks

Each country is expected to have an inter-agency Network on Protection from Sexual Exploitation and Abuse (PSEA). UNICEF often co-leads PSEA Networks, which serve as the primary body for coordination and oversight on preventing, mitigating and responding to sexual exploitation and abuse (SEA). The networks function under the auspices of the RC/HC, and membership includes focal points from each UN entity, NGO and international organization on the ground, including the Conduct and Discipline Unit if a UN peace-keeping mission is present. Where appropriate, government focal points are also members of the PSEA Network. The country-level network is responsible for developing an inter-agency action plan for addressing SEA in the country.

Appropriate linkages are required between the PSEA Network and other relevant coordination fora – in particular the GBV and CP sub-clusters. Coordination between GBV sub-clusters/working groups and PSEA Networks can help to ensure PSEA Networks operate within safe, ethical and good practice standards for responding to survivors of SEA. GBV sub-clusters/working groups should support PSEA Networks to:

- Implement a survivor-centred approach to SEA response;
- Establish good practice procedures for victim/survivor assistance;
- Access information regarding existing GBV referral pathways and services; and
- Ensure appropriate ongoing case management for SEA survivors.

Resources

- **Terms of Reference for In-Country Network on Protection from Sexual Exploitation and Abuse by UN/NGO/IGO Personnel, and other SEA resources**
  <www.pseataskforce.org/>

5 See <www.gbvguidelines.org>.

Peace and security actors

> *"Protection of civilians has increasingly become an objective humanitarians share with UN peace operations. Interaction between peace operations and humanitarian actors is necessary to ensure better protection outcomes by exchanging information and analysis on protection issues, and seeking ways to maximize synergies in areas of mutual concern."*[6]

In armed conflict contexts, there may be a UN political or peacekeeping mission or another international military presence with a mandate to protect civilians, including from sexual violence perpetrated in the context of armed conflict. In some settings, GBV sub-clusters or working groups may need to interact with UN Missions on conflict-related sexual violence (CRSV) issues.

In some contexts, UN forces are engaged in combat operations and are themselves a party to the conflict. In these contexts, it is essential that humanitarian agencies preserve their actual and perceived neutrality, impartiality and independence and maintain their ability to negotiate access and deliver assistance.[7] It is vital that this coordination is done through the appropriate civil-military coordination channels and in line with principles for civil-military (civ-mil) coordination.

Tools

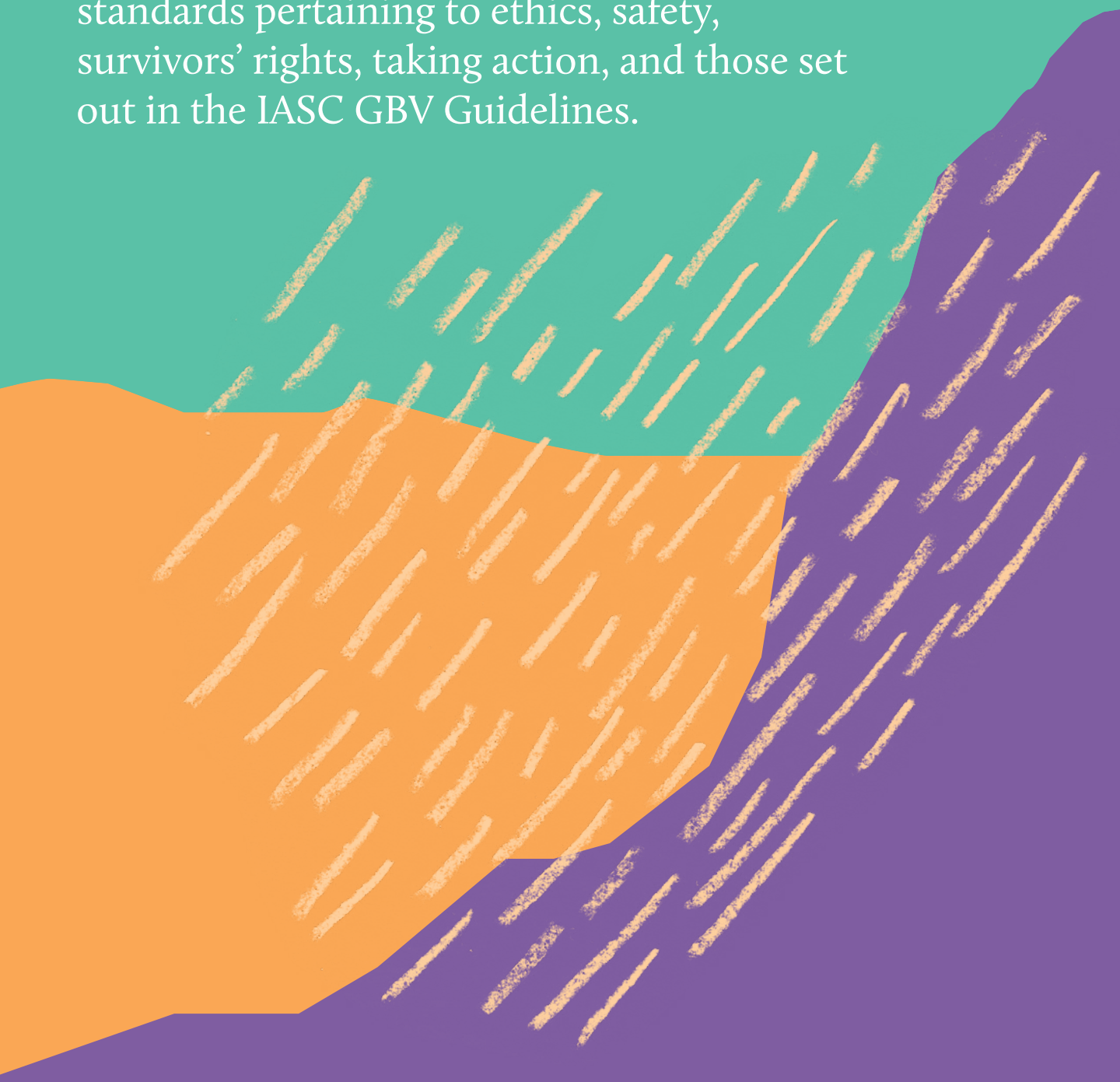
See **Kit 3.3: Programming – Building Accountability**.

Resources

- **United Nations Civil-Military Coordination Field Handbook**
  UNOCHA Civil-Military Coordination Section (2015)
  <https://docs.unocha.org/sites/dms/Documents/CMCoord%20Field%20Handbook%20v1.0_Sept2015.pdf>
- **Diagnostic Tool and Guidance on the Interaction Between Field Protection Clusters and UN Missions**
  Global Protection Cluster (2013)
  <www.globalprotectioncluster.org/_assets/files/tools_and_guidance/GPC_Diagnostic_Tool_Interaction_UN_Missions_2013_EN.pdf>
- **Civil-Military Guidelines and Reference for Complex Emergencies**
  UNOCHA (2008)
  <https://docs.unocha.org/sites/dms/Documents/ENGLISH%20VERSION%20Guidelines%20for%20Complex%20Emergencies.pdf>
- **Guidelines for the Coordination between Humanitarian Actors and the United Nations Mission in South Sudan**
  UNCT and UNMISS (2014)
  <https://docs.unocha.org/sites/dms/Documents/A05%20Guidelines%20for%20the%20Coordination%20between%20Humanitarian%20Actors%20and%20the%20UNMISS.pdf>
- **UN OCHA Humanitarian Civil-Military Coordination Publications**
  <https://www.unocha.org/legacy/what-we-do/coordination-tools/UN-CMCoord/publications>

6 von Einsiedel, S., 'Non-Military Protection of Civilians in UN Peace Operations: Experiences and Lessons', United Nations University, Tokyo, 2015.
7 Global Protection Cluster, *Diagnostic Tool and Guidance on the Interaction between field Protection Clusters and UN Missions*, GPC, Geneva, 2013.

GBV coordination bodies must ensure that all other actors with a role in GBV prevention, mitigation and response are familiar with the basic standards for practice – in particular, standards pertaining to ethics, safety, survivors' rights, taking action, and those set out in the IASC GBV Guidelines.



MRM task force and MARA working group

In settings where Security Council Resolution (SCR) 1612 applies, the Special epresentative of the Secretary-General (SRSG) or RC/HC establishes a 1612 Country Task Force for Monitoring and Reporting (CTFMR) related to the Monitoring and Reporting Mechanism (MRM). In settings where SCR 1960 applies, the SRSG or RC/HC establishes a Monitoring, Analysis and Reporting Arrangements (MARA) working group. These bodies are made up of all relevant UN entities, represented at the most senior level in-country.

This may include: representatives of the peacekeeping or political mission, UNICEF, OCHA, UNHCR, UNHCHR, UNDP, UNFPA and UN Women. The CTFMR is co-chaired by the highest UN authority in the country (whether that be the SRSG or RC/HC) and the UNICEF Representative.[9]

Collecting and reporting information on rape and other forms of sexual violence remains a significant challenge for many MRM taskforces and MARA working groups.[10] As co-lead of the CTFMR, UNICEF plays a key role in ensuring good coordination and linkages between the CTFMR, the GBV and CP sub-clusters/working groups, and MARA working groups. UNICEF also has a responsibility to promote ethical, safe, child- and survivor-centred processes and practices within the MRM – one strategy for addressing the challenge of collecting and reporting sexual violence-related information.

The MRM and MARA are expected to capitalize and build on existing human rights, child protection and GBV coordination mechanisms and databases established by UN peacekeeping missions and within the humanitarian cluster system. Particular emphasis should be placed on collaboration and coordination between peacekeeping and humanitarian actors, and such collaboration should be undertaken in a manner consistent with humanitarian principles.[11]

Tools

See **Kit 3.3: Programming – Building Accountability**.

Resources

- **Monitoring and Reporting Mechanism (MRM) on Grave Violations against Children in Armed Conflict**
  <http://watchlist.org/publications/global-study-on-the-implementation-of-the-un-led-monitoring-and-reporting-mechanism-mrm/>
- **Provisional Guidance Note: Implementation of Security Council Resolution 1960 (2010) On Women, Peace and Security**
  UN Office of the SRSG on Sexual Violence in Conflict (2011)
  <www.refworld.org/docid/4e23ed5d2.html>

8 von Einsiedel, S., 'Non-Military Protection of Civilians in UN Peace Operations: Experiences and Lessons', United Nations University, Tokyo, 2015.
9 United Nations Office of the Special Representative of the Secretary General for Children and Armed Conflict, United Nations Department of Peacekeeping Operations, and United Nations Children's Fund, *Guidelines on the Monitoring and Reporting Mechanism on Grave Violations against Children in Situations of Armed Conflict*, UNICEF, New York, 2014.
10 United Nations Office of the Special Representative of the Secretary General for Children and Armed Conflict, United Nations Department of Peacekeeping Operations, and United Nations Children's Fund, *Global Good Practices Study: Monitoring and Reporting Mechanism on Grave Violations against Children in Situations of Armed Conflict*, UNICEF, New York, 2013.
11 United Nations Action Against Sexual Violence, 'Provisional Guidance Note: Implementation of Security Council Resolution 1960 (2010) On Women, Peace and Security', UN Action, New York, 2011.

Tips for coordinating with other actors

As an agency with a responsibility for cluster leadership in a number of sectors – and one that plays a key role in monitoring and reporting sexual violence in armed conflict and promoting accountability for PSEA – UNICEF is well-positioned to promote effective interactions and complementarity between different stakeholders to improve the protection and rights of girls and women. COs can help build and sustain effective engagement between GBV coordination bodies and other humanitarian, peace and security actors in the following ways:

a) **Agree on the coordination architecture and relationships; and**

b) **Provide technical support and guidance on ethical, safe, and child- and survivor-centred principles of GBV coordination.**

a) Agree on the coordination architecture and relationships

- ✔ Identify each mechanism/group with a mandate for some aspect of GBV prevention and response, including humanitarian cluster/sectors, PSEA Networks, the MRM task force, the MARA working group, and other UN political or peace-keeping mission bodies, such as civ-mil coordination mechanisms.
- ✔ Clarify, document and share information about the mandate and scope of operations of each mechanism/group.
- ✔ Agree on the coordination architecture, relationships, and methods of communication and collaboration between the GBV sub-cluster/working group and each of the other groups. For instance, bring MARA, MRM, GBV and CP sub-cluster/working group lead agencies together to define the coordination architecture, linkages, principles and procedures for interaction on CRSV monitoring and response.
- ✔ Identify a Focal Point within the GBV sub-cluster for each of the other issues/mechanisms – for example, a Focal Point for CRSV, MARA or MRM.
- ✔ Where there are UN peacekeeping missions, develop Standard Operating Procedures (SOPs) for coordination between humanitarian and UN peacekeeping missions that set out mandates and processes for collaboration on GBV/CRSV information sharing, joint assessment and planning for protection of civilians.

b) Provide technical support and guidance on ethical, safe, and child- and survivor-centred principles of GBV coordination

- ✔ Sensitize other actors – including other clusters/sectors, human rights monitors and organizations, and civilian and military personnel within UN missions – on survivor-centred principles and practices in monitoring and reporting GBV, including CRSV.
- ✔ Provide training to MRM, MARA, PSEA and civ-mil protection of civilian mechanisms to ensure all information collection and sharing, service delivery, and accountability processes are premised on survivors' rights to safety, confidentiality and self-determination.
- ✔ Support the development of guidance for operationalizing ethical and safe survivor-centred principles within MRM and MARA monitoring, including special considerations for children. Guidance must explicitly address:
  - Safety and confidentiality of all individuals who provide information about sexual violence and other forms of GBV to UN-led monitoring mechanisms;
  - Self-determination and informed consent regarding information sharing; and
  - The best interests of the child in all monitoring procedures and practices.

Sin Chai, Viet Nam

The following is a checklist detailing essential actions for effective GBV coordination with others.

Coordinating with others checklist	
Inter-agency coordination architecture is agreed upon with clearly defined mandates, areas of collaboration and communication protocols between the GBV sub-cluster and different groups in place.	○
CRSV, PSEA, MARA, MRM and cluster liaison Focal Points are in place within the GBV sub-cluster/working group.	○
SOPs are in place for civil-military engagement and coordination on CRSV.	○
Other actors are sensitized on survivor-centred principles and practices when collecting and sharing GBV-related information and engaging with survivors.	○
Training is offered to MRM, MARA, PSEA and civ-mil protection of civilian mechanisms on survivors' rights, ethics and safety.	○

Iraq

Rapid GBV Assessments

Tools

Tools referenced in this section can be found in the *Minimum GBViE Response Package Tools Booklet* of this Kit.

Rapid Assessment Tool 1: Good Practice Checklist

Rapid Assessment Tool 2: GBV Service Mapping Tool

Rapid Assessment Tool 3: GBV Service Capacity and Quality Audit Tool

Rapid Assessment Tool 4: Barriers to Care Analysis and Planning Tool

Rapid Assessment Tool 5: WASH and Dignity Kit Sample Focus Group Discussion Guide

Rapid Assessment Tool 6: GBV Risk and Safety Focus Group Discussion Guide

Rapid Assessment Tool 7: GBV Risk and Safety Key Informant Interviews

Rapid Assessment Tool 8: Participatory Safety Mapping Exercise

Rapid Assessment Tool 9: Participatory Safety Walk Guide

Rapid Assessment Tool 10: GBV Risk and Safety Observation Guide

Rapid Assessment Tool 11: Community Safety Planning Guide

Introduction to rapid GBV assessments

Rapid assessments consist of information gathering and analysis exercises that are focused solely on the GBV situation in a specific emergency setting. They are carried out by GBV actors, including UNICEF and partners, to identify and prioritize immediate needs and gaps in GBV prevention and response, as well as to support the design, monitoring and evaluation of GBV interventions.

Generating and sharing information on GBV in an emergency may have any or all of the following objectives:

- To investigate the nature, scope and scale of GBV occurring and to understand who is affected and how;
- To identify and address immediate needs of survivors of GBV;
- To identify capacity, gaps and barriers in survivor-centred systems and services for care, support and safety;
- To investigate risk and to implement risk mitigation options for reducing girls' and women's vulnerability to GBV;
- To engage humanitarian actors across sectors in identifying, analysing and addressing risks and reducing vulnerabilities, in line with the **IASC GBV Guidelines**; and
- To generate baseline data for programme monitoring and evaluation.

★ See the IASC GBV Guidelines

A rapid GBV assessment aims to collect and analyse *basic information about the GBV situation* to inform UNICEF's and partners' immediate response, in line with UNICEF's Minimum GBViE Response Package.

During the acute phase of an emergency, rapid assessments are used to gather information about the immediate needs of affected girls and women, as well as safety risks and solutions for protecting girls and women from GBV.

UNICEF may conduct a rapid GBV assessment with partners in the following circumstances:

- In the days and weeks following a sudden-onset emergency, where there is inadequate existing information and no inter-agency or sub-cluster assessments are planned; and/or
- In protracted or complex contexts, where the security or humanitarian situation changes significantly and no inter-agency or sub-cluster assessments are planned.

It is important to recognize that rapid assessments reflect a 'snapshot' in time, and the findings need to be acted on as quickly as possible.

For more information on how to do rapid assessments, see **Kit 2: Assessment**.

This section is linked to tools to assist COs and partners in undertaking rapid GBV assessments in emergency contexts. A rapid GBViE assessment aims to collect and analyse *basic information about the GBV situation* to inform UNICEF's and partners' *immediate response* to GBV, and advocate for humanitarian actors and duty bearers to act to meet the needs of survivors and prevent further GBV from occurring.

When to do rapid assessments

UNICEF may undertake a rapid GBV assessment in the days and weeks following an emergency, where there is inadequate existing information and no inter-agency or sub-cluster assessments are planned; as well as when the security or humanitarian situation changes significantly in complex contexts, and there are no inter-agency or sub-cluster assessments planned.

During the acute phase of an emergency, rapid assessments are used to gather information about the immediate needs of affected girls and women, as well as problems and solutions for protecting girls and women from GBV.

UNICEF uses information generated from rapid assessments to inform the following priority actions:

1. To design and deliver a minimum GBViE response package; and
2. To advocate on behalf of girls and women with clusters/sectors, government and other duty bearers for action to improve GBV care and support services and to prevent GBV.

The eleven tools in this section are designed to facilitate rapid collection of relevant information to enable UNICEF and partners to deliver the Minimum GBViE Response Package.

Assessment tools included in this section that are associated with different aspects of the Minimum Response Package are listed in the table below.

Minimum GBViE Response Package	Rapid GBV Assessment Tool
Age-appropriate clinical and crisis care for sexual assault	Tool 2: GBV Service Mapping Tool Tool 3: GBV Service Capacity and Quality Audit Tool Tool 4: Barriers to Care Analysis and Planning Tool
Dignity kits	Tool 5: WASH and Dignity Kit Sample Focus Group Discussion Guide
Community safety assessments and plans **GBV risk mitigation across clusters and sectors**	Tool 6: GBV Risk and Safety Focus Group Discussion Guide Tool 7: GBV Risk and Safety Key Informant Interviews Tool 8: Participatory Safety Mapping Exercise Tool 9: Participatory Safety Walk Guide Tool 10: GBV Risk and Safety Observation Guide Tool 11: Community Safety Planning Guide

Before an assessment

- ✓ **Analyse all existing information on the humanitarian and GBV situation**, including information about the affected population and their circumstances, what is known about GBV before the crisis/emergency, and information generated since. Make sure to review literature, research, reports, service data, etc.
- ✓ **Plan the assessment carefully**, identifying the objectives, timeframe, proposed tools and resources required, including the size of the team and their training needs.
- ✓ **Conduct a risk assessment,** considering risks associated with the assessment itself, as well as risks associated with specific assessment activities and methods, such as focus group discussions with affected communities and safety walks.
- ✓ **Adapt the tools** to meet the assessment objectives, the context and the culture. Always consider the balance between the need to collect data from multiple sources and the need to collect and analyse information quickly to take immediate action to improve girls' and women's safety.
- ✓ **Make sure that the circumstances and needs of marginalized groups are reflected** in assessment objectives and tools. (See Info Sheet on **At-Risk Groups** in *Section 5*).
- ✓ **Identify how information will be fed back to the community.**

Resources

Population-specific assessment resources

Survivors and children born of rape

- **Research Toolkit: Understanding and addressing the needs of survivors and their children born of sexual violence in conflict**
  UNICEF (2012)

Adolescent girls

- **Strong Girls, Powerful Women: Program planning and design for adolescent girls in humanitarian settings**
  Women's Refugee Commission (2014)
  <www.womensrefugeecommission.org/girls/resources>
- **Girl Safety Toolkit**
  Girl Hub (2014)
  <www.girleffect.org/media?id=3050>
- **Girls in Emergencies and Humanitarian Settings Resource List**
  Coalition for Adolescent Girls
  <http://coalitionforadolescentgirls.org/resources-by-topic-2/>

Girls and women with disabilities

- **I See That its Possible: Building Capacity for Disability Inclusion in Gender-based Violence (GBV) Programming in Humanitarian Settings**
  Women's Refugee Commission (2015)
  <www.womensrefugeecommission.org/disabilities/disability-inclusion>
- **Including Adolescent Girls with Disabilities in Humanitarian Programs**
  Women's Refugee Commission (2015)
  <www.womensrefugeecommission.org/girls/resources/1252-girls-disabilities-2015>
- **Working to Improve Our Own Futures: Inclusion of Women and Girls with Disabilities in Humanitarian Action**
  Women's Refugee Commission (2016)
  <www.womensrefugeecommission.org/disabilities/resources/1342-networks-women-disabilities>

Other

- **Rapid Humanitarian Assessments in Urban Settings**
  Assessment Capacities Project (April 2015)
  <www.acaps.org/resources/assessment#resource-572>

Waryuguleh, Ethiopia

Overview of the tools

Tool	Purpose
Tool 1: Good Practice Checklist	To assist UNICEF and partner staff in undertaking rapid GBV assessments in line with **good practice** principles.
Tool 2: GBV Service Mapping Tool	To map **availability** of existing GBV response services and document information about them. The tool will help UNICEF and partners to: • Identify which services are currently available for adult and child GBV survivors in a geographical area; • Identify key service gaps; and • Develop a directory of services and begin the process of developing inter-agency referral protocols.
Tool 3: GBV Service Capacity and Quality Audit Tool	To assess the **capacity and quality** of health, psychosocial and safety services for GBV survivors. The tool will help UNICEF and partners to: • Learn about types of GBV being reported to service providers; and • Identify gaps in survivor-centred clinical management, crisis care and immediate safety services for sexual violence survivors and those at-risk.
Tool 4: Barriers to Care Analysis and Planning Tool	To help identify and address **barriers** faced by different groups in the community in accessing GBV services. The tool will help UNICEF and partners to: • Learn from the community about barriers to service; and • Identify solutions to the barriers.
Tool 5: WASH and Dignity Kit Sample Focus Group Discussion Guide	To assess the needs and preferences of adolescent girls and women to guide procurement of **Family Hygiene and Dignity Kits**. The tool will help UNICEF and partners to: • Learn about menstrual hygiene management practices and preferences; and • Identify appropriate gender-sensitive non-food items (NFIs) to increase dignity and safety for adolescent girls and women.
Tool 6: GBV Risk and Safety Focus Group Discussion Guide	To use semi-structured in-depth discussions with different groups of females and other community members to learn about **GBV risks and responses**. The tool will help UNICEF and partners to learn more about: • Perceptions of GBV risk and safety solutions in the community; • Types of GBV community members are concerned about; and • Community responses to sexual violence.

Tool	Purpose
Tool 7: GBV Risk and Safety Key Informant Interviews	To collect information from different community members and camp management actors/local authorities about **service-related GBV risks** in the setting. This provides UNICEF and partners with an opportunity to learn about: • Different perceptions of girls' and women's risk and safety in the community; • Danger zones in the setting; • Existing strategies for improving safety; and • Specific risks associated with basic services such as shelter, food, water and security.
Tool 8: Participatory Safety Mapping Exercise	To learn from different groups of girls and women about: • Their key **safety concerns** in the community; • Locations where they feel safe and unsafe, and threats that contribute to this; and • Strategies for improving their safety and protection.
Tool 9: Participatory Safety Walk Guide	To enable adolescent girls and women to identify and articulate the **safety concerns and problems** they face in particular geographical areas and in accessing services. Where safe and appropriate to do so, this tool empowers them to communicate directly with service providers and other duty bearers regarding their safety needs and to engage in joint problem-solving and decision-making regarding safety and protection.
Tool 10: GBV Risk and Safety Observation Guide	To assist in the collection and recording of observations related to girls' and women's **safety and security** in a camp or community to help build an understanding of the GBV situation. The tool may be used in one of two ways: • To triangulate information generated through other rapid assessment activities – for example, to complement information collected in focus group discussions and key informant interviews; or • As the main information collection method in insecure environments where asking community members questions about the GBV situation might put them at risk – for example, in settings where there is a military presence within a camp or community.
Tool 11: Community Safety Planning Guide	To bring community stakeholders together to analyse gaps in safety and accountability identified through the rapid assessment process, and to strategize how to make changes to enhance the safety of girls and women and develop **safety action plans**. This tool helps to: • Mobilize affected communities to improve girls' and women's safety and protection from GBV; • Strengthen the capacities of rights holders to make their claims; • Strengthen the capacities of duty bearers to meet their obligations toward the protection of emergency-affected populations; and • Promote girls' and women's voices, visibility and agency in humanitarian relief planning and management.

Sapa, Vietnam

Responding to GBV Survivors in Emergencies

Info Sheets

Health Consequences of GBV

Boys and Sexual Abuse

Minimum Initial Services Package (MISP)

Age-Appropriate Healthcare for GBV Survivors

Psychological First Aid

Addressing GBV-Related Risks in Health Assessments and Initial Programme Design

Psychological, Emotional and Social Consequences of GBV

Defining 'Psychosocial' and 'Mental Health'

Psychosocial Care Actors

Suicide Risk Assessment and Response

Vicarious Trauma

Alternative Care for Children

Considerations for Setting up Safe Houses/Shelters

Tools

Tools referenced in this section can be found in the *Minimum GBViE Response Package Tools Booklet* of this Kit.

Healthcare Tool 1: GBV Health Response Audit Tool

Healthcare Tool 2: Health Facility Readiness for Clinical Management of Rape Services Checklist

Healthcare Tool 3: Client Satisfaction Survey

Healthcare Tool 4: Health Service Monitoring Sheet

Psychosocial Support Tool 1: Psychosocial Response Audit Tool

Psychosocial Support Tool 2: Participatory Psychosocial Service Assessment and Monitoring Tool

Psychosocial Support Tool 3: Client Satisfaction Survey

Psychosocial Support Tool 4: Psychosocial Service Monitoring Sheet

Safety Tool 1: GBV Survivor Safety Response Audit Tool

Safety Tool 2: Safe Shelter Policy and Procedures Template

Safety Tool 3: Sample Shelter Worker Job Description

Safety Tool 4: GBV Safety Service Monitoring Sheet

Healthcare for GBV Survivors

Why healthcare for survivors is important

Health Consequences of GBV

Minimum Initial Services Package (MISP)

Survivors of GBV have the right to the highest attainable standard of health. GBV has many serious short-and longer-term **health consequences**, including injury and trauma, sexually transmitted diseases, reproductive health problems and unwanted pregnancy. At its worst, GBV can be fatal. Poor health status associated with GBV has a direct impact on survivors' family functioning, economic and community participation, mobility, and educational attendance and attainment.

Appropriate healthcare for sexual violence and other forms of GBV is a life-saving intervention in emergency-affected areas. Health response to reduce mortality and morbidity associated with sexual violence is a priority from the first stages of humanitarian action.

Boys and Sexual Abuse

While most survivors of sexual violence are girls and women, males also experience sexual violence. Men and **boys** who are survivors of sexual violence should also have access to good quality care and support services, as all survivors need, and have the right to, care and support to help them heal and recover from violence. Humanitarian actors must work together to make services available to *all* survivors, regardless of their gender or age.

Conflict and disasters disrupt healthcare systems, many of which are already fragile in resource-poor settings. As a result, health services for sexual violence survivors may be limited in the aftermath of the emergency. The humanitarian community plays a critical role in ensuring adequate coverage and quality of services for the medical management of sexual violence and other forms of GBV. From the onset of a humanitarian crisis, response to sexual violence should be delivered in line with the **Minimum Initial Service Package (MISP)** for Reproductive Health (RH). The MISP is a standard for humanitarian actors[1] and outlines which RH components are most important in preventing death and disability – particularly among girls and women.

Capacity Development

- **Minimum Initial Service Package (MISP) for Reproductive Health in Crises Distance Learning Module**
  Interagency Working Group in Reproductive Health in Crisis
  <http://iawg.net/minimum-initial-service-package/>

1 The MISP is a standard in the Sphere *Minimum Standards in Disaster Response*, as well as in Inter-Agency Standing Committee (IASC) Health Cluster tools and guidance. The MISP also meets the life-saving criteria for the Central Emergency Response Fund (CERF).

UNICEF's health response to GBV

CCC Health Programme Actions[2]

Ensure the re-establishment of disrupted essential care services for women and children, including the provision of essential drugs, diagnostics and supplies.

Priority essential health services will include clinical and psychosocial services for victims of sexual violence and/or child abuse.

Objectives

Age-Appropriate Healthcare for GBV Survivors

In line with UNICEF's Core Commitments for Children in emergencies (CCCs),[3] UNICEF country office (CO) Child Protection, Health and HIV sections should collaborate on planning and delivering interventions to improve access to **age-appropriate GBV-related health services**, with a priority focus on clinical management of sexual violence in the early stages of an emergency or during complex situations.

The objectives of UNICEF's health response to GBViE include:

- To promote child and adult survivors' rights to the highest attainable standard of health through increasing availability, accessibility and quality of clinical sexual assault services; and
- To support national health systems[4] in responding to GBV through emergency preparedness and ongoing response and recovery efforts.

A phased approach to healthcare

A holistic and phased healthcare response to GBV involves taking actions *before* emergencies happen, *during* the initial phases of humanitarian response, and as part of *ongoing response and recovery efforts*.

Emergency preparedness

Prior to the outbreak of an emergency, UNICEF's healthcare response to GBV involves strengthening national systems for GBV-related health service delivery and building the capacity of national actors to plan for and respond to emergencies.

Immediate response

Immediately following a rapid-onset disaster, and during complex and protracted emergencies, UNICEF's health response centres on supporting international and national actors to make CMR services for child, adolescent and adult survivors available. This involves making the following sex- and age-appropriate treatments available:

- The option of emergency contraception (EC);
- Preventative treatments for sexually transmitted infections (STIs);
- Post-exposure prophylaxis (PEP) for prevention of HIV transmission;
- Tetanus and hepatitis B vaccinations;
- Wound care; and
- Basic crisis support.

2 United Nations Children's Fund, 'Core Commitments for Children in Humanitarian Action', Health Commitment Programme Actions, UNICEF, New York, 2010, p. 26.
3 See <www.unicef.org/publications/index_21835.html>.
4 A good health system requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities; and logistics to deliver quality medicines and technologies.

Dhaka, Bangladesh

Ongoing response and recovery

Psychological First Aid

Once a minimum set of sexual assault services are universally available for emergency-affected populations, UNICEF's efforts focus on building the capacity of national health systems to deliver comprehensive health response to all forms of GBV. Comprehensive health response includes making the following age-appropriate services available:

- Comprehensive CMR services, including wound and injury management, preventative treatment for STIs, emergency contraception, and PEP for HIV/AIDS;
- Follow-up treatment and care for chronic physical health outcomes for all forms of GBV and associated health problems (for example, fistula repair);
- Voluntary counselling and testing (VCT) for HIV;
- HIV treatment, care and support services;
- Crisis support, sometimes known as **'psychological first aid'**;[5]
- Mental health assessment and management, such as psychological or psychiatric evaluation and care;
- Health-related legal services (known as 'medico-legal' services), such as preparation of documentation and giving evidence in justice processes;
- Health information and surveillance mechanisms; and
- Public health information and education campaigns.

5 Crisis support is sometimes called 'psychological first aid'; however, in a survivor-centred model, the terms 'crisis care' or 'crisis support' are preferred. While they can be the same thing, psychological first aid is only used immediately following a crisis or traumatic incident, whereas crisis support or counselling may be provided throughout a survivor's recovery.

In addition to making a minimum set of services available, health response to GBViE must address barriers girls and women face in access to healthcare services and facilities, such as:

- Distance to health facilities;
- Policies that stipulate pre-requisites for medical examination and treatment; and
- Costs associated with care, including transport, fees for medical examination and treatment, accommodation, costs of medico-legal procedures, etc.

Resources

Key international guidelines for health response to GBV

Emergency phase

- **Reproductive health-related resources to implement the minimum initial service package (MISP) at the onset of an emergency**
  Interagency Working Group on Reproductive Health in Emergencies
  <http://iawg.net/areas-of-focus/misp/>
- **Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons**
  World Health Organization (2004)
  <www.who.int/reproductivehealth/publications/emergencies/924159263X/en/>
- **Caring for Child Survivors of Sexual Abuse in Humanitarian Settings**
  International Rescue Committee/ UNICEF (2012)
  <http://gbvresponders.org/response/caring-child-survivors/>
- **Mental Health and Psychosocial Support in Humanitarian Emergencies: What should humanitarian health actors know?**
  Inter-Agency Standing Committee
  <www.who.int/mental_health/emergencies/what_humanitarian_health_actors_should_know.pdf>
- **Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings**
  UNFPA and Save the Children USA (2009)
  <www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf>
- **Guidelines for HIV/AIDS Interventions in Emergency Settings**
  Inter-Agency Standing Committee
  <http://data.unaids.org/publications/External-Documents/iasc_guidelines-emergency-settings_en.pdf>
- **Guidelines for the Care of Sexually Transmitted Infections in Conflict-Affected Settings**
  Women's Refugee Commission (2004)
  <www.womensrefugeecommission.org/resources/document/602-guidelines-for-the-care-of-sexually-transmitted-infections-in-conflict-affected-settings>

Preparedness/ongoing response and recovery

- **Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO clinical and policy guidelines**
  World Health Organization (2013)
  <http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf>
- **Healthcare for Women Subjected to Intimate Partner Violence or Sexual Violence: A clinical handbook**
  World Health Organization (2014)
  <http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf>
- **Guidelines for Medico-Legal Care for Victims of Sexual Violence**
  World Health Organization (2003)
  <www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/>
- **Working with Men and Boy Survivors of Sexual and Gender-Based Violence in Forced Displacement**
  UNHCR (2012)
  <www.refworld.org/pdfid/5006aa262.pdf>

Resources (continued)

- **Improving the Health Sector Response to Gender-Based Violence: A resource manual for healthcare professionals in developing countries**
  International Planned Parenthood Federation (2010)
  <www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf>
- **Mainstreaming Emergency Contraception in Developing Countries: A Toolkit for Policy Makers and Service Providers**
  Population Council (2013)
  <www.popcouncil.org/uploads/pdfs/2013RH_ECToolkit.pdf>
- **Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents Who Have Experienced Sexual Violence: A companion guide**
  United States Agency for International Development (2016)
  <https://aidsfree.usaid.gov/sites/default/files/2016.2.1_aidsfree_comp_guide_gender_tagged.pdf>
- **Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies: mhGAP humanitarian intervention guide**
  World Health Organization (2016)
  <http://apps.who.int/iris/bitstream/10665/162960/1/9789241548922_eng.pdf?ua=1>

Considerations for country offices

After conducting a **determinants analysis** and deciding on UNICEF's health response in emergencies, COs should consider:

- How best to **integrate GBV health services** into other UNICEF health interventions and services;
- **Critical needs and gaps** in availability, accessibility and quality of healthcare;
- How to best **complement and work with other organizations** providing healthcare to survivors;
- **Capacity of partners** to assess, manage and monitor healthcare interventions, and the level of need for ongoing training, supervision and monitoring; and
- **UNICEF's capacity to procure, store, transport and manage resources,** including equipment, supplies, financial resources and logistical support.

Where it is *not* deemed appropriate for UNICEF to deliver GBV-related health interventions, the CO should advocate within the Health cluster for the implementation of the MISP from the outset of an emergency.

Santarem, Brazil

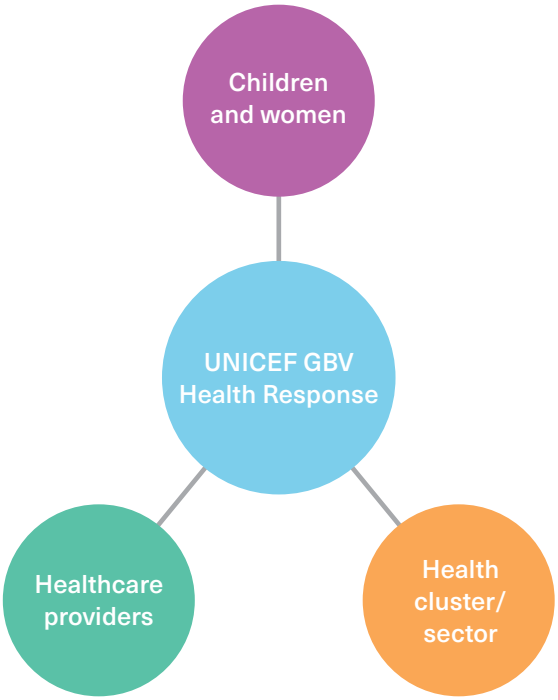
Stakeholders in health response to GBV

CO Child Protection, Health and HIV sectors should work together to collect relevant information and plan and manage UNICEF's health response to GBViE. **Key stakeholders** in the assessment, design and implementation of GBV health programmes include:

- Children (especially girls) and women;
- Healthcare providers, including government, non-government and other humanitarian and community service providers; and
- The Health cluster or alternative sector coordination mechanisms.

Children and women

It is essential to consult with affected girls and women of different ages to learn about the knowledge, attitudes, norms and behaviours relating to help-seeking after experiencing GBV, as well as the barriers faced by children, adolescents and adults in accessing GBV-related healthcare. Consulting with different age groups to ascertain the problems and barriers faced by different groups of survivors is essential to ensuring that all survivors can access healthcare.



While it may not be possible to consult extensively, especially in the early days of emergency response, some discussions must be held with representatives from affected communities, such as children's and women's groups and networks. In areas where there are cyclical emergencies, it is easier to have discussions with girls and women as part of emergency preparedness planning.

Healthcare providers

During emergency response, government and non-government healthcare providers may already be delivering CMR services, and national and international humanitarian health actors operating in displaced and community settings are key partners in delivering GBV health services and strengthening systems. During preparedness and recovery, emphasis should be placed on working with the national Health sector to ensure a regulatory and policy environment is in place that is conducive to fulfilling survivors' rights to health. In situations where the state is unable or unwilling to fulfil these rights, UNICEF works to support alternative service delivery systems.

Health cluster and other sector coordination mechanisms

GBV health services are planned in coordination and collaboration with the Health sector. National Health sector coordination actors and cluster leads will provide valuable information on the regulatory and policy environment – such as national essential medicines lists and treatment protocols; geographic focus and coverage gaps in GBV-related health service delivery; and selecting the most effective models of service delivery.

Steps in GBV health response

There are three steps to ensuring a good quality UNICEF health response to GBV:

Step 1: Assessment and design
- 1.1 – Assessing the context
- 1.2 – Results-based programme design

Step 2: Implementation
- 2.1 – Fostering positive social norms related to GBV help-seeking
- 2.2 – Creating an enabling legal and policy environment for GBV-related healthcare
- 2.3 – Strengthening health service capacity and improving quality of care
- 2.4 – Coordinating with others

Step 3: Monitoring
- 3.1 – Selecting indicators to monitor progress and quality

Step 1: Assessment and design

1.1 Assessing the context

Addressing GBV-Related Risks in Health Assessments and Initial Programme Design

In the **early stages of an emergency**, assessment of GBV healthcare focuses on collecting information about:

- The availability of, access to and quality of CMR services; and
- Help-seeking knowledge, behaviours and barriers.

During the **preparedness phase and ongoing response and recovery**, GBV health assessments analyse:

- GBV-related healthcare systems and services, including the availability of, access to and quality of healthcare for all forms of GBV prevalent in the context; and
- Community uptake and use of health services in line with the health determinant analysis.

Tools

Healthcare Tool 1: GBV Health Response Audit Tool

See *Section 3: Rapid GBV Assessments* in this book.

1.2 Results-based programme design

UNICEF applies a **results-based approach** to programme design so that:

- ✔ Interventions are based on a logical pathway for creating impact;
- ✔ Interventions are results-oriented, and changes or effects are clearly identified; and
- ✔ Interventions can be monitored and evaluated.

Once priority needs, capacities, gaps and bottlenecks in GBV health service delivery have been assessed, design of UNICEF's GBViE health interventions involves the following:

1. **Identify UNICEF's role, priorities and partnerships** for (1) addressing bottlenecks and barriers to the availability, accessibility and quality of clinical sexual assault services and/or (2) supporting national health systems to respond to GBV.
2. **Define the desired results or outcomes of UNICEF and partner interventions** in one or more of the following areas:
   - Fostering positive social norms related to GBV help-seeking;
   - Creating an enabling legislative and policy environment;
   - Strengthening health service capacity and improving quality of care; and/or
   - Building community knowledge and uptake of GBV health services.
3. **Identify outputs and strategies for achieving the outcomes, as well as indicators** for measuring progress during implementation. See below for key strategies for promoting access to good quality healthcare.
4. **Review and finalize the programme design** prior to implementation, ensuring its alignment with best practices, ethics and safety. Don't forget to consider how the health interventions will be evaluated as part of programme design.

Tools

See **Kit 4: Evaluation** for more information about different types of evaluative activities in emergency settings.

Key strategies for promoting access to good quality healthcare include:

- *Training and development* – for example, training of different levels of health workers and different organizations involved in health support.
- *Advocacy* – for example, advocating with humanitarian donors for increased funding and coverage of health services, or advocating with local authorities to amend policies that block access to healthcare.
- *Technical support* – for example, providing technical expertise in legislative or policy review processes.
- *Funding* – for example, funding health providers to deliver CMR services in the early stages of emergency response, or funding government GBV health policy implementation during preparedness and recovery.
- *Operational assistance and inputs* – for example, supplying clinics with essential CMR-related drugs and equipment for child, adolescent and adult survivors.
- *Communication interventions* – for example, delivering information, providing education and creating dialogue with the community on the importance and benefits of seeking healthcare after sexual assault.

Examples of strategies in different phases of emergency health response are shown on the following page.

Examples of strategies to strengthen healthcare

Determinant	Immediate response	Preparedness/Ongoing response/Early recovery
Enabling environment	• Facilitate community education on the harms associated with sexual violence and the importance of supporting survivors' access to healthcare. • Advocate within the humanitarian system for implementation of the MISP. • Advocate within the humanitarian system for adequate funding for GBV-related healthcare. • Advocate for removal of policy or procedural barriers that prevent survivor from accessing healthcare.	• Deliver social norm change interventions using multiple communication and media channels to reduce stigma and silence associated with sexual violence and other forms of GBV and to promote help-seeking. • Audit legal and policy framework for age-appropriate GBV health service delivery, and identify areas for policy review and development. • Provide technical and financial assistance to develop and implement national health policies and protocols for sustainable scale-up of GBV health services.
Supply and quality	• Train government and non-government health service providers in line with protocols and standards for survivor-centred care. • Fund non-government health providers to deliver post-rape care. • Procure and supply essential drugs and equipment. • Provide technical support for inter-agency referral system to link survivors accessing healthcare with psychosocial, safety and legal support. • Provide technical support for the implementation of GBV health information systems.	• Pre-position essential CMR-related drugs and equipment for child and adult rape survivors. • Conduct gap analysis of local and national capacities in GBV health systems and services. • Fund and provide technical support to national health services to develop and implement GBV health protocols in line with international standards, and establish and monitor clinical services. • Train and supervise government healthcare providers in line with international standards and survivor-centred care. • Provide technical support for the establishment of GBV-related health surveillance systems.
Demand	• Deliver information campaigns to build community knowledge about existence of services and benefits of healthcare. • Raise awareness on signs of sexual violence in children, as children (especially those with disabilities) may not be able to report violence themselves.	• Implement communication strategies to promote community support for survivor help-seeking.

Resources

- **UNICEF Programme Policy and Procedures Manual**
  - Chapter 3: Programme Preparation
  - Chapter 4: Programme Implementation and Management

  <https://unicef.sharepoint.com/teams/OED/PPPManual/SiteAssets/Welcome%20to%20the%20Programme,%20Policy%20and%20Procedure%20Manual.aspx?wa=wsignin1.0>

- **UNICEF Technical Notes: Special Considerations for Programming in Unstable Situations**
  <www.mona.uwi.edu/cardin/virtual_library/docs/1255/1255.pdf>

Capacity Development

- **UNICEF Programme Planning Process (PPP) e-learning course**
  <https://agora.unicef.org/course/info.php?id=6825>

Step 2: Implementation

Implementing a good quality healthcare response to GBViE involves fostering positive social norms; creating an enabling legal and policy environment; strengthening capacity and improving quality of care; and coordinating with others.

2.1 Fostering positive social norms related to GBV help-seeking

In situations where discriminatory social norms prevent survivors from accessing healthcare – for example, by maintaining silence about sexual violence or causing providers to blame and re-traumatize survivors – **communication for change interventions** can help foster positive norms that encourage, rather than inhibit, help-seeking and that support a survivor's recovery.

Communication strategies that use multiple channels of communication achieve a higher proportion of positive outcomes. Strategies must extend beyond individuals and households to include service providers, traditional and religious leaders, and decision-makers at different levels to engender community-wide change.[6]

Resources

- **Behaviour Change Communication in Emergencies: A toolkit**
  UNICEF (2006)
  <www.unicef.org/rosa/Behaviour.pdf>

- **Communication for Humanitarian Action Toolkit (CHAT) Working Version**
  UNICEF (May 2015)
  <www.unicefinemergencies.com/downloads/eresource/docs/Communication%20for%20Development/6-C4D-CHAT_Proof-2.pdf>

- **Communities Care: Transforming Lives and Preventing Violence Toolkit**
  UNICEF (2014)

- **Shifting Social Norms to Tackle Violence Against Women and Girls**
  United Kingdom Department for International Development (2016)
  <www.gov.uk/government/uploads/system/uploads/attachment_data/file/507845/Shifting-Social-Norms-tackle-Violence-against-Women-Girls3.pdf>

- **Social Norms Professional Development Pack**
  GSDRC/University of Birmingham (2016)
  <www.gsdrc.org/professional-dev/social-norms/>

6 Marcus, R and Page, E., 'Changing discriminatory norms affecting adolescent girls through communication activities: A review of evidence', Overseas Development Institute, London, 2014.

2.2 Creating an enabling legal and policy environment for GBV-related healthcare

The legal and policy context related to sexual violence and other forms of GBV has a strong influence on survivors' access to and uptake of healthcare. In some settings, existing laws and policies may prevent survivor-centred healthcare from being fully accessible in emergencies. For example, in some settings, legislation criminalizes victims or witnesses to rape. Policies stipulating that survivors must report to police before being able to access healthcare can also create barriers to care. In some countries, healthcare providers may be obliged to report cases of child sexual abuse and/or other forms of sexual violence; in some jurisdictions, it can be a crime not to.

Where such barriers do exist, UNICEF COs can play a critical role in catalysing positive change. In **preparedness and recovery phases**, COs can support government health-related law and policy reform efforts; they can also support the implementation of health legislation and policies that promote age-appropriate GBV-related healthcare.

During **immediate response**, UNICEF and partners can advocate with national and/or local officials to amend or change policies that create barriers to healthcare – or simply increased awareness on established policies that will help reduce these barriers. For example, in settings where there is a mistaken belief that a rape survivor must first report to police before seeking medical care, UNICEF and partners may implement an information and education campaign to officials, service providers and the public to ensure they have correct information. In other settings where it *is* stipulated that rape survivors must go first to police before seeking medical treatment, UNICEF and partners may advocate with authorities for a change to this policy.

Resources

- **Handbook on Legislative Reform: Realizing child rights**
  UNICEF (2008)
  <www.unrol.org/files/Handbook%20on%20Legislative%20Reform.pdf>
- **Justice in Matters Involving Child Victims and Witnesses of Crime: Model law and related commentary**
  UNDOC and UNICEF (2009)
  <www.unicef.org/albania/Justice_in_matters.pdf>
- **Legislative Reform on Selected Issues of Anti-Gender Discrimination and Anti-Domestic Violence: The impact on children**
  UNICEF (2009)
  <www.unicef.org/policyanalysis/files/Legislative_Reform_on_Selected_Issues_of_Anti-Gender_Discrimination_and_Anti-Domestic_Violence_-_the_Impact_on_Children.pdf>
- **Handbook for Legislation on Violence Against Women**
  United Nations Department of Economic and Social Affairs (2010)
  <www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>
- **Do Our Laws Promote Gender Equality? A handbook for CEDAW-based legal reviews**
  UN Women (2012)
  <http://unwomen-asiapacific.org/docs/cedaw/archive/FINAL_CEDAW_Handbook.pdf>
- **Handbook for National Action Plans on Violence Against Women**
  UN Women (2012)
  <www.un.org/womenwatch/daw/vaw/handbook-for-nap-on-vaw.pdf>
- **Virtual Knowledge Center to End Violence Against Women**
  - Legislation Module

  UN Women
  <www.endvawnow.org/en/modules/view/8-legislation.html>

- **Engaging Men in Public Policies for the Prevention of Violence Against Women and Girls**
  UN Women, UNFPA, EME/CulturaSalud and Promundo (2016)
  <http://endvawnow.org/uploads/tools/pdf/1470922012.pdf>

2.3 Strengthening health service capacity and improving quality of care

When building capacity for delivery of GBV healthcare for survivors, COs should consider the following:

a) **Models of service delivery;**

b) **Procurement and supply of essential equipment and drugs; and**

c) **Training, development and supervision of health workers.**

a) Models of service delivery

Clinical care for survivors of GBViE can be provided using a variety of models. Selecting the most appropriate model in each emergency will depend on the capacities and constraints in each context and must involve consultation with health actors. The following are examples of commonly used models supported by UNICEF.

- **GBV services delivered through primary healthcare:** Sexual violence services are offered through primary healthcare facilities, and all clinicians on duty can provide clinical examination and treatment of sexual assault or other forms of GBV.
- **GBV services integrated into population-specific health services:** Clinical management of rape and other forms of GBV is available within specific healthcare units, such as reproductive or maternal health services.
- **GBV services integrated into other services:** Initial GBV healthcare services are available through other facilities, with referral to health centres made on a case-by-case basis as required.
- **Stand-alone GBV services:** Specialized GBV healthcare is offered by trained providers in a designated location, often with other GBV services made available to survivors.

Services can be temporary, permanent, facility-based or mobile. Mobile clinical services are used to reach areas with no or limited access to health facilities during immediate response to sudden-onset disasters, as well as during complex emergencies.

A new approach linked to the concept of mobile care is **community-based care**: the delivery of basic clinical management services by community health workers. UNICEF and partners are pioneering new methods of post-rape care outreach through training, equipping and supporting community health workers, particularly in settings characterized by insecurity and limited capacity of the healthcare system.

Each approach has advantages and disadvantages, and COs will need to assess which are the most appropriate models for different populations and geographical areas to ensure maximum coverage of timely post-rape care services in different phases of response. When supporting the rebuilding of national health systems, consideration must be given to which models are economically feasible, cost-effective and sustainable.

In addition to initial examination and treatment, consideration needs to be given to **provision of follow-up care and referral** for related healthcare, such as fistula repair.

Resources

- **Increasing Access, Increasing Healing: Mobile approach to GBV service provision and community mobilisation in Lebanon**
  International Rescue Committee (2016)
- **Emergency Mobile Teams: Gender-based violence**
  GBV Sub-Cluster Iraq
  <www.humanitarianresponse.info/system/files/documents/files/gbv_emergency_mobile_teams_v4.pdf>

b) Procurement and supply of essential equipment and drugs

Ensuring an adequate supply of essential drugs and equipment is a priority. Challenges can include:

- Drugs for CMR being used to treat other health problems and therefore being unavailable for rape survivors when needed;
- Not having the necessary cold chain and procurement systems in place to source and distribute medication during an emergency response;
- Maintaining an adequate supply to meet the needs on the ground; and
- Ensuring appropriate drug regimens are available to treat children as well as adults.

COs must work closely with key partners, such as UNFPA, to coordinate timely procurement, pre-positioning and supply of essential drugs and equipment for CMR. Pre-positioning drugs and equipment as part of preparedness efforts is an important strategy for COs to consider with national partners, especially in disaster-prone or fragile contexts.

It is important that the supply of essential drugs and equipment is supported with appropriate training for clinicians. Without appropriate training, health workers may incorrectly administer treatment regimens or not administer them at all.

Tools

Healthcare Tool 2: Health Facility Readiness for Clinical Management of Rape Services Checklist

Resources

- **UNICEF Guidance Note on Procurement and Supply Chain Management for Commodities Used in the Clinical Management of Sexual Assault**
  UNICEF (2017)

c) Training, development and supervision of health workers

Humanitarian actors, including UNICEF, have developed a range of e-learning and face-to-face training materials for health workers to respond to sexual violence in emergencies. A variety of inter-agency training materials are available, with a focus on the development of survivor-centred attitudes and behaviours by healthcare providers. Training should focus on clinical management, including medico-legal procedures, for child, adolescent and adult survivors. This includes appropriate administration of drugs. Health workers must also be trained in providing referrals for psychosocial care, safety and protection of survivors. Training should be delivered by experienced clinicians with appropriate medical qualifications and expertise.

While there are limited training packages for building capacity of health workers to respond to intimate partner violence, the WHO clinical guidelines and clinical handbook (see resources on the following page) can be used to develop training materials.

In the early stages of emergency response, COs and partners should focus on building clinical skills for responding to sexual violence. However, once these services are established, training must be expanded to cover management of other forms of GBV

prevalent in the community, including intimate partner violence. Consideration should be given to providing training on screening for different forms of GBV in settings where there are services in place to support this.

In addition to training health workers on clinical and other aspects of GBV treatment and management, wherever possible, other health facility staff should also receive appropriate training. 'Whole-of-facility' training is considered best practice and will help to ensure survivors' needs and rights are protected throughout their interactions with health providers.

Juba, South Sudan

When planning training, COs must consider initial and ongoing clinical training needs, development of competent clinical practice, and supervision of health workers. Training and staff development should not be one-off activities. Developing competency in any skill requires practice, supervision and the opportunity for reflection. Following the training, it is essential to build in on-the-job supervision, monitoring and support to assist health workers in applying new knowledge and skills in clinical practice. Where it is difficult to provide on-site supervision (for example, due to insecurity, inaccessibility of facilities or a lack of trained personnel), consider creative ways of providing supervision, such as remote supervision sessions using the internet or on-site team-based supervision and de-briefing.

Furthermore, it is critical that GBV training for health workers and other health facility staff assess and address values, attitudes and beliefs regarding GBV and survivors. Even if clinicians have excellent clinical skills, they can still cause harm to those seeking help if their assistance is not compassionate and survivor-centred. In such cases, others in the community will not feel confident to come forward for healthcare.

Resources

- **Healthcare for Women Subjected to Intimate Partner Violence or Sexual Violence: A clinical handbook**
  World Health Organization (2014)
  <http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf>
- **Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO clinical and policy guidelines**
  World Health Organization (2013)
  <http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf>

Capacity Development

GBV health training materials

Face-to-face

- **UNICEF Communities Care Programme Toolkit: Community Health Worker Training Package**
  UNICEF (2014)
- **Clinical Care for Sexual Assault Survivors; A Multi-Media Training Tool Facilitator's Guide**
  IRC/UCLA
  <http://cim.ucla.edu/clinical-care-for-sexual-assault-survivors.html>

Moroto Uganda

- **Caring for Survivors of Sexual Violence in Emergencies Medical Modules**
  Gender-Based Violence Area of Responsibility
  - Training Guide:
    <www.gbvims.com/wp/wp-content/uploads/2.-Training-Guide.doc>
  - Medical Facilitator Manual:
    <www.gbvims.com/wp/wp-content/uploads/6.-Medical-Modules-Facilitator-Manual.doc>
  - Medical Participant Manual:
    <www.gbvims.com/wp/wp-content/uploads/5.-Medical-Modules-Participant-Manual.doc>
  - PowerPoint Presentations:
    <www.gbvims.com/wp/wp-content/uploads/PPT-Presentation-for-Medical-Modules.zip>
- **Caring for Child Survivor Training Materials**
  International Rescue Committee
  <http://gbvresponders.org/response/caring-child-survivors/#CCSTraining Materials>
- **Mental Health and Gender-Based Violence: Helping survivors of sexual violence in conflict – a training manual**
  Health and Human Rights Info
  <http://hhri-gbv-manual.org/>

Distance and e-learning

- **Clinical Management of Rape Survivors e-learning course**
  WHO/UNHCR/UNFPA
  <www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/>
- **Emergency Contraception for Conflict-Affected Settings Distance Learning Module**
  Reproductive Health Response in Conflict Consortium
  <http://reliefweb.int/report/world/emergency-contraception-conflict-affected-settings-reproductive-health-response>

2.4 Coordinating with others

Good coordination is a cornerstone of GBV response, and it is vital that GBV health services coordinate with others. There are two related aspects to coordinated care that must be considered.

The first is **inter-agency coordination**, which involves making sure all agencies and organizations providing care, support and protection services to GBV survivors work collaboratively together to respond to GBV and seamlessly refer and care for survivors. Inter-agency systems coordination usually involves developing shared protocols for referral and service delivery and meeting regularly to facilitate good communication and joint problem solving.

The second aspect of coordinated care is **case coordination**, which is a foundation of a survivor-centred approach. This involves making sure each survivor can receive care, support and protection services in a coordinated manner and according to her unique needs and circumstances. Case coordination usually involves implementing a case management system so that survivors can receive tailored services based on their individual wishes. More information on case management can be found in *Section 4.2: Strengthening Psychosocial Support for GBV Survivors.*

Resources

- **Handbook for Coordinating Gender-Based Violence Interventions in Humanitarian Settings**
  GBV AOR (2010)
  <www.refworld.org/docid/52146d634.html>
- **Establishing GBV Standard Operating Procedures**
  Inter-Agency Standing Committee Sub-Working Group on Gender (2008)
  <http://www.globalprotectioncluster.org/_assets/files/tools_and_guidance/gender_based_violence/GBV_Standard_Operational_Procedures_2008_EN.pdf>
- **Interagency Gender-based Violence Case Management Guidelines**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>

Capacity Development

- **Interagency Gender-based Violence Case Management Training Materials**
  Gender-based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>

Step 3: Monitoring

3.1 Selecting indicators to monitor progress and quality

The exact choice of outcome and output indicators will be determined by the CO based on specific objectives and interventions selected; the phase of humanitarian response; and the feasibility of monitoring in emergency contexts. However, some sample outputs and indicators for monitoring changes in key determinants of availability, accessibility and quality of healthcare are given in the table on the following pages. Remember, indicators need to be measured both *before* and *after* an intervention to see if there have been any changes.

Sample outcomes, outputs and indicators for GBViE health programmes

Sample outcomes	Sample outputs	Sample output indicators
Enabling environment		
Social norms encourage help-seeking by child, adolescent and adult survivors of GBV.	There is increased community dialogue on GBV.	• Changes in beliefs and attitudes about GBV among participants in communications activities • Increase in # of people exposed to communications activities who believe others in the community seek healthcare after GBV
Government policies facilitate access to healthcare for survivors of GBV.	Government health policies and procedures reflect minimum standards and good practice in clinical management of child, adolescent and adult sexual assault survivors.	• Existence of national policies meeting international standards for clinical care of sexual assault for child, adolescent and adult survivors • Proportion of health facilities adhering to national protocols for CMR
	Local authorities encourage medical treatment for sexual violence survivors without the need to first report to police.	• Child, adolescent and adult survivors of sexual violence can report directly to health facilities for medical care
GBV health response is adequately funded, prioritized and coordinated within humanitarian response.	All humanitarian donors have adequate information about GBV and the humanitarian response plan.	• # of MISP advocacy materials developed and disseminated to humanitarian donors • # of GBV advocacy materials developed and disseminated to humanitarian donors
	GBV and Health cluster co-leads meet regularly to share information and coordinate GBV health response.	• # of meetings held between GBV and Health cluster actors monthly
	UNICEF Child Protection, Health and HIV programme staff jointly plan UNICEF sexual violence response.	• Joint Child Protection, Health and HIV plan is in place for UNICEF and partner health response
	Referral networks are established in all districts/ camps.	• % of health workers who know how to refer survivors for follow-up medical and psychosocial care

Sample outcomes	Sample outputs	Sample output indicators
Supply		
Clinical management of rape services are available for child, adolescent and adult survivors in all districts/camps.	Health facilities/outreach services have essential equipment and supplies in place for CMR.	• % of functioning health facilities that offer CMR services • % of population with access to functioning health facilities that offer CMR services • % of health facilities with essential drugs, including antibiotics for STI presumptive treatment, emergency contraception, and post-exposure prophylaxis for HIV • % of health facilities with equipment and supplies for CMR • % of facilities following procedures for timely replenishing of drugs and supplies
	Health facilities/outreach services are adequately staffed by appropriately trained personnel.	• # of health workers trained in CMR • # of post-training on-the-job supervision sessions • Changes in knowledge, attitudes and practices of health workers regarding GBV immediately post-training • Changes in knowledge, attitudes and practices of health workers regarding GBV six months post-training • % of health facilities with at least one health worker trained in clinical management of sexual assault • % of health facilities with at least one health worker trained in specific care needs of child GBV survivors • # of female health workers trained/facility
Demand		
Communities use GBV health services.	Survivors of GBV can afford direct and indirect costs of sexual violence health services.	• Sexual assault health examination is free • Medical certificates for sexual assault are free • Transport available for survivors of sexual violence to attend health facilities
	Social barriers to survivors accessing healthcare are identified and decreased.	• # of community-level barriers to sexual violence healthcare identified • % of community-level barriers removed

Sample outcomes	Sample outputs	Sample output indicators
Demand (continued)		
Communities use GBV health services. (continued)	The community is aware of and confident in sexual violence health services.	• % of community members with knowledge of health services for clinical care of sexual assault • Increase in # of child/adolescent survivors who come forward for healthcare
Quality		
GBV health services are of good quality.	CMR services are delivered in line with survivor-centred principles.	• % of GBV survivors who receive appropriate care • % of trained health workers who know how to promote patient safety • % of trained health workers who know how to protect and promote their patient's rights to confidentiality and privacy • % of patient records stored securely and appropriately coded to ensure confidentiality • % of health workers who can demonstrate appropriate engagement and empathy • % of patients surveyed who express satisfaction with healthcare

Tools

Rapid Assessment Tool 3: GBV Service Capacity and Quality Audit Tool

Healthcare Tool 3: Client Satisfaction Survey

Healthcare Tool 4: Health Service Monitoring Sheet

Resources

- **Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions Along the Relief to Development Continuum**
  United States Agency for International Development (2014)
  <www.usaid.gov/sites/default/files/documents/2151/Toolkit%20Master%20%28FINAL%20MAY%209%29.pdf>

- **Violence Against Women and Girls: A compendium of monitoring and evaluation indicators**
  Measure Evaluation (2008)
  <www.measureevaluation.org/resources/tools/gender/violence-against-women-and-girls-compendium-of-indicators>

- **Situation Analysis of Health Services for Survivors of Sexual Assault: Health facility checklist**
  Sexual Violence Research Initiative (2006)
  <www.svri.org/sites/default/files/attachments/2016-04-13/SituationalAna.pdf>

- **Guidance on Monitoring and Evaluation for Programming on Violence Against Women and Girls**
  United Kingdom Department for International Development (2012)
  <www.gov.uk/government/uploads/system/uploads/attachment_data/file/67334/How-to-note-VAWG-3-monitoring-eval.pdf>

Minimum health response checklist

The following is a checklist detailing minimum essential actions for effective GBV health response throughout the phases of an emergency.

Preparedness		Immediate response	
Audit national health protocols and systems to identify gaps in survivor-centred healthcare.	○	Fund and support non-government and/or government health providers to deliver post-rape care.	○
Train national health workers in CMR for child and adult survivors.	○	Procure and maintain adequate supplies of essential CMR-related drugs and equipment for child and adult survivors.	○
Stockpile essential CMR-related drugs and equipment for child and adult survivors.	○	Provide technical support for establishment of interagency referral system to link survivors with psychosocial, safety and legal support.	○

Yei, South Sudan

Section 4.2

Strengthening Psychosocial Support for GBV Survivors

The importance of psychosocial care

Psychological, Emotional and Social Consequences of GBV

Defining 'Psychosocial' and 'Mental Health'

The harmful **psychological, emotional and social effects of GBV** can be devastating for individuals and their families, even destroying family relationships and community cohesion. GBV is a risk factor for common mental health problems, including post-traumatic stress disorder (PTSD), depression, anxiety, and sleeping and eating disorders. Poor **psychosocial well-being and mental health** have a negative impact on survivors' normal functioning, physical health, and economic and educational participation.

A survivor's recovery is greatly impacted by family and community responses. In unsupportive environments, survivors can be further harmed by breakdown in interpersonal relationships, blaming, shaming, stigmatization and outright rejection from families. These harmful responses can lead to social exclusion and isolation, further compounding emotional and psychological distress.

Providing psychosocial support to survivors can address interrelated psychological and social consequences of GBV; promote coping, resilience and recovery from the normal traumatic stress responses associated with GBV; and prevent the development or worsening of mental health and other problems.

UNICEF's psychosocial response to GBV

UNICEF supports the psychosocial recovery and well-being of all emergency-affected people through advocacy, assistance and services that help meet basic physical needs and assist families and communities in resuming normal day-to-day life.

UNICEF recognizes that while most survivors of GBV will recover using their own coping mechanisms (drawing on family and community resources), all survivors have the right to accurate and helpful information about the effects of GBV, the range of human responses to traumatic events, and available services to help them achieve safety and cope with these effects. Furthermore, UNICEF recognizes that some individuals require focused support to resume normal functioning.

Objectives

In line with UNICEF's Core Commitments for Children (CCCs)[7] in emergencies, country offices (COs) should act to improve access to age-appropriate psychosocial services for survivors of GBV, with a priority focus on psychosocial support for sexual violence survivors in the early stages of an emergency response.

Psychosocial Care Actors

The objective of UNICEF's psychosocial response to GBViE is to work with formal and informal **psychosocial care actors** to strengthen age-appropriate social and psychological supports for survivors to respond to psychosocial problems and promote their resilience and recovery.

A phased approach to psychosocial support in emergencies

A holistic and phased psychosocial support response to GBV involves taking certain actions *before* emergencies happen, *during* the initial phases of humanitarian response, and as part of *ongoing response and recovery efforts*.

Emergency preparedness

Prior to the outbreak of an emergency, UNICEF's preparedness activities involve strengthening national and community systems for delivering GBV-related psychosocial support services, as well as building the capacity of national actors to plan for and respond to emergencies.

Focused support during immediate response

Immediately following a rapid-onset disaster and during complex emergencies, UNICEF prioritizes psychosocial support for child, adolescent and adult survivors of sexual violence to help reduce distress and enable survivors to resume normal functioning and reintegrate into family and community life.

Focused psychosocial interventions for sexual violence survivors during immediate response include:

- **Safe spaces** where children and women can seek help and receive information, advocacy and referral for healthcare and safety needs;
- **Crisis support**[8] for survivors of recent sexual assault or other traumatic GBV incidents;
- **Community information** on sexual violence and other forms of GBV to reduce stigma and blame and promote community compassion and acceptance of those affected; and
- **Community self-help and resilience** strategies.

Comprehensive support during ongoing response and recovery

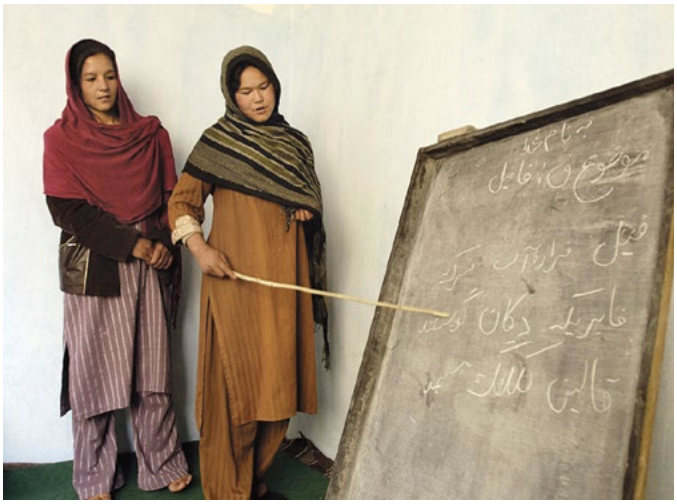
Once basic psychosocial supports are available for sexual assault survivors, UNICEF concentrates on building national capacity for providing psychological care and social support services for survivors of other forms of GBV, such as intimate partner violence and forced marriage. Common psychosocial interventions during ongoing response and recovery include:

- **Safe spaces** where children and women survivors can access services and programmes and receive information, referral and advocacy that promote well-being and coping;
- **Crisis support** for survivors of recent sexual assault or other traumatic GBV incidents to reduce distress, meet basic needs, promote connectedness and ensure safety;

7 See <www.unicef.org/publications/files/CCC_042010.pdf>.

8 Crisis support is sometimes called 'psychological first aid'; however, in a survivor-centred model, the terms 'crisis care' or 'crisis counselling support' are preferred. While they can be the same thing, psychological first aid is used immediately following a crisis or traumatic incident, whereas crisis counselling and support may be provided throughout a survivor's recovery.

- **Case management and supportive case work services** that provide ongoing emotional, practical and problem-solving support and referral to foster healing, recovery and reintegration;
- **Culturally appropriate individual, group or family counselling;**
- **Self-help and peer support** groups and networks;
- **Social and economic empowerment activities,** including formal and informal education, livelihoods and social protection programmes for survivors and at-risk girls and women;
- **Survivor-centred traditional healing and restorative justice** processes;
- **Community education** campaigns to reduce stigma attached to different forms of GBV and promote community acceptance of – and support for – those affected, including survivors of sexual violence and children born of rape;
- **Advocacy for specialized mental health services,** including psychological or psychiatric evaluation, treatment and care; and
- **Tailored psychosocial care services for specific populations,** such as children born of rape or children/women recruited and used by armed groups.



Bamyan, Afghanistan

Resources

Key international guidelines for mental health and psychosocial response to GBV

- **Guidelines for Mental Health and Psychosocial Support in Emergencies**
  Inter-Agency Standing Committee (2007)
  <www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial _june_2007.pdf>
- **Mental Health and Psychosocial Support for Conflict-Related Sexual Violence: Principles and interventions**
  World Health Organization (2012)
  <http://apps.who.int/iris/bitstream/10665/75179/1/WHO_RHR_HRP_12.18_eng.pdf>
- **Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings**
  International Rescue Committee and UNICEF (2012)
  <http://gbvresponders.org/response/caring-child-survivors/>
- **Do's and Don'ts in Community-Based Psychosocial Support for Sexual Violence Survivors in Conflict-Affected Settings**
  World Health Organization (2012)
  <www.searo.who.int/entity/emergencies/documents/dos_and_donts_psycho_support_sexviolence_survivors.pdf>
- **Mental Health Responses for Victims of Sexual Violence and Rape in Resource-Poor Settings**
  Sexual Violence Research Initiative (2011)
  <www.svri.org/sites/default/files/attachments/2016-04-13/MentalHealthResponse.pdf>
- **Promoting Mental Health: Concepts, emerging evidence, practice**
  World Health Organization (2004)
  <www.who.int/mental_health/evidence/en/promoting_mhh.pdf>
- **World Health Organization Mental Health and Psychosocial Support in Emergencies website:**
  <www.who.int/mental_health/resources/emergencies/en/>

- **Primary-Level Mental Healthcare for Common Mental Disorder in Resource-Poor Settings: Models and practice**
  Sexual Violence Research Initiative (2009)
  <www.svri.org/sites/default/files/attachments/2016-01-19/primaryhealth.pdf>

At-risk populations

- **My Safety My Wellbeing: Equipping adolescent girls with key knowledge and skills to help them to mitigate, prevent and respond to gender based violence**
  International Rescue Committee (2016)
  <https://resourcecentre.savethechildren.net/library/my-safety-my-wellbeing-equipping-adolescent-girls-key-knowledge-and-skills-help-them>
- **I'm Here: Adolescent girls in emergencies**
  Women's Refugee Commission (2016)
  <www.womensrefugeecommission.org/resources/document/1078-i-m-here-report-final-pdf>
- **I See That It Is Possible: Building capacity for disability inclusion in GBV in humanitarian settings**
  Women's Refugee Commission (2016)
  <www.womensrefugeecommission.org/resources/document/945-building-capacity-for-disability-inclusion-in-gender-based-violence-gbv-programming-in-humanitarian-settings-overview>
- **Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents Who Have Experienced Sexual Violence: A companion guide**
  United States Agency for International Development (2016)
  <https://aidsfree.usaid.gov/sites/default/files/2016.2.1_aidsfree_comp_guide_gender_tagged.pdf>
- **Working with Men and Boy Survivors of Sexual and Gender-Based Violence in Forced Displacement**
  UNHCR (2012)
  <www.refworld.org/pdfid/5006aa262.pdf>

Considerations for country offices

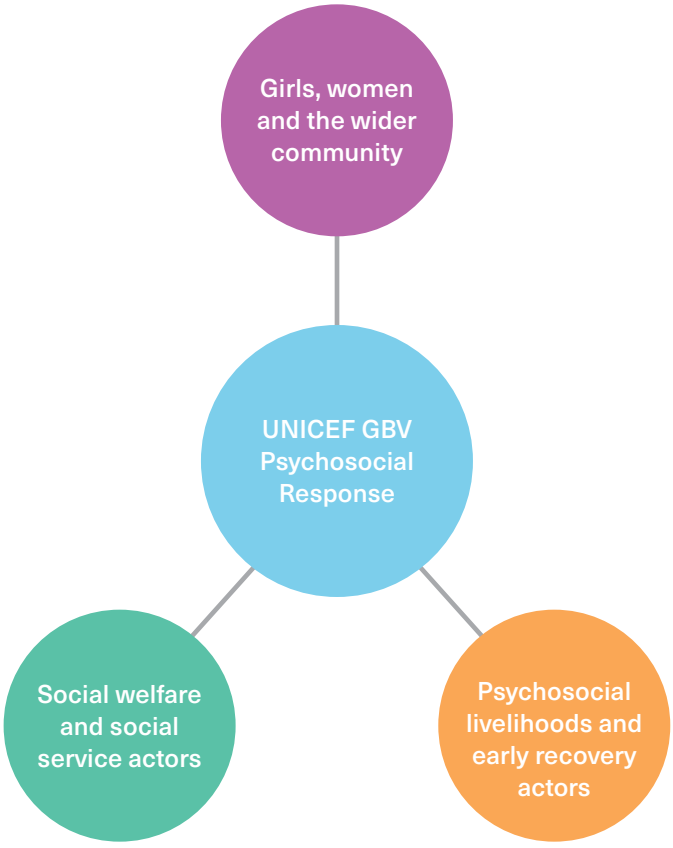
A CO should consider the following when designing UNICEF's psychosocial response to GBV in emergencies:

- How to best **integrate psychosocial support programming** for GBV survivors into broader child protection, psychosocial, social protection and humanitarian programming. For example, how can focused services be integrated into emergency education, child-friendly spaces, children's health services, nutrition, child protection, education, livelihoods and/or social protection programming?
- **Critical needs and gaps** in psychosocial care.
- How to assess needs and **provide support for specific groups of survivors**, such as married girls; adolescent girls; women and their children born of rape; and girls, boys and women participating in disarmament, demobilization and reintegration (DDR) programmes.
- **Capacity of partners** to assess, manage and monitor psychosocial interventions, and the level of need for ongoing training and supervision of staff.
- How to **evaluate psychosocial outcomes** for survivors.

Stakeholders in psychosocial response to GBV

Key stakeholders in the needs assessment and design of focused psychosocial support programmes for survivors of GBV include:

- Girls, women and the wider community;
- Government and non-government social welfare and social service actors; and
- Psychosocial, livelihoods and early recovery actors.



Girls, women and the wider community

It is essential to engage with affected girls, women and other community members of different ages to learn about: community responses and resources; psychosocial impacts of different types of GBV in the community; and needs of different groups of survivors. Information about community attitudes, norms and behaviours is critical to designing effective communications campaigns to promote positive norms and to build survivor-centred community knowledge and behaviours.

Consulting with different ethnic, cultural and age groups is important to ascertain different psychosocial problems faced by survivors – and the solutions to them – such as community reintegration of children and women recruited and used by armed groups, and mothers and their children born of rape.

Community-based children's and women's networks and other community groups are key stakeholders in the delivery of psycho-social care to survivors.

Government and non-government social welfare and social service actors

During emergency response, government and non-government social welfare and social service providers deliver crisis support, case management, counselling, information, referrals and advocacy services for survivors of GBV. They also implement psychosocial support and reintegration programmes aimed at fostering individual and collective coping and well-being during immediate and ongoing response and recovery.

National social welfare and social service providers – most commonly ministries for social welfare, women, children and gender – are key stakeholders during preparedness and recovery in developing supportive policies for psychosocial

Bompata Encampment, Democratic Republic of Congo

response to GBV against girls and women. At the community level, non-government organizations (NGOs) and community-based organizations (CBOs) deliver direct services to survivors and are critical partners in programme design, delivery and monitoring.

Psychosocial, livelihoods and early recovery actors

All humanitarian actors engaged in focused psychosocial work are stakeholders in planning GBV psychosocial interventions. This includes the Child Protection sub-cluster; mental health, psychosocial and early recovery working groups; and livelihoods actors.

Not only do these groups have important information and expertise on psychosocial needs and programming; they also deliver important psychosocial services to which GBV survivors can be referred and integrated, such as economic empowerment programmes for at-risk adolescents and livelihoods training for girls and women demobilizing from armed groups.

Steps in psychosocial response to GBV

There are three steps to ensuring good quality psychosocial response to GBV, as shown below:

Step 1: Assessment and design
- 1.1 – Assessing the context
- 1.2 – Results-based programme design

Step 2: Implementation
- 2.1 – Fostering positive social norms to promote psychosocial well-being
- 2.2 – Creating an enabling legal and policy environment
- 2.3 – Strengthening psychosocial care and reintegration for survivors
- 2.4 – Coordinating with others

Step 3: Monitoring
- 3.1 – Selecting indicators to monitor progress and quality

Step 1: Assessment and design

1.1 Assessing the context

In the **early stages of emergency response**, psychosocial assessments for GBV response focus on collecting information about:

- Community responses and attitudes to survivors of sexual violence;
- Psychosocial needs and priorities for survivors; and
- Existing capacity for crisis care and case management in the affected community.

Tools

Psychosocial Response Tool 1: Psychosocial Response Audit Tool

See *Section 3: Rapid GBV Assessments* in this book.

1.2 Results-based programme design

UNICEF applies a **results-based approach** to programme design so that:

- ✔ Interventions are based on a logical pathway for creating impact;
- ✔ Interventions are results-oriented, and changes or effects are clearly identified; and
- ✔ Interventions can be monitored and evaluated.

Once priority needs, capacities, gaps and bottlenecks in psychosocial care have been determined, design of UNICEF's GBViE psychosocial interventions involves the following (see next page):

1. **Identify UNICEF's role, priorities and partnerships** for delivering focused psychosocial support, including crisis care, case management, counselling, and group and community support activities. For population-wide psychosocial support, this can also include social protection programmes targeting all at-risk girls and women; play groups for children; formal education; economic strengthening activities; and others.
2. **Define the results or outcomes of UNICEF and partner intervention based on determinants** for child, adolescent and adult survivors' emotional and social well-being in one or more of the following areas:
   - Fostering social norms to support psychosocial healing and well-being of survivors of GBV;
   - Creating an enabling legal and policy environment;
   - Strengthening capacity of formal services and informal actors to provide psychological care and social reintegration for survivors; and/or
   - Building community knowledge, beliefs, practices and behaviours to foster psychosocial resilience and recovery.
3. **Identify outputs and strategies** for achieving the outcomes, as well as **indicators** for measuring progress during implementation. See the next column for key strategies for promoting psychosocial support.
4. **Review and finalize the programme design** prior to implementation, ensuring its alignment with best practices, ethics and safety. Don't forget to consider how the programme will be evaluated as part of programme design.

Tools

See **Kit 4: Evaluation** for more information about different types of evaluative activities in emergency settings.

Key strategies for promoting psychosocial support in humanitarian settings include:

- *Advocacy* – for example, advocating with humanitarian donors for adequate funding for psychosocial programmes, including focused reintegration programs for different groups of girls and women; or advocating with community leaders and structures to ensure community responses are compassionate, are survivor-centred and respect each person's right to self-determination.
- *Training and development* – for example, training community-based social workers and volunteers in crisis support and case management.
- *Technical support* – for example, supplying technical expertise in legislative or policy review and development processes or in establishing case management systems.
- *Funding* – for example, funding NGOs to deliver case management services to survivors of rape in the early stages of emergency response; funding establishment and resourcing of safe spaces; and funding social protection programmes.
- *Operational assistance and inputs* – for example, supplying safe spaces with material supplies such as clothing and other non-food items to meet survivors' basic needs.
- *Communication interventions* – for example, supporting community education and dialogue on the consequences of sexual violence and the benefits of responding with compassion.

Examples of strategies to strengthen psychosocial support deployed in different phases of emergency response are listed below.

Examples of strategies to strengthen psychosocial support

Determinant	Immediate response	Preparedness/Ongoing response/Early recovery
Enabling environment	• Advocate within the humanitarian system for funding and technical support to mental health and psychosocial programmes. • Advocate with traditional leaders for changes in customary practices that are not survivor-centred, such as forced marriage of rape survivors to the perpetrator.	• Initiate communication campaigns to reduce stigma and silence associated with GBV and promote community support and acceptance of survivors. • Provide technical and financial assistance to develop and implement social service policies and protocols for sustainable scale-up of social protection and social services for child and adult survivors of GBV.
Supply and quality	• Fund establishment and resourcing of temporary safe spaces for girls and women to seek information and assistance in displaced settings. • Fund material support for survivors to meet immediate and basic needs. • Train social workers and community volunteers in crisis support/psychological first aid for survivors of recent sexual assault or other traumatic GBV incidents. • Resource community-based survivor self-help and resilience strategies.	• Provide technical and financial assistance to integrate safe spaces into existing government and non-government social service and health infrastructure. • Train community-based social workers and volunteers to provide crisis and ongoing emotional/practical support to survivors. • Fund and provide technical support to develop survivor-centred case management protocols, and establish and monitor services. • Train and supervise government and non-government social service providers in line with survivor-centred case management. • Train school focal points on psychosocial impacts of GBV, and support school-based resilience programs. • Fund community-based survivor-centred healing and restorative justice initiative. • Provide technical and financial assistance to social protection and social and economic empowerment activities for adolescent girls and women.
Demand	• Initiate community awareness campaign on sexual violence to reduce stigma, promote community compassion toward those affected, and encourage help-seeking.	• Initiate multi-media communication campaigns to build knowledge and awareness on mental health and psychosocial consequences of GBV and promote social acceptance and support for survivors of GBV and their families.

Resources

- **UNICEF Programme Policy and Procedures Manual**
  - Chapter 3: Programme Preparatio
  - Chapter 4: Programme Implementation and Management

  <https://unicef.sharepoint.com/teams/OED/PPPManual/SiteAssets/Welcome%20to%20the%20Programme,%20Policy%20and%20Procedure%20Manual.aspx?wa=wsignin1.0>

- **UNICEF Technical Notes: Special Considerations for Programming in Unstable Situations**
  <www.mona.uwi.edu/cardin/virtual_library/docs/1255/1255.pdf>

Capacity Development

- **UNICEF Programme Planning Process (PPP) e-learning course**
  <https://agora.unicef.org/course/info.php?id=6825>

Step 2: Implementation

Implementing good quality psychosocial support to survivors of GBV involves fostering positive social norms; building enabling legislation and policies; strengthening psychosocial care and reintegration for survivors; and coordinating with others.

2.1 Fostering positive social norms to promote psychosocial well-being

UNICEF is increasingly using **social norms perspectives** to foster health- and violence-related behaviour change, even in emergency-affected settings. Social norms that lead to victim-blaming, stigmatization and discrimination against survivors of GBV, or that lead to further disempowerment or violence (such as norms prescribing that raped girls should marry the perpetrators to protect their honour), can contribute to poor psychosocial well-being and mental health problems for survivors.

Communication strategies that use multiple channels of communication achieve a higher proportion of positive outcomes. Strategies need to extend beyond individuals and households to include service providers, traditional and religious leaders, and decision-makers at different levels to engender community-wide change.[9]

UNICEF is continually developing and piloting community-based approaches to communication for social norms change; COs that adopt social norms approaches in emergencies are encouraged to draw on existing materials and lessons learned as they develop interventions.

Resources

- **Behaviour Change Communication in Emergencies: A Toolkit**
  UNICEF (2006)
  <www.unicef.org/rosa/Behaviour.pdf>

- **Communication for Humanitarian Action Toolkit (CHAT) Working Version**
  UNICEF (May 2015)
  <www.unicefinemergencies.com/downloads/eresource/docs/Communication%20for%20Development/6-C4D-CHAT_Proof-2.pdf>

- **Social Norms Professional Development Pack**
  GSDRC/University of Birmingham (2016)
  <www.gsdrc.org/professional-dev/social-norms/>

9 Marcus, R and Page, E., 'Changing discriminatory norms affecting adolescent girls through communication activities: A review of evidence', Overseas Development Institute, London, 2014.

Resources (continued)

- **Communities Care: Transforming Lives and Preventing Violence Toolkit**
  UNICEF (2014)
- **Shifting Social Norms to Tackle Violence Against Women and Girls**
  United Kingdom Department for International Development (2016)
  <www.gov.uk/government/uploads/system/uploads/attachment_data/file/507845/Shifting-Social-Norms-tackle-Violence-against-Women-Girls3.pdf>

2.2 Creating an enabling legal and policy environment

During **immediate response**, CO efforts to influence policy centre on reducing policy or procedural barriers, where they exist, to survivors accessing psychosocial care and support. During **preparedness and recovery**, COs should advocate for and engage with legislative and policy review processes that direct resources toward government health, social service and protection systems and social safety nets for girls and women.

North Darfur, Sudan

In addition to existing national policies, UNICEF COs can play an influential role in shaping national recovery and development priorities – for example, through ensuring the rights and needs of adolescent girl and women survivors of GBV are respected and that they have equal access to economic recovery and development initiatives.

Resources

- **Handbook on Legislative Reform: Realizing child rights**
  UNICEF (2008)
  <www.unrol.org/files/Handbook%20on%20Legislative%20Reform.pdf>
- **Justice in Matters Involving Child Victims and Witnesses of Crime: Model law and related commentary**
  UNDOC and UNICEF (2009)
  <www.unicef.org/albania/Justice_in_matters.pdf>
- **Legislative Reform on Selected Issues of Anti-Gender discrimination and Anti-Domestic Violence: The impact on children**
  UNICEF (2009)
  <www.unicef.org/policyanalysis/files/Legislative_Reform_on_Selected_Issues_of_Anti-Gender_Discrimination_and_Anti-Domestic_Violence_-_the_Impact_on_Children.pdf>
- **Handbook for Legislation on Violence Against Women**
  United Nations Department of Economic and Social Affairs (2010)
  <www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>
- **Engaging Men in Public Policies for the Prevention of Violence Against Women and Girls**
  UN Women, UNFPA, EME/CulturaSalud and Promundo (2016)
  <http://endvawnow.org/uploads/tools/pdf/1470922012.pdf>

Aleppo, Syria

- **Do Our Laws Promote Gender Equality? A handbook for CEDAW-based legal reviews**
  UN Women (2012)
  <http://unwomen-asiapacific.org/docs/cedaw/archive/FINAL_CEDAW_Handbook.pdf>
- **Handbook for National Action Plans on Violence Against Women**
  UN Women (2012)
  <www.un.org/womenwatch/daw/vaw/handbook-for-nap-on-vaw.pdf>
- **Virtual Knowledge Centre to End Violence Against Women**
  - Legislation Module

  UN Women
  <www.endvawnow.org/en/modules/view/8-legislation.html>

2.3 Strengthening psychosocial care and reintegration for survivors

When implementing focused psychosocial care for survivors, COs should consider the following:

a) **Investing in formal and community-based systems;**

b) **Models of service delivery;**

c) **Establishing crisis support;**

d) **Provision of material support to meet basic needs;**

e) **Establishing a case management system;**

f) **Survivor-centred healing and reintegration activities;**

g) **Economic and social empowerment initiatives; and**

h) **Training and supervising social workers and community volunteers.**

a) Investing in formal and community-based systems

To strengthen psychosocial response to GBV, COs should invest in both formal systems and informal sources of psychosocial care for survivors, recognizing that most survivors of GBV do not formally report to services. Community-based networks and groups are especially important sources of help for survivors in settings where the state has limited capacity, or where there has been a breakdown in formal institutions or structures. In some settings, community-based networks may be the only source of help available.

COs should build relationships between formal and informal sources of care and support and ensure different actors have the resources required to meet basic needs and provide crisis care. For example, peer-based networks, community-based women's and children's organizations, and community/religious leaders can all be mobilized to

provide survivors with material and practical support during immediate response and can give vital information and linkage with formal psychosocial actors and programmes.

When using community volunteers and community-based support mechanisms to deliver crisis support or case management services to GBV survivors, COs must take care to ensure an adequate level of resourcing, support and supervision is given to volunteers to address issues such as confidentiality, self-determination and safety for both survivors and volunteers. While community-based child protection mechanisms are important and effective for detecting and responding to a range of child protection problems in the community, if is critically important to recognize their limitations.

b) Models of service delivery

Psychosocial support services can be provided via a wide variety of service delivery models. They are commonly offered though safe space programming or other community facilities; however, they can be made available in a wide range of permanent or temporary centres, safe spaces or shelters, such as health facilities, women's centres or children's services.

Psychosocial support services can be static or mobile. **Mobile services** are used when there is limited access to a population; this may be in sudden-onset disasters or during protracted/complex emergencies. In stable camp-based or community settings, more **permanent safe spaces** can be established. These may be women-friendly, adolescent-friendly, child-friendly or integrated safe spaces, serving more than one population. Which model a CO adopts depends on the type of emergency, the context and available resources.

When establishing emergency psychosocial support for GBV survivors, it is important to consider the services' **accessibility** to different groups. For example, it is important to ensure services are child- and adolescent-friendly and are non-stigmatizing, and that those accessing them will not be identified or labelled as 'rape victims'.

Psychosocial services can include brief and even one-off interventions – for example, when working with populations that are transient, regularly displaced or difficult to access due to security or geography. Brief interventions focus on providing crisis support to help with coping and meeting immediate basis needs (see below).

Elements of **minimum psychosocial intervention** include:

- Providing compassionate and supportive assistance and helpful information about:
  - The health, emotional and psychological consequences of and responses to GBV;
  - Psychoeducation for parents and carers of child survivors;
  - Availability of other services; and
  - Legal rights.
- Identifying immediate problems and needs, and assisting in resolving them, including:
  - Referral to and support at other services, especially healthcare;
  - Assistance with establishing emotional safety and positive coping strategies for people in distress or struggling with normal activities (for children, this involves also working with parents/carers to support children in distress); and
  - Providing material support.

Regardless of the model used and whether minimum or expanded psychosocial support services are provided, it is important to have a calm and safe place where survivors of GBV can privately receive care and support. Expanded services include case management, advocacy and counselling, and material and practical help. Safe

spaces also provide an important venue for delivering a range of formal and informal education and economic programmes that can assist those at risk of GBV and those who are recovering from it.

Tools

See *Section 5.3: Safe Space Programming* in this book.

Resources

- **Increasing Access, Increasing Healing: Mobile approach to GBV service provision and community mobilisation in Lebanon**
  International Rescue Committee (2016)
- **Emergency Mobile Teams: Gender-Based Violence**
  GBV sub-cluster Iraq
  <www.humanitarianresponse.info/system/files/documents/files/gbv_emergency_mobile_teams_v4.pdf>

c) Establishing crisis support

Crisis support helps those who have experienced a traumatic event to cope and resume functioning. It involves using compassionate and supportive listening and giving useful information and practical support to:

- Help the person feel safe and calm;
- Meet immediate needs, such as healthcare and protection;

Sapa, Vietnam

- Establish connection and facilitate support; and
- Empower survivors by providing helpful information so they know what to expect and can decide what to do next.

Crisis support can be offered in mobile, static, temporary or permanent psychosocial support services or safe spaces.

Crisis support is usually most helpful following a traumatic GBV incident when the person is highly distressed. However, because sexual violence and other forms of GBV can create ongoing feelings of fear and distress long after an incident occurs – and because many survivors may not be able to establish physical and emotional safety due to the nature of their circumstances or ongoing exposure to GBV or other traumatic events – crisis support may be used some time after an incident.

Social workers and community volunteers who provide crisis support to GBV survivors need training on the effects of GBV and the range of emotional and psychological responses to such incidents. They must also be trained in culturally and age-appropriate methods of responding to stress and distress, including **suicide risk assessment and response**. They must be aware of available services and trained in good communication, including active listening and communicating with children; and they must also receive support on managing their own stress and the effects of **vicarious trauma**. When implementing crisis care interventions, COs must build in a supervision system with appropriately trained staff available to ensure good practice in crisis care for survivors.

Suicide Risk Assessment and Response

Vicarious Trauma

Resources

- **International Psychological First Aid: Guide for field workers**
  World Health Organization (2011)
  <www.searo.who.int/srilanka/documents/psychological_first_aid_guide_for_field_workers.pdf?ua=1>
- **Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity**
  World Health Organization (2016)
  <www.who.int/mental_health/emergencies/problem_management_plus/en/>

Capacity Development

- **Psychological First Aid: Facilitator's manual for orienting field workers**
  World Health Organization (2014)
  <www.who.int/mental_health/emergencies/facilitator_manual_2014/en/>
- **Mental Health and Gender-Based Violence: Helping survivors of sexual violence in conflict – a training manual**
  Human Rights Health Info (2012)
  <http://hhri-gbv-manual.org/>

d) Provision of material support

Material support can be essential for helping survivors regain a sense of dignity; meet basic needs for food, clothing and shelter; and access life-saving services, such as healthcare. While all efforts should be made to link GBV survivors with existing humanitarian services to meet basic needs, COs should also consider the need to directly provide material support for survivors (such as food for herself and her children and clothing) and ensure that flexible funding or in-kind support is available to cover GBV-related needs (such as transport to health facilities). In some settings, provision of material support to survivors and to those at risk of GBV through dignity kit distribution has proven to be an effective method for engaging girls and women and facilitating their access to a wide range of information and support services.

Tools

See *Section 5.2: Dignity Kit Programming* in this book.

Titicaca, Bolivia

e) Establishing a case management system

Case management is a structured method of providing help to individuals with complex or multiple needs. In a case management system, one organization takes responsibility for making sure all issues and problems facing a survivor and her family are identified and that services are delivered and followed up on in a coordinated and holistic way. It is a six-step process with **two objectives**:

1. Achieving good outcomes through service delivery tailored around individual needs and circumstances; and
2. Empowering survivors through supporting their decision-making according to their age and developmental level.

In principle, case management can be implemented by staff of any agency or organization with some training and resources. For example, social workers, nurses or community volunteers can all act as case managers – however, they all require specific knowledge, skills, resources and supervision to do so effectively.

COs should work closely with response actors to provide technical and funding support for the establishment of client-centred case management systems, *remembering that not all survivors need or want this help.*

Resources

- **Interagency Gender-Based Violence Case Management Guidelines**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>
- **Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings**
  International Rescue Committee and UNICEF (2012)
  <http://gbvresponders.org/response/caring-child-survivors/>
- **Gender-Based Violence Information Management System website and resources**
  < www.gbvims.com/>

Capacity Development

- **Interagency Gender-Based Violence Case Management Training Materials**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>

f) Survivor-centred healing and reintegration activities

Traditional or culturally appropriate healing and reintegration activities can play an important role in helping individuals and communities process and recover from traumatic incidents, including GBV. COs should support such activities once it has been established that they do not have any detrimental or harmful effects on survivors.

★ See the IASC GBV Guidelines

Resources

- **Sexual Abuse Survivors and the Complex of Traditional Healing**
  The Nordic Africa Institute (2009)
  <http://biblioteca.hegoa.ehu.es/system/ebooks/19111/original/Sexual_Abuse_Survivors.pdf?1355244761>
- **Restoring Hope and Dignity: Manual for Group Counseling**
  Centre for Victims of Torture
  <www.cvt.org/group-counseling-manual>

Mogadishu, Somalia

g) Economic and social empowerment initiatives

The connection between girls' and women's empowerment and their reduced exposure to GBV in emergencies is becoming better understood. Carefully designed empowerment activities that build social and economic assets,[10] as affirmed in the **IASC GBV Guidelines**,[11] can help survivors regain a sense of control, worth and productivity; they can also help to protect survivors and others at risk against sexual assault and exploitation by reducing their vulnerabilities and increasing their opportunities, bargaining power and influence.[12]

Historically, GBV programs have provided small-scale skills training and other livelihoods inputs to help survivors help themselves and build income-generating capacity of survivors and those at risk. Increasingly, however, the role of economic and social empowerment as vital tools of GBV prevention and response are being recognized.

During **immediate response** to an emergency, COs and partners can:

- Extend UNICEF-supported cash transfer and other emergency social protection initiatives to girls and women to reduce their immediate vulnerability to GBV; and
- Begin age- and gender-sensitive livelihoods and market assessments.

Once a **situation has stabilized**, COs and partners can deliver a package of age- and gender-specific services to vulnerable girls and women to increase their economic security and agency. The mix and types of asset-building services that UNICEF and partners implement in each setting will depend on the economic and social context, including market conditions and girls' circumstances in each situation.

10 Assets are defined as physical, financial, human, natural and social resources that can be acquired, developed, improved, and/or transferred across generations.
11 See <http://gbvguidelines.org>.
12 Quisumbing (2003) cited in Quisumbing, A. and Kovarik, C., *Investments in Adolescent Girls' Physical and Financial Assets: Issues and Review of Evidence,* Girl Hub, London, 2013.

Resources

- **Conditionality in Cash transfers in Emergencies: UNICEF's approach**
  UNICEF (2016)
  <http://www.unicefinemergencies.com/downloads/eresource/docs/Cash%20in%20Emergencies/Conditionality%20in%20Cash%20Transfers%20-%20UNICEF's%20Approach-2.pdf>
- **Integrated Social Protection Systems: Enhancing equity for children**
  UNICEF (2012)
  <www.unicefinemergencies.com/downloads/eresource/docs/Cash%20in%20Emergencies/UNICEF_Social_Protection_Strategic_Framework_full_doc_std(1).pdf>
- **Integrating Cash Transfers into Gender-based Violence Programs in Jordan: Benefits, risks and challenges**
  International Rescue Committee (2015)
  <www.cashlearning.org/downloads/erc-irc-action-research-web.pdf>
- **Guide for Protection in Cash-Based Interventions**
  - Practitioner Guide
  - Tips for Mainstreaming
  - Risk and Benefits Analysis Tool

  UNHCR (2015)
  <www.womensrefugeecommission.org/issues/livelihoods/research-and-resources/1280-protection-in-cash-based-interventions>
- **Empowered and Safe: Economic strengthening for adolescent girls in emergencies**
  Women's Refugee Commission (2014)
  <www.womensrefugeecommission.org/images/zdocs/Econ-Strength-for-Girls-Empowered-and-Safe.pdf>
- **A Double-Edged Sword: Livelihoods in emergencies**
  Women's Refugee Commission (2014)
  <www.womensrefugeecommission.org/resources/document/1046-a-double-edged -sword-livelihoods-in-emergencies>
- **Preventing Gender-Based Violence, Building Livelihoods Guidance and Tools for Improved Programming**
  Women's Refugee Commission (2012)
  <www.womensrefugeecommission.org/resources/document/798-preventing-gender-based-violence-building-livelihoods-guidance-and-tools-for-improved-programming>
- **CLARA: Cohort Livelihoods and Risk Analysis**
  Women's Refugee Commission (2016)
  <www.womensrefugeecommission.org/issues/livelihoods/research-and-resources/1231-clara-tool>
- **Building Effective Women's Economic Empowerment Opportunities**
  International Center for Research on Women (2016)
  <www.icrw.org/publications/building-effective-womens-economic-empowerment-strategies-3/>
- **Violence Against Women and Girls Resource Guide: Finance and enterprise development brief**
  World Bank (2015)
  <http://www.vawgresourceguide.org/sites/default/files/briefs/vawg_resource_guide_finance_and_enterprise_development_brief_april_2015.pdf>
- **Violence Against Women and Girls Resource Guide: Social protection brief**
  World Bank (2014)
  <www.vawgresourceguide.org/sites/default/files/briefs/vawg_resource_guide_social_protection_brief_-_nov_26.pdf>
- **The Cash Learning Partnership website**
  <www.cashlearning.org/>

Capacity Development

- **UNICEF Humanitarian Cash Transfer Programming and Social Protection Linkages**
  <www.unicefinemergencies.com/downloads/eresource/Cash_in_Emergencies.html>
- **Women's Refugee Commission Preventing Gender-based Violence, Building Livelihoods E-Learning**
  <http://womensrefugeecommission.org/elearning>
- **UNHCR Guide for Protection in Cash-Based Interventions Training Module**
  <www.womensrefugeecommission.org/issues/livelihoods/research-and-resources/1280-protection-in-cash-based-interventions>

h) Training and supervising social workers and community volunteers

Social workers and community volunteers need initial and ongoing training to make sure they have the skills required for working with GBV survivors. A variety of inter-agency training materials are available with a focus on developing survivor-centred attitudes and behaviours. Training for social workers and community volunteers should focus on crisis care and case management for child, adolescent and adult survivors who have recently experienced sexual violence. Staff working with survivors requiring ongoing intervention to preserve their safety will also benefit from training in problem solving and supportive counselling.

When planning trainings, COs need to consider initial and ongoing training needs, as well as supervision of social workers and community volunteers. Training should never be a one-time activity; paid staff and volunteers require ongoing and refresher trainings from knowledgeable and experienced personnel. Developing competency in any skill requires practice, supervision and the opportunity for reflection. It is essential to build in on-the-job supervision, monitoring and support post-training to assist social workers, case workers and volunteers in applying new knowledge and skills toward their work with survivors. Where it is difficult to provide on-site supervision – for example, due to inaccessibility of facilities, insecurity or a lack of trained personnel – consider creative ways of doing this, such as remote supervision sessions using the internet or on-site team-based peer supervision and learning.

Furthermore, it is critical that GBV training for psychosocial support workers assesses and addresses values, attitudes and beliefs regarding GBV and survivors. Psychosocial helpers can cause harm to those seeking help if their assistance is not compassionate and survivor-centred. In such cases, others in the community will not feel confident to come forward for help.

Capacity Development

GBV psychosocial training materials

- **Causes and Effects of Gender-Based Violence Training Module**
  <http://hrlibrary.umn.edu/svaw/advocacy/modelsessions/causes_effects.PDF>
- **Community Workers' Guide to Understanding Gender-Based Violence and Child Protection Basic Concepts**
  UN Relief and Works Agency for Palestine Refugees in the Near East (2016)
  <http://reliefweb.int/report/world/community-workers-guide-understanding-gender-based-violence-and-child-protection-basic>
- **Caring for Survivors of Sexual Violence in Emergencies Training Guide**
  Inter-Agency Standing Committee Sub-Working Group on Gender in Humanitarian Action
  <http://unicefinemergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf>

Gao, Mali

- **Communities Care: Transforming Lives and Preventing Violence Toolkit, Part Three**
  - Survivor-Centred Care Training Module
  - Psychosocial Support Training Module

  UNICEF (2014)

- **Caring for Child Survivor Training Materials**
  International Rescue Committee
  <http://gbvresponders.org/response/caring-child-survivors/#CCSTrainingMaterials>

- **The Psychosocial Care and Protection of Children in Emergencies Teacher Training Manual**
  UNICEF (2009)
  <http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1064/Psychosocial_Care_and_Protection.PDF>

- **Mental Health and Gender-Based Violence: Helping survivors of sexual violence in conflict – a training manual**
  Health and Human Rights Info
  <http://hhri-gbv-manual.org/>

- **Training Handbook on Psychosocial Counselling for Children in Especially Difficult Circumstances: A trainer's guide**
  UNICEF (2003)
  <https://resourcecentre.savethechildren.net/library/training-handbook-psychosocial-counselling-children-especially-difficult-circumstances>

- **Psychological First Aid: Facilitator's manual for orienting field workers**
  World Health Organization (2014)
  <www.who.int/mental_health/emergencies/facilitator_manual_2014/en/>

2.4 Coordinating with others

It is vital that psychosocial support services coordinate with others providing services to survivors. There are two related aspects to coordinated care that need to be considered.

The first is **inter-agency coordination**, which involves making sure all agencies and organizations providing care, support and protection services to GBV survivors work collaboratively together to respond to GBV and are able to seamlessly refer and care for survivors. Inter-agency systems coordination usually involves developing shared protocols for referral and service delivery and meeting regularly to facilitate good communication and joint problem solving.

The second aspect of coordinated care is **case coordination**, which is a foundation of a survivor-centred approach. This involves making sure each survivor can receive care, support and protection services in a coordinated manner and according to her unique needs and circumstances. As noted above, good case coordination usually involves implementing a case management system so that survivors can receive tailored services based on their individual circumstances, wishes and needs.

Resources

- **Handbook for Coordinating Gender-Based Violence Interventions in Humanitarian Settings**
  GBV AOR (2010)
  <www.refworld.org/docid/52146d634.html>
- **Establishing GBV Standard Operating Procedures**
  Inter-Agency Standing Committee Sub-Working Group on Gender (2008)
  <http://www.globalprotectioncluster.org/_assets/files/tools_and_guidance/gender_based_violence/GBV_Standard_Operational_Procedures_2008_EN.pdf>
- **Interagency Gender-based Violence Case Management Guidelines**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>

Step 3: Monitoring

3.1 Selecting indicators to monitor progress and quality

The exact choice of outcomes, outputs and indicators will be determined by the CO based on specific objectives and interventions selected; the phase of humanitarian response; and the feasibility of monitoring in emergency contexts. However, the table on the following page illustrates sample outputs and indicators for monitoring changes in psychosocial support programmes. Remember, indicators need to be measured *before* and *after* an intervention to see if there have been any changes.

Sample outcomes, outputs and indicators for GBViE psychosocial response

Outcome	Sample outputs	Sample indicators
Enabling Environment		
Social norms encourage family and community compassion and acceptance for child, adolescent and adult survivors of GBV.	Increased community awareness on psychological and social impacts of GBV; needs of survivors; and family and community role in psychosocial support.	• Changes in beliefs and attitudes about GBV among participants in communications activities. • Increase in expressions of public support for GBV survivors. • Increase in # of people exposed to communications activities who believe others in the community help GBV survivors.
	Increased community dialogue on GBV.	
	Traditional leaders encourage rights and well-being of GBV survivors.	• Decrease in # of traditional leaders who prescribe forced marriage of rape survivors to the perpetrator. • Increase in # of traditional leaders who express public support of and refer GBV survivors to psychosocial support services.
Government policies facilitate psychological and social support and protection for GBV survivors.	Government social service and protection policies reflect psychological and social support needs of GBV survivors.	• Increase in # of GBV survivors accessing Government social service and protection initiatives.
GBV psychosocial response is adequately funded, prioritized and coordinated within humanitarian action.	All humanitarian donors have adequate information about GBV, as well as UNICEF and wider GBV humanitarian response plan.	• # of GBV advocacy materials developed and disseminated to humanitarian donors.
	GBV, child protection and other psychosocial actors meet regularly to review and coordinate GBV psychosocial response.	• # of meetings held between GBV and Health cluster actors monthly.
	Referral networks established in all districts/camps.	• % of survivors referred for psychosocial care by source.

Outcome	Sample outputs	Sample indicators
Supply		
Age-appropriate focused psychosocial support services are available for survivors in all districts/camps.	Safe spaces have essential equipment and supplies and are staffed by appropriately trained staff/volunteers.	• # of safe spaces offering age-appropriate services for survivors of GBV. • % of population with access to functioning safe spaces. • % of safe spaces with essential equipment and supplies (e.g. material supplies for basic needs, toys for children, educational materials, etc.). • # of safe space workers/volunteers trained on GBV. • # of safe space workers/volunteers trained on crisis care. • Changes in knowledge, attitudes and practices of safe space workers regarding GBV immediately post-training. • Changes in knowledge, attitudes and practices of safe space workers regarding GBV six months post-training. • % of safe spaces with at least one worker trained to care for, refer and case manage GBV survivors.
	Social workers and community volunteers are trained and resourced to provide crisis support to survivors of recent sexual assault or other traumatic GBV incidents.	• # of social workers/volunteers trained to provide age-appropriate crisis care to sexual violence survivors. • % of population with access to trained crisis support workers. • Changes in knowledge, attitudes and practices of crisis care workers regarding GBV immediately post-training. • Changes in knowledge, attitudes and practices of crisis care workers regarding GBV six months post-training. • % of crisis care workers trained to refer and case manage GBV survivors.
	Information, referral and case management services are available, resourced and provided by trained staff/volunteers.	• Case management protocol outlining roles and responsibilities of different actors and case management process are followed. • Existence of case management documentation forms. • # of social workers/volunteers trained on age-appropriate case management for GBV survivors. • % of population with access to trained case workers. • % of clients with clearly documented case plans. • Changes in knowledge, attitudes and practices of case workers immediately post-training. • Changes in knowledge, attitudes and practices of case workers six months post-training. • % of case workers trained in age-appropriate crisis care for survivors.

Outcome	Sample outputs	Sample indicators
Supply (continued)		
Age-appropriate focused psychosocial support services are available for survivors in all districts/camps. **(continued)**	Other psychological, social and economic reintegration support services for survivors have essential equipment and supplies and are staffed by trained staff/volunteers.	• # of social workers/volunteers trained on GBV and on competency for service delivery. • Changes in knowledge, attitudes and practices of staff immediately post training. • Changes in knowledge, attitudes and practices of staff six months post training.
Demand		
Survivors use GBV psychosocial services.	Social barriers to participation in psychosocial activities are reduced.	• # of community-level barriers to sexual violence healthcare identified. • % of identified community-level barriers removed.
	The community is aware of and confident in case management and other GBV psychosocial services.	• # of community awareness sessions. • # of community members participating in awareness sessions by age and sex. • % of community members who can state where to access GBV crisis care or case management services. • # of child/adolescent and adult survivors who use GBV psychosocial services.
Quality		
Focused GBV psychosocial support services are culturally appropriate and of good quality.	Safe spaces, crisis care, case management and other psychosocial services are delivered according to survivor-centred principles.	• % of case managed GBV survivors with appropriate case plans. • % of case plans with evidence of survivor input/ self-determination. • % of trained safe space/crisis care/case workers who know how to promote client safety. • % of trained safe space/crisis/case workers who know how to protect and promote their patient's rights to confidentiality and privacy. • 100% of client records are stored securely and appropriately coded to ensure confidentiality. • % of safe space/crisis/case workers who can demonstrate appropriate engagement and empathy. • % of clients surveyed who express satisfaction with services.

Tools

Rapid Assessment Tool 3: GBV Service Capacity and Quality Audit Tool

Psychosocial Tool 2: Client Satisfaction Survey

Psychosocial Tool 3: Psychosocial Service Monitoring Sheet

Resources

- **Violence Against Women and Girls: A compendium of monitoring and evaluation indicators**
  Measure Evaluation (2008)
  <www.measureevaluation.org/resources/tools/gender/violence-against-women-and-girls-compendium-of-indicators>

- **Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions Along the Relief to Development Continuum**
  United States Agency for International Development (2014)
  <www.usaid.gov/sites/default/files/documents/2151/Toolkit%20Master%20%28FINAL%20MAY%209%29.pdf>

- **Guidance on Monitoring and Evaluation for Programming on Violence Against Women and Girls**
  United Kingdom Department for International Development (2012)
  <www.gov.uk/government/uploads/system/uploads/attachment_data/file/67334/How-to-note-VAWG-3-monitoring-eval.pdf>

Tangwani, Pakistan

Minimum psychosocial response checklist

The following is a checklist detailing minimum essential actions for effective GBV psychosocial response throughout the phases of an emergency.

Preparedness	Immediate response
Review national social service policies, social protection policies and customary systems against survivor-centred principles.	Establish safe spaces for girls and women to seek help and receive information, advocacy and referral for healthcare, safety options and meeting basic needs.
Train social service and community workers in crisis care, case management and culturally appropriate counselling.	Train social workers and volunteers in crisis support for survivors of recent sexual assault or other traumatic GBV incidents.
Advocate for specialized mental health services, including psychological or psychiatric evaluation, treatment and care.	Provide technical support for establishing an inter-agency referral system to link survivors with health, safety and legal support.
Deliver community education to promote help-seeking and promote community compassion and acceptance of GBV survivors.	Deliver community sensitization on sexual violence consequences and services to promote help-seeking and promote community compassion and acceptance of those affected.

Section 4.3

Improving GBV Survivor Safety in Emergencies

The importance of survivor safety

Girls and women who speak out or seek help after experiencing rape or other forms of GBV can be at very real risk of further violence. Violence, and the threat of it, is used by perpetrators and their supporters to prevent survivors from speaking out or reporting what has happened, to punish them for doing so, or to force them to retract a report.

Violence may also be used as a punishment within customary law, such as in situations where a rape survivor is blamed for the assault and accused of adultery. Violence can be perpetrated by a survivor's own relatives as punishment for bringing shame or dishonour to the family or for going against social expectations. For example, a girl escaping a forced marriage may be punished by her own family for refusing to follow the community norm. While parents are primary duty bearers of children's rights to safety and protection, at times families can be a source of harm or can fail to protect girls from GBV.

While many survivors who are at risk of further violence get the protection and safe haven they need from their families or support networks, a small number will require additional help. For some survivors, outside assistance will be short-term; for others who face life threatening or ongoing risk of harm, there may be a need for longer-term protection options.

Providing safety to at-risk GBV survivors and their children is challenging – it can even be difficult in stable, well-resourced settings where there is a legislative and policy framework outlining survivors' rights to safety and duty bearers' responsibilities for providing it. Even with good legal and social protection for survivors, responsive law enforcement and well-coordinated support services, guaranteeing safety for survivors can be hard and dangerous work. Providing safety can be especially complex in insecure environments, such as settings where the usual protection mechanisms are not functioning, where there are limited resources, or where there are strong social norms that lead to blaming and stigmatizing of survivors. These issues may be compounded where the state is a party to a conflict and a source of threat. Further, when the source of the threat is powerful (such as armed actors or security forces), the risks can be particularly high, and establishing safety can be especially challenging.

Even in conflict- and disaster-affected settings, however, survivors of GBV and their children have the right to safety and protection from further violence and harm. While it can be resource-intensive and complicated to provide safety services such as safe houses

or emergency shelters in emergency settings, UNICEF and other duty bearers have a responsibility to make locally appropriate safety options available and reduce exposure to further violence, exploitation and abuse. It is very important, therefore, that appropriate consideration, resources and technical support are given by GBV actors, including UNICEF, to establishing safety services.

There are a variety of approaches to providing safety for at-risk survivors of GBV and their children. What constitutes an appropriate option will depend on the setting – for example, whether it is a camp setting, spontaneous settlement or community-based; whether it is remote or urban; the type of violence and source of the threat; the level of community support for survivors; and other factors.

UNICEF's GBV survivor safety response

Objective

The objectives of UNICEF's GBViE survivor safety response include:

- To realize survivors' rights to safety by supporting community-based actors to identify and manage locally appropriate safety options for survivors and their children who are at serious risk of further violence, exploitation or abuse; and
- To strengthen national and local systems to provide safety and protection for GBV survivors and their children as part of emergency preparedness and ongoing response.

A phased response

A holistic and phased safety response to GBV involves taking particular actions *before* emergencies happen, *during* the initial phases of humanitarian response, and as part of *ongoing response and recovery efforts*.

Immediate response

Immediately following a rapid-onset disaster or during complex and protracted emergencies, UNICEF's priority is to coordinate and collaborate with other actors involved in responding to GBV to identify and put in place the best safety options for survivors at risk of further harm or violence. COs must consider:

- Available resources and security;
- Survivors' rights to self-determination, confidentiality and privacy;
- The needs of children of survivors;
- Best interests of the child and good practices in protective intervention with at-risk child survivors and children of survivors; and
- The importance of community-based solutions and action.

UNICEF works with partners to ensure survivors have access to safety-related information and case management services (for more information about case management, see *Section 4.2: Strengthening Psychosocial Support for GBV Survivors*.) **For women survivors**, safety intervention through case management focuses on helping them identify their safety needs and develop a plan to address them. **For girl survivors**, safety intervention through case management involves assessing the risk of further violence and acting to make the child safe when others in the family are unable to do so, making sure to involve non-offending family members where possible. Interventions also need to cater to the children of survivors.

Three common strategies for providing safety to at-risk GBV survivors include:

1. **Community-based protection** – where members of the community, particularly leaders, take responsibility for protecting at-risk children and women and holding perpetrators to account. Community-based solutions reduce the need for safe houses, allowing survivors to remain with their families and continue with normal daily life, which has been shown to be better for the psychosocial well-being of the survivor.

Alternative Care for Children

2. **Alternative accommodation** – where survivors and their children can live short-, medium- or long-term in a safe environment. There are many different forms of short- and long-term accommodation options for adults and **alternative care for children**, including:
   - Kinship placements with extended family or close friends of the family;
   - Foster care placements;
   - Safe houses and shelters set up for housing survivors of sexual abuse, intimate partner violence or trafficking (and their children, as necessary);
   - Guesthouses, hotels, community-based facilities (such as church buildings), women's centres, children's centres and similar accommodations;
   - Residential care in group homes or facilities; and
   - Independent living for older adolescents and adults.
3. **Relocation** – in situations where there are no other options for guaranteeing the safety of a survivor at high risk of serious harm. In these cases, temporary or permanent relocation may be the only viable method of guaranteeing the survivor's safety. Relocation may be to another camp for displaced people, to another part of the country, or, for refugees, even to a third country.

Emergency preparedness and ongoing response/recovery

Prior to the onset of an emergency or once a situation has stabilized, UNICEF invests in building capacity of national safety and protection systems. This includes building the capacity of the legal and policy framework for protective interventions, accommodations and out-of-home care services for girls and women experiencing GBV. It also includes working with government and community actors to develop and implement good practice standards and guidelines for managing safety services for survivors of GBV.

Resources

- **Safe Haven: Sheltering displaced persons from sexual and gender-based violence**
  Human Rights Center, University of California (2013)
  <http://reliefweb.int/sites/reliefweb.int/files/resources/51b6e27b9.pdf>
- **Virtual Knowledge Centre to End Violence Against Women**
  - Shelter Module

  UN Women
  <http://endvawnow.org/en/modules/view/15-shelter.html>
- **Guiding Principles and Field Handbook on Working with Unaccompanied and Separated Children**
  Interagency Working Group on Unaccompanied and Separated Children (2016)
  <www.unicef.org/protection/IAG_UASCs.pdf>
- **Guidelines for the Alternative Care of Children**
  United Nations (February 2010)
  <www.unicef.org/protection/alternative_care_Guidelines-English.pdf>
- **Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children**
  The Centre for Excellence for Looked After Children in Scotland (2012)
  <www.alternativecareguidelines.org/Home/tabid/2372/language/en-GB/Default.aspx>
- **The Role of Case Management in the Protection of Children: A guide for policy and programme managers and caseworkers**
  Child Protection Working Group (2014)
  <http://cpwg.net/wp-content/uploads/sites/2/2014/09/Interagency-Guidelines-for-Case-Management-and-Child-Protection.pdf>
- **Alternative Care in Emergencies Toolkit**
  Interagency Working Group on Unaccompanied and Separated Children (2013)
  <www.unicef.org/protection/files/ace_toolkit_.pdf>

Considerations for country offices

A CO should consider the following when designing UNICEF's safety response to GBV in emergencies:

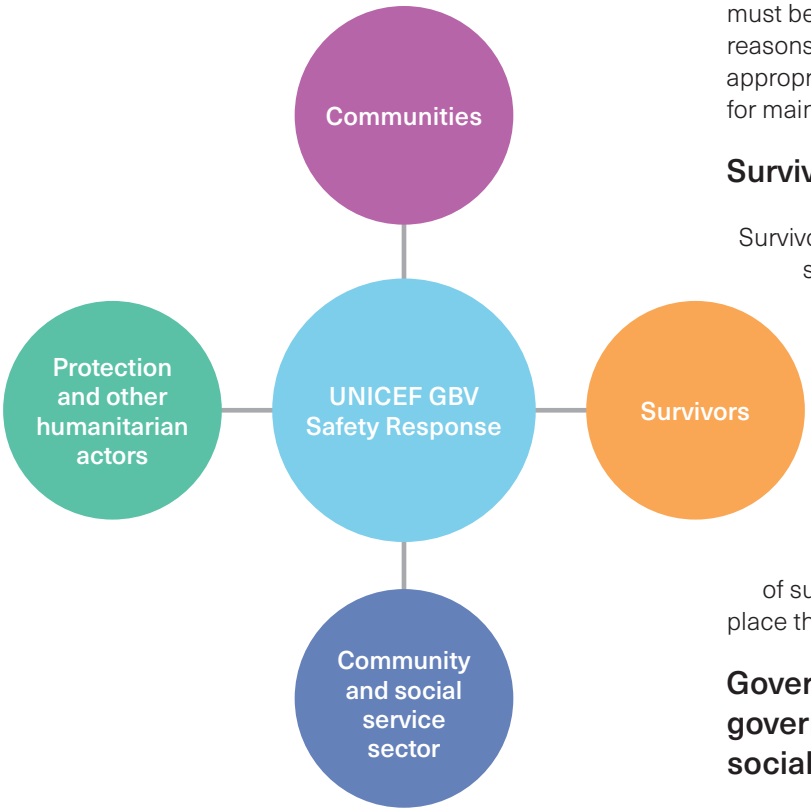
- The **legislative framework,** including legislation on child protection and out-of-home care for children;
- **Pre-disaster or conflict safety service models** adopted in the country;
- **Safety risks and needs** of different populations (for example, victims of organized sex trafficking; survivors of sexual violence war crimes in need of witness protection; children escaping sexual abuse occurring within the family; girls/women and their children born of rape; girls/women demobilizing through DDR or release programmes; etc.);
- **How to link survivors** in need of safety with other humanitarian programming, such as emergency education, child-friendly spaces, children's health services, or nutrition, livelihoods and social protection programming;
- **Capacity of partners** to assess, manage and monitor safety options for survivors and their children;
- **Technical and resourcing requirements** for establishing and maintaining quality services;
- The need to develop clear **operational procedures and guidance** that address both client and worker safety and security, especially when perpetrators are members of security forces;
- **When and when not to integrate** safety options for GBV survivors with other emergency shelter programs – for example, it is not appropriate to place sexually abused girls in residential facilities that also accommodate older boys or young men;
- **Sustainability and local ownership;**
- **Crisis versus longer-term** protection needs and options; and
- The need for **ongoing and intensive case management services** for children and women at risk of harm, as well as the need for well-trained, experienced, supervised and supported case workers for high-risk cases.

Jalozai camp, Pakistan

Stakeholders in GBV survivor safety response

Key stakeholders in the assessment and design of safety options for GBViE survivors include:

- Communities;
- Survivors;
- Government and non-government community and social service sectors; and
- Protection and other humanitarian actors.



Communities

It is essential that community representatives are actively engaged in designing and delivering safety programmes for survivors of GBV. Community actors may devise local safety solutions and run safe shelters where these are used. There will always be some segments of the community that are already providing, or are willing to provide, safety for survivors, and these individuals and groups must input into the design and management of survivor-centred safety options. They should also be supported as change agents in shifting community norms that stigmatize, blame and further victimize survivors. Women's and children's rights and welfare organizations should be involved from the outset of all community consultation processes.

Ideally, wider community support can be obtained for shelter services; however, this is not advisable in situations where the existence and location of shelter services must be kept highly confidential for security reasons. COs will need to determine the appropriate level of community participation for maintaining survivor and worker safety.

Survivors

Survivors of GBV are well-placed to identify safety and security problems faced by different age groups, vulnerable populations and those experiencing different types of violence. Survivors of different types of GBV should be considered key informants during safety-related assessments; at the same time, it is paramount that the safety and confidentiality of survivors be maintained so as not to place them at risk of further violence.

Government and non-government community and social service providers

During emergency response, government and non-government child protection, social service and community welfare organizations may already be running shelter or safety facilities/services. As such, they are important stakeholders in humanitarian response. During preparedness and recovery, particular emphasis should be placed on working with

national government and non-government actors to ensure development of good practice standards and guidelines based on survivor-centred principles.

Protection and other humanitarian actors

Protection actors – especially the Child Protection (CP) sub-cluster – will provide valuable information on pre-emergency protection and safety practices; standards and models for alternative care for children in the country; and information, resources and advocacy on a case-by-case basis.

When establishing safe shelters or safe houses in internally displaced persons (IDP) or refugee camps, it may be appropriate to engage camp management, security and humanitarian actors (such as food, shelter, non-food item and health actors) so long as this does not create a threat to the safety of safe shelter residents.

Harar, Ethiopia

Steps in GBV survivor safety response

There are three steps to ensuring a good quality safety response to GBViE:

Step 1: Assessment and design
- 1.1 – Assessing the context
- 1.2 – Results-based programme design

Step 2: Implementation
- 2.1 – Fostering positive social norms that promote survivor safety
- 2.2 – Supporting governments to develop and implement safety and protection policies and standards
- 2.3 – Delivering safety services for at-risk survivors
- 2.4 – Providing training, development and supervision of case workers, shelter workers and community volunteers
- 2.5 – Coordinating with others

Step 3: Monitoring
- 3.1 – Selecting indicators to monitor progress and quality

Step 1: Assessment and design

1.1 Assessing the context

In the early stages of emergency response, safety assessment focuses on collecting information about:

- What specific safety and security threats survivors of GBV face and from whom;
- Priority safety needs;
- Existing safety models and services in the community for girls and women at risk of further violence and their children; and
- Possible solutions where safety options are inadequate.

Kathmandu, Nepal

Tools

Safety Tool 1: GBV Survivor Safety Response Audit Tool

See *Section 3: Rapid GBV Assessment* in this book.

1.2 Results-based programme design

UNICEF applies a **results-based approach** to programme design so that:

- ✔ Interventions are based on a logical pathway for creating impact;
- ✔ Interventions are results-oriented, and changes or effects are clearly identified; and
- ✔ Interventions can be monitored and evaluated.

Once priority needs, capacities and gaps in safety services for GBV survivors have been determined, design of UNICEF's GBViE safety interventions involves the following:

1. **Identify UNICEF's role, priorities and partnerships** for providing safety options for survivors of GBV and their children.
2. **Define the results or outcomes for UNICEF and partner interventions** for increasing safety for at-risk GBV survivors and their children based on determinants in one or more of the following the areas:
   - Fostering protective social norms for survivors that encourage community support and protection;
   - Strengthening legislation and policy related to survivor safety;
   - Making good quality safety services available and accessible for different groups of at-risk survivors, including those with children; and/or
   - Building community knowledge, beliefs and practices that improve safety for survivors.
3. **Identify outputs and strategies** for achieving the outcomes, as well as **indicators** for measuring progress during implementation. See the next column for key strategies for promoting survivor safety.
4. **Review and finalize the programme design** prior to implementation, ensuring its alignment with best practices, ethics and safety. Don't forget to consider how the programme will be evaluated as part of programme design.

Tools

See **Kit 4: Evaluation** for more information about different types of evaluative activities in emergency settings.

Key strategies for promoting survivor safety include:

- *Advocacy* – for example, advocating with humanitarian donors for adequate funding for emergency case management and safety services.
- *Technical support* – for example, supplying technical expertise in establishing protocols for safe houses.
- *Funding* – for example, funding non-government organizations (NGOs) to establish and run safe houses and deliver intensive case management support to at-risk survivors in the early stages of emergency response.
- *Operational assistance and inputs* – for example, supplying safe houses with material support such as clothing and other non-food items to meet survivors' and their children's immediate basic needs.
- *Training and development* – for example, training case workers and shelter workers in crisis support and case management.

Examples of strategies in different phases of emergency response are illustrated on the following page.

Examples of strategies for building survivor safety

Determinants	Immediate response	Preparedness/Ongoing response and recovery
Enabling environment	• Advocate within the humanitarian system for adequate funding of safety services. • Provide technical support for the establishment and management of case management system.	• Deliver multi-media communications campaigns to build or strengthen protective social norms and foster community action to ensure survivor safety. • Provide technical and financial assistance to develop and implement policies and protocols for sustainable scale-up of safety services for survivors of GBV.
Supply and quality	• Fund operational costs of community-based safe accommodation, including material support for community placement and safe shelter. • Provide technical support for staff training and development of case management guidelines for survivors at high risk of further violence and their children. • Provide technical support for development of operational guidelines for safe shelter facilities. • Provide training and supervision of case workers and shelter staff.	• Provide technical and financial assistance to deliver age-appropriate safety and protection services. • Provide technical support to develop national shelter/emergency accommodation service standards. • Train paid and volunteer case workers and shelter workers to manage placements and facilities, and provide ongoing emotional and practical support to survivors and their children. • Establish supervision and support structures for case workers and shelter workers interacting with at-risk clients.
Demand	• Initiate community awareness campaigns to end victim-blaming and impunity for perpetrators, and promote community-based protection for survivors.	• Initiate community mobilization to promote community responsibility and solutions for protection of survivors.

Resources

- **UNICEF Programme Policy and Procedures Manual**
  - Chapter 3: Programme Preparation
  - Chapter 4: Programme Implementation and Management

  <https://unicef.sharepoint.com/teams/OED/PPPManual/SiteAssets/Welcome%20to%20the%20Programme,%20Policy%20and%20Procedure%20Manual.aspx?wa=wsignin1.0>

- **UNICEF Technical Notes: Special Considerations for Programming in Unstable Situations**
  <www.mona.uwi.edu/cardin/virtual_library/docs/1255/1255.pdf>

Capacity Development

- **UNICEF Programme Planning Process (PPP) e-learning course**
  <https://agora.unicef.org/course/info.php?id=6825>

Step 2: Implementation

Implementing good quality safety services for survivors involves creating positive social norms; supporting governments to develop and implement safety and protection policies and standards; delivering safety services for at-risk survivors and their children; providing training, development and supervision for case workers, shelter workers and community volunteers; and coordinating with others.

2.1 Fostering positive social norms that promote survivor safety

Social norms are incredibly influential: they can either create safety threats for GBV survivors or they can promote a protective and safe environment. Social norms that foster victim-blaming, stigmatization and discrimination against survivors of GBV or that link family honour with female sexual purity, for example, put survivors at risk of further violence. Norms that encourage sanctioning and accountability of perpetrators while advocating acceptance and support for survivors, on the other hand, contribute to building safety and protection from further violence.

UNICEF is increasingly using **social norms perspectives** to foster health and violence-related behaviour change, even in emergency-affected settings. Social norms that lead to victim-blaming, stigmatization and discrimination against survivors of GBV or that lead to further disempowerment or violence – such as norms prescribing that raped girls should marry the perpetrators to protect their honour – can contribute to poor psychosocial well-being and mental health problems for survivors.

A variety of communication strategies should be employed to promote survivors' rights to safety and perpetrator accountability. COs should consider communication interventions that foster positive norms to encourage community support, acceptance and safety for survivors. Communication strategies that use multiple channels of communication achieve a higher proportion of positive outcomes. Strategies need to extend beyond individuals and households to include service providers, traditional and religious leaders, and decision-makers at different levels to engender community-wide change.[13]

UNICEF is continually developing and piloting community-based approaches to communication for social norms change. COs that adopt social norms approaches in emergencies are encouraged to draw on existing materials and lessons learned as they develop interventions.

13 Marcus, R and Page, E., 'Changing discriminatory norms affecting adolescent girls through communication activities: A review of evidence', Overseas Development Institute, London, 2014.

Resources

- **Behaviour Change Communication in Emergencies: A Toolkit**
  UNICEF (2006)
  <www.unicef.org/rosa/Behaviour.pdf>
- **Communication for Humanitarian Action Toolkit (CHAT) Working Version**
  UNICEF (May 2015)
  <www.unicefinemergencies.com/downloads/eresource/docs/Communication%20for%20Development/6-C4D-CHAT_Proof-2.pdf>
- **Communities Care: Transforming Lives and Preventing Violence Toolkit**
  UNICEF (2014)
- **Shifting Social Norms to Tackle Violence Against Women and Girls**
  United Kingdom Department for International Development (2016)
  <www.gov.uk/government/uploads/system/uploads/attachment_data/file/507845/Shifting-Social-Norms-tackle-Violence-against-Women-Girls3.pdf>
- **Social Norms Professional Development Pack**
  GSDRC/University of Birmingham (2016)
  <www.gsdrc.org/professional-dev/social-norms/>

2.2 Supporting governments to develop and implement safety and protection policies and standards

Once a situation has stabilized, COs should concentrate on building the capacity of national safety and protection systems, including the legislative and policy framework for protecting GBV survivors and their children. UNICEF encourages governments to ensure such frameworks are aligned with international child protection standards for out-of-home care for children. UNICEF also promotes child-centred family and kinship care for child survivors of GBV who cannot live at home due to ongoing safety risks. In countries where there is an established foster care system, UNICEF may support the government to review this system and identify areas where additional support, technical guidance or material input is required so that child survivors in foster care have their safety and protection needs met.

National frameworks need to specify the roles and responsibilities of formal protection actors (such as police and statutory child protection actors), as well as the roles of social service and community welfare actors, in providing community-based safety solutions for GBV survivors and their children. They must also set and monitor standards for services.

Resources

- **Handbook on Legislative Reform: Realizing child rights**
  UNICEF (2008)
  <www.unrol.org/files/Handbook%20on%20Legislative%20Reform.pdf>
- **Legislative Reform on Selected Issues of Anti-Gender discrimination and Anti-Domestic Violence: The impact on children**
  UNICEF (2009)
  <www.unicef.org/policyanalysis/files/Legislative_Reform_on_Selected_Issues_of_Anti-Gender_Discrimination_and_Anti-Domestic_Violence_-_the_Impact_on_Children.pdf>
- **Justice in Matters Involving Child Victims and Witnesses of Crime: Model law and related commentary**
  UNDOC and UNICEF (2009)
  <www.unicef.org/albania/Justice_in_matters.pdf>
- **Handbook for Legislation on Violence Against Women**
  United Nations Department of Economic and Social Affairs (2010)
  <www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf>

Nepal

Resources (continued)

- **Handbook for National Action Plans on Violence Against Women**
  UN Women (2012)
  <www.un.org/womenwatch/daw/vaw/handbook-for-nap-on-vaw.pdf>
- **Do Our Laws Promote Gender Equality? A handbook for CEDAW-based legal reviews**
  UN Women (2012)
  <http://unwomen-asiapacific.org/docs/cedaw/archive/FINAL_CEDAW_Handbook.pdf>
- **Engaging Men in Public Policies for the Prevention of Violence Against Women and Girls**
  UN Women, UNFPA, EME/CulturaSalud and Promundo (2016)
  <http://endvawnow.org/uploads/tools/pdf/1470922012.pdf>
- **Virtual Knowledge Centre to End Violence Against Women**
  - Legistlation Module

  UN Women
  <www.endvawnow.org/en/modules/view/8-legislation.html>

2.3 Delivering safety services for at-risk survivors

When establishing or supporting safety services for at-risk GBV survivors, UNICEF COs and partners need to consider:

a) Case management protocols and procedures for at-risk clients;

b) Emergency accommodation models and guidelines;

c) Community-based protection options; and

d) Relocation.

a) Case management protocols and procedures for at-risk clients

Survivors at risk of harm or further violence need intensive case management (see *Section 4.2: Strengthening Psychosocial Support for GBV Survivors* for more information on case management). It is essential to develop clear case management protocols for at-risk clients that outline:

- Case worker-to-client ratio;
- Regularity of supervision meetings to discuss at-risk clients;
- Risk assessment and decision-making responsibilities for emergency safety services, including responsibilities of case workers and supervisors;
- Criteria and threshold for accessing emergency accommodation;
- Best interests of the child in relation to child survivors and children of survivors;
- Regularity of contact between the case worker and client;
- Material support and resource allocation (such as per diem for food allowance, educational costs, transport, etc.);
- Placement options and exit plans covering medium- and long-term strategies to address ongoing safety concerns of at-risk clients;
- Risk review protocols;
- Case management responsibilities for clients in emergency accommodation (for example, roles and responsibilities of case workers and shelter workers); and
- Procedures for ensuring client confidentiality and self-determination.

Resources

- **Gender-Based Violence Information Management System website and resources**
  <www.gbvims.com/>

- **Interagency Gender-Based Violence Case Management Guidelines**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>

- **The Role of Case Management in the Protection of Children: A guide for policy and programme managers and caseworkers**
  Child Protection Working Group (2014)
  <http://cpwg.net/wp-content/uploads/sites/2/2014/09/Interagency-Guidelines-for-Case-Management-and-Child-Protection.pdf>

- **Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings**
  International Rescue Committee and UNICEF (2012)
  <www.humanitarianresponse.info/en/operations/somalia/document/irc-caring-child-survivors-guidelines>

Capacity Development

- **Interagency Gender-based Violence Case Management Training Materials**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>

b) Emergency accommodation models and guidelines

There are a variety of models for providing emergency accommodation options for at-risk survivors and their children. There is no best model, and selecting the appropriate option will depend on:

- The context (such as whether it is a rural or urban setting, small refugee camp or large community, etc.); and
- The threats, risks and security needs of survivors, taking into consideration the source of the threat (for example, whether they need protection from family members or from armed groups, as well as the level of threat).

Where possible and appropriate, COs should consider establishing or supporting a mix of options for preserving the safety, dignity and self-determination of at-risk survivors. These options should reflect age-appropriate needs and the needs of women with and without children, as well as the different threats faced by survivors. With several safety options available, the risks and needs of each client requiring protection can be carefully assessed to determine the option that is most appropriate given her circumstances. Consideration should be given to the reasons safety is required, types of security risks, length of stay, individual needs and other factors.

There are several **benefits and advantages** of such a flexible approach. For example, services are tailored to the needs and circumstances of individual survivors; it uses existing resources and structures; and it supports development of local and community-based solutions to survivor safety, which should reduce security risks for survivors and for partners.

The **disadvantage** of this approach is that it requires time and resources to identify, assess and manage multiple safety options. However, as mentioned previously, communities should be engaged as much as possible in the design of emergency accommodation options. Such engagement leads to locally appropriate and relevant solutions and to greater community buy-in and ownership, and a supportive community can provide much needed security to individuals and facilities. At the same time, it is important to be aware of the limits of community engagement, especially in situations where there is high risk and a need for a high level of confidentiality surrounding a survivor's location.

Examples of emergency accommodation options include the following:

Family and kinship placement – for survivors who are at risk of harm from family members with whom they reside, but would be safe if accommodated with other or extended family members. Safe family placements should be the priority for girls and adolescents. These types of placements are suitable for survivors who cannot remain at home due to the threat of further GBV – such as girls sexually abused in the household or married girls/women experiencing intimate partner violence – who still have the support of extended family members. If there is a risk of retaliation or violence from relatives, family placements are not an appropriate option. Clear protocols must be developed to guide decision-making in these circumstances.

Placement with community members – for survivors who have no family accommodation options or for whom extended family also pose a threat to their safety (for example, when the survivor is seen to be bringing shame on the family and is at risk from family members). Community members may be able to identify who is best placed in the community to provide safe accommodation.

Safe houses or shelters – involving a dedicated facility when family or community placements are not possible or appropriate. Safe houses can target a specific client group, such as girls escaping forced marriage, women or girls escaping intimate partner violence, trafficked girls and women at risk of being re-trafficked or survivors in need of witness protection. Alternatively, safe houses can be used to accommodate all girls and women and their children who need safe shelter. There are many important **considerations for COs and partners when setting up or supporting safe houses or shelters**, such as security, staffing, resourcing and the need for clear policy and procedures for managing the service. It is essential that that these are carefully addressed so that services are appropriate to the context, well-managed, and do not cause harm or put staff or community members at risk of violence.

Considerations for Setting up Safe Houses/Shelters

Alternative emergency accommodation – where safe houses are not the best option. At-risk survivors and their children can be accommodated alone or in groups in a variety of facilities such as apartments, houses, guesthouses, hotels, children's homes, residential care centres, religious buildings, community facilities, (such as women's centres) and other facilities. When establishing, supporting or managing safe houses or other alternative emergency accommodation for survivors of GBV, COs and partners need to ensure guidelines are in place that specify the policies and procedures for day-to-day management of these facilities in line with good practice.

During the preparedness and ongoing response phases, UNICEF and partners must work with other actors to develop clear protocols on emergency alternative placements for GBV survivors. These protocols should cover:

- The philosophy and approach underpinning the service or placement;
- Security for survivors, for family and community members accommodating them, and for shelter staff;
- Length of stay and process for review of placement;
- Family contact, especially for child survivors;
- Responsibilities for supporting placements, including material or financial support for host families or community members to meet basic costs of care; and
- Continued engagement of survivors in meaningful social, economic and educational activities.

Tools

Safety Tool 2: Safe Shelter Policy and Procedures Template

Safety Tool 3: Sample Shelter Worker Job Description

Resources

Establishing shelters

- **Virtual Knowledge Centre to End Violence Against Women**
  - Shelter Module

  UN Women
  <http://endvawnow.org/en/modules/view/15-shelter.html>
- **Protocols of Care for Government Shelters for survivors of GBV in Jordan**
  Build-Up Team for Humanitarian Action Jordan (2015)
- **Safe Haven: Sheltering displaced persons from sexual and gender-based violence**
  Human Rights Center, University of California (2013)
  <http://reliefweb.int/sites/reliefweb.int/files/resources/51b6e27b9.pdf>

Alternative care for children

- **Guiding Principles and Field Handbook on Working with Unaccompanied and Separated Children**
  Interagency Working Group on Unaccompanied and Separated Children (2016)
  <www.unicef.org/protection/IAG_UASCs.pdf>
- **Alternative Care in Emergencies Toolkit**
  Interagency Working Group on Unaccompanied and Separated Children (2013)
  <www.unicef.org/protection/files/ace_toolkit_.pdf>
- **Guidelines for the Alternative Care of Children**
  United Nations (February 2010)
  <www.unicef.org/protection/alternative_care_Guidelines-English.pdf>
- **The Role of Case Management in the Protection of Children: A guide for policy and programme managers and caseworkers**
  Child Protection Working Group (2014)
  <http://cpwg.net/wp-content/uploads/sites/2/2014/09/Interagency-Guidelines-for-Case-Management-and-Child-Protection.pdf>

Lesbos, Greece

c) Community-based protection options

Mobilizing community-based protection options involves supporting the community to take responsibility for and action to protect their own community members. This model is only appropriate where the community itself is not a source of threat and where there is a high level of community support for survivors. This model allows a survivor and her children to remain with or close to their family and continue normal daily life. Examples include community or women's policing groups; providing security and material support for survivors in their own homes; or providing support in community-run safe houses. A community-based response requires strong community support, ownership and leadership. In situations where there is significant stigma or blaming of survivors, it may be necessary to first carry out communication activities to foster supportive attitudes toward survivors within the community.

d) Relocation

In situations where there are no other options for guaranteeing the safety of a survivor who is at serious risk of harm, temporary or permanent relocation or evacuation may be the only viable method of guaranteeing safety. Relocation may be to another camp for displaced people, to another part of the country, or, for some refugees, permanent re-settlement in a country of asylum or third country. UNICEF and partners need to work closely with UNHCR and other protection actors such as UN Peacekeeping Missions, where relevant, in the case of relocation, evacuation or resettlement of refugees, always bearing in mind the need for confidentiality.

There are specific guidelines on actions to be taken when carrying out a relocation or evacuation of a child survivor.

Resources

- **Guiding Principles and Field Handbook on Working with Unaccompanied and Separated Children**
  Interagency Working Group on Unaccompanied and Separated Children (2016)
  <www.unicef.org/protection/IAG_UASCs.pdf>
- **Guidance Note on Safety and Security of Survivors of Gender Based Violence in Humanitarian Settings in South Sudan**
  GBV Sub-Cluster South Sudan (2015)
  <http://orly.citylogic.co.za/wp-content/uploads/2016/09/UNFPA-Guidance-Note-on-Safety-and-Security-of-Survivors-final.docx>

2.4 Providing training, development and supervision of case workers, shelter workers and community volunteers

Safety service support staff and volunteers, including paid and volunteer case workers and shelter workers, require:

a) Initial and ongoing training; and

b) Regular supervision and support.

a) Initial and ongoing training

When planning trainings, COs need to consider initial and ongoing training needs, as well as supervision of staff. Training should never be a one-time activity; paid staff and volunteers require ongoing and refresher trainings from knowledgeable and experienced personnel. Developing competency in any skill requires practice, supervision and the opportunity for reflection. It is essential to build in on-the-job supervision, monitoring and support post-training to assist social workers, case workers and other safety support staff in applying new knowledge and skills toward working with survivors and managing their safety. Where it is difficult to provide on-site supervision – for example, due to inaccessibility of facilities, insecurity or a lack of trained personnel – consider creative ways of doing this, such as remote supervision sessions using the internet or on-site, team-based peer supervision and learning.

Case workers and shelter workers need initial and ongoing training to make sure they have the skills required for working with clients at high risk of GBV. A variety of inter-agency training materials are available with a focus on development of survivor-centred attitudes and behaviours. Training for social workers and community volunteers should focus on crisis care and case management for child, adolescent and adult survivors. Shelter workers need training on service

Siyarahi Settlement, Nepal

guidelines and protocols (including security management for a shelter service); safety planning; and crisis support for survivors who have recently experienced violence (see *Section 4.2: Strengthening Psychosocial Support for GBV Survivors* for more information). Staff working with survivors who require ongoing intervention to preserve their safety will also benefit from training in problem solving and supportive counselling.

Capacity Development

- **Psychosocial Care for Women in Shelter Homes**
  UN Office on Drugs and Crime (2011)
  <www.unodc.org/documents/southasia/Trainingmanuals/Psychosocial_care_for_women_in_shelter_homes.pdf>
- **Causes and Effects of Gender-Based Violence Training Module**
  <http://hrlibrary.umn.edu/svaw/advocacy/modelsessions/causes_effects.PDF>
- **Community Workers' Guide to Understanding Gender-Based Violence and Child Protection Basic Concepts**
  UN Relief and Works Agency for Palestine Refugees in the Near East (2016)
  <http://reliefweb.int/report/world/community-workers-guide-understanding-gender-based-violence-and-child-protection-basic>
- **Interagency Gender-based Violence Case Management Training Materials**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>

New York, USA

Capacity Development (continued)

Vicarious Trauma

- **Caring for Survivors of Sexual Violence in Emergencies: Training Guide**
  Inter-Agency Standing Committee Sub-Working Group on Gender in Humanitarian Action
  <http://unicefinemergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf>
- **Communities Care: Preventing Violence and Transforming Lives Toolkit, Part Three Survivor-Centred Care**
  - Survivor-Centred Care Training Module
  - Psychosocial Support Training Module

  UNICEF (2014)
- **Caring for Child Survivor Training Materials**
  International Rescue Committee
  <http://gbvresponders.org/response/caring-child-survivors/#CCSTrainingMaterials>
- **Mental Health and Gender-Based Violence: Helping survivors of sexual violence in conflict – a training manual**
  Health and Human Rights Info
  <http://hhri-gbv-manual.org/>
- **Training Handbook on Psychosocial Counselling for Children in Especially Difficult Circumstances: A trainer's guide**
  UNICEF (2003)
  <https://resourcecentre.savethechildren.net/library/training-handbook-psychosocial-counselling-children-especially-difficult-circumstances>
- **The Psychosocial Care and Protection of Children in Emergencies Teacher Training Manual**
  UNICEF (2009)
  <http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1064/Psychosocial_Care_and_Protection.PDF>
- **Psychological First Aid: Facilitator's manual for orienting field workers**
  World Health Organization (2014)
  <www.who.int/mental_health/emergencies/facilitator_manual_2014/en/>

b) Regular supervision and support

Workers and community members who serve high-risk clients often work in stressful environments and may themselves be subject to threats of harm or violence from perpetrators and their supporters. Witnessing violence can sometimes lead to secondary or **vicarious traumatization** for staff and volunteers, especially if these staff or volunteers have also experienced violence themselves. Because of this, workers need a high level of supervision and support.

It is important to have a system in place whereby staff and volunteers receive regular supervision from more senior staff – not only to jointly monitor safety risks and threats of clients, but also to provide them with the opportunity to discuss their concerns, monitor and manage stress, and receive support.

In addition to individual supervision, group supervision, regular team meetings and on-the-job coaching and mentoring are all important strategies for staff support and development.

Resources

- **Interagency Gender-Based Violence Case Management Guidelines**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>
- **Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings**
  International Rescue Committee and UNICEF (2012)
  <http://gbvresponders.org/response/caring-child-survivors/>

Capacity Development

- **Interagency Gender-Based Violence Case Management Training Materials**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>
- **Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers, Supervision, Coaching and Mentoring Modules**
  Child Protection Working Group (2014)

2.5 Coordinating with others

It is vital that psychosocial support services coordinate with others providing services to survivors and their children. There are two related aspects to coordinated care that need to be considered.

The first is **interagency coordination**, which involves making sure that all agencies and organizations providing care, support and protection services to GBV survivors work collaboratively together to respond to GBV and can seamlessly refer and care for survivors. Interagency coordination usually involves developing shared protocols for referral and service delivery and meeting regularly to facilitate good communication and joint problem solving.

The second aspect of coordinated care is **case coordination**, which is a foundation of a survivor-centred approach. This involves making sure each survivor can receive care, support and protection services in a coordinated manner and according to her unique needs and circumstances. As noted above, good case coordination usually involves implementing a case management system so that survivors can receive tailored services based on their individual circumstances, wishes and needs. More information on case management can be found in *Section 4.2: Strengthening Psychosocial Support for GBV Survivors.*

Resources

- **Establishing GBV Standard Operating Procedures**
  Inter-Agency Standing Committee Sub-Working Group on Gender (2008)
  <http://www.globalprotectioncluster.org/_assets/files/tools_and_guidance/gender_based_violence/GBV_Standard_Operational_Procedures_2008_EN.pdf>
- **Interagency Gender-based Violence Case Management Guidelines**
  Gender-Based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>
- **Handbook for Coordinating Gender-Based Violence Interventions in Humanitarian Settings**
  GBV AOR (2010)
  <www.refworld.org/docid/52146d634.html>

Step 3: Monitoring

3.1 Selecting indicators to monitor progress and quality

The exact choice of process and outcome indicators used for monitoring will be determined by the CO based on specific objectives and interventions selected; the phase of humanitarian response; and means of verification for monitoring changes in safety services. Some sample outputs and indicators for monitoring changes in safety interventions are given in the table on the following page. Remember, indicators need to be measured *before* and *after* an intervention to see if there have been any changes over time.

Bangui, Central African Republic

Sample outcomes, outputs and indicators for GBViE safety response

Sample outcomes	Sample outputs	Sample output indicators
Enabling environment		
Social norms encourage community and family protection for survivors of GBV and accountability for perpetrators.	There is increased community awareness on safety, rights and needs of GBV survivors. There is increased community dialogue on GBV survivor safety. Traditional leaders speak out about GBV perpetrator accountability.	• Changes in beliefs and attitudes about blame for GBV among participants in communications activities • Increase in expressions of public support for GBV survivors • Increase in # of people exposed to communications activities who believe others in the community protect GBV survivors • # of community leaders expressing public support for survivor safety
Survivors' rights to safety and protection are reflected in national legislative and policy frameworks.	Strong partnerships, clear roles and accountabilities exist between government and non-government safety actors.	• National protocols adopted on safety response to at-risk girls and women

Sample outcomes	Sample outputs	Sample output indicators
Enabling environment (continued)		
Safety options for at-risk survivors and their children are adequately funded, prioritized and coordinated within humanitarian action.	All humanitarian donors have adequate information about GBV, as well as UNICEF and wider GBV humanitarian response plan.	• # of GBV advocacy materials developed and disseminated to humanitarian donors • % of requested funding received
	Referral networks are established in all districts/camps.	• % of at-risk survivors referred for safety
Supply		
Safety services are available for survivors.	Safety services for GBV survivors and their children have essential equipment and supplies.	• # and type of safety options available for girls and women, including those with children • % of safe shelters with clear operating procedures and security protocols • % of safe shelters with essential equipment and supplies (e.g., food, water, sanitation, material supplies for basic needs, toys for children, etc.) • Case management protocol in place outlining roles and responsibilities of different actors and case management process
	Safety services are staffed by appropriately trained staff/volunteers.	• # of safe shelter workers/volunteers trained on GBV • # of safe shelter workers/volunteers trained on crisis care • Changes in knowledge, attitudes and practices of safety workers immediately post-training • Changes in knowledge, attitudes and practices of safety workers six months post-training • % of safe shelters with at least one worker trained in case management
Demand		
Survivors utilize safety options.	At-risk GBV survivors can afford direct and indirect costs of alternative accommodation/safety services.	• Safety services are free
	Social barriers to survivors accessing emergency safety services are reduced.	• # of community-level barriers to survivor safety identified • % of identified community level barriers removed

Sample outcomes	Sample outputs	Sample output indicators
Quality		
Emergency safety services are of good quality and meet basic standards.	Case management and alternative accommodation for at-risk GBV survivors are provided in line with survivor-centred principles and with guidelines and standards for out-of-home care for children.	• % of GBV clients using safety services with appropriate case plans • % of case plans with evidence of survivor input/ self-determination • % of trained case workers and shelter workers who know how to promote client safety • % of trained case workers and shelter workers who know how to protect and promote their patient's rights to confidentiality and privacy • % of safe space/crisis/case workers who can demonstrate appropriate engagement and empathy • 100% of client records stored securely and appropriately coded to ensure confidentiality • % of clients surveyed who express satisfaction with safety services • % of safe shelters with essential equipment and supplies in line with minimum standards (including Sphere guidelines, Child Protection Minimum Standards and Alternative Care in Emergencies Guidelines)

Tools

Safety Tool 4: GBV Safety Service Monitoring Sheet

Resources

- **Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions Along the Relief to Development Continuum**
  United States Agency for International Development (2014)
  <www.usaid.gov/sites/default/files/documents/2151/Toolkit%20Master%20%28FINAL%20MAY%209%29.pdf>

- **Violence Against Women and Girls: A compendium of monitoring and evaluation indicators**
  Measure Evaluation (2008)
  <www.measureevaluation.org/resources/tools/gender/violence-against-women-and-girls-compendium-of-indicators>

- **Guidance on Monitoring and Evaluation for Programming on Violence Against Women and Girls**
  United Kingdom Department for International Development (2012)
  <www.gov.uk/government/uploads/system/uploads/attachment_data/file/67334/How-to-note-VAWG-3-monitoring-eval.pdf>

Minimum safety response checklist

The following is a checklist detailing minimum essential actions for effective GBV safety response throughout the phases of an emergency.

Preparedness	Immediate response
Review national legislative and policy provisions for safety and protection factors for at-risk GBV survivors, including criteria for placement of children. ○	Fund and train community-based actors to provide case management and emergency accommodation for at-risk GBV survivors and their children. ○
Identify, assess and build capacity of existing safety and protection services and practices for girls and women at risk of harm in line with good practice standards. ○	Provide technical support for the development of safe shelter guidelines for survivors of GBV. ○
Support development of national standards for safety services for survivors of GBV and their children. ○	Provide funding and technical support for training and supervision of case workers, shelter workers and volunteers. ○

Info Sheets – Responding to GBV Survivors in Emergencies

Health Consequences of GBV

There are many short- and long-term negative consequences of GBV on survivors – at worst, GBV can be fatal.

The table below details some of the common negative health outcomes of GBV for girls and women.[1]

Acute physical	Chronic physical	Reproductive	Mental health
• Injury • Shock • Disease • Infection	• Disability • Somatic complaints • Chronic infection • Chronic pain • Gastrointestinal disorders • Eating disorders • Sleep disorders • Chronic fatigue	• Miscarriage • Unwanted pregnancy • Unsafe abortion • STI, including HIV • Menstrual disorders • Pregnancy complications • Gynaecological disorders	• Depression • Anxiety • Suicidal or self-harming thoughts and behaviour • Traumatic stress • Eating and sleeping disorders • Substance abuse

- The immediate and longer-term **physical, reproductive** and **mental health consequences** of gender-based violence vary from person to person depending on individual and contextual factors, the type and nature of violence experienced, the survivor's developmental level and stage, and the care and support she receives.
- The different effects of GBV can be interrelated; for example, physical well-being affects psychological well-being. For this reason, we need to view survivors holistically and consider all the different impacts, not just those we can see.
- Both physical and mental health needs of survivors should be addressed through health interventions in emergencies. Health interventions must reflect the ways in which health needs are interrelated with other needs of the survivors. The Health sector therefore works closely with other actors to holistically address consequences and promote the rights of survivors.

1 World Health Organization, *World Report on Violence and Health,* WHO, Geneva, 2002; World Health Organization, *Guidelines for medico-legal care for victims of sexual violence*, WHO, Geneva, 2003; Taylor, J. and S. Stewart, *Sexual and Domestic Violence: Help, recovery and action in Zimbabwe,* Women and the Law in Southern Africa, Harare, 1991; Heise, L., M. Ellsberg and R. Gotttmoeller, 'A global overview of gender-based violence', *International Journal of Gynecology and Obstetrics,* no. 78, 2002; Sexual Violence Research Initiative, 'Mental Health Responses for Victims of Sexual Violence and Rape in Resource-Poor Settings', SVRI, Pretoria, 2011.

Boys and Sexual Abuse

Source: International Rescue Committee and United Nations Children's Fund, *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings,* UNICEF, New York, 2012, pp. 29–31.[1]

Many facts and information related to sexual abuse are applicable to both boys and girls; however, there are specific issues related to boy child survivors. Research studying the specific issues related to male survivors of sexual abuse in humanitarian settings is scant. Moreover, the differences between male and female victimization is largely impacted by cultural beliefs and stereotypes of femininity and masculinity, which vary across contexts. With this acknowledgment, current research on male experiences of sexual abuse finds that beliefs impact how boys, particularly adolescents, experience and externalize sexual abuse:

- A boy may see himself as less than male (emasculation).
- He may see himself as being powerless and thus flawed.
- He may see himself as being labeled as sexually interested in males (homosexual).
- Adolescent boys may also believe that no matter what, all sexual activity is appropriate for males.

In general, males, especially adolescent males, may be much less likely to disclose and/or speak about their abuse experiences because being a victim can be seen as a countercultural experience for an adult male and/or male child/adolescent.

Service providers working with male survivors must be aware of the specific facts and issues related to a boy's experience of sexual abuse. Service providers need to pay very close attention to their own beliefs and attitudes about a boy's experience of sexual abuse, as harmful beliefs may affect a child's willingness to disclose and cause further psychological harm. Some key facts for service providers include:

Acknowledging that boys can be sexually abused. An overview of studies in 21 countries found that 3–29% of men reported sexual victimization during childhood. Most of the abuse occurred within the family circle. The statistics show that the majority are sexually abused by adult males; however, there are also cases of adult females sexually abusing boys, and/or male children/adolescents abusing boys.

Understanding that sexual abuse does not cause homosexuality. Service providers are responsible for educating child survivors, caregivers and community members about the effects of sexual abuse. Homosexuality carries an additional stigma across communities and mistaken beliefs about the effects of sexual abuse may make it more difficult for a male teen sexually abused by an adult male to disclose.

Recognizing that boys do not always prefer to speak with male service providers. In fact, the opposite may be true. Never assume that a boy will feel more comfortable speaking with a service provider of his or her own gender. Rather, children should ideally be offered a choice of male or female service provider.

1 Available at: <http://gbvresponders.org/response/caring-child-survivors/>.

Recognizing there can be internal (individual) and external (social) barriers to receiving care. Social stigma, including the fear of being labeled homosexual, as well as issues related to victimization and masculinity may make it difficult for boys to seek help. Moreover, in many settings, services for sexual violence are geared toward women and girls; boys may not be aware of similar opportunities for them to seek help.

Accepting that boys require care, support and treatment to recover and heal. Male child survivors have the same needs as female child survivors – they need to feel safe, cared for, believed, encouraged and assured that seeking help and/or acknowledging sexual abuse is the right thing to do.

Minimum Initial Services Package (MISP)

Source: Women's Refugee Commission, 'Minimum Initial Services Package Fact Sheet', WRC, New York, 2006.[1]

What is the MISP?

The Minimum Initial Service Package (MISP) for Reproductive Health (RH) is a set of priority activities to be implemented during the early stages of an emergency (such as a conflict or natural disaster). When implemented at the onset of an emergency, the MISP saves lives and prevents illness, especially among women and girls. The MISP is not just kits of equipment and supplies; it is a set of activities that must be implemented in a coordinated manner by appropriately trained staff at the beginning of a crisis. It can be implemented without carrying out a new needs assessment, as documented evidence already justifies its use. The MISP prevents excess maternal and neonatal mortality and morbidity, reduces HIV transmission, prevents and manages the consequences of sexual violence, and includes planning for the provision of comprehensive RH services. The components of the MISP form a minimum requirement; comprehensive RH services should be provided as soon as the situation allows.

Goal

The goal of the MISP is to reduce mortality, morbidity and disability among populations affected by crises, particularly women and girls. These populations may be refugees, internally displaced persons (IDPs), or populations hosting refugees or IDPs.

MISP objectives and activities

- **Identify an organization(s) and individual(s) to facilitate the coordination and implementation of the MISP** by:
  - ensuring the overall RH Coordinator is in place and functioning under the health coordination team
  - ensuring RH focal points in camps and implementing agencies are in place
  - making available supplies for implementing the MISP and ensuring its use
- **Prevent sexual violence and provide appropriate assistance to survivors** by:
  - ensuring systems are in place to protect displaced populations, particularly women and girls, from sexual violence
  - ensuring medical services, including psychosocial support, are available for survivors of sexual violence
- **Reduce the transmission of HIV** by:
  - enforcing respect for universal precautions
  - guaranteeing the availability of free condoms
  - ensuring that blood for transfusion is HIV-free

1 Available at: <www.womensrefugeecommission.org/resources/document/download/163>.

- **Prevent excess maternal and neonatal mortality and morbidity** by:
  - providing clean delivery kits to all visibly pregnant women and birth attendants to promote clean home deliveries
  - providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility
  - initiating the establishment of a referral system to manage obstetric emergencies
- **Plan for the provision of comprehensive reproductive health services,** integrated into Primary Healthcare, as the situation permits by:
  - collecting basic background information identifying sites for future delivery of comprehensive RH services
  - assessing staff and identifying training protocols
  - identifying procurement channels and assessing monthly drug usage and needs

Age-Appropriate Healthcare for GBV Survivors

Adapted from: The Royal Australasian College of Physicians, 'Standards for the Care of Children and Adolescents in Health Services', RACP, Sydney, 2008.

Dimensions of age-appropriate GBV health services

Age-appropriate GBV health services reflect the rights, needs and developmental stages of children of different ages and stages of development throughout the care and treatment process. The dimensions of age-appropriate GBV healthcare are:

- Respect for the rights of children and adolescents throughout treatment and care processes;
- Facilities that are child-friendly and promote children's and adolescents' safety from physical, psychological or sexual harm;
- Availability of appropriate written treatment protocols and drugs for child and adolescent survivors, and equipment that is appropriate in size and design;
- Care is provided by staff with appropriate education and training in the care and treatment of children and adolescents; and
- There is adequate and appropriate parent/carer and family support and involvement in care.

Minimum standards for age-appropriate GBV healthcare

Rights

- The rights of children and adolescents are upheld at all times, and they and their families are always treated with respect, sensitivity and dignity.
- The special needs of children and adolescents are respected, as are their rights to be consulted and informed about their care and treatment.
- Parents/carers are consulted and kept informed about the care of their child or adolescent.
- Consideration is given to the rights of all children and adolescents to be involved in decision making about their own health. In particular, cognitively mature adolescents have the right to make decisions relating to their own health and to maintain their privacy, including in respect to their parents/carers.
- Policies and guidelines specific to the health service reflect the rights of all children/adolescents and their families. The policies and guidelines are informed by the United Nations Convention on the Rights of the Child (UNCROC)
- The cultural beliefs and practices of all persons attending the health service are respected and taken into consideration when providing care.

Facilities

- There is a safe, private and appropriately supervised dedicated area where child and adolescent survivors receive treatment.
- Child and adolescent survivors have safe access to latrines. If there are no separate facilities, a parent or staff member should accompany a child.

- There are age-appropriate decorations, such as posters, furniture, equipment and ample light.
- Any education materials are child-friendly.
- When ages are mixed, the needs of the youngest children are considered.
- Facilities for parents and carers to stay nearby to their child are provided; for example, a chair.
- Clothing is available for child survivors who require it.
- Resources are available to support health workers in engaging child and adolescent survivors in decision-making.
- Children and adolescent survivors are cared for on wards that are appropriate for their age and stage of development. In the event when separate accommodation for children/adolescents and adults is not possible, there is a designated area where children and adolescents can be accommodated.
- Actual age is less important than the needs and preferences of the individual child or adolescent.
- Children, adolescents and parents/carers are consulted during the planning of new health facilities.

Equipment

- There are written protocols for interviewing, examining and treating child and adolescent survivors of sexual assault.
- Appropriate drugs are available for treatment of child and adolescent survivors of sexual assault.
- Children and adolescents are cared for utilizing equipment that is specifically designed to meet their needs, size and developmental age.

Staff

- Child and adolescent survivors are cared for by staff trained to meet their physical, psychosocial, developmental and communication needs.
- All clinical staff providing care and treatment to child and adolescent GBV survivors have appropriate knowledge, training and skills in developmentally appropriate communication and interviewing, and performing a physical examination of a child and adolescent survivor of sexual assault.
- Parents/carers are considered as an integral part of the child's treatment and recovery and are provided with appropriate information and support to help their child's recovery. For example, they are given helpful information by staff about the effects of GBV and how to help their child cope with them.

Psychological First Aid

Source: World Health Organization, *International Psychological First Aid: Guide for field workers*, WHO, Geneva, 2011, pp. 3–5.[1]

What is psychological first aid (PFA)?

Psychological first aid (PFA) describes a humane, supportive response to a fellow human being who is suffering and who may need support. PFA involves the following themes: providing practical care and support, which does not intrude; assessing needs and concerns; helping people to address basic needs (for example, food and water, information); listening to people, but not pressuring them to talk; comforting people and helping them to feel calm; helping people connect to information, services and social supports; protecting people from further harm.

PFA is an alternative to "psychological debriefing" which has been found to be ineffective. In contrast, PFA involves factors that seem to be most helpful to people's long-term recovery (according to various studies and the consensus of many crisis helpers). These include:

- feeling safe, connected to others, calm and hopeful;
- having access to social, physical and emotional support; and
- feeling able to help themselves, as individuals and communities.

Who is PFA for?

PFA is for distressed people who have been recently exposed to a serious crisis event. You can provide help to both children and adults. However, not everyone who experiences a crisis event will need or want PFA. Do not force help on people who do not want it, but make yourself easily available to those who may want support.

There may be situations when someone needs much more advanced support than PFA alone. Know your limits and get help from others, such as medical personnel (if available), your colleagues or other people in the area, local authorities, or community and religious leaders. People who need more immediate advanced support might include:

- people with serious, life-threatening injuries who need emergency medical care
- people who are so upset that they cannot care for themselves or their children
- people who may hurt themselves
- people who may hurt others

People in these situations need medical or other help as a priority to save life.

When is PFA provided?

Although people may need access to help and support for a long time after an event, PFA is aimed at helping people who have been very recently affected by a crisis event. You can provide PFA when you first have contact with very distressed people. This is usually during or immediately after an event. However, it may sometimes be days or weeks after, depending on how long the event lasted and how severe it was.

1 Available at: <www.searo.who.int/srilanka/documents/psychological_first_aid_guide_for_field_workers.pdf?ua=1>.

Addressing GBV-Related Risks in Health Assessments and Initial Programme Design

Source: Gender-Based Violence Area of responsibility, 'Tip Sheet: Addressing Gender-based Violence (GBV)-Related Risks in Health Assessments and Initial Programme Design', Global Protection Cluster, (nd).[1]

In the early stages of an emergency, Health cluster assessment questions on GBV should focus on collecting information about availability and quality services, as well as the GBV-related concerns and help-seeking behavior of the community.

Key linkages between Health and GBV

- Timely, appropriate health response to sexual violence is a life-saving intervention. Survivors can reduce the risk of HIV transmission is they seek medical care within 72 hours (3 days) and pregnancy if within 120 hours (5 days) of the assault.
- Health services are often the first – and sometimes only – point of contact with GBV survivors.
- If survivors are treated with dignity, respect and compassion, they are more likely to discuss their experience with service providers, which can lead to better-informed interventions and better outcomes for survivors.

Note: Because sexual violence is always present in emergencies, implementation of the Minimum Initial Services Package (MISP) for reproductive health – which includes clinical care for sexual violence – is a standard responsibility of the Health cluster. These services must be prioritised from the outset of the emergency, regardless of whether or not an assessment has taken place.

GBV issues to examine in Health assessments

Community

- Are women and girls aware of the health consequences of GBV, particularly sexual violence?
- Are women and girls aware of the benefits of seeking healthcare and available services? Do women and girls indicate that survivors can come forward and seek help in a safe, secure, anonymous, and confidential environment?
- Have women and girls been consulted about their health needs, the quality/appropriateness of existing health services and gaps in available services? If so, how?
- Do women and girls report any barriers or prerequisites to accessing healthcare, such as the need for a husband/partner's consent or a police report?
- Do community health workers provide outreach to the community that includes GBV messaging?

1 Available at: <www.humanitarianresponse.info/system/files/documents/files/GBV%20Tip%20Sheet%20Health%20FINAL.pdf>.

Health infrastructure

- How many functioning health facilities provide services for GBV survivors? What services are available? How far away are these facilities from the affected population?
- How available are the drugs – including antibiotics for STI presumptive treatment, emergency contraception, and post-exposure prophylaxis for HIV – equipment and supplies for clinical management of rape survivors (CMR)? What is the procedure for replenishing these supplies?
- Are services for survivors integrated into existing healthcare facilities (so that survivors can seek treatment without being easily identified by the community)?
- Do national medical protocols allow for the provision of clinical care for survivors of sexual violence per WHO's CMR guidelines?
- Are there national and agency-specific policies/protocols that adhere to ethical and safety standards (privacy, confidentiality, respect, non-discrimination, informed consent)?
- What are the laws on abortion? Is it legal/illegal in all cases? Some cases? Are there exceptions for pregnancies that result from rape?
- Are there mandatory reporting laws for certain types of violence or when an incident involves a certain type of survivor (i.e. a child)?

Health facilities

- How many members (or what percentage) of the clinical staff have been trained on CMR? How many of the CMR-trained staff are female?
- Are there female receptionists and interpreters working at the health facility?
- Are there private rooms in health facilities for survivors to be interviewed and examined?
- Do health facilitates have separate male and female latrines that lock from the inside and washing areas, and are in secure locations with adequate path lighting at night?
- What are the potential barriers to survivors' access to GBV-related health services, such as getting to and from the facility, opening times, costs, privacy, confidentiality, language, cultural issues? (See AAAQ framework)
- What referral systems are in place for survivors of GBV (to security/police, safe shelter, psychosocial services, legal, community services, other)? Are these institutions safe (i.e. do not expose the survivor to further risks)?
- Does the facility have a system in place for collecting, storing and analysing data on reported cases of GBV that protects survivor confidentiality? If yes, what system? Are records kept in a secure place and appropriately coded to ensure confidentiality?

Summary of the AAAQ Framework

The "Availability, Accessibility, Acceptability, Quality (AAAQ)" framework is useful for assessing all types of GBV services and particularly for identifying barriers to services that may not be immediately apparent.

Availability refers to the existence of services. Essentially, are services sufficient in terms of quantity and type?

Accessibility includes many components such as:

- **Physical accessibility:** Are facilities located within a reasonable distance? Is the route to and from the facility safe to travel? Are there other forms of physical barriers, such as armed guards outside the facility?
- **Financial accessibility:** How is the service funded? Do users have to pay a fee? If so, is the fee reasonable/manageable given the economic circumstances/means of those who need this type of care?
- **Bureaucratic/administrative accessibility:** Are there procedural steps a survivor must complete before accessing certain services? For example, must s/he report to the police before receiving medical treatment? Are the facilities open at times that are convenient given the daily/weekly rhythm of community members?
- **Social accessibility:** Do service providers respect and practice non-discrimination in the provision of services? Are certain groups excluded from services because of language or communication barriers? Are there female doctors, nurses and (if necessary) interpreters? Are there stigma issues related to a person being seeing in/around a certain facility? Are other responsibilities, such as childcare, affecting certain individuals' ability to access services?
- **Information accessibility:** How is information about services communicated to the community? Is it accessible to those who need it (i.e. is it available in various languages?)? Are there alternatives to printed information in order to reach illiterate members of the community? Is personal information treated confidentially?

Acceptability: Are the services respectful of the culture of individuals, minorities, peoples and communities? Are services designed to respect relevant ethical and professional standards? Do service providers respect confidentiality and informed consent? Are services gender-sensitive? Are there certain characteristics of the service providers (gender, international vs. local staff, etc.) that make the community more/less comfortable accessing services?

Quality: Do service providers possess the necessary skills/training? Are there adequate supplies (drugs that aren't expired, etc.)? Is the environment appropriate? Are the facilities safe and sanitary? Quality also extends to the way people are treated before, during and after accessing services.

Psychological, Emotional and Social Consequences of GBV

Adapted from: United Nations Children's Fund, 'Psychosocial Support Training Module', *Communities Care: Transforming Lives and Preventing Violence Toolkit,* UNICEF, New York, 2014.

- The **nature and severity of the after-effects of GBV** are determined by the type, duration and severity of the violence; the individual's age and developmental level; her psychosocial circumstances; and the care and support she receives.
- The **effects can be interrelated:** for example, physical well-being affects psychological well-being. For this reason, we need to view people holistically and consider *all* of the different impacts, not just those we can see.
- Although the focus is often on physical outcomes of violence, there are **outcomes that can't always be observed.** When thinking about consequences of GBV, it's important to consider each person's physical, emotional, intellectual, social and spiritual aspects.
- In conflict-affected settings, the effects of sexual violence can be worsened by aggravating factors – for example, if survivors experience other forms of violence and atrocities; if there are multiple perpetrators; if the assaults are particularly brutal; if the assaults are public; if there is nowhere safe to recover; or if survivors are not able to get their basic needs met.

Psychological & emotional consequences	Social consequences
• Depression	• Blaming the victim and social stigma
• Anxiety and fearfulness	• Rejection by family and community
• Anger	• Social isolation
• Shame, self-hate, self-blame	• Withdrawal from social and community life, including education
• Self-harm	• Reduced contribution to family and community life
• Suicidal thoughts and behaviour	• Economic costs, including the costs of health and social services and the costs of losses in earning potential
• Low self-esteem	• Being forced to marry the perpetrator
• Sexual disorders	
• Traumatic stress	
• Eating and sleeping disorders	
• Substance abuse	
• Post-traumatic stress disorder (PTSD)	

Psychological and emotional consequences

Psychological effects generally refer to inner thoughts, ideas and emotions; because of this, they can be less visible or even completely hidden. Psychological and emotional effects of GBV can be both immediate and long-term. It is very important to remember that everyone shows emotions differently, and whether or not there are obvious signs of distress does not mean that violence did or did not take place. Attempting to judge or interpret someone's well-being by how they show their reactions outwardly is not useful, as reactions will vary from person to person, depending on the person's age, their life situation, the circumstances surrounding the violence, the response of support persons, and the broader culture in which the person lives.

Social consequences

Social consequences of GBV include the impact on a person's interpersonal relationships within the immediate and extended family, such as relationships with husbands/intimate partners, parents, siblings and children. It also includes relationships with other people in the wider social network and community.

While stress and anxiety can impact a survivor's ability to communicate with and relate to others, harmful social consequences are most often the result of how others view and treat people who have experienced GBV. Victim blaming (i.e., when the survivor of GBV is blamed for somehow having 'caused' or 'asked for' the violence) and social stigma can lead to social rejection and isolation, rejection from family, family breakdown, withdrawal and isolation from community life, and loss of role function, such as decreased capacity to work or care for children.

As with other stressors and traumatic events, people are affected by GBV in different ways. The psychological and emotional consequences depend on multiple factors, such as the type and duration of the violence; the survivor's age and previous experiences; their relationship to the perpetrator(s); and the response survivors receive from family members and the wider community.

Defining 'Psychosocial' and 'Mental Health'

Defining 'psychosocial'

- The term '**psychosocial**' refers to the dynamic interplay between people's psychological well-being and experiences (thoughts, emotions and behaviour) and their social well-being and experiences (relationships, traditions and culture).
- The relationship between the two is reciprocal: **psychological well-being** supports social relationships and functioning, while **social well-being**, in turn, supports mental health and psychological functioning.

Defining 'mental health'[1]

- **Mental health** can be conceptualized as a state of well-being in which the individual realizes their own abilities, can cope with the normal stresses of life, can work productively, and is able to contribute to their community.
- In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community. This core concept of mental health is consistent with its wide and varied interpretation across cultures.
- Mental health contributes to all aspects of human life. It has both material and immaterial, or intrinsic, values – for the individual, society and culture. Mental health also has a reciprocal relationship with the well-being and productivity of a society and its members. Its value can be considered in several related ways:
  - Mental health is essential for the well-being and functioning of individuals.
  - Good mental health is an important resource for individuals, families, communities and nations.
  - Mental health, as an indivisible part of general health, contributes to the functions of society and has an effect on overall productivity.
  - Mental health concerns everyone, as it is generated in our everyday lives in homes, schools, workplaces and leisure activities.
  - Positive mental health contributes to the social, human and economic capital of every society.
  - Spirituality can make a significant contribution to the promotion of mental health, and mental health in turn can influence spiritual life.

1 World Health Organization, 'Promoting Mental Health: Concepts, Emerging Evidence, Practice', WHO, Geneva, 2004.

Psychosocial Care Actors

Source: United Nations Children's Fund, 'Psychosocial Care Training Module', *Communities Care: Preventing Violence and Transforming Lives Toolkit*, UNCEF, 2014.

Different types of psychosocial support provided by formal and informal sources of care help survivors manage the immediate responses to GBV, as well as meet longer term needs.

Formal service providers	Informal sources of care and support
• Social workers and other staff from government ministries of social welfare, child protection, health, etc. • Social and community workers from non-government organizations • Social and community workers and volunteers from community organizations, such as women's groups, child welfare groups and networks, religious charities, etc.	• Friends • Family members • Peers • Community leaders • Traditional healers • Religious leaders

Compassionate listening, providing information and referral, advocacy, and help with formal processes, such as medical examinations, are the foundations of quality community-based care for survivors. Other help survivors find useful include:

- caring, non-judgmental listening, support and comfort in a safe environment
- information about consequences, rights and what help is available
- assistance with meeting basic immediate needs (e.g., for medical care, clothing, etc.)
- referral and advocacy to get required services
- safety and protection from further violence and harm
- support for family and community acceptance and reintegration
- longer term support to cope with difficult emotions and ongoing psychological distress
- skills training, livelihoods and other economic support.

Suicide Risk Assessment and Response

Source: Gender-Based Violence Information Management Steering Committee, *Interagency Gender-Based Violence Case Management Guidelines: Providing care and case management services to gender-based violence survivors in humanitarian settings*, GBVIMS, Steering Committee, 2017.[1]

One of the most serious consequences of GBV is a survivor's risk of suicide. It can be expected that survivors will have feelings of wanting to die, end their life or "disappear." If a survivor is expressing such feelings, it is important that a more in-depth assessment be carried out. The main task is to determine whether or not this is a feeling only, or a **feeling with an intention to act** (i.e., the intention to actually take one's life). Some staff worry that if they ask a person whether they are having suicidal thoughts, they may encourage the person to think about suicide. There is no evidence to suggest this is true.

Organizations will need to have clear policies on how suicide risk cases are handled, which should be based on the staff's and supervisors' own capacity to carry out suicide risk assessments. If staff have not been specifically trained how to do this, then a supervisor should be notified immediately, and a referral to more specialized mental health services should be considered, if available.

If it is within your organizational policy and you have been properly trained, you should follow the suicide risk assessment guidance below, which includes the following steps:

Step 1: Assess current/past suicidal thoughts

Step 2: Assess risk: lethality and safety needs

Step 3: Address feelings and provide support

Step 4: Develop a safety agreement

Before beginning, you should reassure the person that it is okay to have feelings of sadness or wanting to die, and that whatever they are feeling is normal. In many cultures and religions, suicide may be looked upon as "weak" or may even be forbidden. To feel safe and comfortable to talk to you about what they are feeling, the person will need to know that you will not judge them.

Step 1: Assess current/past suicidal thoughts

Explain to the person: *"I'm going to ask you some questions that may be hard for you to answer, but I am worried about you, so I want to know that you are going to be ok."*

Ask the person questions that can help you assess their current and past suicidal thoughts. This will be different from one culture/context to another. Some sample questions include:

- *Are you feeling so bad that you're considering suicide? That sounds like a lot for one person to take. Have you thought about killing yourself to escape?*
- *Do you think about dying? Or wish you were dead? Are you or have you ever thought about hurting or killing yourself?*
- *Has all that pain you're going through made you think about hurting yourself?*
- *Do you ever wish you could go to sleep and just not wake up? How often? Since when?*

1 Available at: <https://gbvresponders.org/response/gbv-case-management/>.

Based on the person's responses, you may or may not need to continue with the suicide risk assessment.

a) **If the person answers "no"**, and there are no signs that they intend to harm or kill themselves, it is likely the risk of suicide or self-harm is low. In this case, the caseworker will likely discontinue the assessment. Again, this is determined on a case-by-case basis and depending upon whether there are other signs that the person may be suicidal.

b) **If the survivor answers "yes"** to either of the questions, say to the survivor, *"Please tell me more about these thoughts"*, and then proceed to the next step.

Step 2: Assess risk: lethality and safety needs

You should gently probe for clues to determine if the person has a plan. You should **assess past suicide attempts** because they signal higher risk. Such questions can include:

"Tell me about how you would end your life. [Allow survivor to answer]. What would you do? When did you think you would do it? Where did you think you would do it? Are (guns/pills/other methods) (at home/easy to get)?"

"Have you ever started to do something to end your life but changed your mind? Have you ever started to do something to end your life but someone stopped you or interrupted you? What happened? When was that? Tell me how many times that happened."

a) **If the person is unable to explain a plan** for how they would take their own life and/or has no history of attempts, the risk is less immediate. At this point, you should support the person by exploring strategies for coping with difficult feelings and thoughts, and if needed, develop a safety agreement with the survivor (see Step 4).

b) **If the survivor is able to explain a plan and/or indicates they have already attempted suicide**, the risk is more immediate. You should continue to the next step.

Step 3: Address feelings and provide support

It is critical that you stay calm if the person expresses suicidal thoughts and a plan. It may be the opposite of your instinct, but do not try to talk the person out of it nor offer advice about what they should do. The feeling they have is serving a purpose for them – it is their last attempt to feel that they are in control of something. Tell them:

"I understand that you are feeling this way and I am sorry. I know that it was hard for you to share that. You are very brave for telling me. It is very important to me that you do not hurt yourself. And I would like us to come up with a plan together for how we can help you to not do this. Is this okay with you?"

Step 4: Develop a safety plan

Developing a safety agreement with the survivor is a way for you to help them identify their own mitigation and prevention strategies. Explain the purpose of the agreement.

Help the person identify warning signs:

- ✔ *"Tell me what happens when you start to think about killing yourself or wanting to hurt yourself? What do you feel? What do you think about? How will you know when you are going to need to use these strategies?"*
  - List the warning signs (thoughts, images, thinking processes, mood and/or behaviors) using the survivor's own words.

Help the person identify strategies to feel better:

Explain to the survivor, "We want to find other things you can do to make yourself feel better."

- ✔ *"When you have thought about killing yourself before, what prevented you from doing it?"*
- ✔ *"Tell me some things you can do to help yourself feel better when you start to think about hurting yourself or wanting to end your life. What has helped you feel better in the past? Is there someone you can talk to or go to?"*
  - Based on what the person says, agree that they will use these strategies/do these helpful things instead of hurting themselves.
- ✔ Ask the person what might get in the way of them using these strategies to feel better. In other words, you want to identify strategies that are practical and feasible for the person to do.

If the person is not able to identify any strategies, you should confer with a supervisor and discuss the potential for a referral to mental health services, or if not available, to emergency medical care.

Identify a safety person:

Explain to the person that in addition to the strategies they have identified, a friend or another family member must be notified to act as a "safety person" for the survivor. This should be someone who can be with the person all the time for at least the following 24 hours.

"I want to help you stay safe. Can you think of someone in your family or a friend who could stay by your side? Can we work together to get that person to agree to stay by your side in order to keep you safe?"

If the person cannot identify anyone, you should confer with a supervisor and discuss the potential for an immediate referral to mental health services, or if not available, to emergency medical care. You will need to accompany the person, as it will not be safe to leave them alone.

You can document the safety plan you have made with the survivor, which may be helpful for the person to keep with them as a reminder in times of crisis. As with any documentation, only provide it to the person if they will find it helpful and if it is safe to do so.

Vicarious Trauma

Source: Health and Human Rights Info, *Mental Health and Gender-Based Violence: Helping survivors of sexual violence in conflict – a training manual*, HHRI, Oslo, 2012, pp. 21 and p. 139.[1]

Being exposed vicariously to traumatic events, for example by listening to catastrophic testimonies, may generate some of the same trauma reactions that would occur if you were involved in a serious incident. You may struggle to manage your emotions, have problems in your relationships, find decision-making difficult, have physical problems (aches and pains, illnesses), feel hopeless, think your life has no meaning, or experience a collapse in self-esteem.

When working with severely traumatised people, close attention should be paid to helpers' reactions. Helpers too are at risk.

- **Secondary traumatisation.** Helpers sometimes develop the same symptoms as those they help. They may experience hyper arousal, avoidance or distancing, and commonly experience intrusive images and nightmares after hearing or witnessing the traumatic suffering of survivors. Even a single story can create intrusive images.
- **Vicarious traumatisation.** As they accumulate experience of human suffering, helpers' attitudes may evolve. They may become cynical or pessimistic about the world. This can cause them to undervalue themselves and others, or lose their belief in the possibility of change; they become indifferent. Over time, some helpers may feel that their personality has changed.
- **Compassion fatigue.** This state resembles vicarious traumatisation but may also affect professionals in caring positions who are highly exposed to, but do not work only with trauma. It describes a form of 'burn-out' that, in addition to changing cognitive attitudes, causes people to feel exhausted and demotivated, demoralised, bored and hopeless, leading to sleeping problems and sometimes to somatic difficulties and substance abuse.

In all the above states, the helper feels that her problems, needs and well-being, and her private networks, do not merit attention; and that her own risks and hazards are insignificant. Such an attitude has severe consequences. The person is no longer available as an emotional resource to others; the quality of her work may decline; her family and other relationships may suffer; and she herself is likely to be unhappy and may become psychologically destabilised.

Advice

When symptoms of secondary traumatisation occur, the techniques used to help victims (such as stabilisation exercises, sleeping advice, etc.) can often be helpful to the helpers themselves. Helpers need to understand that it is important to recognise their own needs and reactions, and understand what triggers and modifies them.

1 Available at: <http://hhri-gbv-manual.org>.

In cases of vicarious traumatisation and compassion fatigue, additional factors may be relevant.

- Those most at risk tend to be individuals who set extremely high standards, find it difficult to set limits, and impose unrealistic demands on themselves. They need to be helped to recognise that they cannot do everything, are not indispensable, and cannot be responsible for all that happens. They need to learn how to: share or vary their workload; take holidays and schedule time for rest and relaxation; confide in friends and give themselves permission to plan time with them and with family; eat well; exercise regularly; and organise proper support and supervision for themselves at work.
- Vicarious traumatisation and compassion fatigue are likely to be more frequent in organizations that impose heavy demands on their staff and do not adequately regulate and manage their workflow, and where staff work in isolation without feedback from colleagues. The working environment should provide feedback and support, sound supervision, and opportunities to train and learn.

If you employ an interpreter, make sure that her welfare is also taken care of. Even an experienced professional interpreter may be emotionally overwhelmed by the stories she hears. Though it does not happen very often, interpreters may be unable to hide their emotions. Helpers can try to look after the survivor and interpreter by acknowledging that it is painful for them and for her too, to listen to the horrible, unjust experiences that survivors report.

Alternative Care for Children

Sources: United Nations, *Guidelines for the Alternative Care of Children*, 2010;[1] and Interagency Working Group on Unaccompanied and Separated Children, *Alternative Care in Emergencies Toolkit,* 2013.[2]

What is alternative or interim care for children?

Alternative care is care provided for children by caregivers who are not their biological parents.[3] This care may take the form of informal or formal care. Alternative care may include kinship care; foster care; other forms of family-based or family-like care placements; residential care; or supervised independent living arrangements for children.

Placing children in care

For UNICEF, it is considered a last resort to place children in any form of institutional care. Evidence indicates the negative impact of institutions on child heath, mental and physical development, as well as overall well-being. In addition, some evidence indicates that there is an increased possibility of abuse, exploitation and neglect in non-family based care.

In situations where children who are at-risk of further GBV must be removed from their families to ensure their ongoing well-being and safety, the preference is to find a placement that is either kinship, foster, family-based or family-like care. This should be closely monitored and supported by a case manager, by continued access to services, and by economic strengthening for vulnerable families.

In some situations, there is no choice but to place child survivors temporarily into some form of interim or alternative care arrangement that is not family-based.

Which child survivors may need to be placed in alternative care?

Alternative care may be needed for children who continue to be vulnerable to ongoing physical or sexual violence in their current living situation, or who are living without some form of suitable parental care and protection. This includes:

- **Separated, unaccompanied or orphaned children** who have been subjected to GBV.
- **Children engaged in one of the worst forms of child labour**, including children who are being commercially sexually exploited or trafficked.
- **Children formerly associated with armed forces or groups** needing interim or temporary care after having been released.[4]
- **Children coming out of detention** where sexual violence may have been used as a form of torture.[5]

1 Available at: <www.unicef.org/protection/alternative_care_Guidelines-English.pdf>.
2 Available at: <www.unicef.org/protection/files/ace_toolkit_.pdf>.
3 This information sheet does not consider the needs of children staying in safe houses with their mother. It is assumed that the care, well-being and development of these children is the primary responsibility of their parent or guardian.
4 Children recruited and used by armed forces or groups are defined as any person under the age of 18 years old who is, or who has been, recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities. See 'The Paris Principles: Principles and Guidelines on Children Associated with Armed Forces or Armed Groups', 2007.
5 Research and monitoring reports have identified sexual violence against boys in the context of detention, as a form of torture, punishment or humiliation in locations as varied as Libya, Syria, OPT, and Afghanistan.

- **Child who have been in a forced/child marriage.**
- **Children exposed to ongoing GBV within the family**, where there is an ongoing risk of violence, abuse or exploitation and it is not deemed safe for them to stay within their family environment.

Guiding principles for alternative care

The following principles guide decisions around alternative or interim care:

Family as the first choice for care and support to children. Fundamentally, children's well-being, development and care are best achieved when in a family setting. Agencies and case workers should therefore enable and ensure, as far as possible, that children remain with their parents, caregivers or other close family members.

State responsibility. Children who live in situations where they have inadequate or no parental care may be at risk of further violence. When a child's own family is unable, even with appropriate support, to provide adequate care for the child, or abandons or relinquishes the child, the State is the primary duty bearer to ensure the rights of the child and provide some form of alternative care.

Best interests of the child. Any decisions taken with regards to alternative or interim care for a child should be made on a case-by-case basis, ensuring the child's safety, security and survival. The process for making arrangements for the care of the child should uphold the principles of the best interests of the child, the child's right to participation and consultation (in a way that is suitable for and adapted to their age), and non-discrimination.

Guidance on decision-making about a child's care arrangements

Decisions should be made in a timely fashion, particularly for infants and young children. Prompt action may prevent further abuse, exploitation and violence and thus reduce the psychological and physical impact of any protection concerns.

A child is likely to have multiple 'interests' with the potential to affect their safety, well-being and development, and some of these interests may be in conflict or inconsistent with each other. It is necessary to consider all these interests and determine the best course of action regarding the child. A case worker should:

- **Consult the child** regarding their views on all matters relating to care options. The ability of the child to express their opinions will depend on the child's level of development and evolving capacities. The case worker may need to use alternative communication techniques such as using play, art or drawing, role play, or adapted communication tools.
- **Represent the child** and their views, helping the child to have their voice, opinions and concerns heard by decision makers.
- **Communicate any decisions** made regarding interim care back to the child in a way that is appropriate to their age and stage of development. This should include an explanation of why certain choices were taken. It is possible that the decision made in the best interests of the child may be against the child's own wishes; this must be handled with delicacy and the rationale explained in full.
- **Keep the child up to date** on long-term solutions with regards to their care, either for reunification or placement in another family-like setting.

Ensuring alternative or interim care is suitable

Group homes

- Have groups of 6–8 children. They may be of mixed sexes, but should have separate sleeping and sanitary facilities.
- Group children together with any siblings and/or with those from the same ethnic, religious or community background. Certain children may need to be separated for reasons such as previous association with conflicting armed forces or groups.
- You may have a mix of ages and genders to emulate a family-like setting. Adolescent children may support in the care of those younger than themselves.
- Children with physical disabilities should be placed in groups with those who may be able to offer some support.
- Children with severe physical and/or mental disabilities or experiencing extreme distress should be referred to specialist foster care or appropriate residential care.

Interim care centres

- Interim care centres, whilst providing shelter for a larger number of children, should still seek to emulate a family-like setting. This is achieved by providing care based on small groupings of children with sufficient caregiver-to-children ratios.
- Where a large building or space is being used, this should be divided into areas where each family-like group can live, sleep, cook and eat together.
- The maximum length of time any child spends in an emergency care centre should be 12 weeks, unless there are exceptional circumstances. Wherever possible, this should be much shorter, such as a few days or up to 4–6 weeks.

Logistical considerations

Location

- Identify a location close to home or the community of origin wherever possible.
- Ensure proximity to necessary basic services for ease of access. In addition to services required by adult survivors, children will need to be able to continue their education whilst in any form of alternative care arrangements.
- Use structures that are embedded in the community.

Physical structures

- Buildings and structures should resemble those in the area and not stand out.
- Shelters must provide facilities and living conditions that resemble those of the surrounding community, whilst still meeting Sphere standards.[6]

Staffing

Skills and training required for care of children

Staff working in a care center where there are children should:

6 See <www.sphereproject.org/>.

- Have skills and abilities to care for and respond to the needs of children of varying ages and levels of development in a family group.
- Have experience caring for children, either through their own extended families, their own child-rearing or their profession.
- Have some knowledge of basic child health and development.
- Be trained on child safeguarding.

Staff responsibilities in relationship to care for children

The caregivers in a group home for child survivors of sexual violence play a key role in creating a family-like atmosphere and ensuring children's well-being. This is done by providing appropriate attention and support to the small group of children in their care, and by creating routines similar to those found in families from the same community.

- Build a relationship with the children based on the fact that children need a loving and nurturing environment to survive and thrive. This must be balanced against the fact that the child will only temporarily be in their care, and thus the bond must be seen as impermanent.
- The caregiver should help the children access education, recreation, health and other required services, and should liaise with social work/community outreach/child protection staff in case management activities.
- The caregiver should prepare food and eat with their group of children.
- The caregiver should sleep on site, in the same building, whilst children are sleeping, though in a separate room.

Activities and routines

Residential care should ideally be based on a small-group home model whereby the caregiving staff not only look after the children, but also take on the usual parenting responsibilities – such as helping with school work, doing recreational activities with the children, and interacting with other children and families from the local community.

Ensure children are occupied during the day in education, skills training or social activities appropriate to their needs, stage of development, and community norms.

A daily routine of scheduled meals, play, learning (in various forms), activities, relaxation and sleep must be established and agreed between all the managers, carers and children. This must include:

- Appropriate activities outside the buildings which continue relationships in the community, assuming these do not create risks of confidentiality breach or safety risks for the children.
- Caregivers playing with the children and engaging them in a range of creative, active and imaginative ways of passing time that supports cognitive development and psychosocial well-being.
- Helping children who are in education with any school work.
- Reading to or with children, wherever this is possible. Older children can be given access to a collection of books and quiet time to read rather than being read to.
- Where children have become parents as an outcome of the sexual violence, tailored life-skills may be necessary – such as parenting classes, child care, breastfeeding support, etc.

Children should be allowed to maintain contact with parents or family members if this does not place them at continued risk.

Considerations for Setting up Safe Houses/Shelters

Source: Human Rights Center, Safe Haven: *Sheltering Displaced Persons from Sexual and Gender-Based Violence*, University of California, 2013, pp. 7–10.[1]

The following must be carefully considered before setting up safe and effective safe house/shelters in emergency settings:

1. Promote community buy-in, especially in camp settings.

Community support for protection mechanisms to assist individuals fleeing sexual and gender-based violence is particularly important in what can be the closed universe of a refugee or internal displacement camp – where anonymity, mobility, and access to police protection may be limited.

Shelter providers and funders should seek community input into the design and location of camp-based safe shelter systems wherever possible. This may open the door to development of community-host options as well as create support for traditional safe houses.

Where a safe shelter structure already exists, public campaigns and targeted engagement with local residents and community leaders should aim to foster greater community under- standing of its purpose and goals. Greater acceptance has the potential to improve support for the staff and ease residents' access to services. It may also improve survivors' transition from a shelter back into the community. Outreach through community advocates and open-house meetings with community leaders may foster necessary transparency and mutual support.

2. How to ensure the security of both residents and staff.

Ensuring the security of both staff and residents must be a priority and shelter services should be funded to assess their security needs and develop site-appropriate security measures.

Directly consulting with staff and residents to identify their security concerns can help in creating effective protection and response mechanisms. These measures can range from structural protections (e.g., guards, fences, and alarm systems) to behavioral standards (e.g., restrictions on confidentiality, visitors, or residents' movement). Community engagement and support can be an important security asset, especially when staff and residents travel outside the shelter walls. Utilizing neighborhood-based escorts and sharing knowledge of local risks or allies may be helpful.

Finally, whenever possible, individuals must be referred to shelters according to their security needs. Inappropriate placement in low-security models may endanger both the shelter seeker and those living or working in that space; conversely, unnecessary placement in high security programs can hinder a resident's community contact, unduly hampering her later reintegration.

1 Available at: <http://reliefweb.int/sites/reliefweb.int/files/resources/51b6e27b9.pdf>.

3. Provide support for both residents and staff.

For residents, greater funding is needed for counseling, healthcare, vocational training services for survivors, and education opportunities for their children.

Funds are also required to support shelter staff in the stressful work that they do. In this study, staff routinely expressed their need for emotional support services. Shelter providers should be responsible for routinely monitoring the well-being of staff and offering support resources for the practical and emotional needs of staff. Staff requested support that would help them do their jobs better, specifically counseling training for all staff members regardless of position and increased staffing to ease their burden and allow for time off.

Future funding should also support a systematic assessment to identify priorities of both staff and residents, in order to highlight the most important areas of investment for each shelter.

4. Consider appropriate placement and exit strategies from the beginning.

Shelter providers should consider each resident's transition strategies and readiness from as early as possible. This may include assessment of which type of shelter is needed in an individual case and making an appropriate referral, if necessary. Programs should also foster recovery and independence (through counseling, training, and income generation, when possible) and avoid the creation of reliance on the shelter environment. Shelter residents should have meaningful engagement in all levels of decision-making about their transition options. Options may include short-term safe shelter stays leading to relocation within a camp or to a supportive urban area.

5. Explore and develop a diversity of shelter options.

A diversity of shelter options can help providers to accommodate residents' varying security needs and desires for community connection. Policymakers, coordinating bodies, and funders should explore and support a wide range of safe shelter possibilities within a single camp or community. This diversity may also ensure flexibility of transfer later, as a shelter resident's needs or wishes evolve.

6. Conduct shelter mapping, coordination, and exchange.

Effective referral and coordination systems are required for providers to take advantage of diverse options and to place shelter-seekers in appropriate lodging at the outset. Communication and exchange can also bridge gaps between government and civil society programs, as well as enable referrals between safe shelter programs serving displaced communities and mainstream shelters. Robust coordination systems also enable better access to supportive services in the health and legal sectors.

A thorough mapping of safe shelter programs (and their eligibility criteria, length of permitted stay, security features, etc.) is an important first step in facilitating coordination and referral.

An oversight body should be charged with regularly updating a safe shelter index, as well as organizing periodic convenings to enhance referral, build relationships, and share resources and strategies among shelter programs and relevant service providers.

7. Identify and close protection gaps.

A mapping of available safe shelter programs should be undertaken in each displacement context to illuminate protection gaps such as male or LGBT survivors. To address these gaps, coordinating bodies should engage mainstream shelter programs in both camps and urban areas in strategies to safely house members of marginalized victim groups.

Similarly, coordinating bodies should connect members of marginalized victim groups from refugee communities with services and shelters serving their nonrefugee counterparts in urban areas.

Training to help staff at mainstream safe shelter programs work with refugees (including training in how to overcome language and cultural barriers, as well as how to address displacement-related health issues) could help to close the refugee protection gap.

8. Assess macro-level barriers to, and implications of, safe shelter protection in displacement settings.

The effective provision of safe shelter to refugees, internally displaced persons, and other migrants fleeing sexual and gender-based violence requires frank assessment of structural and political barriers to protection. Examining government practice and policy regarding these groups and issues is a critical step. The impact of postconflict or postdisaster humanitarian aid may also require a clear-eyed examination, since funding priorities directly influence who can and cannot be sheltered.

9. Evaluate program impacts.

Funders should support the evaluation of the shelter programs' impact in context-specific, commonsense ways. Measures of success may vary. Complicated reporting matrices may not be appropriate.

Instead, exit interviews with residents, regular follow-up with former residents, and focused case notes on the realization of recovery goals and exit strategies may be helpful measures. It may also be instructive to conduct periodic surveys of community leaders to gauge local perception of the safe shelter program, as well as to obtain external views about residents' transitions back "home" over time.

Confidential coordination with other safe shelter programs may also help providers to identify repeat cases and may offer opportunities to reassess weak exit strategies.

Gao, Mali

Building Safety and Resilience

Info Sheets

At-Risk Groups

Sexual Exploitation and Abuse

UNICEF WASH and Dignity Kit Contents

Women- and Girls-Friendly Spaces

A Survivor-Centred Approach

Levels of Participation

Social Protection in Emergencies

Tools

Tools referenced in this section can be found in the *Minimum GBViE Response Package Tools Booklet* of this Kit.

Community Safety Tool 1: Community Safety Monitoring Sheet

Dignity Kit Tool 1: Good Practice Checklist

Dignity Kit Tool 2: Dignity Kit Monitoring Sheet

Safe Space Programming Tool 1: Assessment and Design Checklist for Women- and Girls-Friendly Spaces

Safe Space Programming Tool 2: Monitoring Sheet for Women- and Girls-Friendly Spaces

Section 5.1

Community Safety Planning and Action

Why community safety planning and action is important

UNICEF recognizes that communities have responsibilities and capacities for their own protection. Building on community strengths and resources in emergencies is an important strategy for activating local protection responses and promoting safety from gender-based violence (GBV). Furthermore, putting the voices and perspectives of the community – girls and women in particular – at the centre of humanitarian assistance and protection efforts is a cornerstone of UNICEF's human rights-based approach to humanitarian action.

While communities may not be able to address all of the threats facing girls and women in emergency settings, they do play an important role in identifying and analysing GBV-related risks in displaced and other humanitarian environments. Communities can take locally and culturally appropriate action to address those safety problems over which they have influence, and they can advocate with duty bearers and other actors to take action to fulfil their responsibilities for protecting girls and women from GBV.

UNICEF's approach to community safety planning and action

UNICEF's community-based approach to building safety and resilience puts girls and women at the centre of humanitarian action as active participants in their own protection, rather than as passive recipients of humanitarian assistance.

Facilitating community-based safety planning and action to address GBV contributes to achieving UNICEF's commitments on preventing violence, exploitation and abuse of children and women in emergencies as set out in the *Core Commitments for Children in Humanitarian Action* (CCCs).[1]

1 For more information about the CCCs, see <www.unicef.org/publications/files/CCC_042010.pdf>.

The **objectives** of using a community-based approach to reduce GBV-related risks are:

- To engage and mobilize affected communities to improve girls' and women's safety and protection from GBV; and
- To strengthen the capacities of rights holders to make their claims while strengthening the capacities of duty bearers to meet their obligations toward protection of emergency-affected populations.

To support communities to identify GBV-related protection problems and take action to reduce GBViE risks, UNICEF country offices (COs) and partners can do the following:

- **Assist communities to conduct safety audits.** Participatory safety audits enable those most affected by the emergency to identify and analyse GBV-related risks and threats within the immediate environment. Safety audits provide a structured method for bringing community members together to collect data and examine the community, humanitarian and external factors that contribute to GBV in a camp, community or other setting.
- **Facilitate collaborative safety action planning.** Safety planning involves bringing stakeholders together to (i) analyse and discuss gaps in safety and accountability discovered through the audit process and (ii) to strategize how to make changes to reduce risks and enhance girls' and women's safety. A concrete safety action plan outlines gaps, responsibilities, resources and timelines for changes, and it can be used to monitor and evaluate the effectiveness of changes over time.
- **Support implementation of safety plans.** Each plan will be different and based on local circumstances. UNICEF provides various types of assistance and resources for implementing safety plans, depending on the problems and solutions identified. Assistance might include technical support; material resources and inputs, such as protection items; communication-based interventions; and advocacy with humanitarian, State and non-State actors to fulfill their responsibilities.
- **Monitor effectiveness of actions and emerging safety problems.** Ongoing monitoring is required to determine whether safety strategies and interventions have been successful; to identify new risks or threats that may emerge in a camp, community or other emergency-affected setting; and to address them accordingly.

A note on the role of community-based GBV mechanisms in responding to individual cases

In many settings, community members are mobilized to detect GBV survivors, report cases to authorities, and sometimes even resolve or mediate cases. *UNICEF does not support this practice as it has the potential to cause harm to survivors and to community members*. Good practice is to equip community actors with information so that they can increase awareness in the community about available GBV services and how to access them. All community-based protection actors, including GBV and Child Protection (CP) groups, must be trained on a survivor-centred approach so that if cases are brought to their attention, they can respond appropriately, always respecting the safety, confidentiality and self-determination of survivors.

A phased approach

A holistic and phased approach to community-based safety planning and action involves implementing certain activities *before* emergencies happen, during the *initial phases* of humanitarian response, and as part of *ongoing* response efforts.

Preparedness

As part of preparedness planning in disaster-prone contexts and complex emergencies, COs should focus on building UNICEF and partner field staff knowledge and skills in conducting participatory GBV safety audits and safety planning processes. Investing in organizational capacity for participatory approaches will deliver benefits across other areas of UNICEF's programming and humanitarian assistance.

COs may also pre-position common protection items, such as lighting and whistles, for immediate use following population displacement. In situations where there has been previous displacement, it is important to learn from past experiences about which items have been effective in improving girls' and women's safety and security.

Immediate response

During immediate response to a rapid-onset emergency, or in changing circumstances during protracted or other crises, COs should initiate participatory GBV safety audits and action planning with communities in UNICEF's areas of operation. These efforts can also be initiated in other geographical areas if deemed appropriate after consultation with the GBV sub-cluster.

Lesbos, Greece

In situations where field staff have not had the opportunity to participate in training on participatory safety assessments, UNICEF GBV specialists can provide technical support to partners to assist them in planning for and carrying out community safety audits and planning processes.

After key safety and security risks and problems have been identified and a local safety plan has been developed to address them, COs and partners should support the implementation of safety plans by providing relevant resources, inputs and support as required.

Immediately following a rapid-onset disaster or change in population circumstances, UNICEF COs can foster girls' and women's empowerment by promoting their voices, visibility and agency in humanitarian relief planning and management. They can also monitor their equal and safe access to essential services and resources to reduce their vulnerability to GBV.

Ongoing response

Once a situation has stabilized, UNICEF and partners should monitor the effectiveness of interventions put in place to improve girls' and women's safety and security. It is also important to monitor the emergence of new GBV-related risks or threats. As necessary, further safety assessments can be conducted to explore risks facing specific populations (such as female-headed households, adolescent girls, or girls and women with disabilities) or to look at specific locations of concern (such as schools within displaced settings). Participatory safety audits and safety planning processes can also be adapted and used in areas of return.

Resources

- **Participation Handbook for Humanitarian Field Workers**
  Active Learning Network for Accountability and Performance and Groupe Urgence Rehabilitation Developpement (2009)
  <www.alnap.org/resource/8531>
- **The Participation of Children and Young People in Emergencies**
  UNICEF (2007)
  <www.unicef.org/eapro/the_participation_of_children_and_young_people_in_emergencies.pdf>
- **A Toolkit for Monitoring and Evaluating Children's Participation: Children and young people's experiences, advice and recommendations**
  Save the Children (2014)
  <http://resourcecentre.savethechildren.se/library/toolkit-monitoring-and-evaluating-childrens-participation-children-and-young-peoples>
- **Guidelines for Children's Participation in Humanitarian Programming**
  Save the Children (2013)
  <http://resourcecentre.savethechildren.se/library/guidelines-childrens-participation-humanitarian-programming>

Capacity Development

- **Introducing Participatory Approaches, Methods and Tools Training Module**
  Food and Agricultural Organization
  <www.fao.org/docrep/006/ad424e/ad424e03.htm>

In situations where it is not deemed appropriate for UNICEF to implement community-based safety assessments and action plans to reduce GBV-related risks, the CO should advocate with other relevant clusters and working groups, such as Camp Coordination and Camp Management (CCCM) and Protection, for a community-based approach to girls' and women's protection and for promoting safer camps and services.

Stakeholders in community safety planning

Key stakeholders in participatory community safety audits and safety planning include:

- Girls, women and other community members;
- Community groups and networks;
- Humanitarian service providers; and
- Relevant security actors.

At-Risk Groups

Girls, women and other community members

Community members are the primary stakeholders in participatory assessments to identify and address GBV-related risks in the local environment. Girls and women should be actively involved in identifying safety and security threats they face, such as unsafe facilities and locations. Different groups within the community will be involved in analysing the causes of safety problems and designing strategies to fix them. Communities also have a responsibility to act on safety problems over which they have some influence or control.

Women's representatives from the affected community should be encouraged to take the lead in safety assessments where it is safe for them to do so. Representatives from different groups of girls and women within the community should be consulted to ensure the experiences and perspectives of all ages and ethnicities are considered, as well as other marginalized people, such as girls and women with disabilities. Where field staff have appropriate skills and it is safe to do so, adolescent and younger girls can be involved in identifying and planning responsive strategies to reduce their exposure to specific threats.

Community groups and networks

Community-based groups and organizations representing children's and women's rights and interests are also important stakeholders in safety audits and planning. These groups often have in-depth knowledge of the problems facing girls and women in the community, as well as knowledge of issues facing particularly marginalized or **at-risk groups**.

Iridimi Camp, Chad

Other community-based actors that should be involved in safety planning to prevent GBV include community-level decision-makers and authorities, such as religious and traditional leaders.

Humanitarian service providers

Humanitarian actors working in displaced camps or other emergency-affected communities – especially camp management and service providers in Shelter, WASH, Non-Food Items (NFI), Education and Protection – are not only key informants in safety assessments; they are also responsible for working with community-level actors to trial and monitor recommended strategies to eliminate GBV-related threats.

Security actors

National and international military and civilian police have a role in improving security and protection from GBV. Of course, where security forces are perpetrating GBV, engagement with them needs to be carefully planned and led by appropriate parties.

Steps in community safety planning

There are three steps to support community-based action to reduce GBV-related risks and improve girls' and women's safety in emergency settings:

Step 1: Conducting a safety audit and developing a safety plan
- 1.1 – Assess risks posed by safety assessments
- 1.2 – Form a working group
- 1.3 – Provide support for data collection and analysis
- 1.4 – Support the working group to develop an action plan
- 1.5 – Consider how to evaluate effectiveness of the safety plan once it has been implemented

Step 2: Implementing safety action plans
- 2.1 – Improve the physical environment
- 2.2 – Distribute protection items
- 2.3 – Enhance security
- 2.4 – Build safe, accountable services and practices

Step 3: Monitoring
- 3.1 – Identify how each safety plan will be monitored
- 3.2 – Select indicators to monitor safety assessment and planning process and quality

Step 1: Conducting a safety audit and developing a safety plan

To conduct safe, effective and participatory community safety audits and facilitate a community-based response to identified problems, COs and partners should:

1.1 Assess risks posed by safety assessments;

1.2 Form a working group;

1.3 Provide support for data collection and analysis;

1.4 Support the working group to develop an action plan; and

1.5 Consider how to evaluate effectiveness of the safety plan once it has been implemented.

1.1 Assess risks posed by safety assessments

Before conducting a participatory safety audit, it is essential to determine whether the activity itself poses a risk to the community. In highly insecure environments, women and other community members seen participating in protection-related assessments may be threatened or targeted by perpetrators, such as armed actors, who do not wish information to be made public. *Extreme care needs to be taken in such situations to thoroughly consider any potential harm that could result from a community-based assessment.*

If participatory safety audits do go ahead in insecure environments, UNICEF and partners will need to ensure a mechanism is put in place to monitor, report and respond to any negative repercussions for community members or staff.

Resources

- **Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies**
  World Health Organization (2007)
  <www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf>

1.2 Form a working group

COs and partners should form a working group made up of community stakeholders. It will be necessary to hold a workshop to orient the group to the safety audit purpose and process, as well as the process for developing a plan to address safety issues identified. The working group will be responsible for managing the safety audit and planning process, including determining the scope, geographical location and timing of the safety audit; obtaining permission from the community; and providing feedback to the community after the audit. Members of the working group will require basic training on ethics and safety.

1.3 Provide support for data collection and analysis

Immediately following a rapid-onset emergency, or during renewed population displacement in complex situations, safety audits should initially focus on collecting information about:

- Unsafe locations in and around displaced settings;
- Risks associated with shelter and site layout;
- Risks associated with access to and use of facilities and services;
- Risks related to access to basic resources, such as food and fuel; and
- Potential solutions for reducing risks and improving safety.

Follow-up safety audits can be carried out during ongoing response in stabilized and protracted situations. These might focus on collecting information about:

- Effectiveness of risk-reduction or safety strategies put in place;
- New risks or safety problems that have arisen; and/or
- Safety problems facing at-risk populations in the community, such as girls and women with disabilities, girls attending school, etc.

Tools

Rapid Assessment Tool 6: GBV Risk and Safety Focus Group Discussion Guide

Rapid Assessment Tool 8: Participatory Safety Mapping Exercise

Rapid Assessment Tool 9: Participatory Safety Walk Guide

Rapid Assessment Tool 10: GBV Risk and Safety Observation Guide

1.4 Support the working group to develop an action plan

Once the audit has been conducted and GBV risks and threats have been documented, a second workshop should be held to bring the working group together with other stakeholders to develop a concrete safety action plan. This workshop should focus on presenting and discussing the data and problems found through the audit; examining why each problem is occurring; defining priorities for action; and identifying practical and feasible strategies for addressing them.

The working group should develop a concrete plan for implementing risk reduction strategies. The plan should clearly outline the duties, responsibilities, timelines and resources required for each action. It is

important to identify who has responsibility for each action. If the responsibility for an action lies with an external actor, it will be necessary to agree on how the issue and recommendation will be communicated to them. For example, will the community directly advocate for action by the external actor, or will UNICEF or partners advocate on the community's behalf?

Tools

Rapid Assessment Tool 11: Community Safety Planning Guide

1.5 Consider how to evaluate effectiveness of the safety plan once it has been implemented

UNICEF uses a variety of evaluative methods in humanitarian settings to learn, improve upon and build evidence about what GBV interventions and programmes work best. Evaluative activities such as programme reviews that focus on learning are most appropriate in the early stages of emergency response to assess effectiveness of safety plans.

Tools

See **Kit 4: Evaluation** for more information about different types of evaluative activities in emergency settings.

Step 2: Implementing safety action plans

The strategies adopted to reduce risks associated with GBV in each setting will depend on the risks and threats present, which may be different in every context. The following information is based on common safety problems and suggested responses to them in emergency-affected settings. *It is not intended to be a prescriptive or exhaustive list, and the strategies highlighted here should not replace locally identified solutions.*

Common responses to safety problems include:

2.1 Improve the physical environment;

2.2 Distribute protection items;

2.3 Enhance security; and

2.4 Build safe, accountable services and practices.

2.1 Improve the physical environment

There are many examples of GBV that occur in displaced and other emergency-affected settings due to poor design of shelter, facilities and services, such as:

- Sexual assault by strangers due to accommodating single women and adolescent girls in unsafe locations in camps or with people they do not know;
- Sexual assault and harassment in and around public facilities (such as bathrooms and latrines) that are inappropriately located or without locks and lighting; and
- Sexual assault in unlit public areas where there is little security or supervision.

Simple strategies for mitigating these risks include, for example, ensuring adequate lighting around sanitation facilities and ensuring facilities have locks. Strategies such as these are well-documented but are not routinely put in place after rapid-onset emergencies.

Colombia

A lack of planning and proactive site and service design can be particularly problematic in spontaneous shelters where there is no authority or camp management agency in place. Clear guidance on how to minimize such risks is set out for each sector in the **IASC GBV Guidelines**.[2]

★ See the IASC GBV Guidelines

Tools

See **Kit 3.6: Programming – Integrating GBV Risk Mitigation Across UNICEF Sectors and Clusters**.

2.2 Distribute protection items

In some contexts, distributing protection items such as flashlights and whistles to girls and women can improve their safety by allowing them to walk in the dark in unsafe public areas and call for help if needed. COs should work in coordination with other actors to ensure adequate supply of relevant NFIs to community protection actors or to at-risk girls and women. Consideration must be given to the need for ongoing energy supply for lighting, such as batteries or kerosene.

Tools

See *Section 5.2: Dignity Kit Programming* in this book.

2.3 Enhance security

A lack of security and rule of law can increase the risk of some forms of GBV – such as sexual assault and harassment by community members, armed actors or others – in and around camps, shelters, public spaces and communities.

Enhancing security can reduce some GBV-related threats. Increased peacekeeping patrols can deter perpetrators outside a camp or community from entering; peacekeeping escort systems can be deployed to improve security for girls and women collecting firewood; and a security presence by community watch groups within camps and shelters can make known danger zones inside camps safer.

UNICEF can contribute to enhancing security in several different ways. For example, COs and partners can:

- Build confidence and skills so that community representatives can conduct safety audits and advocate with authorities for increased security at the local level;
- Engage in high-level advocacy at district and national levels within the Protection cluster, as well as with relevant duty bearers and security actors, for specific action to protect girls and women from GBV; and
- Provide technical advice and guidance on good practice in establishing and managing community watch groups in displaced settings. Community-based safety mechanisms require clear guidelines, training and supervision. For example, *community watch groups should never be tasked with detecting survivors and bringing them to authorities for action. This is not good practice and must be discouraged*. Instead, members of community watch groups should be trained on identifying and reporting safety risks and on providing communities with accurate information about available services so survivors and families can make informed decisions regarding care and support.

2 Available at: <http://gbvguidelines.org>.

Resources

- **Gender-Based Violence in Emergencies Advocacy Handbook**
  Gender-Based Violence Area of Responsibility (2014)
  <http://educationcluster.net/wp-content/uploads/sites/3/2015/02/GBV-in-Emergencies_Advocacy-Handbook_final.pdf>
- **Advocacy Toolkit: A guide to influencing decisions that affect children's lives**
  UNICEF (2010)
  <www.unicef.org/evaluation/files/Advocacy_Toolkit.pdf>
- **Saving Lives, Protecting Children: Advocacy in emergencies**
  UNICEF (2008)
  <www.unicefinemergencies.com/downloads/eresource/docs/Advocacy/2008-11-12-UNICEFAdvocacyGuidelines.pdf>
- **UNICEF Core Commitments for Children CCC E-Resource: Humanitarian Advocacy**
  <www.unicefinemergencies.com/downloads/eresource/Advocacy.html>

Tools

See **Kit 3.3: Programming – Building Accountability** for more information on engagement and advocacy with armed groups to address conflict-related sexual violence.

2.4 Build safe, accountable services and practices

The humanitarian environment and the ways in which assistance and services are delivered can actually increase the risk of GBV. For example:

Sexual Exploitation and Abuse

- A lack of access to resources for survival can lead to **sexual exploitation and abuse** of children and women, who may have no other choice than to exchange sex to meet their basic needs;
- A lack of firewood, fodder or shelter materials near areas of displacement means that girls and women must travel great distances to find resources, increasing their risk of attack or harassment;
- Unaccompanied children can be at risk of sexual abuse in alternative care placements or institutions that aren't properly vetted;
- Girls can face sexual assault or harassment travelling to and from – or while attending – school or child-/adolescent-friendly spaces; and
- Girls and women can face sexual assault travelling to and from food distribution sites.

The following actions can be taken to help prevent and mitigate risk associated with humanitarian services and practices. They include:

a) Establishing reporting systems;

b) Advocating with service providers;

c) Promoting safe access to resources; and

d) Increasing community knowledge and awareness.

a) Establish reporting systems

Communities can establish reporting systems for GBV-related safety problems stemming from unsafe services and lack of resources. This way, issues can be brought to the attention of authorities and other relevant agencies for action. As noted above, it is essential that caution be taken with community-based reporting mechanisms: it must be clear they are for reporting *safety problems* and *not for reporting individual cases of GBV*. In many settings, community groups are given the task of identifying and following up on cases of GBV; however, this is not good practice and can be harmful.

Any information shared through community reporting systems should never identify details about a survivor, as this breaches principles of confidentiality and self-determination.

Harar, Ethiopia

b) Advocate with service providers

Where problems associated with unsafe services or practices are due to a lack of awareness on the part of service providers, community members should be supported in drawing the attention of the service provider to the problem and advocating with relevant actors to take action to improve safety. UNICEF and partners can also advocate on behalf of communities with government authorities or humanitarian actors at the national level to act on identified GBV-related protection problems caused by unsafe services and practices.

c) Promote safe access to resources

Where problems arise due to a lack of access to resources such as fuel, UNICEF and partners can help communities advocate with humanitarian actors for improved technologies, alternative fuels, and livelihood and environmental activities.

Resources

- **Decision Tree Diagrams on Factors Affecting Choice of Fuel Strategy in Humanitarian Settings**
  Inter-Agency Standing Committee (2009)
- **Guidance Note on SAFE Access to Firewood and Alternative Energy in Humanitarian Settings**
  Food and Agricultural Organization (2013)
- **Beyond Firewood: Fuel alternatives and protection strategies for displaced women and girls**
  Women's Refugee Commission (2006)
  <www.womensrefugeecommission.org/joomlatools-files/docman-files/fuel.pdf>
- **Handbook on Safe Access to Firewood and Alternative Energy (SAFE)**
  World Food Programme (2012)

d) Increase community knowledge and awareness

Emergency-affected communities have the right to information that can help protect them. Information campaigns can ensure that girls and women know about unsafe areas, what they are entitled to receive, how to report abuses and what to do if their reports do not generate action. Communication strategies that use multiple channels of communication achieve a higher proportion of positive outcomes.

Resources

- **Communication for Humanitarian Action Toolkit (CHAT): Working Version**
  UNICEF (May 2015)
  <www.unicefinemergencies.com/downloads/eresource/docs/Communication%20for%20Development/6-C4D-CHAT_Proof-2.pdf>

Step 3: Monitoring

3.1 Identify how each safety plan will be monitored

Monitoring is essential for ensuring that strategies set out in safety action plans are implemented effectively and actually reduce girls' and women's exposure to GBV. Monitoring should also be used to identify any new risks or threats that emerge in the community over time.

Each safety action plan should clearly outline how and when recommended improvements will be measured. Safety audit tools – including questionnaires, safety walks and participatory safety ranking – can be repeated over time, and the findings can be compared to see how girls' and women's perceptions and experiences have changed.

3.2 Select indicators to monitor safety assessment and planning process and quality

The exact choice of indicators and way of measuring them will be determined by the CO based on specific objectives and interventions selected; the phase of humanitarian response; and the feasibility of monitoring in emergency contexts.

The table below offers some sample outcomes, outputs and indicators that may assist CO GBV and CP staff and partners in monitoring safety audit and safety planning processes. Remember, indicators need to be measured both *before* and *after* an intervention to see if there have been any change.

Tools

Community Safety Tool 1: Community Safety Monitoring Sheet

Sample outputs and indicators for GBViE community safety assessment and planning

Sample outcome	Sample outputs	Sample output Indicators
Girls' and women's safety and protection from GBV in and around displaced settings/affected communities is improved.	Field staff are competent to facilitate participatory safety audits and planning processes.	• # of staff trained on participatory safety audit process
	Sufficient funds are available to adequately resource community safety plans.	• % of community safety plans fully funded
	Key GBV-related risks and threats are identified related to the physical environment, access to basic resources, and humanitarian services and practices.	• % of target camps/communities that have established a community safety working group • % of target camps/communities that have conducted a participatory safety audit • # of GBV-related safety problems identified and documented in each camp/community
	Safety action plans developed by the community and relevant stakeholders address identified risks and threats.	• % of target camps/communities with a safety action plan
	Safety action plans are implemented and their impact is monitored.	• % of camps communities in which safety action plans are implemented • % of girls and women that report increased perception of safety

Section 5.2

Dignity Kit Programming

Why gender-sensitive NFI distribution is important

In the aftermath of an emergency, adolescent girls and women have gender-specific reproductive health, hygiene and protection needs. UNICEF and other humanitarian actors recognize the need to distribute **gender-sensitive non-food items (NFIs)** to adolescent girls and women to promote their rights to health, dignity and protection in emergencies.

Supplementing standard NFI distributions to displaced people with gender-sensitive NFIs – such as menstrual management materials, culturally appropriate garments and protection items – has many positive benefits for girls' and women's safety, security, well-being and functioning in emergency settings.

Distribution of gender-sensitive NFIs can also serve as an important entry point for protection, education, psychosocial and health-related interventions. For example, it can provide an opportunity to engage girls and women in education and other activities related to GBV prevention and response, reproductive health, hygiene promotion, HIV prevention and psychosocial support.

Examples of Gender-Sensitive NFIs

Sanitary items for menstrual hygiene management allow girls and women to move freely and continue with daily tasks.

Suitable clothing, such as headscarves, help girls and women maintain dignity and freedom of movement to attend school and move around in public.

Protection items such as torches and whistles allow girls and women to light up areas where they are at risk of attack or attract attention if they need help.

Radios keep girls and women informed about risks and threats.

Firewood/energy saving stoves minimize risk of attack when collecting firewood.

UNICEF's approach to dignity kit programming

Reflecting UNICEF's *Core Commitments for Children in Humanitarian Action* (CCCs),[3] along with its mandate to promote and protect the rights of girls and women to health, dignity and safety from GBViE, Child Protection (CP) and Water, Sanitation and Hygiene (WASH) sections – together with Supply Division – have developed two kits to better serve the needs of adolescent girls and women and their children in emergencies.

These two new kits[4] include:

1. The *Immediate Response WASH and Dignity Kit;* and
2. The *Family Hygiene* and *Dignity Kit*.

UNICEF WASH and Dignity Kit Contents

Both **UNICEF WASH and dignity kit contents** are designed for families of five people with up to two girls and women of reproductive age (13–49 years). The **objectives** of kit distribution are:

- To meet family hygiene needs and promote the hygiene, dignity and protection of girls and women in humanitarian emergencies; and
- To serve as an entry point for UNICEF CP, WASH, Health, HIV and Education interventions.

The *Immediate Response WASH and Dignity Kit* is designed for distribution in the **first phase** (<8 weeks) of emergency response. It is a lifesaving pre-packaged kit, assembled by UNICEF Supply Division in Denmark and shipped to country offices (COs) upon request. In some situations, such as countries with frequent/recurring emergencies, local procurement options for this kit should be established as part of emergency preparedness, based on lessons learned from previous emergencies in which items are most suitable and culturally appropriate.

The *Family Hygiene and Dignity Kit* is designed for distribution in **either the first phase** (<8 weeks) **or the second phase** (>8 weeks) of an emergency response. In most situations, this kit should *not* be ordered from Supply Division; rather, it should be locally procured and customized with culturally and context-specific items after discussion with girls and women on the ground (ideally as part of emergency preparedness). Acknowledging, however, that there are specific situations where some countries have limited supply options, a standard pre-packaged 15-item kit will be available from Supply Division.

COs need to include sufficient relevant information about the contents, use and benefits of the items included in the kit. For example, information should be provided about the purpose and disposal of sanitary napkins in situations where people are not familiar with them. Furthermore, kit distribution provides an important opportunity and should be used to communicate relevant information and education materials for girls and women, such as reproductive and other health information; material on GBV risks and services; information for adolescents on menstruation and hygiene; and material on UNICEF WASH, Health or Education services.

Information should also be provided along with the kits about people's rights in relation to the distribution. For highly literate communities, a written leaflet can be produced to accompany the kits; for less literate populations, the most appropriate communication method must be determined. This information should include:

- **Hygiene promotion**, including guidance on the correct use of any WASH infrastructure that has been set up for the emergency (in particular, where people are used to practicing open defecation);

3 For more information on the CCCs, see <www.unicef.org/publications/files/CCC_042010.pdf>.
4 The new kits replace the Adult Hygiene Kit, Family Water Kit and sub-kits on the Emergency Supply List (ESL) and will be pre-stocked by Supply Division as per normal ESL guidelines.

- Culturally relevant **sexual and reproductive health (SRH) information** on danger signs during pregnancy and delivery, the importance of obstetric care, availability of SRH services, and other related information;
- Information on **known risks of GBV** in the location, such as unsafe areas, threats associated with water/firewood collection, the benefits of seeking post-rape care within 72 hours, GBV services available and what to expect when seeking help from services; and
- **Menstrual management and hygiene information** for adolescent girls.

Resources

- **Menstrual Health Education Resource**
  Irise International (2013)
  <www.bridge.ids.ac.uk/global-resources/resource/A72822>

Capacity Development

- **Menstrual Hygiene Matters: Training guide for practitioners**
  WaterAid (2015)
  <www.bridge.ids.ac.uk/global-resources/resource/A72816>

A phased approach

A holistic and phased approach to dignity kit programming involves implementing certain activities before emergencies happen (*preparedness*), during the initial phases of *immediate response* to a crisis, and as part of *ongoing response* efforts.

Depending on the level of preparedness and local procurement options, **three scenarios** are possible:

- **Scenario A:** Full local procurement
- **Scenario B:** Little-to-no preparedness/ partial local procurement
- **Scenario C:** Limited-to-no local procurement possible

Bangui, Central African Republic

Baluwa village, Nepal

Preparedness

COs should consult with girls and women regarding menstrual hygiene management and other hygiene practices to identify culturally appropriate items. They should then procure stock as part of preparedness planning. See **Steps in dignity kit programming** on the following pages for information on assessment.

Immediate response

- **Scenario A:** Where COs have pre-positioned *Family Hygiene and Dignity Kit* supplies, they should establish distribution plans and review targeting criteria with partners before distributing the kits.
- **Scenario B:** Where COs do not have pre-positioned WASH and dignity kit supplies for the immediate response but have some capacity for local procurement over the longer term (>8 weeks), they should procure and distribute *Immediate Response WASH and Dignity Kits* as soon as possible after a rapid-onset emergency. They should also start local procurement of *Family Hygiene and Dignity Kits* for the ongoing response.
- **Scenario C:** Where COs do not have pre-positioned WASH and dignity kit supplies, they should procure and distribute *Immediate Response WASH and Dignity Kits* as soon as possible after a rapid-onset emergency. If it is not possible to locally procure *Family Hygiene and Dignity Kits* over the longer term (>8 weeks), the CO should start procurement of these kits through Supply in Copenhagen.

Ongoing response

- **Scenario A:** The CO should monitor distributions of *Family Hygiene and Dignity Kits* carried out in the immediate response and monitor the use of kit contents. The CO should also distribute additional kits and replenish items as necessary.
- **Scenario B:** The CO should monitor distributions of *Immediate Response WASH and Dignity Kits* carried out in the immediate response and monitor the use of kit contents. The CO should also start to distribute *Family Hygiene and Dignity Kits* procured locally as soon as feasible after the disaster.
- **Scenario C:** The CO should monitor distributions of *Immediate Response WASH and Dignity Kits* carried out in the immediate response and monitor the use of kit contents. The CO should also start to distribute *Family Hygiene and Dignity Kits* procured from Copenhagen as soon as feasible after the disaster.

Stakeholders in dignity kit programming

UNICEF Child Protection, WASH and – where relevant – Education and Communication for Development (C4D) sectors should work together to collect relevant information and plan and manage WASH and dignity kit distributions.

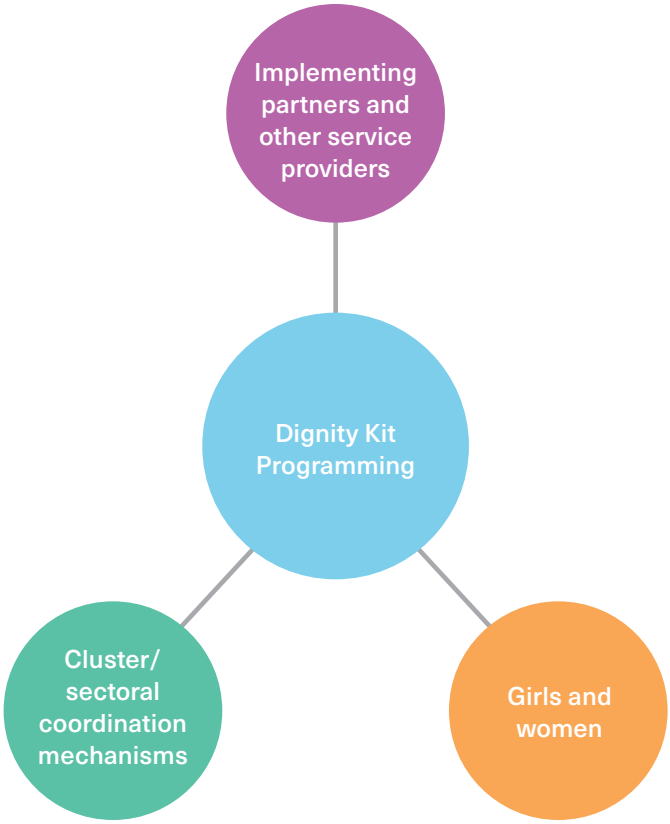
Key stakeholders to consult during WASH and dignity kit assessment, design and implementation include:

- Affected girls and women;
- Implementing partners and other service providers; and
- Clusters and other sectoral coordination mechanisms.

Affected girls and women

Adolescent girls and women are primary stakeholders in UNICEF WASH and dignity kit distributions. Girls and women of different ages should be consulted on the acceptability and use of items in customized kits; protection needs that can be met through NFI distribution; and information that will accompany each kit. Where possible, provide girls and women with samples of items during consultations so they can choose. If there are multiple nationalities, ethnicities and/or religious groups in a camp, it will be necessary to consult girls and women from each group, as values and practices around dignity and menstrual hygiene management may vary among different populations.

While it may not be possible to consult on pre-packaged kits, time must be made for some discussions with representatives from affected communities either during preparedness planning or prior to procurement and distribution of customized kits.



Implementing partners and other service providers on the ground

Implementing partners and other humanitarian actors operating in the camp or community – including Camp Management agencies and other service providers in NFIs, Shelter, Health and Protection – can provide input into kit customization, vulnerability criteria, targeting of kits, distribution planning and risk management. Ongoing coordination with these actors will also be essential during kit distribution and monitoring.

Clusters and other sectoral coordination mechanisms

Consult with leads and members from clusters and alternative sectoral coordination mechanism to ensure relevant lessons from other NFI distributions, including information on unintended consequences, are taken into account in kit design and distribution. Cluster coordinators and members will be able to provide valuable input into customization of kit contents; geographical focus and coverage for distribution; and safety and security issues.

Steps in dignity kit programming

There are three steps in dignity kit programming, as shown below:

Step 1: Assessment and design
- 1.1 – Identify kit contents
- 1.2 – Define the geographical area for distributions
- 1.3 – Determine targeting criteria for distributions
- 1.4 – Identify risks and unintended consequences of distributions
- 1.5 – Consider how to evaluate the effectiveness of dignity kits

Step 2: Procurement and distribution
- 2.1 – Procurement
- 2.2 – Distribution

Step 3: Monitoring
- 3.1 – Plan how to monitor dignity kit programming

Step 1: Assessment and design

During assessment and design for WASH, family hygiene and dignity kit distribution, COs should take the following actions:

1.1 Identify kit contents;

1.2 Define the geographical area for distributions;

1.3 Determine targeting criteria for distributions;

1.4 Identify risks and unintended consequences of distributions; and

1.5 Consider how to evaluate the effectiveness of dignity kits.

1.1 Identify kit contents

When designing customized *Family Hygiene and Dignity Kits*, considerations in identifying items should include:[5]

- Relevance and usability of the items;
- Cultural appropriateness;
- Quality of the items;
- Quantity;
- Frequency of distribution;
- Environmental considerations; and
- Price.

It is important to include information on the use and benefits of the items in the kits; for example, information about the purpose, disposal and/or cleaning of the menstrual hygiene management materials in cases where people are not familiar with that specific product.

Tools

Rapid Assessment Tool 5: WASH and Dignity Kit Sample Focus Group Discussion Guide

5 United Nations Population Fund, 'Dignity Kit Programming Guidelines', Humanitarian and Fragile Contexts Branch in Programme Division, UNFPA, New York, 2013.

1.2 Define the geographical area for distributions

Through consultation with Shelter, Camp Management, WASH and Protection Cluster lead agencies and members, define the geographical area (the region, district, camp, settlement or community) for the distribution. Geographical coverage for distribution will be influenced by:

- Distribution of similar NFIs by other actors;
- Location and number of affected people;
- Presence of distribution partners; and
- Access, including infrastructure damage, ongoing conflict and security, and/or political instability.

1.3 Determine targeting criteria for distributions

Clear and specific selection criteria for the target population who will receive the kits should be agreed through consultation with girls and women, community leaders, local organizations and actors, and clusters. The criteria should be communicated to the community prior to distribution to promote transparency.

Vulnerability and need – based on factors such as age, health status, security and family composition – must be considered when developing targeting criteria. For example, the possibilities of younger menstruating adolescent girls and older women with delayed menopause must be discussed, as must family composition (for example, in communities that practice polygamy).

1.4 Identify risks and unintended consequences of distributions

When developing the *Family Hygiene and Dignity Kit*, it will be important to identify potential safety and security risks associated with kit distribution and address those risks during response design. Managing risks involves ensuring monitoring mechanisms are put in place for identifying unintended consequences of kit distribution, such as inappropriate disposal of sanitary materials. Risks to consider include safety and security of kit recipients (for example, threat of harassment, humiliation or attack traveling to or from distribution); risk of recipients being targeted for theft of items contained in the kit; and unsafe use or disposal of items included in the kits, such as blocking latrines and unsanitary waste disposal.

Dolakha, Nepal

1.5 Consider how to evaluate the effectiveness of dignity kits

UNICEF uses a variety of evaluative methods in humanitarian settings to learn, improve upon and build evidence about what GBV interventions and programmes work best. Evaluative activities such as programme reviews that focus on learning are appropriate in the early stages of emergency response to assess the effectiveness of dignity kit programming.

Tools

See **Kit 4: Evaluation** for more information about different types of evaluative activities in emergency settings.

Step 2: Procurement and distribution

2.1 Procurement

Considerations for procurement quantity include how often distributions will be required depending on people's capacity to meet their own needs. Some items, such as soap and disposable sanitary materials, will require repeat distribution monthly to replenish supplies.

Procurement processes for WASH, family hygiene and dignity kits depend on the phase of emergency response and the availability of items on the local market. Prior to ordering the kits from Supply Division, **COs should first attempt to source all contents locally**. This should take place as part of preparedness activities; however, where this is not possible, the appropriate prepackaged *Immediate Response WASH and Dignity Kit* and/or *Family Hygiene and Dignity Kit* should be ordered from Supply Division.

2.2 Distribution

A distribution plan developed in consultation with all stakeholders is an important part of response design. Where UNICEF is managing the distribution, refer to the Supply team for appropriate guidance on the organization of the distribution.

Step 3: Monitoring

3.1 Plan how to monitor dignity kit programming

Post-distribution monitoring on acceptance and use of WASH, family hygiene and dignity kit items should take place as soon as possible after distribution in cases where repeat distributions are planned in order to adjust the kits or the distribution process as needed. Monitoring processes should also look at unintended consequences of kit distribution, such as sale of items from the kit or unsafe waste disposal of sanitary items.

Monitoring can be done through individual interviews and by group discussion and findings. Emerging issues and lessons should be documented; used to make adjustments if further distributions are planned; and/or shared with others to ensure lessons and good practice are followed in other UNICEF and partner kit distributions.

Tools

Dignity Kit Tool 2: Dignity Kit Monitoring Sheet

Section 5.3

Safe Space Programming

Why safe spaces are important

'Safe spaces' are widely used by humanitarian actors to offer community-based, structured, age-appropriate and gender-specific services to displaced and other emergency-affected communities.[6] While there are a variety of safe space models used in humanitarian settings, safe spaces generally offer a range protection, non-formal education and psychosocial supports to children, adolescents and women during emergencies.

Different types of safe spaces supported by UNICEF

- Child-friendly spaces
- Youth-friendly spaces
- **Women- and girls-friendly spaces**
- Integrated safe spaces

Women- and Girls-Friendly Spaces

Core Commitments for Children (CCCs)

Child Protection Programme Actions[7]

Safe space programming helps to achieve UNICEF's commitments to support community-based safe environments and engage local capacities to address violence, exploitation and abuse.

Support community-based safe environments for women and children, including child-friendly spaces, with particular attention to girls, adolescents and their caregivers, and provide support for early childhood development activities.

Engage local capacities to address violence and exploitation; and support service providers, law enforcement actors, women's rights groups, communities and children to prevent violence, exploitation and abuse, including GBV.

6 Madfis, J., D. Martyris and C. Triplehorn, 'Emergency Safe Spaces in Haiti and the Solomon Islands', Disasters, vol. 34, no. 3, 2010, pp. 845-864.

7 For more information, see the Child Protection Commitment Programme Actions in United Nations Children's Fund, *Core Commitments for Children in Humanitarian Action*, UNICEF, 2010, p. 34, available at <www.unicef.org/publications/files/CCC_042010.pdf>.

UNICEF's approach

UNICEF's approach to safe space programming involves ensuring that girls and women have access to dedicated safe spaces.

There are two **objectives** of establishing women- and girls-friendly (WGF) spaces:

- To promote girls' and women's rights to safety, dignity and empowerment in emergencies by offering a range of social, economic and other support services, including those that address GBV; and
- To engage and support local capacities to address GBV.

South Africa

The model of service delivery and type of facilities used for WGF spaces, as well as the nature of activities offered in each safe space, will depend on the context, needs and capacities on the ground in each emergency. It is, however, essential that regardless of the model, girls and women have access to dedicated safe spaces.

Key **determinants** of effective safe space programming to address GBV include:

- **An enabling environment,** which refers to appropriate allocation of resources to establish and manage WGF spaces and deliver good quality interventions in all UNICEF-supported safe spaces; capacity of partners to effectively manage and coordinate safe spaces and GBV interventions; and community norms that impact girls' and women's access to safe spaces.
- **Appropriate and good quality services,** which refers to appropriate facilities, essential commodities and supplies, and well-trained staff to deliver relevant interventions and activities – including GBV information, education, communication, mobilization, empowerment activities and GBV response interventions based on local need and context.
- **Community demand and uptake of services and activities,** which refers to accessibility, relevance and usefulness of GBV and other related activities offered within safe spaces.

A phased approach

A holistic and phased approach to safe space programming involves implementing certain activities *before* emergencies happen, during the *immediate phase* of humanitarian response, and as part of *ongoing response and early recovery* efforts.

Preparedness

In disaster-prone contexts or during complex emergencies, it is recommended that COs invest in **learning about GBV and related risks** and vulnerabilities faced by girls and women in the community during previous disasters or population displacement. Where relevant, COs and partners should review lessons from safe space programming in past emergency response efforts to identify priorities for WGF spaces and for GBV activities within all safe spaces.

During preparedness, COs also need to **build partner capacity** to establish and manage WGF spaces and implement GBV prevention and response activities as a component of all safe space programming.

Immediate response

Immediately following a rapid-onset disaster and during complex and protracted emergencies, COs and partners should establish WGF spaces in a manner appropriate to the context to provide a safe venue for girls and women to come to and receive information, assistance and support. The following activities and services should be made available through each WGF space:

- **A place to safely gather and access information and psychosocial support;**
- **Dissemination of appropriate GBV-related safety and other information** to the community;
- **Coordination and advocacy** with authorities, service providers and other CP and GBV actors on GBV-risk and vulnerability reduction;
- **Distribution of gender-sensitive non-food items (NFIs)** to build girls' and women's resilience to GBV;
- **Community mobilization** against GBV, including safety assessments and planning; and
- **A confidential reporting, referral and support mechanism** for survivors of GBV, and those at-risk, to promote access to appropriate health and psychosocial care and support and reduce further exposure to GBV.

Ongoing response and early recovery

Once a situation has stabilized, safe spaces can serve as a platform for an expanded set of community mobilization, education and empowerment activities that help to help build girls' and women's resilience and capacity; reduce risks of GBV; and contribute to its prevention. These activities can include:

- **Strengthened child protection** response to GBV;
- **Targeted prevention interventions** to help prevent prevalent forms of GBV, such as intimate partner violence or child marriage;
- **Education and social/economic empowerment interventions,** such as peer and group education or activities to build girls' and women's social and economic knowledge, skills and resources; and
- **Expanded specialized GBV response services,** including case management; age-appropriate psychosocial support (PSS); legal assistance; medical services; referrals to other services as needed; social and recreation activities; life skills courses; skills/vocational development; and information on reproductive health, coping strategies, hygiene promotion and women's rights.

In addition to making a range of information, services and programmes *available* for girls and women through safe spaces, UNICEF and partners must address barriers at the service and community level that different groups face in *accessing services* – such as adolescent girls, married girls, girl mothers, girls and women with disabilities, or those recruited and used by armed groups. These include physical and social barriers, as well as barriers created through the service itself. For example, adolescent girls have different needs and interests than adult women, and they often report they are not interested in participating in activities alongside their mothers. Common barriers to access include the following:

- Girls who attend school are likely to have different needs and interests than those who are out of school or those who are married;
- Elderly women may have mobility problems or have difficulties in participating in activities requiring good eyesight or dexterity;
- Girls and women who are working, and particularly female heads of households, may struggle to find the time to participate in activities during standard opening hours; and
- Girls and women from minority communities may feel intimidated or unwelcome.

Kashmor, Pakistan

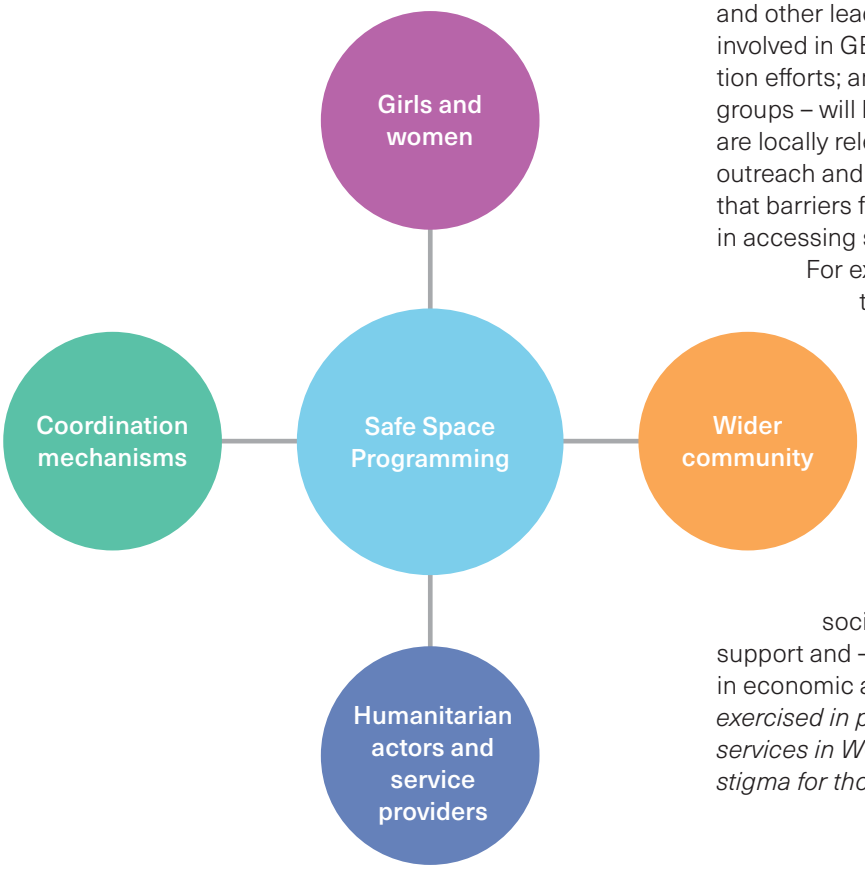
Resources

Key guidelines for safe spaces in emergencies

- **Promoting Positive Environments for Women and Girls Friendly Spaces in South Sudan**
  HealthtNetTPO and UNICEF (2016)
  <http://www.childrenofsouthsudan.info/wp-content/uploads/2017/06/WGFS-Guidelines-for-South-Sudan_FINAL-VERSION.pdf>
- **A Practical Guide to Creating Child Friendly Spaces**
  UNICEF (2011)
  <http://cpwg.net/wp-content/uploads/sites/2/2011/09/A_Practical_Guide_to_Developing_Child_Friendly_Spaces_-_UNICEF_11.pdf>
- **Guidance Note on 'Makani' My Space Approach**
  UNICEF
  <www.unicef.org/jordan/Makani_Guidelines_English(1).pdf>
- **Women and Girl Safe Spaces: A guidance note based on lessons learned from the Syria crisis**
  UNFPA (2015)
  <www.unfpa.org/resources/women-girls-safe-spaces-guidance-note-based-lessons-learned-syrian-crisis>
- **Guidelines for Child Friendly Spaces in Emergencies**
  Inter-Agency Standing Committee (2011)
  <www.unicef.org/protection/Child_Friendly_Spaces_Guidelines_for_Field_Testing.pdf>

Stakeholders in safe space programming

For effective safe space programming, UNICEF country office GBV and CP staff and partners need to work collaboratively with numerous stakeholders during emergency preparedness, immediate response and ongoing response/recovery. Key stakeholders in the assessment, design and implementation of safe spaces include girls and women; the wider community; other humanitarian actors and service providers; and relevant coordination mechanisms.



Girls and women

It is essential to consult with girls and women of different ages when planning WGF spaces. It is not always possible to consult extensively with the community during the early days of emergency response. In areas where there are cyclical emergencies, it is easier to have discussions with girls and women as part of emergency preparedness planning. Once established, safe spaces provide an ideal venue for engaging different groups to identify GBV-related problems and vulnerabilities they face.

The wider community

Appropriately engaging groups within the wider community – including faith-based and other leaders; local resource people involved in GBV prevention or mobilization efforts; and community-based CP groups – will help ensure that WGF spaces are locally relevant and have maximum outreach and uptake. It will also help ensure that barriers faced by marginalized groups in accessing safe spaces are addressed. For example, experience shows that in many settings, it is essential to proactively engage parents and other gatekeepers so that adolescent girls can participate in programmes run through safe spaces. It is important to promote WGF spaces as locations where girls and women can socialize, obtain assistance and support and – in some instances – engage in economic activities. *Caution must be exercised in publicizing GBV response services in WGF spaces, as this can create stigma for those using the service.*

Quetta, Pakistan

Humanitarian actors and service providers

Addressing GBViE requires collaborative relationships with other groups and organizations working in a camp or community. Different service providers have particular responsibilities, resources and expertise to contribute to safe spaces. Identifying and coordinating with all providers of GBV-related services – as well as providers of other relevant health, shelter, food, NFI, education and other social services – can help ensure that activities implemented in safe spaces complement other GBV programmes and initiatives. It also ensures that the strong linkages required for effective GBV prevention and response are built from the beginning.

GBV, CP and other relevant coordination mechanisms

Establishing WGF spaces requires good communication, collaboration and coordination with all GBV and CP actors to ensure complementarity of services; good linkages and relationships with others working on GBV and CP; and information sharing regarding GBV risks and responses in each camp or community.

Steps in establishing women- and girls-friendly spaces

There are three steps in establishing and managing WGF spaces to improve girls' and women's safety, dignity and empowerment in emergency settings.

Step 1: Assessment and design

1.1 Assessing the context

In the early stages of emergency response, **key assessment priorities** for establishing and managing WGF spaces include:

a) **Assessing and addressing partner capacity for establishing and managing WGF spaces;**

b) **Adopting a participatory approach to assessment and design of WGF spaces;**

c) **Identifying appropriate WGF space models for the setting;**

d) **Identifying safe site location and facility design; and**

e) **Identifying relevant services and activities and tailoring them to the local context.**

a) Assessing and addressing partner capacity for establishing and managing WGF spaces

Partners require adequate material, financial, technical and human capacity for establishing and managing safe and effective WGF spaces. Supporting capacity development of local and national actors is a priority for UNICEF: it contributes to the development of national systems and the empowerment of local actors, and it fosters sustainability of services over time by phasing out management by international actors. Capacity of local actors varies from context to context, and capacity development needs and approaches will also vary; however, considering capacity of local partners from the outset will help to make sure their capacity development needs are prioritized.

Some minimum capacity and resource requirements UNICEF and partners will need to assess and address include:

- Infrastructure and materials required to establish and manage WGF spaces;
- Staffing, including appropriate training and support for staff and volunteers; and
- Technical support and guidance.

Infrastructure and materials required to establish and manage WGF spaces. Whether a safe space is temporarily established in a tent immediately following a population displacement or established in a more permanent structure, it is important to make provision for the following during immediate response:

- ✔ Tents or sheeting for erecting temporary emergency safe spaces and an appropriate physical structure for more permanent WGF spaces (the type will vary depending on the circumstances and context – in some settings, existing buildings and services may be used, while in others they may need to be constructed);
- ✔ Furniture and equipment appropriate to the activities that will be carried out at the WGF space;
- ✔ A private space within each facility where individual girls or women can meet confidentially with social workers or volunteers, and where distressed girls and women can recover;
- ✔ Safe and accessible latrine facilities nearby;
- ✔ Gender-sensitive NFIs (such as female hygiene kits for distribution to particularly at-risk girls and women or survivors) and protection items (such as whistles and lights); and
- ✔ Resources for case management, including lockable filing cabinets if documentation will be kept on-site; materials for collecting and disseminating information to the community, such as writing materials for documenting issues and problems and for developing safety information and messages; and materials for broadcasting messages through appropriate communication channels in the community.

A Survivor-Centred Approach

Infrastructure and materials required for communication, education, mobilization and empowerment activities during ongoing response will depend on which activities are implemented in the WGF space.

Staffing, including appropriate training and support for staff and volunteers. Good programming requires an adequate number of well-trained and well-supported staff and volunteers. At minimum during emergency response to a rapid-onset emergency or displacement, there needs to be a sufficient number of WGF space staff present on-site to manage the activities and to conduct community outreach. Consideration should be given to recruiting staff and participants of different ethnic groups and languages as required.

During immediate response, all WGF space staff should be trained on GBV; GBV-related risks and vulnerabilities in the context; and responding to survivors, including taking **a survivor-centred approach**, providing referrals to other services, and providing appropriate support for survivors and others in distress or at risk. Beyond immediate response, all WGF space staff and volunteers should be trained on GBV; responding appropriately to survivors; and ethics and safety in GBV work. Each safe space will require staff with specialized knowledge and skills in responding to survivors of different ages and stages of development, as well as those at risk of GBV. This includes training on crisis care and case management for child, adolescent and adult survivors, as well as providing information and support to parents and carers of child survivors who have recently experienced sexual violence. Staff working with survivors requiring intervention to preserve their safety will also benefit from training in problem solving and supportive counselling. A variety of inter-agency training materials are available with a focus on developing of survivor-centred attitudes and behaviours.

Additionally, each WGF space will require the appropriate number and qualification of staff based on the activities they offer. For example, if a WGF space offers economic or livelihoods activities, group education,

life skills or recreational activities, the staff supporting these initiatives will need the appropriate knowledge and skills.

It is vital that UNICEF and partners have a plan in place to ensure the initial and ongoing training needs of staff are identified and met. Training is not a one-time activity; paid staff and volunteers require ongoing and refresher trainings from knowledgeable and experienced personnel. Developing competency in any skill requires practice, supervision and the opportunity for reflection. It is essential to build in on-the-job supervision, monitoring and support post-training to assist WGF space social workers, case workers and volunteers in applying the new knowledge and skills when working with survivors and carrying out other responsibilities. Where it is difficult to provide on-site supervision (for example, due to inaccessibility of facilities, insecurity or a lack of trained personnel), consider creative ways of doing this, such as remote supervision using the internet or on-site, team-based peer supervision and learning.

Tools

See *Section 4: Responding to GBV Survivors in Emergencies* in this book.

Capacity Development

GBV training materials

- **Causes and Effects of Gender-Based Violence Training Module**
  <http://hrlibrary.umn.edu/svaw/advocacy/modelsessions/causes_effects.PDF>
- **Caring for Child Survivor Training Materials**
  International Rescues Committee
  <http://gbvresponders.org/response/caring-child-survivors/#CCSTrainingMaterials>
- **Communities Care: Preventing Violence and Transforming Lives Toolkit Part Three: Survivor-Centred Care**
  - Survivor-Centred Care Training Module
  - Psychosocial Support Training Module

  UNICEF (2014)

Kiryandongo, Uganda

- **Caring for Survivors of Sexual Violence in Emergencies: Training Guide**
  IASC Sub-Working Group on Gender in Humanitarian Action
  <http://unicefinemergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf>
- **Community Workers' Guide to Understanding Gender-Based Violence and Child Protection Basic Concepts**
  UN Relief and Works Agency for Palestine Refugees in the Near East (2016)
  <http://reliefweb.int/report/world/community-workers-guide-understanding-gender-based-violence-and-child-protection-basic>
- **Training Handbook on Psychosocial Counselling for Children in Especially Difficult Circumstances: A trainer's guide**
  UNICEF (2003)
  <https://resourcecentre.savethechildren.net/library/training-handbook-psychosocial-counselling-children-especially-difficult-circumstances>
- **Mental Health and Gender-Based Violence: Helping survivors of sexual violence in conflict – a training manual**
  Health and Human Rights Info
  <http://hhri-gbv-manual.org/>
- **The Psychosocial Care and Protection of Children in Emergencies Teacher Training Manual**
  UNICEF (2009)
  <http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1064/Psychosocial_Care_and_Protection.PDF>
- **Psychological First Aid: Facilitator's manual for orienting field workers**
  World Health Organization (2014)
  <www.who.int/mental_health/emergencies/facilitator_manual_2014/en/>

Technical support and guidance. UNICEF COs are encouraged to work with partners to develop guidelines for WGF spaces, set programming standards, and assist partners in understanding and meeting those standards when implementing safe space programming. Even a simple checklist can assist UNICEF in clarifying expectations and standards against which the management, service delivery and strategic planning of each WGF space can be assessed.

Partners may also require initial and ongoing technical support and guidance from UNICEF GFV and CP specialists and others when designing and delivering different activities in WGF spaces. Whether a safe space is going to offer literacy classes, health information, or livelihoods activities to build resilience, it is important that the activities are good quality and delivered in line with national and international standards and practice. For example, communications campaigns that are not designed in line with good practice can actually reinforce harmful beliefs and norms related to GBV, and vocational skills training and economic empowerment activities that are not linked to local market analyses may be ineffective.

Tools

Safe Space Programming Tool 1: Assessment and Design Checklist for Women- and Girls-Friendly Spaces

b) Adopting a participatory approach to assessment and design of WGF spaces

Participation by affected people is a central tenant of a rights-based approach to humanitarian action. UNICEF is committed to ensuring appropriate participation of children, adolescents, women and others who are often excluded (for example, girls and women with disabilities) in the assessment, design, implementation and monitoring of WGF spaces.

It is very important to listen to the perspectives, problems and experiences of different groups of girls and women during WGF space assessment and design and involve them in planning the service. Engaging

girls and women from the very beginning, including those who are most marginalized, will help to ensure the services offered are useful, acceptable and relevant to different groups, such as adolescent girls.

Levels of Participation

Ensuring the appropriate **level of participation** by girls and women when designing and delivering WGF spaces is important for many reasons. For instance:

- It helps to identify girls and women who are often socially excluded – and thereby often the most at risk – to make sure they have access to WGF spaces and their perspectives shape the design of the service;
- It fosters community acceptance of WGF spaces by all members of the community, including male leadership, and ensures the services are culturally appropriate;
- It draws on community resources and capacities and helps to build consensus on context-specific priorities for the service; and
- It helps to foster girls' and women's leadership skills and capacities.

The phase of emergency response will dictate the time available for community participation during assessment and design. However, UNICEF is committed to ensuring the voices and perspectives of children and women are central to humanitarian action, which means that time and space *must be made* – even during immediate response – to ascertain their perspectives. Meaningfully engaging communities to learn about their knowledge, preferences, strengths and capacities is an integral part of emergency preparedness planning.

Ensuring the involvement of and buy-in from others in the community is also vital to the success and sustainability of safe spaces. While WGF spaces are targeted to and run by women and girls, their success and sustainability will require the input and support of many stakeholders. Engaging with community leaders and gatekeepers is important to help ensure the acceptance and uptake of safe space facilities and services. This is especially important in settings where social norms act as barriers to females accessing safe spaces – for example, by limiting girls' or women's freedom of movement. Husbands, parents and community leaders have a lot of influence over the ability of women and girls to access services and participate in programmes. It is, therefore, essential to understand the perspectives of these individuals while setting up a safe space and to mobilize community support for the service so that women and girls can safely participate in all activities. Developing culturally appropriate and context-specific key messages on the safe space for men and communities can build acceptance and buy-in.

Resources

- **Participation Handbook for Humanitarian Field Workers**
  Active Learning Network for Accountability and Performance and Groupe Urgence Rehabilitation Developpement (2009)
  <www.alnap.org/resource/8531>
- **The Participation of Children and Young People in Emergencies**
  UNICEF (2007)
  <www.unicef.org/eapro/the_participation_of_children_and_young_people_in_emergencies.pdf>
- **A Toolkit for Monitoring and Evaluating Children's Participation: Children and young people's experiences, advice and recommendations**
  Save the Children (2014)
  <http://resourcecentre.savethechildren.se/library/toolkit-monitoring-and-evaluating-childrens-participation-children-and-young-peoples>
- **Guidelines for Children's Participation in Humanitarian Programming**
  Save the Children (2013)
  <http://resourcecentre.savethechildren.se/library/guidelines-childrens-participation-humanitarian-programming>

Capacity Development

- **Introducing Participatory Approaches, Methods and Tools Training Module**
  Food and Agricultural Organization
  <www.fao.org/docrep/006/ad424e/ad424e03.htm>

c) Identifying appropriate WGF space models for the setting

COs and partners will need to assess the most appropriate WGF space model for each setting, bearing in mind that a variety of approaches may be required in a context, depending on the circumstances. In general, WGF spaces may be:

- ✓ **Temporary or permanent.** In an acute emergency context where UNICEF and partners are responding to rapidly changing security circumstances, destruction of facilities and unpredictable population displacement, temporary safe spaces may be the most appropriate short-term option. In these settings, UNICEF should maintain stocks of appropriate materials. In stabilized settings, WGF spaces tend to be permanent.
- ✓ **Fixed or mobile.** While most WGF spaces are established at fixed locations, in some contexts, mobile services may be used. Mobile services are most likely to be used to access hard-to-reach populations due to social, geographic or security factors. This includes populations on the move or in transit.
- ✓ **Stand-alone or integrated into another service.** A WGF space may be a stand-alone facility with a dedicated building or structure – or it may be a dedicated space within another facility, such as a community service building. WGF spaces may also be located and share space within another safe space or social service programme, such as a shared WGF space in which different activities are offered at different times.

WGF spaces can also use existing facilities or create new structures. In addition to fostering sustainability, there are several benefits to **using an existing facility** such as a community centre, school, health facility or community organization office. For instance:

- Rehabilitating or providing supplies for the facility can be seen as a form of giving back to the community and can create acceptance of the service within the community;
- Safe spaces established within facilities that combine other services/activities, such as community centres or schools, are non-stigmatizing entry point for girls and women; and
- It builds on existing community structures and networks that girls and women are already accessing.

If using an existing public structure, the community's trust and perception of the structure should be considered.

Creating new structures, on the other hand, can allow the space to be tailored to the programme's activities and to girls' and women's needs in each context. New structures will require more resources for start-up and maintenance and typically require longer time to establish community trust.

Regardless of which models are adopted in each setting, they must be female-only for the time they are being used as WGF spaces, and it is important that they are not also used by men to live in or sleep in. This of course does not exclude mothers from bringing children of all genders to the facility when they attend.

There are no internationally agreed standards in terms of the number of safe spaces that should be established per target population. One service per 10,000 to 20,000 individuals is becoming a common standard in some settings;[8] however, consideration needs to be given in each setting to factors such as population density, travel distance to services and popularity of service uptake.

8 United Nations Population Fund, 'Draft UNFPA Guidance on Establishing Safe Spaces', UNFPA, forthcoming 2017.

Resources

- **Increasing Access, Increasing Healing: Mobile approach to GBV service provision and community mobilization in Lebanon**
  International Rescue Committee (2016)

- **Emergency Mobile Teams: Gender-Based Violence**
  GBV sub-cluster Iraq
  <www.humanitarianresponse.info/system/files/documents/files/gbv_emergency_mobile_teams_v4.pdf>

d) Identifying safe site location and facility design

COs need to ensure WGF spaces are located and designed in a way that maximizes the safety and security of girls and women travelling to and from the venue, as well as while they are participating in activities. WGF spaces also have some basic design requirements, such as providing meeting space for group activities while also providing a place where individuals can meet alone with a social worker or volunteer to discuss personal or confidential concerns.

Port-au-Prince, Haiti

Things to consider in the identification of safe locations and facilities include:

- **Surroundings,** such as the presence or military of politically affiliated offices, faith-based organizations/structures, gatherings taking place and overall security;
- **Proximity to other services,** such as healthcare centres and child-friendly spaces;
- **Accessibility,** such as safe roads, modes of transportation, access for people with disabilities and distance to settlements;
- **Structure,** including the need for lockable rooms, bathroom facilities, and at least two meeting rooms (one for structured activities and one for confidential meetings) that can be converted for girls or women to sleep in crisis situations;
- **Opening days and hours,** taking into account the minimum number of days open each week and consulting with girls and women about hours that reflect their domestic, educational and economic time-use; and
- **Making sure there is dedicated space for age-appropriate activities** throughout the opening time – for example, space for adolescent girls and younger girls to gather and participate in activities.

e) Identifying relevant services and activities and tailoring them to the local context

During initial **assessment and design**, COs and partners should consider the appropriate mix of services and activities to offer, recognizing that these will change over time. During immediate response to an unanticipated population movement and within temporary and mobile services, activities will most likely focus on immediate actions to improve safety, health and well-being, while in more stabilized settings, WGF spaces will be able to offer a wider range of psychosocial support, education and empowerment activities. Regardless of the phase of response, do not focus exclusively

on GBV services; rather, offer a broader set of psychosocial support activities while also offering *confidential* GBV care and support to survivors and those at risk.

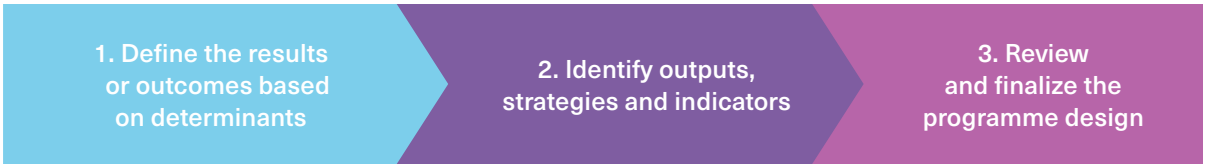
During **immediate response**, it is important to make sure girls and women can access information and resources to build their resilience and well-being and address the specific safety risks and vulnerabilities in the setting, in addition to accessing GBV support services. Information and services must be age-appropriate; for example, information and support needs of a 15-year-old girl are different from those of a 45-year-old woman.

During **ongoing response**, separate support, education and empowerment activities should be considered for older women, younger women, adolescents and younger girls. However, safe spaces should also offer an opportunity for girls and women of different ages to interact and socialize together. As well as mixing with age-mates to obtain peer support, role models of different ages can serve as mentors; for example, adolescent girls can support younger girls, and older women may support and mentor younger women.

1.2 Results-based programme design

UNICEF applies a **results-based approach** to programme design so that:

- ✔ Interventions are based on a logical pathway for creating impact;
- ✔ Interventions are results-oriented, and changes or effects are clearly identified; and
- ✔ Interventions can be monitored and evaluated.



To apply a results-based approach to establishing and managing WGF space programming, COs should:

1. **Define the desired results or outcomes based on determinants** in the following areas:
   - Creating an enabling environment for establishing and managing WGF spaces;
   - Making appropriate and good quality services available in WGF spaces; and
   - Promoting community demand and uptake of GBV activities in WGF spaces.
2. **Identify outputs, strategies and activities** for achieving the outcomes, as well as indicators for measuring progress during implementation. See the table on the following page for examples of strategies used in different phases of response.
3. **Review and finalize the programme design,** ensuring its alignment with best practices, ethics and safety. Don't forget to consider how the interventions will be evaluated.

Tools

See **Kit 4: Evaluation** for more information about different types of evaluative activities in emergency settings.

Key strategies and activities for establishing and managing WGF space programming include the following:

Determinant	Immediate response	Preparedness/Ongoing response/Early recovery
Enabling environment	• Ensure partner staff have capacity to establish and manage temporary WGF spaces in line with standards. • Train staff and volunteers on GBV, psychosocial support, GBV-related risks and vulnerabilities, and responding to survivors (including referral to other services and how to provide appropriate support for survivors and other girls and women in distress or at-risk). • Identify and address factors that inhibit girls' and women's access to safe spaces, including those who are marginalized (e.g., how girls use their time, where and how girls can travel and freedom of movement for women). • Coordinate with other actors and service providers.	• Train staff and volunteers in GBV prevention and response, including a survivor-centred approach, referral to other services, and how to provide appropriate support for survivors and other girls and women in distress or at-risk. • Identify social norms that inhibit access to safe spaces for particular groups (e.g., norms related to how adolescent girls use their time, where and how girls can travel and freedom of movement for women) and implement communications strategies to address them. • Assess and build partner capacity to establish and manage WGF spaces, including implementing an appropriate mix of educational, economic and social empowerment activities.
Supply	• Provide funding for staff and activities to offer GBV-related information and services to individual/groups of girls and women in each temporary WGF space. • Liaise and advocate with other actors and service providers to manage a safety information and warning system and address safety risks and threats. • Participate in community safety assessments and planning. • Procure and supply essential materials and equipment for delivering activities in WGF spaces, including dignity, sanitary and protection items.	• As part of preparedness planning, develop criteria for WGF space location and design, and develop resource and equipment list to deliver minimum set of services during initial response. • Develop site and facility design criteria and standards for WGF spaces in complex or protracted settings. • Support training and supervision of appropriate staffing in each WGF space, including training on GBV. • Fund and provide technical support to develop, implement and monitor a range of education, mobilization, empowerment and GBV prevention/response activities, based on good practice and local needs, capacities, risks and vulnerabilities.

Determinant	Immediate response	Preparedness/Ongoing response/Early recovery
Demand	• Assess and address barriers to access for at-risk groups. • Deliver information campaigns to build community knowledge about existence of services and benefits of community action to support girls' and women's safety, dignity and empowerment. • Engage community in mobilization activities, including participatory safety assessments and action planning. • Deliver mobile or outreach services to at-risk or hard-to-reach groups and populations.	• Assess and address barriers to access for vulnerable groups. • Implement communication campaigns to promote community support for WGF space activities and to promote participation of girls, adolescents and women in relevant education, mobilization and empowerment activities. • Deliver outreach or mobile services to at-risk or hard-to-reach groups and populations.

Kidal, Mali

Resources

- **UNICEF Programme Policy and Procedures Manual**
  - Chapter 3: Programme Preparation
  - Chapter 4: Programme Implementation and Management

  <https://unicef.sharepoint.com/teams/OED/PPPManual/SiteAssets/Welcome%20to%20the%20Programme,%20Policy%20and%20Procedure%20Manual.aspx?wa=wsignin1.0>

- **UNICEF Technical Notes: Special Considerations for Programming in Unstable Situations**
  <www.mona.uwi.edu/cardin/virtual_library/docs/1255/1255.pdf>

Capacity Development

- **UNICEF Programme Planning Process (PPP) e-learning course**
  <https://agora.unicef.org/course/info.php?id=6825>

Step 2: Implementation

Implementing effective WGF spaces that enhance the safety and well-being of women and girls includes:

2.1 Delivering good-quality GBV, education and empowerment services during immediate humanitarian response;

2.2 Delivering good quality GBV, education and empowerment services during ongoing humanitarian response;

2.3 Coordinating with others; and

2.4 Encouraging community uptake of activities in safe spaces.

2.1 Delivering good quality GBV, education and empowerment services during immediate response

Which specific services and activities are offered within each safe space will depend on the phase and type of response; needs and priorities on the ground; the social, cultural and security context; and what services other actors are providing. Further, the type of WGF space model will influence service delivery: for example, temporary and mobile WGF spaces will only be able to offer a limited set of services in comparison to permanent WGF spaces established in a stable setting.

Each WGF space must develop tailored approaches to meeting the age-appropriate needs of different populations in the setting. It will also be necessary to reassess service delivery needs and adjust programming over time to meet the changing needs and circumstances of girls and women as the situation evolves. Regardless of the context, however, the particular needs and circumstances of *adolescent girls of different ages* must be considered when determining the mix of services and activities offered through each safe space.

The following services and activities are appropriate for WGF spaces during **initial response:**

a) Providing a place to gather, access information and receive psychosocial support;

b) Initiating public information and communication strategies;

c) Distributing gender-sensitive emergency NFIs and other material support;

d) Mobilizing the community to build girls' and women's safety; and

e) Providing confidential space for GBV reporting, referral and support.

a) Providing a place to gather, access information and receive psychosocial support

Girls and women often have limited access to public spaces within which they can safely gather and connect with others, obtain information, give and receive emotional and practical support, and build their social support networks. In emergency and displaced settings, this lack of safe space to gather may be compounded by a reluctance of girls and women to leave their shelters – or a reluctance of their families to let them. It can also be exacerbated by a disruption of normal economic and social activities that had provided the opportunity for women to meet prior to the emergency. WGF spaces should provide a venue for both structured and unstructured group activities for girls and women, including recreational and sporting activities as social and peer support for younger girls and adolescents to foster their well-being.

b) Initiating public information and communication strategies

In humanitarian settings, communities have the right to information, yet often have limited access to it. WGF spaces can play

Bir Lahlou, Western Sahara

an important role in making sure that the community – girls and women in particular – can hear what is going on, especially in rapidly changing environments; can understand their humanitarian assistance and protection entitlements and rights; and can voice their concerns and get feedback from authorities and leaders on action to address those concerns. This is especially important is settings where girls and women do not normally mix with people outside of their immediate families.[9]

WGF spaces can serve as information hubs, collecting and disseminating information to help communities meet their needs and access services. One key public information service that WGF spaces can provide is offering age-appropriate, up-to-date information on safety and security for emergency-affected girls and women.

Although information needs and dissemination methods will vary across settings, helpful information for the community during early stages of response can include:

- A warning system to alert girls and women throughout the community to unsafe locations and facilities;
- Information on how to safely access resources for survival (e.g., food, healthcare, water, shelter, cooking fuel and hygiene supplies); and
- Details of affected people's rights and humanitarian entitlements and standards of conduct for humanitarian staff.

Safe space staff should participate in GBV, CP and Protection coordination meetings to provide information from the community, bring back information *to* the community, and ensure girls' and women's perspectives are considered when assessing and improving safety and access to basic needs (such as food, water, shelter, cooking fuel, hygiene supplies, etc.).

In addition to providing information, WGF spaces can initiate or participate in communication campaigns that aim to improve community health, safety and protection. Well-designed communication campaigns play an important role in: building knowledge about GBV and about girls' and women's rights to safety, dignity and empowerment; sparking community discussion and debate; and creating a culture of zero tolerance toward GBV. There is good evidence that *raising awareness of the problem of GBV is not enough* to change attitudes, norms or behaviours; well-designed communication campaigns therefore need to be considered alongside other GBV interventions.

9 World Vision International, *Women, Adolescent and Young Child Spaces: Responding to women and children's needs in emergencies,* WVI, 2013.

UNICEF is increasingly using **social norms perspectives** to foster health- and violence-related behaviour change, even in emergency-affected settings. Social norms that lead to victim-blaming, stigmatization and discrimination against survivors of GBV, or that lead to further disempowerment or violence (such as norms prescribing that a raped girl should marry the perpetrator to protect her honour), can contribute to poor psychosocial well-being and mental health problems for survivors.

Communication strategies that use multiple channels of communication achieve a higher rate of positive outcomes. Strategies need to extend beyond individuals and households to include service providers, traditional and religious leaders, and decision-makers at different levels to engender community-wide change.[10]

UNICEF is continually developing and piloting community-based approaches to communication for social norms change. COs that adopt social norms approaches in emergencies are encouraged to draw on existing materials and lessons learned as they develop interventions.

Resources

- **Behaviour Change Communication in Emergencies: A Toolkit**
  UNICEF (2006)
  <www.unicef.org/rosa/Behaviour.pdf>
- **Communities Care: Transforming Lives and Preventing Violence Toolkit**
  UNICEF (2014)
- **Shifting Social Norms to Tackle Violence Against Women and Girls**
  UK Department for International Development (2016)
  <www.gov.uk/government/uploads/system/uploads/attachment_data/file/507845/Shifting-Social-Norms-tackle-Violence-against-Women-Girls3.pdf>
- **Social Norms Professional Development Pack**
  GSDRC and University of Birmingham (2016)
  <www.gsdrc.org/professional-dev/social-norms/>
- **Communication for Humanitarian Action Toolkit (CHAT): Working Version**
  UNICEF (May 2015)
  <www.unicefinemergencies.com/downloads/eresource/docs/Communication%20for%20Development/6-C4D-CHAT_Proof-2.pdf>

c) Distributing gender-sensitive emergency NFIs and other material support

WGF spaces can serve as a distribution point for gender-sensitive NFIs and other material support that can help improve girls' and women's mobility, dignity and safety and reduce their vulnerability. Gender-sensitive NFIs – such as menstrual management materials, culturally appropriate garments and protection items – have multiple benefits for girls' and women's safety and well-being. For instance, providing basic materials can decrease the likelihood of girls and women needing to engage in exploitative transactional sex to meet basic needs, and torches and whistles can improve safety and allow for more movement in and around displaced settings.

In some settings, distributing dignity kits and other NFIs through safe spaces has proven to be an effective strategy for encouraging girls and women to attend and benefit from services and activities in the space.

Tools

See *Section 5.2: Dignity Kit Programming* in this book.

10 Marcus, R. and E. Page, 'Changing discriminatory norms affecting adolescent girls through communication activities: A review of evidence', Overseas Development Institute, London, 2014.

Baka Khel, Pakistan

d) Mobilizing the community to improve girls' and women's safety

During immediate response, WGF spaces can play an important role in bringing together different groups in the community who are concerned about GBV so they can exchange information, ask questions, discuss safety and security problems, and identify solutions to them. Where relevant, safe space staff can support community members in conducting participatory community safety audits and developing and implementing safety action plans.

In bringing different actors together, safe space staff can link community members with authorities and service providers to raise awareness about GBV-related issues and other problems facing girls and women.

Tools

See *Section 5.1: Community Safety Planning and Action* in this book.

e) Providing confidential space for GBV reporting, referral and support

Girls and women who have experienced GBV have the right to confidential and compassionate care and support to address the harmful physical, emotional, psychological and social consequences of the violence and help them recover. Those at risk of experiencing GBV also require assistance, support and information. Survivors commonly need the following types of care and support to help them recover and heal from the harmful consequences of GBV and to be safe from further violence:

- **Medical treatment and healthcare** to address the immediate and long-term physical and mental health effects of GBV. This may include initial examination and treatment, follow-up medical care, counselling and psychological care, and health-related legal services, such as preparation of documentation and giving evidence in justice processes.

- **Psychosocial care and support** to assist with healing and recovery from emotional, psychological and social effects. This includes crisis care and longer-term emotional and practical support for the survivor and her family; information and advocacy; case management; and education for families.
- **Options for safety and protection** for survivors and their families who are at risk of further violence and who wish to be protected. In the case of girls under the age of 18, CP services are required to protect those at risk of further violence, including alternative care arrangements when there is ongoing violence within the family.
- **Law enforcement and criminal justice response** to promote legal rights and protections for survivors. This includes criminal investigation and prosecution, legal assistance, and court support where they are available and survivor-centred.

WGF spaces need to have appropriately trained social work staff who can provide good quality, confidential, survivor-centred care and support services for GBV survivors and those at risk of GBV. Well-trained, supported and supervised social workers must be available to do the following:

- Appropriately and supportively listen and respond to a survivor's story and provide immediate support to reduce distress;
- Provide helpful age-appropriate information about the consequences of the violence experienced and available help and services;
- Help the survivor (and, in the case of a child survivor, her carers) determine a course of action to respond to her needs and circumstances;
- Make referrals at the survivor's request and assist with access to other services and supports;
- Follow-up and advocate on behalf of survivors as needed; and
- Provide ongoing psychosocial support and education for survivors and their carers.

In some settings, it may be appropriate for WGF spaces to offer overnight crisis accommodation for GBV survivors at risk of immediate harm. If this is the case, it will be necessary to have appropriate sleeping and other supplies for women and their children using the facility.

2.2 Delivering good quality GBV, education and empowerment services during ongoing humanitarian response

In addition to the above activities for immediate response, the following services are appropriate for WGF space programming during **ongoing response** in stabilized settings:

a) **Enhancing child protection response to GBV;**

b) **Establishing interventions to address specific types of GBV; and**

c) **Implementing education and empowerment interventions for girls and women** (which can include social protection activities; microfinance and related financial services; livelihoods strategies; and transformative peer and group education for girls and women).

a) Enhancing child protection response to GBV

There are three ways child protection response to GBV can be strengthened through WGF spaces. Firstly, training all safe space staff and volunteers on GBV and the needs of child and adolescent survivors will strengthen and build capacity of the service to identify and respond to girls experiencing or at risk of GBV.

Secondly, by linking with, training and supporting community-based CP mechanisms, WGF spaces can help community actors respond *appropriately* to individual cases of GBV, as well as contribute to spreading GBV-related information and education

Kinshasa, Democratic Republic of Congo

within the wider community. In many settings, community-based child protection mechanisms are mobilized to detect cases of GBV against children, report cases to authorities, and sometimes even resolve or mediate cases. *UNICEF does not support this practice as it has the potential to cause harm to survivors and to community members*. Rather, UNICEF supports good practice that involves equipping community actors with information so that they can increase awareness in the community about available GBV services and how to access them. All community-based Protection actors, including CP groups, must be trained on a survivor-centred approach so that if cases are brought to their attention, they can respond appropriately – always respecting the safety, confidentiality and self-determination of survivors.

Thirdly, by actively coordinating and linking with other GBV and CP service providers, WGF spaces can help child survivors and those at risk of GBV to access the specialized care and support they require to heal, recover and be safe from further violence.

b) Establishing interventions to address specific types of GBV

Experience shows that different types of GBV can emerge over time due to changing security, economic and social factors. For example, during sustained displacement in some settings, child marriage increases over time as families cope with difficult economic circumstances or seek to protect their daughters from harm. Intimate partner violence, already prevalent throughout the world, also commonly increases in displaced or other emergency-affected communities over time due to economic and social stressors.

With other actors, safe space programmes can continuously monitor and analyse trends, patterns and changes in GBV problems and associated vulnerabilities over time. With this information, they can help to design and implement interventions to address forms of violence as they emerge.

c) Implementing education and empowerment interventions for girls and women

In the past, activities offered through safe spaces focused primarily on the psychosocial and therapeutic benefits of engaging girls and women – especially survivors and those at risk – in income-generating and group activities to enhance their well-being and community reintegration. However, it is now well-recognized that even during emergencies, girls and women have the right to build their knowledge, skills, and social and economic resources and assets. In addition to promoting girls' and women's agency and resilience, education and empowerment interventions targeting specific populations can reduce risk and vulnerability to GBV.

In stabilized settings, WGF spaces increasingly provide much-needed educational and economic opportunities through structured activities and programmes. Such programming requires careful assessment of the realities and constraints on economic activity within each context; for example, in many settings refugees are not permitted to work, while in others, economic opportunities are woefully limited. These constraints notwithstanding, it is critical that in protracted and complex emergency environments, WGF spaces develop appropriate education and empowerment initiatives for girls and women.

In many settings, WGF spaces may not have capacity to deliver comprehensive skills training or livelihoods programming due to the constraints of the service itself or constraints within the context. In these circumstances, every effort should be made to coordinate and work in partnership with relevant actors, including Livelihoods and agricultural sectors, to advocate for the educational and economic needs of girls and women – especially the most vulnerable – and link girls and women with services where they exist.

When designing educational and empowerment initiatives for WGF spaces, UNICEF and partners must consider how to outreach these programmes to especially marginalized groups of girls and women, using targeted initiatives to build their assets and resilience and reduce their vulnerability to GBV. This may include specific education and empowerment interventions for adolescent girls, married girls, girls and women recruited and used by armed groups, and girls and women with disabilities.

The following social protection, microfinance, livelihoods and education programmes for adolescent girls and women should be considered during ongoing response in protracted and complex contexts.[11]

Social Protection in Emergencies

Social protection activities. In settings where the local economy is limited, COs and partners should explore **social protection** strategies to build the resilience of girls and women. Cash or vouchers for work are one social protection mechanism that can be delivered through WGF spaces: for example, girls and women can be paid for manufacturing NFIs such as soap and for packaging dignity kits in WGF spaces.[12]

Cash transfers can significantly impact girls' and women's empowerment by decreasing vulnerability and increasing their self-esteem, well-being and decision-making power.[13] The type of transfer most likely to result in positive outcomes for women has been found to vary widely across region, country and even season, and where relevant, COs should explore the possibility of alternatives to cash. In some settings, women prefer in-kind or food transfers rather than cash.[14]

COs should also assess the viability of expanding, scaling-up or modifying existing social protection cash transfer programmes in chronic crises, in fragile settings or following rapid-onset emergencies. UNICEF CP and GBV specialists should work closely with staff overseeing UNICEF-supported social protection programming to explore ways of leveraging social protection benefits to girls and women through WGF spaces. This could include increasing benefit size and/or expanding social protection measures to more districts/beneficiaries.

Resources

- **Conditionality in Cash Transfers in Emergencies: UNICEF's Approach**
  UNICEF (2016)
  <http://www.unicefinemergencies.com/downloads/eresource/docs/Cash%20in%20Emergencies/Conditionality%20in%20Cash%20Transfers%20-%20UNICEF's%20Approach-2.pdf>
- **Empowered and Safe: Economic strengthening for adolescent girls in emergencies**
  Women's Refugee Commission (2014)
  <www.womensrefugeecommission.org/images/zdocs/Econ-Strength-for-Girls-Empowered-and-Safe.pdf>
- **Integrating Cash Transfers into Gender-based Violence Programs in Jordan: Benefits, risks and challenges**
  International Rescue Committee (2015)
  <www.cashlearning.org/downloads/erc-irc-action-research-web.pdf>
- **Guide for Protection in Cash-Based Interventions**
  - Practitioner Guide
  - Tips for Mainstreaming
  - Risk and Benefits Analysis Tool

  UNHCR (2015)
  <www.womensrefugeecommission.org/issues/livelihoods/research-and-resources/1280-protection-in-cash-based-interventions>

11 Women's Refugee Commission, *Strong Girls and Powerful Women: Programme planning and design in humanitarian settings*, WRC, New York, 2014.
12 WRC, *Strong Girls and Powerful Women: Programme planning and design in humanitarian settings.*
13 For example, in Kenya, UNICEF's orphans and vulnerable children cash transfer programme was found to have a significant impact on women's empowerment among 86 per cent of families benefiting from the programme.
14 WRC, *Strong Girls and Powerful Women: Programme planning and design in humanitarian settings.*

Resources (continued)

- **Integrated Social Protection Systems: Enhancing Equity for Children**
  UNICEF (2012)
  <https://www.unicef.org/socialprotection/framework/files/UNICEF_SPSFramework_whole_doc.pdf>
- **Violence Against Women and Girls Resource Guide: Social Protection Brief**
  World Bank (2014)
  <www.vawgresourceguide.org/sites/default/files/briefs/vawg_resource_guide_social_protection_brief_-_nov_26.pdf>
- **Cash Transfers in Emergencies: A Practical Field Guide**
  HelpAge International (2010)
  <www.humanitarianresponse.info/ru/topics/cash-transfer-programming/document/cash-transfers-emergencies-practical-field-guide>
- **Toolkit: Gender Equality Promotion in Cash Transfer Programs (in Portuguese only)**
  Promundo
  <http://promundoglobal.org/wp-content/uploads/2016/07/caderno_capas_vdigital-1.pdf>
- **The Cash Learning Partnership website**
  <www.cashlearning.org/>
- **SEEP Children, Youth and Economic Strengthening Resources website**
  <http://www.seepnetwork.org/children--youth-and-economic-strengthening-pages-20202.php>

Programme examples

- **Gender Impact Analysis: Unconditional Cash Transfers in South Central Somalia**
  The Somalia Cash Consortium (2012)
  <www.alnap.org/resource/7988>

Quetta, Pakistan

- **Walking the Talk: Cash transfers and gender dynamics**
  Concern Worldwide and Oxfam Great Britain (2011)
  <http://policy-practice.oxfam.org.uk/publications/walking-the-talk-cash-transfers-and-gender-dynamics-131869>
- **"Choice, Dignity and Empowerment?" Cash and Food Transfers in Swaziland: An evaluation of Save the Children's emergency drought response, 2007/08**
  Institute of Development Studies (2008)
  <www.alnap.org/resource/11636>
- **Examining Protection and Gender in Cash and Voucher Transfers**
  World Food Programme and UNHCR (2013)
  <http://reliefweb.int/report/world/examining-protection-and-gender-cash-and-voucher-transfers-case-studies-world-food>
- **Unconditional Cash Transfers in Gaza: An external review**
  Cash Learning Partnership (2012)
  <http://reliefweb.int/report/occupied-palestinian-territory/unconditional-cash-transfers-gaza-external-review>
- **Impact Evaluation of Cash, Food Vouchers, and Food Transfers among Colombian Refugees and Poor Ecuadorians in Carchi and Sucumbíos, Final Report**
  International Food Policy Research Institute and the World Food Programme (2012)
  <http://documents.wfp.org/stellent/groups/public/documents/resources/wfp257675.pdf>

Capacity Development

- **UNICEF Humanitarian Cash Transfer Programming and Social Protection Linkages**
  <www.unicefinemergencies.com/downloads/eresource/Cash_in_Emergencies.html>
- **UNHCR Guide for Protection in Cash-Based Interventions Training Module**
  <www.womensrefugeecommission.org/issues/livelihoods/research-and-resources/1280-protection-in-cash-based-interventions>

Microfinance and related financial services. There is no 'one size fits all' approach to microfinance; rather, there are multiple models that can be used in relief and development settings, ranging from small, self-selected group savings and credit schemes to large structured groups. Which model is most appropriate will depend on local and contextual factors, such as whether there is a functioning banking system for storing savings.[15] Microfinance interventions must include education and training for participants so they can acquire relevant skills, including those required for basic financial management. For microfinance programmes that support girls and women to establish small businesses, interventions should be complemented by business development and management training.

Resources

- **Microfinance Interventions in Building Livelihoods: A Field Manual for Practitioners in Humanitarian Settings**
  Women's Refugee Commission (2012)
  <http://womensrefugeecommission.org/search?q=Microfinance+Interventions+in+Building+Livelihoods+A+Field+Manual+for+Practitioners+in+Humanitarian+Settings>
- **Violence Against Women and Girls Resource Guide: Finance and Enterprise Development Brief**
  World Bank (2015)
  <http://www.vawgresourceguide.org/sites/default/files/briefs/vawg_resource_guide_finance_and_enterprise_development_brief_april_2015.pdf>

15 Women's Refugee Commission, *Building Livelihoods: A Field Manual for Practitioners in Humanitarian Settings*, WRC, New York, 2012.

See the IASC GBV Guidelines

Resources (continued)

- **Economic and Social Empowerment Framework Implementation Guide**
  International Rescue Committee (2012)
  <http://gbvresponders.org/empowerment/eae-tools-resources/>
- **Economic and Social Empowerment VSLA Facilitator Guides**
  International Rescue Committee (2012)
  <http://gbvresponders.org/empowerment/eae-tools-resources/>
- **Financial Education Curriculum**
  Population Council (2013)
  <www.popcouncil.org/uploads/pdfs/2013PGY_FinancialEducation_AGEP.pdf>
- **Financial Education for Adolescent Girls**
  Women's World Bank (2011)
  <www.womensworldbanking.org/PDFs/23_FinanEducationforAdolescentGirls.pdf>
- **Minimum Economic Recovery Standards**
  The Small Enterprise Education and Promotion Network (2010)
  <www.seepnetwork.org/filebin/Minimum_Econ_Recovery_Standards2_web.pdf>

Livelihoods strategies. In addition to cash programming and microfinance interventions, livelihoods activities may be offered through WGF spaces where it is appropriate and viable to do so. These can include:

- Asset restoration (including livestock, tools or equipment);
- Agrarian interventions;
- Vocational and business training and placement programs;
- Market interventions; and/or
- Enterprise development.

Livelihoods programmes must be carefully designed with input from those with appropriate expertise to ensure they are effective and tailored to the economic context. They must also be designed and implemented in line with the recommendations set out in the IASC GBV Guidelines[16] to ensure they promote the protection and empowerment of women and girls and do not inadvertently reinforce GBV-related risks. As with other economic programming such as cash transfer and microfinance, livelihoods interventions – when not carefully designed – can actually increase the risk of GBV by:[17]

- Reinforcing traditional gender roles of women;
- Adding burdens to girls' and women's workloads;
- Increasing tension and conflict at the household level;
- Introducing women to new activities or places that heighten their risk of experiencing violence; and
- Making girls and women targets of attack due to their possession of assets.

While livelihoods experts must assist with the development of appropriate strategies and activities for economic empowerment, UNICEF and partner GBV and CP specialists must also be closely involved with programme design to identify and implement strategies for mitigating risks arising from this type of programming.

Resources

- **A Double-Edged Sword: Livelihoods in emergencies**
  Women's Refugee Commission (2014)
  <www.womensrefugeecommission.org/resources/document/1046-a-double-edged-sword-livelihoods-in-emergencies>
- **Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery**
  IASC (2015)
  <www.gbvguidelines.org>

16 See <www.gbvguidelines.org>.
17 Women's Refugee Commission, *A Double-edged Sword: Livelihoods in Emergencies*, WRC, New York, 2014.

- **Preventing Gender-Based Violence, Building Livelihoods: Guidance and Tools for Improved Programming**
  Women's Refugee Commission (2012)
  <www.womensrefugeecommission.org/resources/document/798-preventing-gender-based-violence-building-livelihoods-guidance-and-tools-for-improved-programming>
- **Empowered and Safe: Economic strengthening for adolescent girls in emergencies**
  Women's Refugee Commission (2014)
  <www.womensrefugeecommission.org/images/zdocs/Econ-Strength-for-Girls-Empowered-and-Safe.pdf>
- **CLARA: Cohort Livelihoods and Risk Analysis**
  Women's Refugee Commission (2016)
  <www.womensrefugeecommission.org/issues/livelihoods/research-and-resources/1231-clara-tool>

Capacity Development

- **Preventing Gender-based Violence, Building Livelihoods E-Learning**
  Women's Refugee Commission
  <http://womensrefugeecommission.org/elearning>

Transformative peer and group education for girls and women. Girls and women need the opportunity to obtain accurate and helpful information and develop critical thinking, communication and problem-solving skills. Many girls and women around the world need to develop literacy, as their access to formal education may have been limited. Before and during emergencies, UNICEF often integrates 'transformative education' through life skills education for girls into formal and informal CP, education or HIV programming; however, married girls and women and other marginalized groups are often unable to benefit from these programmes.

In addition to developing literacy and providing helpful information, well-designed transformative education curriculums foster consciousness and dialogue about rights, responsibilities, gender relations and other power relations.[18] They also build girls' and women's legal and political literacy. WGF spaces should tailor and deliver age-specific group education to girls and women covering the following topics:

- Literacy;
- Legal and human rights, including the right to live free from violence;
- Bodies and health;
- Child health and development;
- Gender and how it relates to household dynamics and decision-making;
- Effective communication and problem solving;
- Leadership skills; and
- Gender, power and violence.

Information must be easy to understand and culturally appropriate, and, wherever possible, it should draw on existing locally based life skills curriculums. Content for group education sessions for girls and women of different ages should be tailored to their age and life stage and should be offered at different times; for example, girls' education sessions can be integrated into sporting activities. Where it is safe to do so, education sessions can be used to provide girls and women with information on available services and resources for survivors.

Resources

- **Adolescent Girls Toolkit Iraq**
  UNICEF and UNFPA (2017)
- **Health and Life Skills Curriculum for Adolescent Girls**
  Population Council
  <www.popcouncil.org/uploads/pdfs/2013PGY_HealthLifeSkills_AGEP.pdf>

18 World Bank, *Voice and Agency: Empowering Women and Girls for Shared Prosperity,* World Bank, Washington D.C., 2014.

Resources (continued)

- **iMatter: Teaching about Puberty, Gender, and Fairness**
  Population Council (2015)
  <https://marketplace.mimeo.com/PopCouncil#name=13>
- **It's All One Curriculum: Guidelines and activities for a unified approach to sexuality gender, HIV, and human rights education**
  International Sexuality and HIV Curriculum Working Group
  <www.itsallone.org/>
- **Program M: Working with young women for empowerment, rights and health**
  Instituto Promundo, Salud y Género, ECOS, Instituto PAPAI and World Education
  <http://promundoglobal.org/wp-content/uploads/2014/12/Program-M-Working-With-Young-Women.pdf
- **Skills for Life: A handbook**
  International Federation of Red Cross and Red Crescent Societies (2013)
  <http://pscentre.org/resources/life-skills-skills-for-life-a-handbook/>
- **Go Girls! Community-based Life Skills for Girls**
  Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (2011)
  <www.aidstar-one.com/sites/default/files/GoGirls_English_Final_Rev1.pdf>

★ See the IASC GBV Guidelines

2.3 Coordinating with others

It is vital that WGF spaces coordinate with others providing humanitarian services and assistance, including those providing services to survivors. There are three aspects of coordination that WGF spaces need to consider.

The first is **coordination with other humanitarian agencies and actors** in the setting. This will help safe space staff to link girls and women with other services, assistance and programmes. It will also provide the opportunity for safe space staff to advocate on behalf of women and girls with other actors; for instance, advocating that unsafe locations, facilities and services be addressed and advocating that GBV interventions be integrated across all humanitarian programming in line with the IASC GBV Guidelines.[19]

The second is **coordination amongst GBV service providers**. All agencies and organizations providing care, support and protection for GBV survivors must work collaboratively to respond to GBV so they can seamlessly refer and care for survivors. One key responsibility of inter-agency coordination mechanisms is to develop standard operating procedures to put in place coordinated and survivor-centred service delivery for GBV survivors. WGF space staff should attend inter-agency coordination meetings to help develop and update standard operating procedures and foster good collaboration, information sharing and problem solving. Things to consider when establishing and improving coordination between GBV response services include:

- Improving availability, access and quality of different services;
- Increasing community knowledge of and confidence in services;
- Reducing how many times survivors need to repeat their story during the helping process;
- Making sure a survivor's rights to privacy and confidentiality are respected and her consent is always obtained in the referral process; and
- Making sure referral mechanisms are working and referral protocols are adhered to.

19 See the Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery,* IASC, 2015, available at <https://gbvguidelines.org>.

Sindhupalchowk, Nepal

Resources

- **Establishing GBV Standard Operating Procedures**
  IASC Sub-Working Group on Gender (2008)
  <http://www.globalprotectioncluster.org/_assets/files/tools_and_guidance/gender_based_violence/GBV_Standard_Operational_Procedures_2008_EN.pdf>
- **Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery**
  IASC (2015)
  <www.gbvguidelines.org>
- **Handbook for Coordinating Gender-Based Violence Interventions in Humanitarian Settings**
  GBV AOR (2010)
  <www.refworld.org/docid/52146d634.html>

The third aspect of coordination is **case coordination**, which is a foundation of a survivor-centred approach. It involves making sure each survivor can receive care, support and protection in a coordinated manner and according to her unique needs and circumstances. Good case coordination usually involves implementing a case management system so that survivors can receive tailored services based on their individual circumstances, wishes and needs. As mentioned earlier, staff at WGF spaces often provide case management services for survivors.

Resources

- **Interagency Gender-based Violence Case Management Guidelines**
  GBVIMS Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>

Capacity Development

- **Interagency Gender-based Violence Case Management Training Materials,**
  Gender-based Violence Information Management Steering Committee (2017)
  <https://gbvresponders.org/response/gbv-case-management/>

Shan State, Burma

2.4 Encouraging community uptake of activities in safe spaces

WGF spaces will not be successful or useful unless the most at-risk girls and women are able to access and benefit from them. Common barriers to access for women and girls include domestic responsibilities and restricted mobility. To ensure at-risk groups in the community can access safe spaces and participate in empowerment activities, UNICEF and partners must learn about and address the factors that affect **access to and use of services** and activities in safe spaces. Common factors to consider include:

- **Competing time demands** on women and adolescent girls, such as domestic, care and income-generation responsibilities (for example, during emergencies, the burden of domestic and care work on adolescent girls can increase dramatically, and responsibilities such as sourcing fuel can affect time use);
- **Community beliefs and practices** that affect girls' and women's mobility and participation, such as reluctance by families to allow adolescent girls to participate in activities outside the home; and
- **Perceived usefulness and relevance** of activities by the target group. Girls and women in particular may need to justify why they are attending safe space programmes, and families may need to see the benefits of participation.

It is incumbent on UNICEF and partners to address barriers to access to WGF space programmes. The first step in doing this is to understand **population composition and dynamics.** Understanding population composition will help develop strategies to reach and consult with less visible groups of girls and women. In addition to age and gender, factors to consider may include:

- Ethnic and religious composition;
- Education level;
- Geography;
- Influence (while those with less influence in the community, such as adolescent girls or women with disabilities, often have less opportunity to participate, their perspectives are essential to understanding the issues related to GBV);
- Disability;
- Sexual orientation; and
- Existence of third genders and people of transgender or gender non-conforming experiences.

Common strategies adopted to improve access to WGF spaces in different settings include:

- Engaging gatekeepers from the outset of programme design to ensure their acceptance of WGF spaces;
- Providing transport so girls and women who live further away can attend;
- Providing childcare so that those caring for children can attend;
- Offering income-generating activities or other incentives to participate;
- Making sure opening hours reflect girls' and women's time-use and availability; and
- Offering mobile and outreach services.

Step 3: Monitoring

Monitoring is essential for ensuring that WGF spaces and their activities are implemented effectively and actually reduce girls' and women's exposure to GBV. Monitoring should also be used to identify any new risks or threats that emerge related to WGF spaces over time.

3.1 Adopting a participatory approach to monitoring

A **participatory approach to monitoring** is recommended in stabilized settings. A participatory approach to monitoring WGF spaces will increase community ownership of the programme and the change process; ensure that problems and unintended consequences are quickly identified and addressed; and provide opportunity for sharing information about positive effects of interventions with the community, thereby helping to reinforce positive changes.

To facilitate participatory monitoring, COs and partners can take the following actions:

a) **Engage community stakeholders in the development of the monitoring plan during programme design;**

b) **Support community stakeholders to collect, check and interpret data and report on the findings; and**

c) **Involve community stakeholders in discussions about significant achievements or setbacks.**

a) **Engage community stakeholders in the development of the monitoring plan during programme design.** Community stakeholders can be involved in:

- Identifying indicators that will provide the information needed;
- Determining how to collect, document and interpret necessary information; and
- Deciding when and how to share and use the findings.

b) **Support community stakeholders to collect, check and interpret data and report on the findings.** Possibilities for reporting include:

- Meetings or workshops involving different stakeholder groups to stimulate deeper understanding, critical reflection and constructive action on findings;
- Photographs and other visual displays;
- Drama;
- Video footage; and/or
- Pamphlets and posters.

c) **Involve community stakeholders in discussions about significant achievements or setbacks.** This will help to identify:

- What has worked or is working well;
- What needs to be adjusted or done differently;
- How risks or unintended consequences should be addressed; and
- How learning from the process can be applied to future interventions.

3.2 Selecting indicators to monitor WGF spaces

While results, outputs and indicators for WGF spaces will be determined at the local level, the table below offers some sample outcomes, outputs and indicators that may assist CO and partner staff when monitoring WGF spaces. Remember, indicators need to be measured both *before* and *after* an intervention to see if there have been any changes.

Sample outcomes, outputs and indicators for women- and girls-friendly spaces

Sample Outcomes	Sample outputs	Sample output indicators
Enabling environment		
WGF spaces are well-managed and coordinated.	Activities within the WGF space are adequately funded.	• Proportion of WGF space budgets with dedicated funding for GBV activities • # of inter-agency meetings and forums attended by WGF space staff
	Activities within the WGF space are well-coordinated with other services and providers.	
Supply		
WGF spaces offer appropriate and good quality activities and GBV services.	WGF space has adequate equipment, materials and supplies required for activities.	• Proportion of WGF spaces with gender-sensitive NFIs for distribution to at-risk girls and women • Proportion of WGF spaces with appropriate materials for collecting and disseminating GBV safety and security information • Proportion of WGF spaces with appropriate materials for facilitating group discussions and community meetings
	WGF space facilities are located and designed in a manner that facilitates access for different groups of girls and women, including those most at risk of GBV.	• # and type of groups of people accessing GBV information or using GBV services by age • % of people asked by age who feel safe and confident in accessing GBV information and services in WGF spaces • % of WGF spaces with dedicated time and space for adolescent girls' groups and programmes
	WGF space is adequately staffed by appropriately trained staff and volunteers.	• % of WGF space staff and volunteers trained on GBV • Changes in knowledge, attitudes and practices of WGF space staff and volunteers regarding GBV post-training
	WGF space offers relevant and useful information, education, mobilization and empowerment activities.	• # and type of community consultations on WGF space programme planning and implementation • # and type of services and interventions offered in each WGF space
Demand		
Communities participate in and value WGF spaces.	Social barriers to accessing WGF space activities for different at-risk groups of girls and women are identified and addressed.	• # of community-level barriers to accessing WGF spaces for different groups identified • % of community-level barriers reduced

Sample Outcomes	Sample outputs	Sample output indicators
Demand (continued)		
Communities participate in and value WGF spaces. **(continued)**	Girls, adolescents and women find activities and GBV response services offered within WGF spaces relevant and useful.	• % of girls, adolescents and women who report satisfaction with activities offered at the WGF space • Increase over time in # of girls, adolescents and women who access activities in WGF spaces • % of girls, adolescents and women who feel safe reporting GBV concerns and problems to WGF space staff • Increase over time in # of girls, adolescents and women who access GBV services in WGF spaces

Resources

- **United Nations Inter-Agency Resource Pack on Research, Monitoring and Evaluation in Communication for Development**
  UNDP (2011)
  <http://www.unicef.org/cbsc/files/RME-RP-Evaluating_C4D_Trends_Challenges__Approaches_Final-2011.pdf>
- **Monitoring and Evaluating Information and Communication for Development Programmes Guidelines**
  UK Department for International Development (2005)
  <http://www.managingforimpact.org/resource/monitoring-and-evaluating-information-and-communcation-development-icd-programmes-guideline>
- **Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators**
  Measure Evaluation (2008)
  <www.measureevaluation.org/resources/tools/gender/violence-against-women-and-girls-compendium-of-indicators>
- **Sustainable Sanitation and Water Management Participatory Monitoring Resources**
  <www.sswm.info/content/participatory-monitoring-and-evaluation>
- **Toolkit for Monitoring and Evaluating Gender-Based Violence Interventions Along the Relief to Development Continuum**
  USAID (2014)
  <www.usaid.gov/sites/default/files/documents/2151/Toolkit%20Master%20%28FINAL%20MAY%209%29.pdf>
- **Guidance on Monitoring and Evaluation for Programming on Violence against Women and Girls**
  Department for International Development (2012)
  <www.gov.uk/government/uploads/system/uploads/attachment_data/file/67334/How-to-note-VAWG-3-monitoring-eval.pdf>
- **Participatory Tools and Approaches Topic Guide**
  Governance and Social Development Resource Centre (2011)
  <www.gsdrc.org/wp-content/uploads/2015/07/ME5.pdf>

Tools

Safe Space Programming Tool 2: Monitoring Sheet for Women- and Girls-Friendly Spaces

Info Sheets – Building Safety and Resilience

At-Risk Groups

Source: Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*, IASC, 2015, pp. 11–13.[1]

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

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

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

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

1 Available at: <www.gbvguidelines.org>.

At-risk groups	Examples of violence to which these groups might be exposed	Factors that contribute to increased risk of violence
Adolescent girls	• Sexual assault • Sexual exploitation and abuse • Child and/or forced Marriage • Female genital mutilation/ cutting (FGM/C) • Lack of access to education	• Age, gender and restricted social status • Increased domestic responsibilities that keep girls isolated in the home • Erosion of normal community structures of support and protection • Lack of access to understandable information about health, rights and services (including reproductive health) • Being discouraged or prevented from attending school • Early pregnancies and motherhood • Engagement in unsafe livelihoods activities • Loss of family members, especially immediate caretakers • Dependence on exploitative or unhealthy relationships for basic needs
Elderly women	• Sexual assault • Sexual exploitation and abuse • Exploitation and abuse by caregivers • Denial of rights to housing and property	• Age, gender and restricted social status • Weakened physical status, physical or sensory disabilities, and chronic diseases • Isolation and higher risk of poverty • Limited mobility • Neglected health and nutritional needs • Lack of access to understandable information about rights and services
Woman and child heads of households	• Sexual assault • Sexual exploitation and abuse • Child and/or forced marriage (including wife inheritance) • Denial of rights to housing and property	• Age, gender and restricted social status • Increased domestic responsibilities that keep them isolated in the home • Erosion of normal community structures of support and protection • Dependence on exploitative or unhealthy relationships for basic needs • Engagement in unsafe livelihoods activities

At-risk groups	Examples of violence to which these groups might be exposed	Factors that contribute to increased risk of violence
Girls and women who bear children of rape, and their children born of rape	• Sexual assault • Sexual exploitation and abuse • Intimate partner violence and other forms of domestic violence • Lack of access to education • Social exclusion	• Age, gender • Social stigma and isolation • Exclusion or expulsion from their homes, families and communities • Poverty, malnutrition and reproductive health problems • Lack of access to medical care • High levels of impunity for crimes against them • Dependence on exploitative or unhealthy relationships for basic needs • Engagement in unsafe livelihoods activities
Indigenous women, girls, men and boys, and ethnic and religious minorities	• Social discrimination, exclusion and oppression • Ethnic cleansing as a tactic of war • Lack of access to education • Lack of access to services • Theft of land	• Social stigma and isolation • Poverty, malnutrition and reproductive health problems • Lack of protection under the law and high levels of impunity for crimes against them • Lack of opportunities and marginalization based on their national, religious, linguistic or cultural group • Barriers to participating in their communities and earning livelihoods
Lesbian, gay, bisexual, transgender and intersex (LGBTI) persons	• Social exclusion • Sexual assault • Sexual exploitation and abuse • Domestic violence (e.g. violence against LGBTI children by their caretakers) • Denial of services • Harassment/sexual harassment • Rape expressly used to punish lesbians for their sexual orientation	• Discrimination based on sexual orientation and/or gender identity • High levels of impunity for crimes against them • Restricted social status • Transgender persons not legally or publicly recognized as their identified gender • Same-sex relationships not legally or socially recognized, and denied services other families might be offered • Exclusion from housing, livelihoods opportunities, and access to healthcare and other services • Exclusion of transgender persons from sex-segregated shelters, bathrooms and health facilities • Social isolation/rejection from family or community, which can result in homelessness • Engagement in unsafe livelihoods activities

At-risk groups	Examples of violence to which these groups might be exposed	Factors that contribute to increased risk of violence
Separated or unaccompanied girls, boys and orphans, including children associated with armed forces/groups	• Sexual assault • Sexual exploitation and abuse • Child and/or forced marriage • Forced labour • Lack of access to education • Domestic violence	• Age, gender and restricted social status • Neglected health and nutritional needs • Engagement in unsafe livelihoods activities • Dependence on exploitative or unhealthy relationships for basic needs • Early pregnancies and motherhood • Social stigma, isolation and rejection by communities as a result of association with armed forces/groups • Active engagement in combat operations • Premature parental responsibility for siblings
Women and men involved in forced and/or coerced prostitution, and child victims of sexual exploitation	• Coercion, social exclusion • Sexual assault • Physical violence • Sexual exploitation and abuse • Lack of access to education	• Dependence on exploitative or unhealthy relationships for basic needs • Lack of access to reproductive health information and services • Early pregnancies and motherhood • Isolation and a lack of social support/peer networks • Social stigma, isolation and rejection by communities • Harassment and abuse from law enforcement • Lack of protection under the law and/or laws that criminalize sex workers
Women, girls, men and boys in detention	• Sexual assault as punishment or torture • Physical violence • Lack of access to education • Lack of access to health, mental health and psychosocial support, including psychological first aid	• Poor hygiene and lack of sanitation • Overcrowding of detention facilities • Failure to separate men, women, families and unaccompanied minors • Obstacles and disincentives to reporting incidents of violence (especially sexual violence) • Fear of speaking out against authorities • Possible trauma from violence and abuse suffered before detention

At-risk groups	Examples of violence to which these groups might be exposed	Factors that contribute to increased risk of violence
Women, girls, men and boys living with HIV	• Sexual harassment and abuse • Social discrimination and exclusion • Verbal abuse • Lack of access to education • Loss of livelihood • Prevented from having contact with their children	• Social stigma, isolation and higher risk of poverty • Loss of land, property and belongings • Reduced work capacity • Stress, depression and/or suicide • Family disintegration and breakdown • Poor physical and emotional health • Harmful use of alcohol and/or drugs
Women, girls, men and boys with disabilities	• Social discrimination and exclusion • Sexual assault • Sexual exploitation and abuse • Intimate partner violence and other forms of domestic violence • Lack of access to education • Denial of access to housing, property and livestock	• Limited mobility, hearing and vision resulting in greater reliance on assistance and care from others • Isolation and a lack of social support/peer networks • Exclusion from obtaining information and receiving guidance, due to physical, technological and communication barriers • Exclusion from accessing washing facilities, latrines or distribution sites due to poor accessibility in design • Physical, communication and attitudinal barriers in reporting violence • Barriers to participating in their communities and earning livelihoods • Lack of access to medical care and rehabilitation services • High levels of impunity for crimes against them • Lack of access to reproductive health information and services
Women, girls, men and boys who are survivors of violence	• Social discrimination and exclusion • Secondary violence as result of the primary violence (e.g. abuse by those they report to; honor killings following sexual assault; forced marriage to a perpetrator; etc.) • Heightened vulnerability to future violence, including sexual violence, intimate partner violence, sexual exploitation and abuse, etc.	• Weakened physical status, physical or sensory disabilities, psychological distress and chronic diseases • Lack of access to medical care, including obstacles and disincentives to reporting incidents of violence • Family disintegration and breakdown • Isolation and higher risk of poverty

Sexual Exploitation and Abuse

All forms of sexual exploitation and abuse (SEA) by humanitarian and peacekeeping personnel are a gross violation of human rights and an abuse of a position of power over vulnerable people. SEA can lead to serious and sometimes life-long consequences for those who are victimized and their families. Further, SEA has wider negative impacts: it undermines the integrity and reputation of the UN and other humanitarian actors, and it can threaten the security of staff and operations, hindering UNICEF and the wider UN from achieving its mission.

Although there has been a decrease in reports, incidents of SEA by UN civilian and military personnel against women and children continue to occur. Underreporting of all forms of sexual violence, including SEA, is widely acknowledged. Recently, sexual harassment and sexual assault of humanitarian workers by fellow staff has also been reported publicly.

The problem of sexual exploitation and sexual abuse by humanitarian workers and peacekeepers is not new; allegations surfaced in numerous conflict-affected settings in the 1990s. However, the release of a report detailing serious and widespread misconduct and abuse of children in West Africa by aid workers and peacekeepers in 2002 brought international attention and condemnation to the issue.

In response to the allegations, the Inter-Agency Standing Committee (IASC) established a task force in 2002 and developed six core principles on SEA.[1] These principles are:

- Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- Sexual activity with children (persons under the age of 18) is prohibited regardless of the local age of consent. Mistaken belief in the age of the child is not a defence.
- Exchange of money, employment, goods or services for sex, including favours or other forms of humiliating, degrading or exploitative behaviour is prohibited. This includes the exchange of assistance that is due to beneficiaries.
- Sexual relationships between staff members and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- Where a member of staff develops concerns or suspicions regarding sexual abuse or exploitation by any person, whether in the UN or not, s/he must report such concerns via the prescribed procedure.
- UN staff members are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of this code of conduct.
- Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.

These principles were incorporated into a zero tolerance policy toward SEA perpetrated by UN and partner personnel. This policy is outlined in the Secretary-General's 2003 Bulletin, *Special measures for protection from sexual exploitation and sexual abuse* (ST/SGB/2003/13). The Bulletin serves as a Code of Conduct (CoC) for UN and partner personnel and prohibits sexual relations in the context of one person taking advantage of another person, regardless of the victim's age. It also prohibits all sexual relations with children under 18 years of age.

1 Available at: <www.pseataskforce.org/uploads/tools/sixcoreprinciplesrelatingtosea_iasc_english.doc>.

Transactional sex is banned. Although the policy does not prohibit all sexual relations with members of the local population, most are considered unequal due to the vulnerability of conflict- and disaster-affected people and the relative power held by humanitarian and peacekeeping personnel, and they are therefore "strongly discouraged."

A comprehensive approach to addressing SEA

UNICEF country offices (COs) must undertake multi-dimensional actions to effectively prevent SEA from occurring and to ethically and appropriately respond to all allegations and complaints of SEA involving humanitarian and peacekeeping personnel. Key pillars of action include: (i) management and coordination of CO efforts to address SEA; (ii) effective systems and procedures for confidentially and effectively reporting and responding to SEA allegations and complaints; (iii) proactive prevention measures; and (iv) community outreach and education related to the issue.

Management and coordination

Implementing comprehensive prevention and response to SEA requires strategic and coordinated action, best implemented via a well-resourced CO SEA action plan. This plan must be championed by senior management and must set out clear accountabilities for all managers and staff.

In addition to coordination across CO departments and programmes, inter-agency coordination is a core component of action to prevent and respond to SEA.

Systems for reporting and responding to SEA allegations and complaints

Each and every report or allegation of SEA received by UNICEF must be appropriately followed up on by COs. In the case of allegations involving children, the Notification Alert must be followed.[2] Responding to allegations also involves providing appropriate care, support and protection for survivors, as well as following procedures for internal reporting set out in the Notification Alert.

2 The UNICEF Notification Alert can be found at the end of this Info Sheet. Contact Child Protection in Emergencies Section at Headquarters for additional UNICEF SEA prevention and response resources and training materials.

Preventive measures

Steps can and must be taken to reduce the likelihood of UNICEF or partner staff breaching the code of conduct and perpetrating sexual abuse or exploitation. COs must take steps to mitigate the risk of staff engaging in SEA-related misconduct in the same way that risks of other misconduct, such as theft, are minimized. Preventive action centres on increasing staff compliance with behavioural standards set out in the Secretary-General's Bulletin *Special measures for protection from sexual exploitation and sexual abuse* (ST/SGB/2003/13)[3] and related UNICEF policies. It also involves strengthening organizational practices such as improving staff recruitment and management processes, building safer partnerships and implementing protective programming.

Community outreach and education

Community members have both a need and a right to access information regarding protection from SEA by humanitarian and peacekeeping personnel, as well as the UN's zero tolerance approach toward it. Providing community members with age-, sex- and ability-appropriate information about how to safely report SEA complaints, and initiating efforts to build trust with communities so that people are willing to come forward and make complaints, are both vital for ending impunity for SEA by humanitarian and peacekeeping personnel.

Challenges in preventing and responding to SEA

It is important to be aware of the complexities and challenges inherent in SEA prevention and response. Sexual violence is a sensitive issue, and even in well-resourced, stable settings, there are significant obstacles to reporting and responding to sexual assault, as well as to coordinating multi-stakeholder preventive action. A common challenge across settings is the underreporting of sexual violence. Survivors are often reluctant to report their experience of sexual assault due to feelings of shame, intense social stigma, and victim-blaming attitudes and behaviours from those around them. Survivors who speak out often face the threat of retaliation in the form of further violence or harassment from perpetrators and/or those supporting the perpetrators. This challenge is further exacerbated in humanitarian settings. Although the following list is not exhaustive, it highlights some of key challenges faced in unstable and/or resource-poor emergency contexts.

A lack of appropriate GBV response services: Poor quality or limited access to health, safety and psychosocial services means survivors may be less likely to come forward, increasing the risk of further harm. It can be extremely difficult to provide appropriate care and assistance to survivors of SEA who do come forward when there are limited or poor quality services available. Further, a lack of legal services may prohibit survivors from asserting their legal rights, where these rights exist.

The nature and context of abuse and exploitation: SEA includes a spectrum of activities and behaviours: some involve the use or threat of force or violence, while others do not outwardly appear to be coercive. For example, in some instances of sexual exploitation, survivors may 'consent' to the activity and therefore not consider it abusive. In such cases, there is often an economic incentive to exchange sexual activity for resources for survival and a subsequent disincentive to report: the survivor may not wish to lodge a complaint or have the matter investigated because of the economic consequences it may cause. In these cases, it is not uncommon for survivors to 'disappear' rather than agree to participate in an

3 See the website of the Inter-Agency Standing Committee Protection from Sexual Exploitation and Abuse Taskforce for this and other SEA-related policies and documents: <www.pseataskforce.org/>.

investigation. In other settings, behaviours that are considered culturally or socially acceptable may constitute abuse or exploitation according to the UN definition.

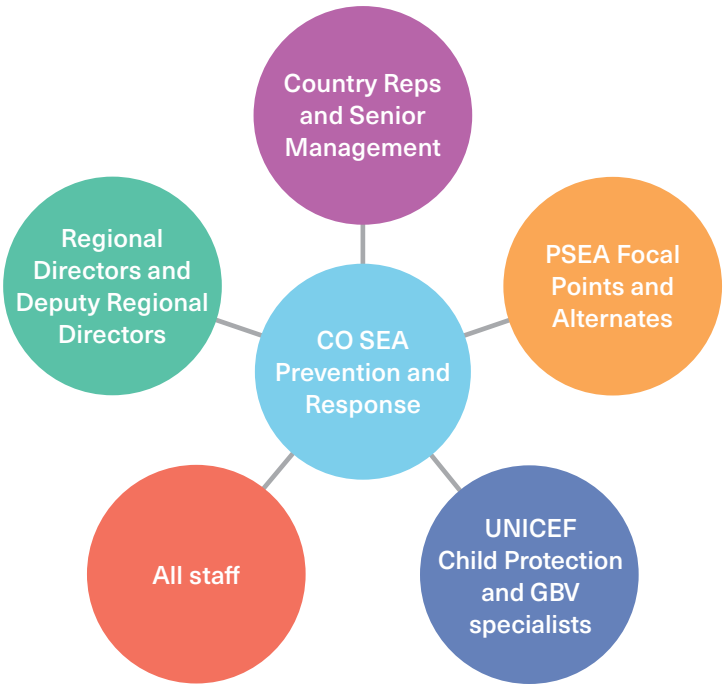
Evidentiary issues: Although the burden of proof is lower for establishing a breach of the UN's code of conduct (as opposed to proving criminal responsibility), it can be very difficult to prove SEA. There are rarely witnesses, and even when there are, they may be afraid of participating in investigations. This problem is compounded in situations where survivors are not the complainant in a case.

Maintaining a survivor-centred approach in conditions of mandatory reporting: A survivor-centred approach to sexual violence affirms the rights of survivors to confidentiality and self-determination – including the right to decide whether or not to formally report the incident. Upholding the full rights of survivors to confidentiality and self-determination is not always possible in the context of mandatory reporting of SEA. Further, maintaining anonymity and safety of survivors and witnesses can also be difficult.

Inconsistent investigative and disciplinary procedures: UN staff, including civilian staff and police, are disciplined by the UN through administrative sanctions, such as fines, dismissal or repatriation, whereas military personnel are disciplined according to the rules of the troop-contributing country. Communities rarely make distinctions between different arms of the UN; therefore, poor practices amongst one organization or entity can reflect badly on the entire UN country mission.

Inadequate resources and technical capacity: Implementing comprehensive SEA prevention and response measures requires resources, specialist knowledge and skills, and adequate capacity – which have not always been prioritized in the past. Further, the issue of SEA has not always been taken seriously by the humanitarian community in some settings.

Accountabilities, roles and responsibilities for preventing and responding to SEA



Senior management staff at all levels are accountable for preventing and responding to SEA. The procedures to report, respond to and monitor allegations of SEA, in line with the Notification Alert, and to take effective actions in preventing SEA, are carried out in coordination with the Division of Human Resources, Supply Division, Office of Internal Audit and Investigation (OIAI) and the Legal Adviser. The specific roles and responsibilities of those offices are identified and explained in other documents.

Regional Directors and Deputy Regional Directors

Regional Directors and Deputy Regional Directors are responsible for:

- Holding in-country management to account regarding their roles and responsibilities for SEA prevention, reporting and response strategies and providing support in identifying adequate resources for implementation;
- Taking appropriate action with regard to onward reporting of alleged cases of SEA, noting in particular the Notification Alert; and
- Supporting the management of external communications concerning an SEA case, particularly media management.

Country Representatives/Heads of Office and other senior managers

UNICEF Country Representatives and senior managers, including Heads of sub or zonal offices, are accountable for taking action to prevent and respond to SEA at country level. This includes operationalizing the four steps for reporting and responding to SEA allegations, noted above.

PSEA Focal Points and Alternates

PSEA Focal Points and Alternates have a significant role in preventing and responding to SEA. They are responsible for:

- Receiving and reporting onward all complaints, reports and questions about alleged acts of SEA committed by UNICEF personnel and personnel of other entities whenever approached;
- Confirming that records are kept, information is held confidentially and appropriate reporting takes place, in line with local reporting procedures; and
- Reporting to the UNICEF Representative or other senior manager, such as the Head of a field office.

The PSEA Focal Point or Alternate is never responsible for questioning or dismissing an allegation, deciding if or how to proceed with an allegation, or making decisions regarding investigations.

UNICEF Child Protection and GBV specialists

Child Protection and GBV staff are often the first to be notified of an SEA incident or allegation. They are also likely to have the expertise and skills to engage with and support victims. Key responsibilities of UNICEF Child Protection and GBV specialists include:

- Supporting PSEA Focal Points, Alternates and other designated staff at field level to identify appropriate referral services and establish protocols for referring victims; and
- Providing guidance and advice to Focal Points and Alternates regarding victims' rights and the best interests of the child throughout the reporting and assistance processes.

UNICEF staff members and related personnel

Regardless of their contractual status, all UNICEF staff and related personnel have the following responsibilities in preventing and responding to SEA:

- Abiding by the standards of behaviour set out in the UN SEA Code of Conduct;
- Reporting all information regarding allegations, suspicions or complaints of SEA to designated Focal Points or supervisors; and
- Contributing to a climate and culture of zero tolerance for SEA in the workplace and community by promoting the rights of women and children to be free from all forms of violence.

Country office checklist for preventing and responding to sexual exploitation and abuse

Reporting	
UNICEF Head of Office is immediately informed of SEA allegations by UN staff or related personnel.	◯
Notification Alert is activated within 24 hours of receipt of an SEA allegation. Allegation is reported using the Significant Incident Report (SIR) for SEA.	◯
Within 12 hours after receiving the SIR, Regional Director makes a decision whether to inform NYHQ.	◯
Where PSEA Task Force has been established by the UNCT, UNICEF informs Task Force as appropriate.	◯
Country Representative consults UNICEF Legal Adviser and other relevant staff to determine the appropriate procedures for reporting to national authorities.	◯
Country Representative reports SEA allegations involving UNICEF staff and related personnel following the Notification Alert and confirms follow-up actions are taken.	◯
Response	
Appropriate information, support, referral and victim assistance are provided or facilitated for child victims of SEA (and adult victims of SEA allegedly perpetrated by UNICEF staff or related personnel) throughout the reporting and investigation process and during follow-up, as needed. Victim assistance includes safety, medical care, psychosocial support, legal services and case management. Relevant Child Protection colleagues are involved in identifying available services and referral procedures for child victims.	◯
OIAI is informed of SEA allegations.	◯

Monitoring	
Mechanisms are in place for monitoring response and follow-up of allegations, including the quality of victim assistance provided by UNICEF and its partners to address the child's safety, health and psychosocial needs, and access to legal assistance. UNICEF's accountability for monitoring SEA response also includes assistance to adult victims of SEA allegedly perpetrated by a UNICEF staff or related personnel.	◯
Mechanisms are in place for monitoring ongoing investigations.	◯
Prevention	
A PSEA Focal Point and Alternate are designated in each CO and each sub or zonal office and are trained on SEA prevention and response.	◯
Focal Points' and Alternates' responsibilities are reflected in Performance Appraisal Reports.	◯
CO is active in inter-agency PSEA Task Force and advocates for establishment of Task Force where it does not exist.	◯
Appropriate linkages are facilitated with other relevant coordination forums.	◯
Victim assistance services are mapped to determine the availability and quality of medical, psychosocial and legal services.	◯
Protocol is established for referring SEA victims.	◯
Victim assistance services are established or strengthened.	◯
PSEA training and capacity-building of partners, peacekeepers and relevant troops is supported.	◯
All staff are trained on SEA and the Code of Conduct.	◯
The Code of Conduct and key UNICEF policies related to SEA reporting, response and prevention are translated into the main local languages and prominently displayed throughout the CO.	◯
SEA awareness is promoted to build staff knowledge and commitment to zero tolerance of SEA.	◯
Senior managers are trained on how to identify and respond to staff stress.	◯
Staff are advised of disciplinary procedures.	◯

Prevention (continued)	
GBV prevention and mitigation strategies are incorporated into the policies, standards and guidelines of sectoral programmes.	○
Communities, especially children and women, are consulted on how to make community-based complaint mechanisms accessible, safe and confidential.	○
Community-based complaint mechanisms are established and announced in UNICEF operational areas.	○
Provisions are in place for anonymous reporting of SEA.	○
Mechanisms are in place to provide feedback to communities on measures taken to prevent and respond to SEA.	○

Essential SEA prevention and response resources

- **UNICEF Minimum Operating Standards for Protection from Sexual Exploitation and Abuse (MOS-PSEA):** Contact Child Protection in Emergencies, Programme Division, Headquarters for a copy.
- **UNICEF Notification Alert package:** Reporting Allegations of Sexual Exploitation and Abuse of Children by UN Personnel or by Foreign Military Personnel Associated with a UN Mandate – contact Child Protection in Emergencies, Programme Division, Headquarters for a copy.
- **UNICEF SEA package** (Eng, Fr): Guidance on conducting child interviews for investigations, Child Interview Monitoring Checklist, SEA UNICEF Training presentation – contact Child Protection in Emergencies, Programme Division, Headquarters for a copy.
- **UNICEF's Standard Programme Cooperation Agreement,** available at: <https://intranet.unicef.org/pd/pdc.nsf/caf1cccd04786f1285256c870076516b/b972e7beaf90edba85257e0a0069239e?OpenDocument>.
- **UNICEF Child Safeguarding Policy,** available at: <https://intranet.unicef.org/pd/pdc.nsf/0/B91A2CD30AA64B2685257FE9007254A4/$FILE/CF%20EXD%202016%20006%20Child%20Safeguarding%20Policy.pdf>.
- **Secretary-General's Bulletin on Special measures for protection from sexual exploitation and sexual abuse** (ST/SGB/2003/13), available at: <www.pseataskforce.org/uploads/tools/1327932869.pdf>.
- **IASC Standard Operating Procedures for Community-Based Complaints Mechanisms (CBCMs),** available at: <https://interagencystandingcommittee.org/accountability-affected-populations-including-protection-sexual-exploitation-and-abuse/documents-51>.
- **IASC AAP/PSEA Best Practice Guide on Inter-Agency Community-Based Complaints Mechanisms (CBCMs),** available at: <https://interagencystandingcommittee.org/accountability-affected-populations-including-protection-sexual-exploitation-and-abuse/documents-50>.

UNICEF Notification Alert to Senior Management: Reporting Allegations of Sexual Exploitation and Abuse of Children by UN Personnel or by International Military Personnel Associated with a UN Mandate

Allegations must be reported to UNICEF senior management

- All UNICEF Personnel have a duty to report to UNICEF senior management allegations of sexual exploitation and abuse of children by UN Personnel or by international military personnel associated with a UN mandate. Reports must be made urgently once an allegation is received. The steps for making these reports (including the template form to use) are set out on the following page.
- Reporting allows UNICEF senior management to make sure the Organization is taking appropriate steps to help the children involved, to stop any on-going exploitation and abuse, and to trigger appropriate investigations and possible referrals to law enforcement.

Who must report what, when, and to whom?

- **Who has to report?** "UNICEF Personnel" means, for these purposes, all staff members; UNVs working with UNICEF; people deployed to UNICEF under Stand-by Personnel arrangements or on reimbursable or non-reimbursable loans; interns; personnel deployed to UNICEF through an employment agency or similar arrangements; and individuals who have a consultancy contract with UNICEF.
- **What has to be reported?** Allegations of sexual exploitation and abuse of children by UN Personnel. Given the nature of the actions involved, all allegations should be reported. However, making an allegation in bad faith against someone or embellishing an allegation are strictly prohibited; appropriate steps will be taken against anyone who does so.
    - "Sexual exploitation and abuse" have been defined in various instruments issued by UNICEF and the UN, but all allegations of sexual conduct by UN Personnel with children – including attempted or threatened conduct of a sexual nature – must be reported. This is especially so if the allegation involves actual or threatened violence or inducements such as protection, food, shelter, or the like. An analysis of whether such conduct meets the technical definitions can occur at a later phase of the process.
    - "Children" also has a definition, and all allegations involving someone who appears or claims to be under 18 must be reported.
    - "UN Personnel" means staff members of the UN Secretariat or any UN System Organization (including UNICEF), UNVs working with any such organization, people deployed to a UN System Organization under Stand-by Personnel arrangements or on reimbursable loans, interns, people deployed to a UN System Organization through an employment agency or similar arrangements, gratis personnel, and individuals who have a consultancy contract with a UN System Organization. It also includes the employees or consultants and sub-contractors of UN System Organizations, civil society implementing partners, and contractors or suppliers. In addition, it includes all personnel associated with international or regional military forces operating as part of a UN Peacekeeping Mission or otherwise under a UN mandate. "International military personnel associated with a UN mandate" is self-explanatory.

- **When Must the Allegations be Reported?** Allegations must be reported urgently once they are received. The maximum time frames for reporting are set out in the matrix below.
- **To Whom Must the Report be Made?** The report must be made directly to the head of the UNICEF office where the person making the report is assigned. That might be a Country Office or a zonal- or sub-office. That person then has obligations to report to more senior colleagues within UNICEF and the UN System at country level. The reporting protocols from there are set out in the matrix below.

Special notes:

- If you are in doubt about whether something has to be reported, report it.
- UNICEF expects that our government partners and donors, UNICEF national committees, civil society implementing partners (local and international), vendors and suppliers, and organizations with a corporate consulting contract with UNICEF, and the employees of all of these, will also report such allegations to UNICEF.

Reporting steps

Step 1

Immediately after receiving an allegation of actual, attempted, or threatened, sexual exploitation and abuse of a child by any UN Personnel, UNICEF Personnel must inform the Head of Office where he or she is assigned. The Head of Office must immediately inform the UNICEF Representative in the country, or the acting Representative, if the initial report is made at a sub- or zonal- office. This report should be made by whatever means is fastest and easiest, e.g., in person, by phone, by text, by email.

Step 2

Within 24 hours after he or she receives the report, the UNICEF Representative must report the allegation to the UNICEF Regional Director.

- The report must be made in writing, using the Significant Incident Report (SIR) for Sexual Exploitation and Abuse (SEA). First reports are often incomplete and may contain details that are later found to be inaccurate. The SIR for SEA may be revised later. All information available at the time of making the report must be included except the names and identifying information of the child which must be removed from all written documents and communications; that information (if known) is to be retained at Country Office level under strict confidentiality.
- The SIR for SEA form requires the Representative to report on steps taken to support the child and his/her family. The SIR for SEA also requires the Representative to express a view on whether the allegation is credible.
- In all cases, the Representative must also inform the most-senior UN official in country (e.g., SRSG of UN Mission, or UNCT RC/HC). This report is provided orally, with an email follow up making clear that the allegation has not been assessed or investigated. The SIR for SEA is a confidential internal UNICEF document and is not provided outside UNICEF.

Step 3

Within 12 hours after he/she receives the SIR for SEA, the Regional Director reviews the information and makes a decision, using his or her best judgment, whether to inform NYHQ. If the Regional Director decides to inform NYHQ, this is done by forwarding the SIR for SEA (with the relevant section of the SIR/SEA completed by the Regional Director):

- Deputy Executive Director Programmes with copy to:
  - Deputy Executive Director Management
  - Chief of Staff (OED)
  - Director Programme Division
  - Director EMOPS
  - Associate Director PD (Child Protection)
  - Country Representative

- If the alleged perpetrator is a UNICEF staff member, UNV working with UNICEF, a person deployed to UNICEF under a Stand-by Personnel arrangement or on reimbursable or non-reimbursable loan, an intern, a person deployed to UNICEF through an employment agency or similar arrangements, or a gratis personnel: the SIR for SEA must also be copied to Director DHR; Chief of Investigations, OIAI; and the Legal Adviser NYHQ.

- If the alleged perpetrator is an individual consultant, or an employee or associate of a corporate vendor or supplier or of an institutional or corporate contractors (sometimes referred to as corporate consultants): the SIR for SEA must also be copied to Director SD; Chief of Investigations OIAI; and the Legal Adviser NYHQ.

The Country Representative, upon advice of and with specific guidance from UNICEF Headquarters, informs appropriate Government authorities and, when relevant, contractors or implementing partners.

UNICEF WASH and Dignity Kit Contents

Immediate Response WASH and Dignity Kit contents

The *Immediate Response WASH and Dignity Kit* contains a set of 8 pre-packaged items, listed in the table below.

Item	Specification	Quantity
1. Soap*	110g bars	12 pieces
2. Bucket	14 litre with lid	1 unit
3. Jerry can	10 litre, flexible	2 units
4. Water purification tablets (chlorine)*	33mg tabs, pack of 50	6 packs
5. Torch (flashlight)	Hand powered	1 unit
6. Multipurpose cloth	Cotton, 1x1.5 m, neutral colour	2 pieces
7. Reusable menstrual pads	2 pad holders – cotton, 3 winged pads, 2 straight pads, 1 storage pouch	2 sets
8. Child potty	Plastic	1 unit

*__Note:__ these quantities are assumed to be sufficient for a family of five for 1 month.

Family Hygiene and Dignity Kit contents

Where local procurement is not viable, *Family Hygiene and Dignity Kits* can be ordered through UNICEF Supply Division as:

1. A standard kit which includes the first 15 items listed below; or
2. A customized kit that includes a mix of any of the 32 items listed below. Customized items should be selected based on needs assessment. These kits cannot be pre-stocked by UNICEF Supply Division and will require longer lead times than the standard kit.

Item	Specification	Quantity
Basic Family Hygiene and Dignity Kit		
1. Soap*	110g bars	12 units
2. Soap box	Plastic	1 unit
3. Bucket	14 litre with lid	1 unit
4. Laundry detergent*	1.5 kg, powder	1 unit
5. Shampoo*	500 ml	3 bottles
6. Adult toothpaste*	150 ml	1 unit
7. Child toothpaste*	75 ml	3 units
8. Adult toothbrush	Medium	2 units
9. Child toothbrush	Medium	3 units
10. Nail clipper	Medium size	1 unit
11. Torch (flashlight)	Hand powered	1 unit
12. Clothes line	10 m	1 unit
13. Multipurpose cloth	Cotton, 1x1.5 m, neutral colour	2 units
14. Reusable menstrual pads	2 pad holders – cotton, 3 winged pads, 2 straight pads, 1 storage pouch	2 sets
15. Safety pins	Pack of 12	1 unit

Item	Specification	Quantity
Supplemental Items		
16. Petroleum jelly	125 ml	2 units
17. Water container for anal cleansing	500 ml, with spout	1 unit
18. Toilet paper*	500 sheets/roll, 4 roll pack	1 pack
19. Sanitary napkins with wings (disposable)*	Medium flow	40 units
20. Underwear, female	Three size pack, 9 total	1 pack
21. Underwear, male	Three size pack, 9 total	1 pack
22. Underwear, boys	Three size pack, 9 total	1 pack
23. Underwear, girls	Three size pack, 9 total	1 pack
24. Towel	70x130 cm	2 units
25. Comb	Plastic	2 units
26. Whistle	Stainless steel	1 unit
27. Reusable baby diapers	12 cloth diapers/pack with plastic covers	2 packs
28. Disposable diapers*	4 sizes available	120 units
29. Baby diaper rash cream	Tube, 110 grams	1 unit
30. Child potty	Made of plastic	1 unit
31. Household lighting	Family size, solar/crank powered	1 unit
32. Bag	Plastic, 100 litres	1 unit

* **Note:** these quantities are assumed to be sufficient for a family of five for 1 month.

** **Note:** the *Family Hygiene* and *Dignity kit* list does not include jerry cans or water purification tablets. These can be ordered separately if needed in the second phase of the emergency response.

Women- and Girls-Friendly Spaces

Source: United Nations Population Fund, 'Women and Girls Safe Spaces: A Guidance Note Based on Lessons Learned from the Syria Crisis', UNFPA Regional Syria Response Hub, 2015.[1]

Why do females need special support in emergencies?

GBV increases in emergencies because of the displacement of communities, absence of law and order, lack of adequate basic support services, breakdown of social support networks, and so on. As a result, females of all ages and stages need protection, support, and access to services in emergencies. Women and girls from marginalized and disadvantaged communities are also increasingly vulnerable and require protection.

What is a female-friendly space?

A female-friendly space (FFS) is a place where females can go to at any time to feel physically and emotionally safe and empowered and have access to information, education, recreational activities, support and services.

The term 'safe' refers to the absence of risks of trauma, stress, violence (or fear of violence), or abuse. In these spaces, women and girls can socialize and re-build their social networks; receive social support; acquire contextually relevant skills; access safe and non-stigmatizing multi-sectorial GBV response services (psychosocial, legal, medical); receive information on issues relating to women's rights, health, and services.

Female friendly safe spaces offer a range of services including resources, information, social networks, etc. FFS are safe spaces for women and girls in the community, culturally-appropriate and tailored to the context. FFS are also known as Women Friendly Spaces (WFS) however the concept of FFS is inclusive of female of all ages and stages.

FFS can be used for various activities such as: individual or group counselling, awareness-raising, skills-building, NFI distribution, recreational activities. Information on critical issues can be shared in these spaces such as where/how to access humanitarian services and information on reproductive health, legal rights, childcare, and prevention and response to GBV. FFS are also safe spaces that promote women's protection and empowerment and therefore help mitigate risk of GBV. They may also include sleeping space for females – or be converted to sleeping areas in the evenings.

In the context of the aftermath of the Nepal earthquake, the Department of Women and Children has requested 10 FFS in each of the affected districts. In order to ensure greater coverage, each FFS needs to include a roving team to be able to reach other VDCs. The roving team should include transportation (by whatever means available/appropriate) and a Roving Case Manager.

1 Available at: <www.unfpa.org/sites/default/files/resource-pdf/UNFPA%20UNFPA%20Women%20and%20Girls%20Safe%20Spaces%20Guidance%20%5B1%5D.pdf>.

What are the guiding principles of a FFS?

- Leadership and empowerment of women and girls
- Women and girls engaged in all aspects of the space
- Safe and accessible
- Integrated in community and contextually-relevant
- Inclusive – all women and girls consulted – especially marginalized
- Coordination for multi-sectoral support and services – and referral
- Needs-based – with ongoing assessments and adjustments as needs change
- Outreach to communities to encourage women and girls to participate
- Feedback mechanisms in place for women and girls – and for community
- Safe and ethical data collection and management

What services and support can be provided in an FFS?

Other sectors and clusters can channel services for females in these spaces – for example:

- **Health:** basic healthcare services and support, access to additional health information, distribution of health commodities, referral to health facilities as needed – with particular focus on sexual and reproductive health
- **Psychosocial:** psychosocial support and psychosocial first aid – trauma related to the earthquake and GBV-specific PSS/PFA
- **Food:** targeted distributions of food for females – particularly female-headed households and marginalized groups of females – for safety concerns and to avoid exploitation or harassment
- **NFIs:** access to Dignity kits and other essential NFIs such as clothing, blankets, family kits, etc.
- **Nutrition:** services, support, and information for mothers, safe space for breastfeeding
- **Early recovery:** access to livelihood and cash for work opportunities
- **Child protection:** align with CFS (Child Friendly Space) – FFS is a child-friendly environment
- **Basic training:** literacy and other educational activities
- **Group activities and awareness:** sport, music, drama, story-telling, etc.
- **Livelihoods:** vocational training, group lending, etc.

How can FFS be used for GBV prevention and response?

FFS are for all females – not just GBV survivors – although these are spaces where survivors would feel comfortable presenting themselves and accessing services and support. It is discouraged to provide community FFS targeted only to survivors as it will stigmatized them

further, rather integrate survivors and vulnerable women into FFS programmes and activities. FFS presents a safer venue to seek support in a more discrete manner and to avoid stigma. For GBV survivors, FFS offer direct access for referral, counseling and other GBV specific prevention and response programs. FFS can support GBV survivors through:

- Access to information
- Referral pathways to access multi-sectoral support
- Case management
- Group activities: training, counselling, discussions, information-sharing, awareness-raising
- Access to socio-economic support
- Shelter and safe sleeping space for vulnerable females
- Outreach activities: creation of women's protection teams, etc.

What types of FFS are there?

FFS are often most effective when they are close to health services and organized in conjunction with child-friendly spaces or any common space where women may gather (nutrition/breastfeeding space, maternity space, etc.). They also may be co-located in these spaces. Types will vary depending on the needs and existing services in each area.

1. **Separate tent – likely adjacent to CFS:** including space for group activities + small rooms for counselling + sleeping area.
2. **Shared tent:** can be co-located with CFS or maternity or nutrition: including shared space for group activities that can be converted to sleeping area at night + small rooms for counselling.
3. **Resource person in other tent:** locating resource person (case manager) in tent of other services (maternity, breastfeeding, nutrition, children, etc.) for information and referral.
4. **Resource person in other tent + sleeping space:** same as above including space that can be converted to sleeping area for vulnerable women (and their children).
5. **Pre-existing physical structure:** assuming existence of appropriate space: including space for group activities + small rooms for counselling + sleeping area + kitchen + bathroom + outdoor space.

A Survivor-Centred Approach

What is a survivor-centred approach?

A survivor-centred approach to GBV response puts the survivor at the centre of the helping process. This means allowing the survivor and/or her caregivers to have control of the helping process by giving her information and allowing her to make decisions about what help she needs and wants and what course of action she should take. Often people in a helping role think it is useful to tell people what to do, rather than allowing them to make their own decisions.

People who have experienced GBV have a right to compassionate care and support that promotes their health, recovery and empowerment. A survivor-centred approach aims to create a supportive environment in which each survivor's rights are respected and in which she is treated with dignity and respect. Using a survivor-centred approach promotes the person's recovery and reinforces her own capacity to make decisions about what to do.

A survivor-centred approach is based on a set of principles that guide the work of all helpers – regardless of their role – in all of their interactions with GBV survivors. This approach recognizes that every survivor:

- Has equal rights to care and support;
- Is different and unique;
- Will react differently to violence;
- Has different strengths, capacities, resources and needs;
- Has the right, appropriate to her age and circumstances, to decide who should know about what has happened to her and what should happen next; and
- Should be believed and treated with respect, kindness and empathy.

Two key elements of a survivor-centred response to GBV are:

1. *Rights-based, survivor-centred principles* applied in the helping process; and
2. *Coordinated care and support*, so that all actors are working together to make services and support accessible to girls and women (see below).

Survivor-centred principles

There are four inter-related and mutually reinforcing **survivor-centred principles:** *safety; confidentiality; dignity and self-determination*; and *non-discrimination*. In the case of child survivors, the additional principle of *'best interests of the child'* also applies. Each principle reinforces the others; for example, confidentiality (principle 2) is essential to promote safety (principle 1) and dignity (principle 3). The principles are described below.

Principle 1: Right to safety

Safety refers to both physical security as well as a sense of psychological and emotional safety. It is important to consider the safety and security needs of each survivor, her family members and those providing care and support.

In the case of conflict-related and politically motivated sexual violence, the security risks may be even greater than usual.

Every person has the right to be protected from further violence. In the case of child survivors, every child has the right to be protected from sexual and other violence; as adults, we all have responsibilities to uphold that right.

Why is safety important?

Individuals who disclose sexual violence or other forms of GBV may be at high risk of further violence from perpetrators, people protecting perpetrators, and/or members of their own family because of notions of family 'honour'. Because of this risk, it is paramount that their ongoing safety be prioritized when providing services and support.

Principle 2: Right to confidentiality

Confidentiality promotes safety, trust and empowerment. It reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned.

Why is confidentiality important?

- Confidentiality promotes safety, trust and dignity.
- Confidentiality reflects the belief that survivors, including children, have the right to privacy and to choose who should know about what has happened.
- Breaching confidentiality inappropriately can put the survivor and others at risk of further harm.
- If service providers and other helpers do not respect confidentiality, other survivors will be discouraged from coming forward for help.

Exceptions to confidentiality

In several situations, there are exceptions to confidentiality, and it is very important that survivors, including children and their caregivers, are not led to believe that nothing they say will ever be shared.

Helpers need to understand and communicate the exceptions to confidentiality, such as:

- Situations in which there is the threat of ongoing violence or harm to a child, and the need to protect the child overrides confidentiality;
- Situations in which laws or policies require mandatory reporting of certain types of violence or abuse against children or adults;
- Situations in which the survivor is at risk of harming themselves or others, including threats of suicide; and
- Situations involving sexual exploitation or abuse by humanitarian or peacekeeping personnel.

Principle 3: Dignity and self-determination

GBV is an assault on the dignity and rights of a person, and all those who come into contact with survivors have a role to play in supporting their dignity and self-determination. For example, survivors have the right to choose whether to access legal services and other support services.

Failing to respect the dignity, wishes and rights of survivors can increase their feelings of helplessness and shame; reduce the effectiveness of interventions; and cause re-victimization and further harm.

Principle 4: Non-discrimination

All people have the right to the best possible assistance without unfair discrimination on the basis of sex, gender, age, disability, race, colour, language, religious or political beliefs, sexual orientation, status or social class.

Best interests of the child principle

Every child is unique and will be affected differently by GBV. Staff require specific training on working with child survivors. Decisions and actions affecting each child should reflect what is best for the safety, well-being and development of that particular child.

The primary purpose of intervening is to provide care, support and protection for individual children – not to meet other objectives.

Strategies for ensuring the best interests of the child include the following:

- Take an approach that takes the individual circumstances of each child into account, including her family situation and her vulnerabilities and strengths. Prioritize her needs for safety, protection, and physical and mental health above other needs.
- Listen to the voice and perspective of the child, and take her wishes into consideration.
- Understand consent as it applies to children, and appropriately obtain permission from a child to collect and share information about them.
- Protect the child from potential or further emotional, psychological and/or physical harm.
- Empower children and families.
- Examine and balance benefits and potentially harmful consequences of each decision or action affecting a child.
- Promote recovery and healing.

See related **Info Sheets** in **Kit 1: Getting Started** on:

Mandatory Reporting of Child Abuse

Guiding Principles for Working with Child Survivors of Sexual Abuse

Obtaining Permission from a Child

Levels of Participation

Source: Active Learning Network for Accountability and Performance in Humanitarian Action and Groupe URD, *Participation handbook for humanitarian field workers – Involving crisis-affected people in a humanitarian response*, ALNAP, London, 2009, pp. 39–44.[1]

- In humanitarian situations, a participatory approach means involving crisis-affected people in the humanitarian response in whatever way, and to whatever extent is possible, in a given context.
- Participation makes a humanitarian response more efficient, effective and relevant to real needs, and it can help identify the most appropriate way of meeting those needs.
- Crisis-affected people can be directly involved in humanitarian responses on an individual level or indirectly via community representatives. In both cases, special care should be taken to ensure that the most vulnerable and socially marginalised people are involved, and that this involvement is done with care and intentionality so as not to risk further harm to these populations.
- There are different ways to involve people in humanitarian responses, and different approaches can be used to continually improve participation throughout the life cycle of a project.
- In order to adopt a genuinely participatory approach, we must not think of those who are affected by a crisis as 'victims', 'beneficiaries, or 'recipients', but as dynamic social actors with capacities and strengths are able to take an active role in decisions affecting their safety and welfare. This shift in perception is of fundamental importance.
- The following table outlines a typology of participation that reflects the different ways humanitarian organizations interact with crisis-affected people, from simply informing them about a humanitarian response, to providing support for local initiatives.

Typology of participation (adapted from Pretty, J.)

Type of participation	Description
Passive participation	The affected population is informed of what is going to happen or what has occurred. While this is a fundamental right of the people concerned, it is not one that is always respected.
Participation through the supply of information	The affected population provides information in response to questions, but it has no influence over the process, since survey results are not shared and their accuracy is not verified.
Participation by consultation	The affected population is asked for its perspective on a given subject, but it has no decision-making powers and no guarantee that its views will be taken into consideration.

1 Available at: <www.alnap.org/resource/8531>.

Type of participation	Description
Participation through material incentives	The affected population supplies some of the materials and/or labour needed to conduct an operation, in exchange for payment in cash or in kind from the aid organization.
Participation through the supply of materials, cash or labour	The affected population supplies some of the materials, cash and/or labour needed for an intervention. This includes cost-recovery mechanisms.
Interactive participation	The affected population participates in the analysis of needs and in programme conception, and has decision-making powers.
Local initiatives	The affected population takes the initiative, acting independently of external organizations or institutions. Although it may call on external bodies to support its initiatives, the project is conceived and run by the community; it is the aid organization that participates in the people's projects.

Tips for promoting participation

Source: Groupe URD, *Participation by Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners*, ALNAP, London, 2003, pp. 15–16.

Successful participation relies first and foremost on the attitude of those engaged in humanitarian action.

Be aware… of the local context and its social and cultural dynamics, of political divisions and lines of power, and of the stakes and potential pitfalls. Being conscious of this enables one to be cautious without being suspicious, to tailor one's expectations to current realities and to avoid undue disappointments. It is central to gaining the respect of those whom you seek to engage.

Listen, observe… with your eyes and with your ears, but, also, with the eyes and the ears of those who you are trying to understand, assist or protect. Bear in mind that affected populations have a holistic and integrated view of their own needs and strategies, and that the earlier you involve them, the greater their motivation to engage in a joint venture. Empathy and reflected understanding can go a long way to making a complex process manageable.

Pay attention to the human factor. Despite all efforts to develop and apply methods to improve the process of participation, successes and failures can often be attributed to the presence of the right person with the right attitude, understanding and skills, being in the right place at the right time. Pay utmost attention to the composition of your team, and allow time to breathe and to deliberate.

Enjoy! At the heart of participation is a meeting of different individuals, cultures, skills, beliefs and values. This is an opportunity to learn and to share experiences; humanitarian aid workers can benefit as much as affected populations.

Social Protection in Emergencies

Source: United Nations Children's Fund, 'Integrated Social Protection Systems: Enhancing Equity for Children', UNICEF, New York, 2012, pp. 88 -90.[1]

UNICEF's broad definition of humanitarian action goes beyond emergency response to include preparedness and early recovery. UNICEF's approach to humanitarian action has thus concentrated on providing relief not only in sudden-onset emergencies but also in chronic crises and fragile contexts. This translates into efforts to:

i. enhance resilience;

ii. promote interventions that will create a solid base for sustainable recovery; and

iii. establish links between emergency response and medium- and long-term development.

There is an increased interest in the potential role social protection can play in the different stages of humanitarian action to address key vulnerabilities, providing children and their families with the necessary tools to prevent as well as mitigate the impacts of emergencies.

Vulnerabilities associated with emergencies: Sudden onset and chronic crises and social protection

Emergencies have the potential to create and/or further exacerbate existing vulnerabilities to poverty and exclusion. Sudden onset emergencies resulting from shocks, for example, may worsen economic hardship due to depletion of assets and resources and increase the threat of violence. Households and children in the poorest sectors and countries are disproportionately vulnerable to and affected by natural hazards: More than 1.7 million people were killed in 23 mega disasters between 1975 and 2008, mainly in developing countries. Families suffer multiple and severe disruptions in an emergency that may affect their ability to protect their children.

Communities that may have provided a safe environment for children are shattered, and the social fabric may become weakened by increased tension over scarce resources. Moreover, armed conflicts have significant impacts on children and their families including limited or no access to social services and lost livelihoods. The capacity of families to provide adequate care for their children is undermined, and children may become the victims of genocide or suffer the effects of displacement, family disintegration and sexual violence. Many are targets of violence or forced to commit violence as child solders, perpetuating cycles of violence and deprivation.

Humanitarian crises will increasingly arise from a combination of complex drivers that build over time. Slow onset or chronic emergencies – understood as situations where a particular shock or trend produces slow and gradual deterioration and where the humanitarian needs are constant while their main drivers are not resolved – pose serious challenges, especially for the most excluded. Drought, demographic change, displacement and/or impacts of climate change may contribute to furthering social exclusion, displacement and long-term food insecurity while leading households to engage in risky coping mechanisms that weaken their ability to escape cycles of poverty and exclusion. Although in some contests there may be some informal protection schemes such as micro savings or community insurance, these are severely weakened by the accumulated impacts of repeated shocks and emergencies.

1 Available at: <www.unicef.org/socialpolicy/files/UNICEF_Social_Protection_Strategic_Framework_full_doc_std.pdf>.

The combined effects of conflict and natural disasters can create irreversible and daunting effects on livelihoods, adding to existing social and economic vulnerabilities and undermining children's protective environment. The increasing complexity of conflicts heightens the need to identify innovative approaches to prevent and counteract their impacts, especially on the most vulnerable.

Linking social protection and humanitarian action: A phased approach to social protection

The link between social protection and humanitarian action is critical as, on the one hand, existing vulnerabilities can lead and/or shape emergencies, and on the other, social protection interventions can help address particular needs associated with humanitarian crises such as loss of assets, limited access to essential food supplies or services and increased risk of epidemic disease. In this sense, social protection can potentially play a key role in prevention and response as well as in post-crises settings.

Pre-crisis: Preparedness and risk management

Interventions at the pre-crisis phase are considered critical in many cases. If crises are predictable or slow-onset, there might be key strategies to reduce impacts and/or enhance households' capacity to cope with foreseen impacts and risks. UNICEF's priorities in this stage include developing risk and vulnerability analysis to help identify the most appropriate strategies to prevent and mitigate risk as well as prepare for response. Social protection can contribute to strengthening livelihoods, increasing households' resilience and preventing or mitigating the negative effects of crises.

During a crisis: Emergency response and early recovery approach

As an approach that recognizes the gap between relief and development programming, early recovery aims to "shape the manner in which humanitarian response is conducted […] to ensure humanitarian response operations become assets for long-term recovery; support recovery initiatives by affected communities, and stabilize local and national capacities to encourage a quicker and sustainable transition to longer-term recovery." In other words, it is key to ensure that response interventions are implemented in such a way that can begin building into local systems and existing capacities, while identifying potential pathways to recovery planning.

Post-crises: Recovery and disaster risk management

Priority actions post-crisis are targeted towards building on humanitarian investments to create and/or strengthen long-term recovery and sustainable development. Social protection can play an important role in transforming relief interventions into long-term recovery programmes. For instance, cash in emergencies can evolve into predictable medium- or long-term protection mechanisms and delivery mechanism created for relief can be strengthened and adapted as building blocks for more permanent systems.

Zaatari Camp, Jordan

Integrating GBV Risk Mitigation Across Sectors and Clusters

Info Sheets

Humanitarian Standards for GBV Mainstreaming

UNICEF CCCs and GBV Prevention and Response

GBV Guiding Principles

Levels of Participation

Confidentiality

Dos and Don'ts with GBV Data

Survivor-Centred Principles

Sexual Exploitation and Abuse

Addressing GBV-Related Risks in WASH Assessments and Initial Programme Design

Addressing GBV-Related Risks in Health Assessments and Initial Programme Design

Tools

Tools referenced in this section can be found in the *Minimum GBViE Response Package Tools Booklet* of this Kit.

GBV Risk Mitigation Tool 1: Sector Audit Checklist for Integrating GBV Risk Mitigation Across Programming

GBV Risk Mitigation Tool 2: WASH Assessment and Monitoring Tool

GBV Risk Mitigation Tool 3: WASH Facility Privacy and Safety Checklist

Introduction

Emergencies increase the risk of gender-based violence (GBV). For example, collecting water or other necessities such as fuel may require girls and women to travel long distances in search of these necessities, buy water or fuel from vendors, or access unsafe or untreated water sources. Girls and women in these scenarios face potential financial and sexual exploitation, sexual violence, abuse and harassment.

Humanitarian Standards for GBV Mainstreaming

Displacement caused by conflict or natural disasters often leads to the separation of families, increasing girls' and women's risk when on the move, upon arrival to camps or other settings, and when accessing humanitarian aid. Upon arrival, girls and women may face limited and unsafe access to services such as registration; food aid; water, sanitation and hygiene (WASH) facilities; healthcare; and fuel/firewood and non-food item distributions. The actions and interventions of humanitarian actors can increase or reduce these risks.

UNICEF CCCs and GBV Prevention and Response

It is critical for all actors to understand that GBV is occurring in every emergency context. Waiting for population-based data on the magnitude of GBV is not a priority in an emergency due to safety, ethical and methodological challenges in collecting such data. All humanitarian personnel, therefore, ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions based on the recommendations in the **IASC GBV Guidelines**,[1] regardless of the presence or absence of concrete 'evidence'.

★ See the IASC GBV Guidelines

All humanitarian assistance and services must be designed, planned and implemented in a manner that maximizes safety and minimizes risks for all emergency-affected people in line with a 'do no harm' approach. This includes minimizing the risks of GBV in emergencies (GBViE). The responsibilities of humanitarian actors to do so are clearly articulated in various **humanitarian standards**, including SPHERE,[2] the Inter-Agency Standing Committee (IASC) *Statement on the Centrality of Protection*,[3] and the IASC *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* (commonly referred to as the '**IASC GBV Guidelines**').[4] UNICEF's internal standards and policies, especially **UNICEF's Core Commitments for Children in Humanitarian Action** (CCCs),[5] also contain commitments directly related to GBV prevention, mitigation and response.

As stated in the IASC GBV Guidelines: "All humanitarian actors must be aware of the risks of GBV and – acting collectively to ensure a comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation. Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations."[6]

The IASC GBV Guidelines clearly spell out the essential actions to be taken by all humanitarian actors across the humanitarian programme cycle to effectively integrate GBV risk mitigation within all humanitarian action. Each humanitarian agency, including UNICEF, must implement the essential actions for GBV mitigation set out in these Guidelines across each sector of their work. Cluster lead agencies, including UNICEF, have additional responsibilities

1 See the Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery,* IASC, 2015, available at <www.gbvguidelines.org>.
2 See <www.sphereproject.org/>.
3 See <https://interagencystandingcommittee.org/principals/content/centrality-protection-humanitarian-action>.
4 See <www.gbvguidelines.org>.
5 See <www.unicef.org/publications/files/CCC_042010.pdf>.
6 Inter-Agency Standing Committee, *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*, IASC, 2015, p. 14.

for making sure appropriate action is taken and reflected within cluster strategies and processes to reduce the risk of GBV and enhance girls' and women's safety in line with the Guidelines.

In line with the IASC GBV Guidelines, UNICEF's **Minimum GBViE Response Package** focuses on putting health, psychosocial and safety services in place for sexual violence survivors as an *initial* priority in emergency settings. This initial focus on sexual violence is due to the immediate and potentially life-threatening health consequences of such violence, coupled with the feasibility of managing these consequences through medical care.

In settings where there are no GBV specialists or GBV health services available, it is incumbent on UNICEF field staff to follow up with health service providers to identify a facility that can provide clinical management of rape services and ensure sectoral staff are able to respond appropriately if a referral is needed.

While establishing health, psychosocial and safety services for survivors of GBV is a component of specialized GBV programming, all humanitarian workers should be able to refer survivors for healthcare following sexual violence. The consequences of sexual violence can be immediate and life-threatening; however, they can be managed with appropriate medical care, making it essential that humanitarian actors be able to properly and safely refer survivors for appropriate services.

Overview of the IASC GBV Guidelines

The IASC GBV Guidelines clearly set out the responsibilities of all humanitarian actors to integrate GBV prevention, mitigation and response interventions into their regular programming. The audience for the Guidelines includes all national and international humanitarian actors operating in settings affected by armed conflict, natural disasters and other humanitarian emergencies. Specifically, the Guidelines are targeted toward programmers – agencies and individuals who can use the information to incorporate GBV mitigation strategies into the design, implementation, monitoring and evaluation of their sector-specific interventions. For UNICEF, this includes WASH, Child Protection, Education, Health and Nutrition programme staff, as well as staff working on communications, monitoring and evaluation, resource mobilization and supply that provide vital operational and other support to programmes.

While the Guidelines are not targeted toward GBV specialists implementing GBV programmes, GBV and gender specialists within UNICEF do need to be familiar with the guidance so they can:

- Help build commitment and capacity of internal and external colleagues to address GBV;
- Provide technical support to UNICEF sectors and UNICEF-led clusters on how to implement the strategies and actions set out in the GBV Guidelines; and
- Help develop and implement multi-sector programmes that include GBV and other sectoral programming components at the country level.

The Guidelines emphasize a mainstreaming approach for addressing GBV within existing sector and cluster tools and process. *The aim is not to create more work or additional tools and systems, but rather to integrate simple practices into already-existing programming so that addressing GBV is a standardized aspect of humanitarian programming.*

The structure of the GBV Guidelines follows the humanitarian programme cycle, with GBV-related considerations and actions for each sector organized in line with the five elements of the cycle. See the figure below.

Element 1: Assessment, analysis and planning

Identifies key questions to be considered when integrating GBV concerns into assessments. Information generated from the assessments can be used to contribute to project planning and implementation.

Element 2: Resource mobilization

Promotes the integration of elements related to GBV prevention and mitigation (and, for some sectors, response services for survivors) when mobilizing supplies and human and financial resources.

Element 3: Implementation

Lists humanitarian actors' responsibilities for integrating GBV prevention and mitigation (and, for some sectors, response) strategies into their programmes. The recommendations are subdivided into three categories: (i) Programming, (ii) Policies, and (iii) Communications and Information Sharing.

Element 4: Coordination

Highlights key GBV-related areas of coordination with various sectors.

Element 5: Monitoring and evaluation

Defines indicators for monitoring and evaluating GBV-related actions through a participatory approach.

Figure 1: The GBV Guidelines and the humanitarian programme cycle

Assessments, analysis and planning

The *Assessment* section of the IASC GBV Guidelines identifies key GBV-related 'areas of inquiry' that can be incorporated into UNICEF sector and UNICEF-led cluster assessment tools. These areas of inquiring are divided into three categories: programming; policies; and communications and information sharing. Guidance is also provided on who to assess, when to asses and how sectors should assess GBV-related issues.

Resource mobilization

The *Resource Mobilization* section of the Guidelines provides information to help include GBV risk mitigation in UNICEF sectoral and UNICEF-led cluster funding proposals. It also addresses other resourcing issues, such as human resources and supplies.

Implementation

The *Implementation* section of the Guidelines provides information on the responsibilities of UNICEF sectors and UNICEF-led clusters for integrating GBV risk mitigation across humanitarian assistance and protection programming. It has three sub-sections – Programming, Policies, and Communications and Information Sharing – and includes concrete strategies and activities for each sector to mainstream GBV into their interventions to increase girls' and women's safety and protection from GBV.

Coordination

Within the GBV Guidelines, the guidance in the *Coordination* section falls into two categories:

1. Areas where UNICEF WASH, Child Protection, Education, Health and Nutrition staff should seek the support of GBV specialists; and
2. Opportunities where two or more UNICEF sectors can coordinate with each other to implement strategies to reduce GBV risks.

Monitoring and evaluation

The *Monitoring and Evaluation* section of the GBV Guidelines includes sample indicators for each sector to use while monitoring and evaluating their programmes. The indicators for each sector are organized in accordance with the humanitarian programme cycle and are designed to be incorporated into existing UNICEF sectoral and cluster monitoring and evaluation systems.

Challenges in addressing GBV across sectors and clusters

There are numerous challenges in mainstreaming GBV risk mitigation across UNICEF sectoral programming and UNICEF-led clusters. Some of the challenges are outlined below. Each must be addressed in order for UNICEF to fulfil its accountabilities and commitments as one of the largest humanitarian actors globally and as a champion of children's rights in emergencies. Following good practice principles and the steps for integrating GBV risk mitigation will assist in overcoming these challenges.

Lack of knowledge and understanding about the issue of GBV and UNICEF's responsibilities for addressing it

There are several misperceptions about the issue of GBV that hinder humanitarian personnel from taking action to address it. Common misperceptions within UNICEF include:

- The belief that GBV is a complex and long-term development issue and not a priority in emergencies;
- A lack of understanding about gender and gender equality and how they relate to UNICEF's work;
- The belief that a lack of prevalence data about GBV means that it's not happening; and
- The belief that UNICEF does not have a mandate to address GBV, does not have a role in addressing GBV and/or does not implement GBViE programming.

In reality, although it might seem like a complicated or long-term problem, there are clear and distinct strategies different actors can and must take to prevent, mitigate and respond to GBV in emergency contexts. Building knowledge about these strategies and about UNICEF's mandate and set of commitments to address GBV, including those set out in the IASC GBV Guidelines, can help to overcome these common misperceptions.

The belief that GBV is the sole responsibility of specialists

Many people, including within UNICEF and partner agencies, believe that addressing GBV in emergencies is the sole responsibility of GBV specialists. In some contexts, even donors may challenge the inclusion of GBV risk mitigation activities in a proposal that is not focused on GBV prevention and response, such as a proposal for nutrition programming.

In fact, all national and international actors responding to an emergency – including UNICEF WASH, Child Protection, Education, Health and Nutrition staff – have a duty to protect those affected by the crisis, which includes protecting them from GBV. While GBV specialists oversee specialized GBV prevention and response interventions that do require specific technical knowledge and skills, no single organization or actor is expected to, or can, do these things alone. Different actors and stakeholders – including governments, communities and actors across the humanitarian system – have important roles to play in preventing, mitigating and responding to GBV. While specialized GBV prevention and response programming is an essential life-saving component of humanitarian action, so is

integrating GBV risk mitigation across *all* sectoral programming.

The first step in addressing this misperception involves building awareness regarding the shared responsibility for addressing GBV among country office (CO) staff, partner staff, and management and staff across the wider humanitarian system – especially staff of cluster member agencies and donor agencies.

Lack of knowledge of what action to take

Even when individuals within UNICEF and partner agencies *do* understand the shared responsibility to protect emergency-affected communities, they may not know what concrete actions to take to effectively integrate GBV interventions into sectoral or cluster assessments and programming. It is common to hear colleagues say that they want to do the right thing to increase girls' and women's safety and not cause harm, but they do not know what practical steps to take.

Addressing this challenge requires building knowledge of CO and partner staff, including staff of cluster member agencies, regarding the concrete actions that can be taken by all actors that will help to build girls' and women's safety and reduce the risk of GBV.

Conakry, Guinea

The perception that GBV risk mitigation will create additional work, create parallel systems or require additional resources

Despite concerns, when done in a systematic manner, integrating GBV risk mitigation strategies and activities does not create additional work for humanitarian actors. It does not require additional resources, nor does it require different or new systems for assessment or programme implementation.

In fact, in UNICEF's experience, the opposite can be true. Taking deliberate action to build girls' and women's safety and agency can contribute to strengthening equity in emergencies, upholding 'do no harm' principles, and improving humanitarian outcomes across all sectors. This approach can also save valuable time and resources. For example, when women are consulted about the timing and location of distributions *before* they take place, such distributions can maximize effectiveness and efficiency from the beginning by more effectively reaching the targeted population and avoiding unintended negative consequences – rather than 'learning the hard way' and needing to adjust programmes later. This approach is therefore critical to helping UNICEF better meet the strategic results, commitments and benchmarks set out within the CCCs. Finally, in some settings, GBV risk mitigation across sectors has led to securing greater financial resources for programming, as donors are keen to fund best practices and more effective approaches, including multisectoral programmes.

Negative experiences with gender, protection or GBV-mainstreaming initiatives

When efforts to mainstream gender and protection-related issues across humanitarian programming are overly complicated, too focused on conceptual issues or not framed in a way that is understandable and meaningful, people can be reluctant to engage in mainstreaming initiatives.

To overcome this, efforts to integrate GBV risk mitigation – as well as other gender and protection-related issues – must be presented as understandable, practical and relevant to the work of each sector. This means making sure the issue is presented in the 'language' of each sector and that both the benefits and pathways to GBV integration are clearly explained.

The belief that the IASC GBV Guidelines are only relevant in acute emergency contexts

GBV Guiding Principles

Levels of Participation

The objectives and strategies for building girls' and women's safety set out in the IASC GBV Guidelines are applicable across the development-to-relief-to-development continuum – from before an emergency hits through to recovery and resumption of development priorities. Emergency preparedness is increasingly important as the world faces a greater number of natural disasters, with a greater number of people forced into displacement. The strategies set out in the Guidelines are equally important to consider during preparedness as they are during recovery and regular programming.

Operational and practical constraints

Many humanitarian settings are characterized by operational and practical constraints, from insecurity and lack of access for affected populations to dwindling resources stretched across greater levels of humanitarian need. In some contexts, it may not always be feasible to meet global standards due to lack of capacity, insufficient resources or insecurity; however, even under these circumstances, there are measures that can be taken to mitigate GBV risks. Addressing operational and practical constraints requires GBV and non-GBV actors to identify what is realistic and achievable in a specific context at a certain point in time and be creative in adapting the guidance of the Guidelines to the local context and reality. Even very small interventions or modifications to programming can have a significant impact in terms of girls' and women's safety, dignity and protection. For example, making even simple changes to latrine siting and construction can prevent harassment and violence against girls and women.

Good practice principles applied to GBV risk mitigation

All efforts to address GBV in emergency settings – including those to integrate GBV risk mitigation across UNICEF WASH, Child Protection, Education, Health and Nutrition programming and within UNICEF-led clusters – must reflect **GBV guiding principles** and practices to ensure that:

- An appropriate **level of participation** is adopted, allowing the greatest amount of age-appropriate participation by children, women and different groups in the community according to the circumstances;
- **No harm** is done to individuals or communities because of humanitarian action; and
- The **rights and safety** of girls and women, and especially those of GBV survivors, are promoted at all times.

UNICEF COs should take the following minimum actions to (1) promote **participation**, (2) adhere to standards of **ethics and safety** and (3) maintain a **survivor-centred approach** in all GBV risk mitigation activities throughout the humanitarian programme cycle.

Participation in risk mitigation across sectors and clusters

✔ **Ensure the appropriate level of community participation.**

Gender-sensitive and age-appropriate participation of and consultation with affected communities is crucial to the design of all humanitarian interventions. Ensuring appropriate levels of participation in the assessment, design and implementation of risk mitigation activities helps to ensure the respective needs and perspectives of males and females of different ages are considered. Extra steps may be necessary to ensure girls' and women's voices are adequately heard. Participation is important for ensuring:

- The situation and communities' needs are properly understood and assessed;
- Girls' and women's experiences and perspectives are at the centre of problem analyses and at the centre of identifying solutions to those problems;
- The vulnerabilities, capacities, needs and rights of marginalized groups are recognized and reflected in programming; and
- Community capacity, strengths and positive coping mechanisms are supported and strengthened through humanitarian programming.

The nature, phase and impact of an emergency will determine the level of community participation possible at that point in time. Further, the potential safety risks associated with girls' and women's participation in programme planning and implementation must be considered, and the level and type of participation adjusted accordingly. GBV specialists and girls' and women's representatives will be able to advise on what, if any, safety risks participation presents and how to address them appropriately.

✔ **Provide communities with feedback.**

Where appropriate and safe, information and action generated by all sectoral assessments and programming responses should be shared with communities. Not only is information helpful for communities as they act to improve the safety of children and women; communities also have a right to information collected about them. Care must be taken, however, to not put community members at risk by disclosing information inappropriately (see **Ethics and safety** below).

Ethics and safety

GBV-related assessments and programme interventions, if not done carefully, can actually *increase* the risk of violence for girls and women. In some emergency settings, simply gathering information about GBV can have serious – even life-threatening – implications for survivors, other community members and those involved in collecting information or addressing GBV. Girls and women who do disclose incidents of GBV may face retaliation from perpetrators and their supporters, as well as reprisal from authorities, as can those supporting them. Such retaliation can range from social exclusion to being charged with criminal offences (such as adultery), subjected to further violence, being forced to marry the perpetrator, or even death (in the case of honour killings). Some forms of GBV can be prosecuted under international law as a war crime or under national law; in these cases, perpetrators – including authorities – may view the sharing of information as a threat.

Consider, for example, what could happen to a survivor or community member who discloses that soldiers stationed next to a village have sexually assaulted young women in the community, and that information gets back to the armed group. Even when no identifying information about any particular individual has been revealed, community members in many settings have often been targeted for punishment by the armed group to stop

7 IASC GBV Guidelines, p. 36.

It is the responsibility of all humanitarian actors to work within a protection framework and understand the safety and security risks that women, girls, men and boys face. Therefore, it is extremely important that assessment and monitoring of general safety issues be an ongoing feature of assistance. This includes exploring – through a variety of entry points and participatory processes – when, why and how GBV-related safety issues might arise, particularly as the result of delivery or use of humanitarian services.[7]

them and others from speaking out in the future. Many survivors never disclose what has happened to them due to fear of reprisal.

All UNICEF and partner staff have an ethical responsibility to promote GBV survivors' well-being and to do no further harm through re-traumatizing them or compromising the safety of others in a community. As actors with a mandate for promoting children's and women's rights, UNICEF staff also have the responsibility to promote a 'do no harm' approach with other humanitarian actors.

It is essential to regularly review ethics and safety dimensions of all humanitarian interventions that directly or indirectly address GBV to minimize any potential risks for survivors, community members and staff.

Tools

Further guidance on ethics and safety can be found in **Kit 2: Assessment**.

✔ **Do not ask girls or women directly about their experience of GBV.**

For ethical reasons, emergency-affected girls and women should never be asked directly about their *personal* experiences of GBV. Doing so can be dangerous and traumatic. Instead, sectoral assessments that integrate questions about GBV may inquire generally about girls' and women's safety as it relates to sectoral programming. For example, a WASH assessment might include questions about community perceptions of girls' and women's risks and safety regarding access to latrines, rather than asking girls or women if they have personally experienced sexual assault while using WASH facilities.

Of course, if individuals choose to disclose their personal experience of GBV during a sectoral assessment or to UNICEF or partner staff implementing humanitarian interventions, staff must be able to respond appropriately and provide relevant and helpful information about

Karachi, Pakistan

available services and supports. It is vital that staff have up-to-date information about available services and referral procedures; are prepared to respond to GBV survivors ethically and safely, if necessary; maintain **confidentiality** at all times; and know what to do in the case of GBV affecting children, especially where a child is at imminent risk of further violence, abuse or exploitation.

Confidentiality

✔ **Consider potential safety risks that may arise through UNICEF and partner sectoral assessments and programmes.**

Potential safety problems from collecting and disseminating GBV-related information must be avoided. Consider the safety implications for individuals and communities seen giving sensitive information about GBV issues, especially when GBV is being perpetrated by armed actors. It is vital that staff understand the basic **'dos and don'ts' with GBV data** collection, security and sharing.

Dos and Don'ts with GBV Data

Remember that safety considerations extend beyond the data collection phase of an assessment. It is essential to consider, for example, the risks of insecurely storing sensitive data, such as data pertaining to sexual violence that constitutes a war crime or a crime against humanity. It is also essential to consider potential safety risks created by disseminating GBV-related information inappropriately. Any written reports should *not* give information that may reveal the identity of key informants, breach their confidentiality, or place them or others at risk in any way. Even GBV-related information that does not breach confidentiality must be treated with extreme care, and caution must be taken before sharing. Especially in conflict settings, inappropriate sharing of even very general GBV-related information can result in additional violence, reprisal attacks or other harms.

✔ **Ensure access to basic medical care for rape survivors.**

Ideally, there should a minimum set of health, psychosocial and safety services available for GBV survivors. Establishing these and sharing information about how to access them is the responsibility of GBV actors. However, in some settings, even basic services for GBV survivors are not available, and there is no GBV specialist to advise on how to respond to cases. In such settings, WASH, Child Protection, Education and Nutrition staff should consult with health actors within the country office and from the Health cluster to identify health facilities that can provide clinical management of rape services, and identify what information to give survivors regarding referral and access to services.

A survivor-centred approach

The survivor-centred approach is a cornerstone of GBV prevention and response. Applying a survivor-centred approach is important because it aims to make sure each survivor's rights are at the forefront of all action and that each survivor is treated with dignity and respect. By putting the survivor at the centre of the helping process, this approach promotes the person's recovery, reduces the risk of further harm, and reinforces her agency and self-determination. A survivor-centred approach recognizes that every survivor:

- Has equal rights to care and support;
- Is different and unique;
- Will react differently to violence;
- Has different strengths, capacities, resources and needs;
- Has the right, appropriate to her age and circumstances, to decide who should know about what has happened to her and what should happen next; and
- Should be believed and treated with respect, kindness and empathy.

Survivor-Centred Principles

✔ **Train staff on survivor-centred principles and how to refer a survivor for care and support.**

In case a person discloses a personal experience of GBV during a sectoral assessment or other activity, UNICEF and partner WASH, Child Protection, Education, Health and Nutrition staff should be able to respond with compassion and know how to refer the survivor for appropriate immediate assistance.

UNICEF's approach to addressing GBV across sectors and clusters

Objectives

Integrating GBV risk mitigation across all humanitarian action in line with the IASC GBV Guidelines is a core component of UNICEF's emergency response work. The following are two objectives of UNICEF's work to mainstream GBV risk mitigation across sectors and clusters.

1. To create the safest environment possible for emergency-affected children and women, through:
   a) Ensuring UNICEF and partner staff act in accordance with humanitarian standards and codes of conduct;
   b) Implementing all humanitarian services and assistance in a manner that maximizes girls' and women's safety and minimizes GBV-related risks; and
   c) Ensuring all UNICEF and partner staff have information and skills to provide appropriate support to survivors who come forward for help.
2. To strengthen all of UNICEF's sectoral programming by operationalizing an equity and right-based approach to humanitarian action, and to improve sectoral outcomes in line with benchmarks set out in the CCCs.

Responsibilities

UNICEF headquarters, regional and country offices have specific responsibilities toward building safer environments for emergency-affected communities through GBV risk mitigation. These responsibilities are tied to UNICEF's status as:

- One of the largest UN humanitarian agencies with significant size and scope of emergency programmes across Child Protection, Health, Education, Nutrition and WASH sectors;
- The lead agency for the coordination of Child Protection, Education, Nutrition and WASH;
- An influential advocate championing issues related to the safety and well-being of children and women in emergencies; and
- A lead agency in the development and roll-out of the IASC GBV Guidelines and a global champion for children and women affected by emergencies.

UNICEF is at the forefront of efforts to build capacity and institutionalize GBV mainstreaming across humanitarian action, with dedicated technical support to help COs implement the strategies and actions set out in the IASC GBV Guidelines. This is being done by adopting a flexible approach; adapting the global guidance to the needs of each UNICEF sector and cluster, as well as to each emergency context; and compiling and sharing good practices and lessons learned from implementing the GBV Guidelines in different settings.

Belet Weyne, Somalia

Stakeholders in GBV risk mitigation

Multiple stakeholders must work together to effectively integrate GBV risk mitigation across sectors and clusters in line with the IASC GBV Guidelines. Key stakeholders include: UNICEF and partner sectoral managers and programme staff; cluster coordinators; GBV specialists; cluster lead and member agencies; governments; and communities.

UNICEF and partner sectoral managers and programme staff

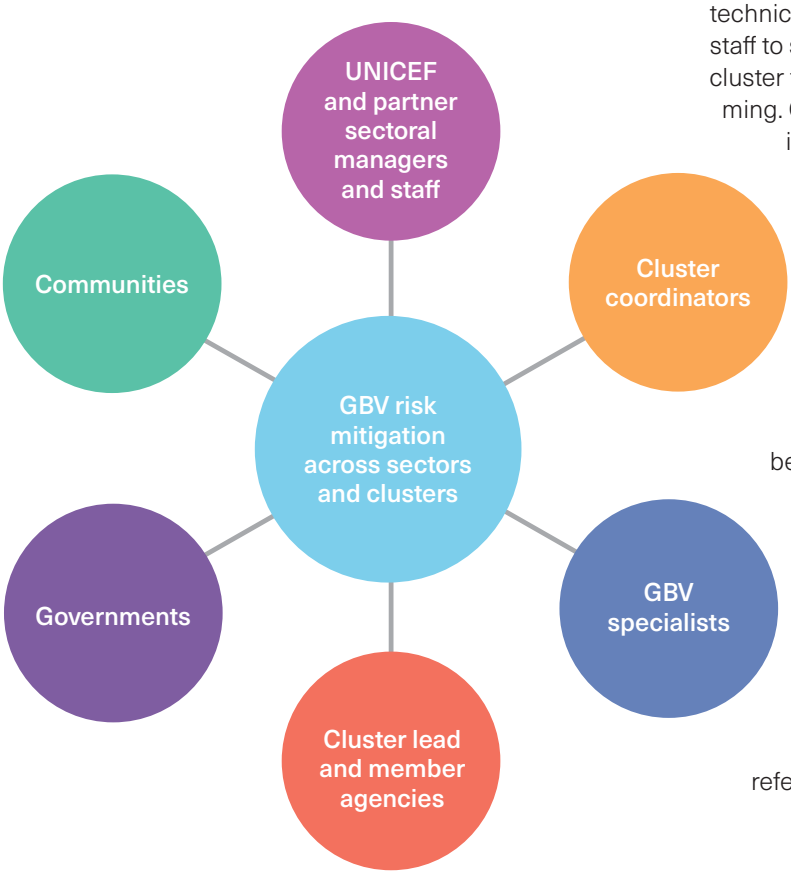
UNICEF WASH, Child Protection, Education, Health and Nutrition managers and staff hold the primary responsibility for integrating GBV risk mitigation across sectoral assessments and programming. When working with implementing partners, UNICEF is responsible for building their capacity on GBV risk mitigation. This includes providing them with training and technical support, as well as integrating recommendations from the GBV Guidelines into funding proposals, project cooperation agreements and other partnership tools, and field monitoring systems.

Cluster coordinators

WASH, Child Protection, Education and Nutrition cluster coordinators hold the primary responsibility for integrating GBV risk mitigation across cluster strategies and processes. Assessments, monitoring tools and cluster reporting mechanisms are good entry points for incorporating recommendations from the GBV Guidelines at the cluster level.

GBV specialists

UNICEF GBV specialists provide training and technical support to UNICEF and partner staff to support each sector and UNICEF-led cluster to integrate GBV across programming. GBV specialists are also involved in the design and implementation of joint programmes addressing GBV, such as programmes that include specialized GBV interventions as well as GBV risk mitigation activities. The *Coordination* section of each thematic area within the IASC GBV Guidelines provides concrete examples of how coordination between GBV specialists and other sectors can contribute to GBV risk mitigation. These include safely integrating GBV-related issues into sectoral assessments; facilitating training for staff of other sectors; and ensuring partners across the humanitarian system have access to up-to-date information on available GBV services and referral mechanisms.



Port-au-Prince, Haiti

Cluster lead and member agencies

All cluster lead and member agencies are responsible for appropriately integrating GBV risk mitigation into their programming in line with cluster strategies and processes. One promising practice is for clusters to designate one or more GBV focal points among their members. The focal points act as liaisons between the cluster and the GBV coordination mechanism; help provide technical support on GBV risk mitigation to other cluster members; and support the cluster coordinators in overseeing implementation of action plans related to GBV interventions.

Governments

States have primary responsibility for upholding the rights of emergency-affected people and communities, and all humanitarian efforts to improve the safety, dignity and rights of girls and women should build national capacity and systems as appropriate to the context. Specific entry points for governments to address GBV include: incorporating GBV risk mitigation into national policies and disaster preparedness/management systems; and promoting GBV capacity-building among government sectoral managers, technicians and service providers, including those in law enforcement, healthcare and education.

Communities

As rights holders, communities not only have the right to participate in all humanitarian decision-making and programming affecting them; they also have responsibilities, capacities and strengths for protecting children and women. Humanitarian programming should seek to build on and support these capacities and strengths. Girls and women, especially, are key stakeholders at the centre of all humanitarian action, and UNICEF and partner efforts to address GBV should promote girls' and women's voices, agency and leadership. Many of the recommendations within the IASC GBV Guidelines aim to increase female participation and leadership throughout all phases of the humanitarian programme cycle.

Steps for integrating GBV risk mitigation across sectors and clusters

Below is step-by-step information to help UNICEF COs integrate GBV risk mitigation across sectoral programming and within cluster response, in line with the IASC GBV Guidelines.

Step 1: Build commitment and capacity within UNICEF country offices, including with senior management and non-programmatic departments within UNICEF.
- 1.1 – Build internal commitment
- 1.2 – Build internal capacity

Step 2: Engage and educate partners, including UNICEF implementing partners and cluster member agencies.
- 2.1 – Inform and educate partners and cluster member agencies

Step 3: Develop and implement risk mitigation strategies across UNICEF WASH, Child Protection, Education, Health and Nutrition programming and UNICEF-led clusters, ensuring that the global recommendations from the IASC GBV Guidelines are appropriately adapted to suit the context.
- 3.1 – Assessment, analysis and planning
- 3.2 – Resource mobilization
- 3.3 – Implementation
- 3.4 – Coordination

Step 4: Monitor progress and evaluate results for continuous learning and improvement in efforts to build girls' and women's safety, dignity and protection.
- 4.1 – Identify relevant indicators and incorporate into sectoral monitoring and evaluation systems
- 4.2 – Ensure cluster monitoring systems and processes reflect GBV-related activities

Step 1: Build commitment and capacity within UNICEF country offices

1.1 Build internal commitment

The leadership and actions taken by humanitarian decision-makers in country have significant influence on the extent to which GBV is recognized as a life-saving priority across all areas of humanitarian response. Positive and proactive leadership also facilitates uptake and implementation of the GBV Guidelines by each humanitarian sector.

In many settings, however, CO management, programming and operational staff are not aware of UNICEF's mandate, commitments and responsibilities for addressing GBV, nor are they familiar with the guidance and tools for mainstreaming GBV risk mitigation across programming. Where such knowledge gaps exist, it is critical that senior managers, as well as programming and operational staff (including those responsible for communications, resource mobilization, supply, monitoring and evaluation, reporting, and other support functions) develop a sound understanding of the issue, how it relates to UNICEF's work, and what effective humanitarian response to GBV looks like.

In COs where there is a UNICEF GBViE or other qualified specialist (such as a gender

specialist), this specialist can take the lead in building awareness of and commitment to GBV risk mitigation among country office colleagues. In settings where there is no GBViE or gender specialist, support will be available through the regional office or headquarters. In addition to GBViE specialists, other staff within Child Protection or other sections – such as the Chief of Child Protection, a gender focal point or any other staff member – should take the lead in advocating for and building knowledge on GBViE, as addressing the issue is a shared responsibility of all UNICEF staff. Regional and headquarters GBV specialists will provide on-site and remote advice and support in such circumstances. The following are key messages for internal advocacy to promote GBV mainstreaming.

- **UNICEF has clear accountabilities and responsibilities for GBViE prevention, mitigation and response.** These stem from UNICEF's mandate, policies, strategy and programming commitments as set out in key organizational documents and in humanitarian guidelines and standards, including the *Core Commitments for Children in Humanitarian Action* (CCCs),[8] the IASC GBV Guidelines[9] and the *Minimum Standards for Child Protection in Humanitarian Action*.[10]
- **As a cluster lead agency, UNICEF is responsible for system-wide action on GBV,** and it must ensure the clusters for which it is responsible integrate GBV risk mitigation activities in line with the IASC GBV Guidelines across all areas of their work in all stages of humanitarian response.
- **Integrating GBV strengthens all of UNICEF's programming;** operationalizes an equity and right-based approach to humanitarian action; and helps to meet the benchmarks set out in the CCCs.

There are many formal and informal opportunities within a CO and within the wider humanitarian system for advocacy and awareness-raising on GBVIE responsibilities. Some examples include:

- Information sessions and team meetings with UNICEF colleagues;
- Written materials and policy briefs for UNICEF and other humanitarian leadership;
- Face-to face meetings with UNICEF managers and leaders; and
- Key events in the humanitarian programme cycle and UNICEF calendar, which can be used as entry points to raise awareness of the IASC GBV Guidelines and to support other sectors to integrate GBV into their planning.

Les Cayes, Haiti

Tools

See **Kit 3.7: Programming – Advocacy** for more information and resources to help build understanding and commitment within the CO to address GBViE.

8 See <www.unicef.org/publications/files/CCC_042010.pdf>.
9 See <https://gbvguidelines.org>.
10 See <www.unicef.org/iran/Minimum_standards_for_child_protection_in_humanitarian_action.pdf>.

1.2 Build internal capacity

Staff within UNICEF WASH, Child Protection, Education, Health and Nutrition sections must have appropriate knowledge to be able to integrate GBV risk mitigation into sectoral programming. Training should be undertaken during preparedness planning wherever possible. Experience shows that training on GBV risk mitigation for sectoral colleagues must be concrete, practical, tailored to the audience and relevant to the context. During emergencies, staff do not need in-depth training on gender concepts; rather, they need easily understood and targeted information on:

- GBViE as a life-saving priority in emergencies, particularly the time-sensitive nature of medical treatment for sexual violence (including post-exposure prophylaxis for HIV and emergency contraception) and the need for immediate referrals;
- The responsibility of all humanitarian actors to have up-to-date information on available GBV services and how to make referrals for life-saving care and support;
- **GBV guiding principles**;
- UNICEF's mandate, commitments and role in GBViE prevention, mitigation and response;
- The distinction between GBV specialized programming and GBV risk mitigation across sectors;
- GBV risk mitigation as an ongoing *process,* rather than a one-time activity or 'tick box' exercise;
- Standards and actions for each sector set out in the Thematic Area Guides of the IASC GBV Guidelines; and
- Available resources and support to assist in implementing GBV risk mitigation (for example, the GBV Guidelines website, technical support staff at regional and headquarters levels, etc.).

GBV Guiding Principles

Resources

- **GBV Guidelines website**
  <http://gbvguidelines.org>
- **Thematic Area Guides**
  - Child Protection
  - Education
  - Health
  - Nutrition
  - WASH
  - Humanitarian Operations and Support Sectors

  IASC (2015)
  <http://gbvguidelines.org/en/additional-resources/print-ready/>

Capacity Development

- **Training Modules on the GBV Guidelines**
  - Module 0: Introduction
  - Module 1: Overview off the GBV Guidelines
  - Module 2: Defining GBV
  - Module 3: GBV in Emergencies
  - Module 4: Responding to GBV Incidents
  - Module 5: Thematic Area Guidance Modules

  <http://gbvguidelines.org/en/training/>

Tools

See **Kit 3.7: Programming – Advocacy** for more information on UNICEF's mandate and commitments on GBV that can be used in training.

Step 2: Engage and educate partners

2.1 Inform and educate partners and cluster member agencies

Making sure UNICEF implementing partners and UNICEF-led cluster member agencies (and, where necessary, other actors such as donors) are knowledgeable about shared responsibilities and humanitarian standards and strategies for addressing GBV is another important step in GBV risk mitigation across sectors and clusters. Like UNICEF staff, partner and cluster member agency staff must be sensitized on the issue of GBV and how to build girls' and women's safety, dignity and protection through WASH, Child Protection, Education, Health and Nutrition programming.

External colleagues need targeted information on:

- GBViE as a life-saving priority in emergencies, particularly the time-sensitive nature of medical treatment for sexual violence (including post-exposure prophylaxis for HIV and emergency contraception) and the need for immediate referrals;
- The responsibility of all humanitarian actors to have up-to-date information on available GBV services and how to make referrals for life-saving care and support;
- Cluster commitments and roles in GBViE mitigation;
- The distinction between GBV specialized programming and GBV risk mitigation across sectors;
- GBV risk mitigation as an ongoing *process,* rather than a one-time activity or 'tick box' exercise; and
- Key messages, standards and actions for each sector set out in the Thematic Area Guides of the IASC GBV Guidelines.

Key messages should be tailored to the audience. For example, training that is targeted to each sector will help clarify the linkages between that sector's work, girls' and women's safety and dignity, and GBV risk mitigation, and it will highlight practical areas for action within sectoral programming. Examples of key messages regarding the relationship between GBV and different sectors are listed below.

Relationship between WASH and GBV:

- Girls and women are often disproportionately affected by WASH issues due to their primary responsibility for collecting water for household use.
- Collecting water can be dangerous and can expose girls and women to the risk of sexual assault as they travel to and from water points.
- Moving around at night to access latrines can place girls and women at risk in secure settings.
- Bathing facilities and latrines located far from dwellings are often the site of sexual assault, especially after nightfall in settings with insufficient or no lighting.
- Bathing facilities and latrines that lock from the inside and are gender-segregated can protect against GBV risk.
- Inadequate or inappropriate sanitary supplies, or lack of access to appropriate ways to maintain/wash these materials, may limit women's and girls' mobility and increase their vulnerability to GBV.

Relationship between Child Protection and GBV:

- Children are directly and indirectly harmed by GBV in emergency contexts.
- Girls can be exposed to higher levels of sexual assault, child marriage, female genital mutilation/cutting (FGM/C) and intimate partner violence.
- Children are harmed by witnessing intimate partner violence – a form of violence that often increases during displacement.

- Even when they are not directly exposed to violence, children are harmed by the damaging effects GBV has on their mothers, who tend to be the primary carers of infants and younger children.
- Unaccompanied and separated children are at particularly high risk of all forms of violence, exploitation and abuse, including GBV.

Relationship between Nutrition and GBV:

- Unsafe access to food distribution sites or nutrition or feeding centres can put girls and women at risk of sexual assault or other violence.
- Families with fewer resources may try to meet the nutritional needs of their daughters by arranging child marriages.
- Girls and women may be forced to exchange sex for food to meet their own and their children's nutritional requirements.
- Disagreements about how to manage limited household food supplies may contribute to intimate partner violence.
- Differential feeding practices when food is scarce can contribute to malnutrition of girls and women.
- GBV can be detrimental to a child's nutrition; for example, injuries or illness caused by GBV can affect a mother's capacity to care for and feed her children, while psychological effects, such as anxiety and depression, can also manifest in reduced capacity to care. Furthermore, in some settings, cultural beliefs around sex and breastfeeding can cause rape survivors to discontinue breastfeeding their infants.
- Failure to appropriately address GBV through nutrition programming can have the following effects:
  - Worsening rather than improving the nutritional status of children affected by GBV;
  - Exacerbating pre-existing vulnerabilities;
  - Creating protection risks and human rights violations for children and women, thereby causing harm to affected populations;
  - Reducing the overall efficiency and effectiveness of UNICEF's nutrition programming; and
  - Negatively affecting UNICEF's ability to achieve nutrition commitments and benchmarks set out in the CCCs and other relevant humanitarian standards.

Not only does GBV mainstreaming impact the well-being, safety and protection of emergency-affected children and women; it also contributes to UNICEF's achievement of commitments and benchmarks across all sectors.

Resources

- **GBV Guidelines website**
  <http://gbvguidelines.org>
- **Thematic Area Guides**
  - Child Protection
  - Education
  - Health
  - Nutrition
  - WASH
  - Humanitarian Operations and Support Sectors

  IASC (2015)
  <http://gbvguidelines.org/en/additional-resources/print-ready/>

Capacity Development

- **Training Modules on the GBV Guidelines**
  - Module 0: Introduction
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  - Module 2: Defining GBV
  - Module 3: GBV in Emergencies
  - Module 4: Responding to GBV Incidents
  - Module 5: Thematic Area Guidance Modules

  <http://gbvguidelines.org/en/training/>

Gaza, Palestine

Step 3: Develop and implement risk mitigation across sectoral and cluster programming

Developing and implementing strategies for integrating GBV across sectors and clusters involves taking specific actions within each phase of the humanitarian programme cycle, as set out in the IASC GBV Guidelines:

3.1 Assessment, analysis and planning;

3.2 Resource mobilization;

3.3 Implementation; and

3.4 Coordination.

Note: Monitoring and evaluation are addressed under **Step 4: Monitor progress and evaluate results**.

Tools

GBV Risk Mitigation Tool 1: Sector Audit Checklist for Integrating GBV Risk Mitigation Across Programming

3.1 Assessment, analysis and planning

GBV risk mitigation within UNICEF WASH, Child Protection, Education, Health and Nutrition sector assessment, analysis and planning

The *Assessment* section of the IASC GBV Guidelines identifies sector-specific 'Areas of Inquiry, with suggested questions sectors can use to inquire about GBV-related concerns in sectoral programming, policies, and communications and information sharing. The questions are designed to be *integrated into each sectors' existing assessment* tools where they exist, although sectoral staff may also be supported to design new tools as required.

The Guidelines provide details for each sector on who to assess, when to asses and how to assess GBV-related issues.

Addressing GBV-Related Risks in WASH Assessments and Initial Programme Design

Addressing GBV-Related Risks in Health Assessments and Initial Programme Design

The following are key points for consideration when **addressing GBV-related risks in UNICEF WASH**, **Health**, Child Protection, Education and Nutrition assessments and initial design.

- In general, GBV-related components of sectoral assessments should focus on potential safety issues related to interventions (seeking the inputs of girls and women where safe and appropriate to do so); potential barriers women and girls may face in accessing services; sector staff's knowledge of available GBV services; and their ability to safely and appropriately provide referrals to survivors.
- Efforts should be made to include the voices of women, girls and other potentially at-risk groups. However, assessors must take special care to ensure that consulting with individuals does not create additional safety risks. (See **Kit 2: Assessment** for additional information on ethics and safety related to GBV assessments.)
- Sectoral assessments should not attempt to collect information related to the scale and/or scope of GBV that is occurring. Under no circumstances should assessments seek to identify individual survivors or perpetrators. Survivors should never be sought out for information collection purposes.
- While assessments are an important foundation for programme design, there are some basic, proactive risk mitigation strategies that can and should be undertaken immediately, such as ensuring sex-segregated and lockable latrines and ensuring separate accommodation for female-headed households, single women and separated/unaccompanied girls.
- In addition to assisting with the modification of assessment tools to include GBV-related issues, GBV specialists can support colleagues in other sectors by helping them to analyse their existing data through a gender or GBV 'lens'. Essentially, this means taking information that may seem unrelated to GBV and examining it from the perspective of women's and girls' safety and/or access to services. For example, if sex-disaggregated nutrition data shows that malnutrition rates are higher for girls than for boys, this could be a direct indication of GBV (in the form of denying food to female children) and/or a signal of other access issues that impede female children from accessing nutrition services (for example, through school feeding programmes).

GBV risk mitigation within UNICEF-led cluster assessment and planning processes, including WASH, Child Protection, Education and Nutrition

UNICEF cluster coordinators are responsible for the following actions to ensure that GBV risk mitigation is integrated within cluster assessments, analysis and planning.

- Introduce the IASC GBV Guidelines during preparedness planning or in the first days of the response in cluster/sector meetings (sharing information about the various communication media through which partners can access them, such as print, Internet, phone apps, etc.).
- Work with GBV specialists to develop appropriate assessment questions related to GBV risk mitigation, and obtain advice on data collection for cluster/sector-specific assessments.
- Include relevant Guidelines recommendations in cluster/sector guidance for cluster reporting (through the 3/4/5Ws, etc.).

Tools

GBV Risk Mitigation Tool 2: WASH Assessment and Monitoring Tool

GBV Risk Mitigation Tool 3: WASH Facility Privacy and Safety Checklist

See *Section 3: Rapid GBV Assessments* in this book.

3.2 Resource mobilization

Resource mobilization for GBV risk mitigation across UNICEF WASH, Child Protection, Education, Health and Nutrition sector programming

The *Resource Mobilization* section of the GBV Guidelines provides tips for addressing GBV in sectoral funding proposals, as well as tips on other types of resources required for GBV risk mitigation, including human resources and supplies.

Some examples of resource considerations for UNICEF sectors when integrating GBV risk mitigation into programming include the following:

- **WASH** – pre-position dignity kits and other supplies to support women's and girls' menstrual hygiene needs.
- **Education** – procure uniforms, menstrual hygiene management materials and other school supplies to support girls' school attendance/retention.
- **Child Protection** – include materials for activities aimed at adolescents in child-friendly space kits.
- **Health** – procure and pre-position drugs and supplies for the clinical management of rape (note: while in many contexts, supplies for the clinical management of rape may be managed by other agencies and/or through other channels, UNICEF should always help to ensure appropriate drugs and equipment for treating child survivors are available alongside the general supplies).
- **All sectors** – procure printed copies of the relevant Thematic Area Guides from the IASC GBV Guidelines; printed copies of the GBV referral pathway to post in key locations, such as UNICEF-supported learning facilities and nutrition centres; and pocket cards containing referral information to distribute to sector staff.

Resource mobilization for GBV risk mitigation within WASH, Education, Child Protection and Nutrition clusters

UNICEF cluster coordinators are responsible for the following actions to help mobilize funding for mainstreaming GBV risk mitigation across cluster agency programming:

- Use information collected on GBV risk factors when drafting cluster-specific proposals, and draw on the Guidelines' recommendations to inform funding proposals.
- Work with national counterparts at different levels of government to ensure national disaster management strategies and programmes include budgeting for GBV activities.
- Advocate with donors on the importance of GBV integration within sectoral interventions and, where necessary, educate them on the shared responsibilities and humanitarian standards for mainstreaming protection-related concerns across all humanitarian action.

3.3 Implementation

Implementing GBV risk mitigation strategies within UNICEF WASH, Child Protection, Education, Health and Nutrition sector programming

The Implementation section of each Thematic Area Guide in the IASC GBV Guidelines sets out strategies and actions to help UNICEF WASH, Child Protection, Education, Health and Nutrition sections effectively integrate GBV risk mitigation into sectoral programming. The strategies and actions are focused on three areas: programming; policies; and communications and information sharing.

UNICEF WASH, Child Protection, Education, Health and Nutrition staff need to ensure that relevant strategies are reflected in sectoral programmes during the design phases of emergency response. Equally

importantly, the strategies and activities must be adjusted over time as the context and circumstances evolve and new risks – as well as solutions and capacities for addressing them – emerge.

The need for ongoing attention to GBV risk mitigation highlights that addressing girls' and women's safety, dignity and empowerment is not a 'one-off' activity; rather, it is a process that needs to be embedded within humanitarian action throughout all phases of humanitarian response.

Sexual Exploitation and Abuse

Resources

- **GBV Guidelines website**
  <http://gbvguidelines.org>
- **Thematic Area Guides**
  - Child Protection
  - Education
  - Health
  - Nutrition
  - WASH
  - Humanitarian Operations and Support Sectors

  IASC (2015)
  <http://gbvguidelines.org/en/additional-resources/print-ready/>

Some examples of activities undertaken by UNICEF sectors in different stages and types of emergencies are highlighted in the next column and on the following pages. These examples are neither prescriptive nor exhaustive; rather, they serve to illustrate different ways in which UNICEF sectoral teams are undertaking and adapting GBV risk mitigation activities in different settings.

WASH

- **Provide menstrual hygiene management materials and information.** Addressing the hygiene management needs of women and girls not only promotes their dignity; it also targets GBV-related vulnerabilities by improving school attendance and retention for female students and teachers; allowing women girls to move freely at all times; freeing up household income to purchase other necessities; and reducing vulnerability to sexual exploitation and abuse.
- **Deliver WASH services at the household level.** Providing services, especially water, at the household level reduces girls' and women's exposure to attacks and exploitation associated with collecting water from communal water points.
- **Build safer WASH facilities.** This includes identifying risks related to WASH facility structure and placement and implementing solutions to these risks (e.g., ensuring latrines are closable and lockable, well-lit and gender-segregated).

Tools

See *Section 5.3: Dignity Kit Programming* in this book.

Resources

- **Gender-Responsive Water, Sanitation and Hygiene: Key elements for effective WASH programming**
  UNICEF (2017)

Gao, Mali

Karachi, Pakistan

Child Protection

- **Implement child-friendly space programming.** Incorporating a range of GBV information, education and support services into child-friendly spaces can help mitigate the risk of GBV. This can include creating education curricula to equip both adolescent girls and boys with knowledge and skills to reduce and prevent violence; training staff to identify and respond appropriately to child survivors of GBV and those at risk of sexual violence, child marriage and other forms of GBV; and building curricula to increase girls' confidence and build their resilience.
- **Target adolescent girls.** Adolescent girls' assets, resources and resilience against GBV can be built upon by providing them with access to information, education, peer support, and economic and social empowerment activities.
- **Target married girls and those at risk of child marriage.** This can include providing married girls and those at risk with a confidential place to discuss challenges they face at home (particularly communication challenges with older husbands), psychosocial support, case management, and referrals to appropriate and specialist services, including reproductive healthcare. It can also include advocating with governments to secure access to education for married girls.
- **Coordinate with others.** Ensure strong linkages and coordinated referral systems between Child Protection specialized services, GBV specialized services and other relevant humanitarian assistance (such as Nutrition and Education) to meet the needs of child survivors, girls at risk of GBV and the children of survivors.

Tips for GBV-related awareness-raising

Any GBV-related public information or awareness-raising materials must be developed in consultation with GBV specialists. Poorly designed materials can be ineffective and can even do more harm than good – for example, when messages inadvertently reinforce social norms that contribute to GBV.

All GBV-related information and awareness-raising materials must include information about available services. If no services are available, raising awareness about GBV should not be the priority, as it is not ethical to raise awareness of a problem without having appropriate responses in place for survivors who wish to seek help.

Tools

See *Section 5.3: Safe Space Programming* in this book.

Education

- **Create safer school facilities.** Approaches for improving the safety of schools and temporary learning centres include conducting safety audits and safety plans to identify and address unsafe locations, including routes to and from school; providing access to safe, gender-sensitive school latrines; implementing codes of conduct for teachers and education staff; and linking educational facilities to GBV referral mechanisms.
- **Promote equity in access to education.** Ensure equal access of girls and boys to temporary learning sites and schools by identifying reasons why girls might not be attending; addressing any bottlenecks wherever possible; addressing menstrual hygiene management needs of female students and teachers/staff; and adapting educational programming as necessary to accommodate married girls and adolescent mothers.
- **Strengthen educational staffing and curricula.** This includes supporting the development and implementation of national codes of conduct for teachers; increasing recruitment, retention and capacity of female teachers; and incorporating information about gender equality and GBV into educational curricula.

Health

- **Promote safe access to healthcare.** To effectively mitigate against GBV, humanitarian actors must consider safety in relation to girls' and women's access to health facilities, such as risks associated with travelling to and from health centres. Consideration must also be given to barriers to access such as costs of care, including reproductive healthcare. Wherever possible, outreach and mobile services should be provided to those with limited or unsafe access to facilities.
- **Recruit and retain female health workers.** Increasing the number of female nurses, mid-wives and doctors in facilities, as well as female community health workers, can help to facilitate the delivery of health information and messages. It can also create additional entry points for survivors and those at risk of GBV to access support and referrals to other services.
- **Build capacity of national health facilities.** Increasing the availability and quality of GBV-related services, including clinical management of rape and referral for psychosocial support and safety services, is essential in emergencies. Health facilities must also have the capacity to manage, treat and meet the needs of child survivors.

Tools

See *Section 4: Responding to GBV Survivors in Emergencies* in this book.

Nutrition

- **Address GBV risks associated with food distribution.** This includes identifying safety risks and threats during food collection, as well as those that manifest at the household level (e.g., intimate partner violence associated with food availability or use, or gender-based nutritional deprivation).
- **Increase safe access to nutrition services.** To effectively mitigate against GBV, nutrition/feeding services for children must be safe for women and children to access.
- **Build capacity of nutrition staff on GBV.** This includes providing training on GBV basics and how to safely and appropriately provide referrals to survivors. It also includes ensuring all nutrition staff have up-to-date information on available GBV services.

Implementing GBV risk mitigation strategies within UNICEF WASH, Child Protection, Education, Health and Nutrition clusters

UNICEF cluster coordinators are responsible for the following actions (separated into programming, policies, and communications and information sharing, as per the IASC GBV Guidelines) to ensure GBV risk mitigation is integrated into UNICEF-led clusters.

Programming

- Promote the employment and retention of women and other at-risk groups as members of staff, and advocate for their active participation and leadership in all sector/cluster-related community activities. This needs to be done with regards to cultural barriers to women's employment, as well as to the potential risks and safety problems this can cause in such settings.
- Work with the GBV coordination mechanism to contextualize the GBV Guidelines for the setting and for each cluster/sector.
- Advocate for cluster/sector partners to reference the GBV Guidelines to inform their programming responses. For example:
    - Attend training on the Guidelines and support cluster/sector membership to attend trainings on the Guidelines; and
    - Promote guiding principles for working with GBV survivors into all responses.
- Plan and implement programmes in an inclusive way so that women, girls and other at-risk groups contribute to programme design and implementation.
- Develop cluster/sector strategies that specifically note GBV risks and how cluster programmes can address these. Take advantage of GBV specialists to enhance cluster/sector programming interventions.
- Create or modify existing tools, and develop additional guidance to support the integration process, as needed.

Policies

- Support the revision and adoption of national, local and customary laws and policies relevant to the cluster that promote and protect the rights of girls, women and other groups at risk of GBV.
- Support the implementation of the UN Secretary-General's Bulletin on *Special measures for protection from sexual exploitation and sexual abuse (*ST/SGB/2003/13), which outlines six core principles for preventing sexual exploitation and abuse that apply to all UN personnel and to staff of partner organizations.
- Develop and implement cluster work plans with clear milestones that include GBV-related inter-agency actions.
- Drawing, as necessary, upon GBV specialists or cluster staff who have attended trainings on the GBV Guidelines, incorporate relevant GBV mitigation strategies into cluster organizational policies, standards and guidelines, and circulate them widely (e.g., standards for equal employment of men and women; procedures to share information on GBV incidents; and cluster procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse).

Communications and information sharing

- Ensure all individuals working in the sector have access to up-to-date information on available GBV services and have been sensitized on how to safely and appropriately provide referrals for survivors.
- Ensure all individuals understand the basics of safe and ethical GBV information sharing, such as confidentiality and informed consent.
- Share experiences of integrating the GBV Guidelines' recommendations into different cluster responses and how this has contributed to an effective response.
- Share cluster/sector strategies that address GBV risks with global clusters and in inter-cluster meetings.

Tips for successfully integrating GBV risk mitigation within sectors and clusters

While GBV risk mitigation is an emerging area of practice, UNICEF has made a concerted effort globally to implement strategies and actions set out in the IASC GBV Guidelines. The following recommendations and tips for success are based on experience across many different settings.

- **Seek technical support.** Support, input and guidance from GBV specialists is highly linked to success. Ongoing collaboration with GBV specialists helps to ensure that GBV risk mitigation initiatives are effective and that they uphold the principle of 'do no harm'. Even when there is no GBV specialist based in the operational location, it is possible to use creative methods of remote collaboration to assess risks and implement and monitor strategies for addressing them. For example, using photos or videos of issues of concern (such as men and women sharing the same latrines, poorly constructed doors, ripped plastic sheeting, etc.) can help to illustrate problems and realities on the ground. Such information sharing must always be done while paying attention to the affected populations' rights to privacy and safety, and due consideration must be given to any potential risks it may create.
- **Consider sustainability from the outset.** Each context brings its own challenges regarding the sustainability of services. These may relate to insecurity, lack of infrastructure or capacity, or decreasing donor funding. Even in difficult circumstances, however, it is both possible and important to consider an exit strategy, focusing on supporting national and local systems and capacity as appropriate.
- **View GBV risk mitigation as an ongoing process,** rather than a one-time activity or 'tick box' exercise.
- **Work collaboratively.** Conduct joint training and workshops involving staff of multiple sections within UNICEF, or multiple clusters, as well as GBV actors. This fosters holistic planning and problem-solving to mitigate GBV risks. It also creates opportunities for GBV actors to learn about the work and challenges of other sectors so they can better understand how to most effectively support sectoral efforts moving forward.
- **Tailor messages and how they are delivered to target audiences.** When it comes to GBV risk mitigation, there are many different stakeholders and potential allies, all of whom are facing their own demands and challenges. To effectively advocate for the importance and added value of integrating GBV risk mitigation into sectoral and cluster programming, it is important to understand the audience and design messaging in a way that will reflect their perspective and level of understanding.
- **Start at the local level and build up.** Generate successes and lessons at the field level, and use these experiences to inform/guide the national-level approach, rather than designing a top-down approach.
- **Acknowledge success and learn from each other.** It is important to recognize successes and innovations by sectors and clusters implementing GBV-related activities and provide an opportunity for other sectoral actors or clusters to learn from success and collaborate on new initiatives.

Tips for GBV specialists supporting sectoral risk mitigation efforts

The following are additional tips for GBV specialists who are supporting the integration of GBV risk mitigation into sectors and clusters.

- **Work collaboratively and focus on building relationships.** Present GBV risk mitigation as a collaborative effort, rather than an oversight, evaluation and/or criticism of other sectors. Create working relationships based on collaboration, problem-solving and mutual support rather than highlighting failures or gaps.
- **Be practical, concrete and creative.** Make practical and achievable recommendations for adapting global guidance to the realities of each situation.
- **Work collectively and learn from others.** Conduct joint workshops involving more than one sector as well as GBV actors. This allows for more holistic strategizing and planning on ways in which different UNICEF sectors might coordinate to mitigate GBV risks. It also creates an opportunity for GBV actors to learn about the day-to-day work and challenges of other sectors and promotes greater understanding of how to most effectively support their efforts moving forward.
- **Promote sectoral/cluster efforts and successes.** Use cluster meetings, inter-cluster working group meetings, and other humanitarian decision-making and coordination processes as an opportunity to recognize and highlight sectoral and cluster efforts to integrate GBV risk mitigation.
- **Highlight linkages between sectoral programming and GBV risk mitigation.** Use reporting (such as donor reports, situation reports, annual reports, etc.) as an opportunity to document and highlight linkages between sectoral programming and GBV risk mitigation that might not be immediately evident.
- **Share and promote good practices, experiences and tools.** Develop and share case studies on effective/promising practices, and share newly developed resources and tools with GBV and sectoral colleagues at UNICEF headquarters and regional offices, as well as with the global inter-agency support team overseeing the roll-out of the GBV Guidelines.

Citrana, Oecuss, East Timor

Moroto, Uganda

3.4 Coordination

Within the GBV Guidelines, the guidance on *Coordination* falls into two categories:

1. Areas where sectors can/should seek the support of GBV specialists; and
2. Opportunities where two or more sectors can coordinate to reduce GBV risks.

Under the first category, all sectors are encouraged to **coordinate with GBV specialists** to:

- Design and conduct assessments that examine GBV risks related to the sector's programming, and strategize with those working in the sector about ways these risks can be mitigated;
- Provide trainings for those working in the sector on issues of gender, GBV and women's/human rights;
- Identify where survivors who may report instances of GBV can receive safe, confidential and appropriate care, and provide staff with the basic skills and information necessary to respond supportively to survivors; and
- Provide training and awareness-raising for the affected community on issues of gender, GBV and women's/human rights as they relate to the sector.

There are also coordination-related activities that can reduce GBV-related risks without necessarily involving GBV specialists. For example, some good practice examples of **coordination between UNICEF sections** include:

- *WASH and Education* – Design and construct WASH facilities at learning centres that are sex-segregated, safe and accessible and otherwise mitigate the risk of GBV.
- *Nutrition and Health* – Integrate information on GBV-related health services into infant and young child feeding programmes.
- *Health and Child Protection* – Ensure child-friendly health facilities and medical treatment for child survivors of GBV.
- *Child Protection and Education* – Monitor routes to educational settings and highlight particularly unsafe areas for children and adolescents.

Step 4: Monitor progress and evaluate results

UNICEF is committed to evidence-based practice as well as to learning and accountability across all programming, including in emergencies. Monitoring and evaluation enable UNICEF to continually improve its performance and achieve results for children and women. The growth of GBV programming in humanitarian settings, including GBV risk mitigation across clusters and sectors, coupled with a need for greater accountability and evidence of the effectiveness of humanitarian action, means that more attention is being paid to the evaluation of interventions.

4.1 Identify relevant indicators and incorporate into sectoral monitoring and evaluation systems

Each thematic area of the GBV Guidelines includes sample indicators that can be used or adapted for monitoring and evaluation. Following the structure of the document, the indicators for each sector are organized in accordance with the humanitarian programme cycle. They have been designed to be incorporated into *existing* sectoral monitoring and evaluation systems without the need for developing additional tools and processes. A few examples of **indicators for UNICEF programmatic sectors** include:

- **WASH:** % of affected areas that have sex-segregated and lockable WASH facilities
- **Child Protection:** % of placements for separated/unaccompanied children that are receiving visits to monitor GBV-related risk factors
- **Education:** % of schools/learning sites with a referral mechanism for GBV survivors; % of active-duty education staff who have signed a code of conduct
- **Health:** % of health facilities with clinical staff who are trained on clinical management of rape and other forms of GBV
- **Nutrition:** % of affected persons who participate in nutrition committees who are female

Basra, Iraq

A note on GBV-related report data

Cluster monitoring should focus on risk mitigation activities; it should never seek to capture any information pertaining to survivors or to reported cases of GBV. This is the responsibility of GBV specialized actors and services, and it is not appropriate for other sectors to use indicators related to GBV survivors under any circumstances.

GBV actors capture report and service-related data and, where safe to do so, share appropriate information regarding any change in the numbers of reported cases over time. However, any change in report rates is not a measure of success or failure of risk mitigation efforts – instead, changes in report rates generally reflect an increase in availability, access and quality of services.

The GBV Guidelines emphasize the importance of monitoring and evaluation as a tool for informing and strengthening programming. In this regard, failing to meet a set target can actually provide a useful learning opportunity. For example, if a sector has aimed to reach at least 50 per cent female respondents but falls short of reaching that target, those implementing the programme may consider changing the time and/or location of the consultations, or speaking with the affected community to better understand the barriers to female participation.

In addition, monitoring and evaluation that applies a gender or GBV 'lens' to data analysis can reveal valuable information – such as potential safety concerns and/or barriers to services faced by women and girls – even when the data on its own may not seem directly related to GBV. For example, a decline in school attendance or retention rates for girls, without a corresponding decrease for boys, could be an indication of GBV occurring in, around or on the way to school; girls dropping out early to be married; lack of appropriate supplies for menstrual hygiene management; or other factors. To determine the cause of the decline, additional investigation and analysis would be needed (ideally with the support of GBV specialists); however, the initial 'red flag' raised by the original data is valuable nonetheless.

4.2 Ensure cluster monitoring systems and processes reflect GBV-related activities

UNICEF WASH, Child Protection, Education and Nutrition **cluster coordinators have the following additional responsibilities:**

- Integrate relevant, contextualized indicators from the GBV Guidelines into regular cluster monitoring activities, and share reports with GBV coordination mechanisms, Humanitarian Country Teams, Inter-Cluster Working Groups and other stakeholders;
- Develop monitoring systems that allow the cluster to track their own GBV-related activities (e.g., including GBV-related activities in the 3/4/5Ws); and
- Advocate for the inclusion of questions related to the effectiveness of GBV risk mitigation in all cluster assessments and evaluations.

Tools

GBV Risk Mitigation Tool 2: WASH Assessment and Monitoring Tool

GBV Risk Mitigation Tool 3: WASH Facility Privacy and Safety Checklist

See **Kit 4: Evaluation** for information about different evaluative activities UNICEF uses for GBV programming in emergencies.

Info Sheets – Integrating GBV Risk Mitigation Across Sectors and Clusters

Humanitarian Standards for GBV Mainstreaming

All humanitarian actors, regardless of the sector in which they work, have a responsibility to design, plan and implement their interventions in a way that minimizes protection risks and maximizes safety, particularly for women, girls and other potentially at-risk groups. This responsibility is clearly articulated in the following humanitarian standards:

SPHERE Humanitarian Charter (2011): "Protection is a core part of humanitarian action and the Protection Principles point to the responsibility of all humanitarian agencies to ensure that their activities are concerned with the more severe threats that affected people commonly face in times of conflict or disaster… Those involved in humanitarian response take steps to avoid or minimize any adverse effects of their intervention, in particular the risk of exposing people to increased danger or abuse of their rights." [1]

IASC Principals' Statement on Centrality of Protection in Humanitarian Action (2013): "Protection of all persons affected and at risk must inform humanitarian decision-making and response, including engagement with States and non-State parties to conflict. It must be central to our preparedness efforts, as part of immediate and life-saving activities, and throughout the duration of humanitarian response and beyond. In practical terms, this means identifying who is at risk, how and why at the very outset of a crisis and thereafter, taking into account the specific vulnerabilities that underlie these risks, including those experienced by men, women, girls and boys, and groups such as internally displaced persons, older persons, persons with disabilities, and persons belonging to sexual and other minorities." [2]

IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action (2015): "All humanitarian actors must be aware of the risks of GBV and – acting collectively to ensure a comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation… Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations." [3]

1 See <www.sphereproject.org/>.
2 See <https://interagencystandingcommittee.org/sites/default/files/centrality_of_protection_in_humanitarian_action_statement_by_iasc_princi.pdf>.
3 See <http://gbvguidelines.org/>.

UNICEF CCCs and GBV Prevention and Response

- *UNICEF's Core Commitments for Children (CCCs) in Humanitarian Action*[1] shape UNICEF's global framework for humanitarian response. The CCCs set out minimum standards for UNICEF's response and promote predictable, effective and timely collective action for children in humanitarian settings.
- The CCCs state that UNICEF will:
  - Monitor and analyse the situation of children, adolescents and women on an ongoing basis, directly and with partners, to ensure joint rapid assessments and timely humanitarian response; and
  - Support humanitarian action based on rapid assessments conducted with partners and affected populations, including children, adolescents and women. These assessments, conducted through joint inter-agency mechanisms or independently, are the first critical step in defining humanitarian response.
- The commitments directly related to preventing and responding to GBV are shown in the following box.

CCCs related to GBV

Health Commitment 2: Children and women access life-saving interventions through population- and community-based activities.

Health Commitment 3: Key health education and behaviour change communication (BCC) messages are disseminated.

WASH Commitment: Toilets in learning environments are equipped with soap and are child-friendly, private, secure and appropriately segregated by gender.

Child Protection Commitment 1: Effective leadership is established for both the Child Protection and GBV areas of responsibility, with links to other cluster/sector coordination mechanisms on critical inter-sectoral issues.

Child Protection Commitment 5: Violence, exploitation and abuse of children and women, including GBV, are prevented and addressed.

Education Commitment 3: Safe and secure learning environments that promote the protection and well-being of students are established.

HIV and AIDS Commitment 2: Children, young people and women access HIV and AIDS prevention, care and treatment during crises.

Human Resources Commitment 3: Sexual exploitation and abuse by humanitarian workers is prevented.

1 See <www.unicef.org/publications/files/CCC_042010.pdf>.

GBV Guiding Principles

UNICEF's GBViE programming is based on evidence and learning from multiple settings on effective approaches and strategies for addressing GBV against girls and women. This evidence and learning is captured in a set of principles that underpin UNICEF's GBV programming.

These principles include the following:

1. GBV is a fundamental and unacceptable violation of human rights, and efforts to address it should be grounded in a rights-based approach.

All girls and women have the right to live free from GBV, including in situations of conflict and disaster. Survivors have the right to health, safety, protection from further violence, and justice. Duty bearers, including the international community, have obligations to uphold these rights, including in emergencies.

2. Ending GBV involves tackling gender inequality and harmful social norms.

Preventing GBV involves promoting gender equality and supporting beliefs and norms that foster equitable, respectful and non-violent relationships. Ending discrimination and inequality based on gender lies at the heart of ending GBV against girls and women.

3. Comprehensive approaches are required to address GBV.

A comprehensive approach bridges development and emergency programming and involves adopting a coordinated, multi-level and multi-sectoral approach. A multi-level approach highlights the importance of structural-, systemic-, community- and individual-level interventions, while a multi-sectoral approach emphasizes the need for coordinated engagement across sectors for preventing, mitigating and responding to GBV.

4. Strong partnerships are essential for holistic, coordinated action against GBV.

No single agency, organization or sector has the skills, resources or mandate to address GBViE alone. Preventing and responding to GBV requires collaborative action and partnerships across sectors/clusters and must involve States, affected communities and other stakeholders. Partnerships must be built and fostered across UNICEF sectors and programmes; across humanitarian actors and clusters; with State and non-State duty bearers; and with civil society and communities.

5. Participation is vital for effective GBV prevention.

Genuine participation by rights holders and communities is empowering, fosters ownership of the problem and ensures locally appropriate solutions to it. The participation and agency of affected people – especially children, adolescents and women – are central in all GBViE efforts throughout programme assessment, design, implementation and monitoring. Without genuine and significant participation from girls, boys and women, major risks may go unidentified, and prevention strategies and suitable responses will be inadequate.

6. Ethical and safety considerations are paramount.

Humanitarian actors have an ethical obligation to do no harm. Ethical and safety dimensions of *all* GBV activities must be considered prior to taking action. Safety of survivors, their supporters, community members and staff is a priority consideration in GBV assessments, programming, monitoring and evaluation in emergencies.

7. A survivor-centred approach is a cornerstone of GBV work.

The safety, rights, dignity and empowerment of GBV survivors is a priority at all times. A survivor-centred approach aims to make sure that each survivor's rights are at the forefront of all action; that each survivor is treated with dignity and respect; and that the person's agency is recognized and supported.

A survivor-centred approach is applied in practice by making sure quality services are available and accessible, and by applying a set of survivor-centred principles to guide the work of everyone – no matter what their role is – in all interactions with survivors.

There are four interrelated and mutually reinforcing principles or standards for behaviour that apply at all times to all actors: *promoting safety, confidentiality, self-determination* and *non-discrimination.*

When working with child survivors, additional considerations for being survivor-centred include making sure that staff are trained in obtaining permission from a child to collect information in an age-appropriate manner.

Levels of Participation

Source: Active Learning Network for Accountability and Performance in Humanitarian Action and Groupe URD, *Participation handbook for humanitarian field workers – Involving crisis-affected people in a humanitarian response*, ALNAP, London, 2009, pp. 39–44.[1]

- In humanitarian situations, a participatory approach means involving crisis-affected people in the humanitarian response in whatever way, and to whatever extent is possible, in a given context.
- Participation makes a humanitarian response more efficient, effective and relevant to real needs, and it can help identify the most appropriate way of meeting those needs.
- Crisis-affected people can be directly involved in humanitarian responses on an individual level or indirectly via community representatives. In both cases, special care should be taken to ensure that the most vulnerable and socially marginalised people are involved, and that this involvement is done with care and intentionality so as not to risk further harm to these populations.
- There are different ways to involve people in humanitarian responses, and different approaches can be used to continually improve participation throughout the life cycle of a project.
- In order to adopt a genuinely participatory approach, we must not think of those who are affected by a crisis as 'victims', 'beneficiaries, or 'recipients', but as dynamic social actors with capacities and strengths are able to take an active role in decisions affecting their safety and welfare. This shift in perception is of fundamental importance.
- The following table outlines a typology of participation that reflects the different ways humanitarian organizations interact with crisis-affected people, from simply informing them about a humanitarian response, to providing support for local initiatives.

Typology of participation (adapted from Pretty, J.)

Type of participation	Description
Passive participation	The affected population is informed of what is going to happen or what has occurred. While this is a fundamental right of the people concerned, it is not one that is always respected.
Participation through the supply of information	The affected population provides information in response to questions, but it has no influence over the process, since survey results are not shared and their accuracy is not verified.
Participation by consultation	The affected population is asked for its perspective on a given subject, but it has no decision-making powers and no guarantee that its views will be taken into consideration.
Participation through material incentives	The affected population supplies some of the materials and/or labour needed to conduct an operation, in exchange for payment in cash or in kind from the aid organization.

1 Available at: <www.alnap.org/resource/8531>.

Type of participation	Description
Participation through the supply of materials, cash or labour	The affected population supplies some of the materials, cash and/or labour needed for an intervention. This includes cost-recovery mechanisms.
Interactive participation	The affected population participates in the analysis of needs and in programme conception, and has decision-making powers.
Local initiatives	The affected population takes the initiative, acting independently of external organizations or institutions. Although it may call on external bodies to support its initiatives, the project is conceived and run by the community; it is the aid organization that participates in the people's projects.

Tips for promoting participation

Source: Groupe URD, *Participation by Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners*, ALNAP, London, 2003, pp. 15–16.

Successful participation relies first and foremost on the attitude of those engaged in humanitarian action.

Be aware… of the local context and its social and cultural dynamics, of political divisions and lines of power, and of the stakes and potential pitfalls. Being conscious of this enables one to be cautious without being suspicious, to tailor one's expectations to current realities and to avoid undue disappointments. It is central to gaining the respect of those whom you seek to engage.

Listen, observe… with your eyes and with your ears, but, also, with the eyes and the ears of those who you are trying to understand, assist or protect. Bear in mind that affected populations have a holistic and integrated view of their own needs and strategies, and that the earlier you involve them, the greater their motivation to engage in a joint venture. Empathy and reflected understanding can go a long way to making a complex process manageable.

Pay attention to the human factor. Despite all efforts to develop and apply methods to improve the process of participation, successes and failures can often be attributed to the presence of the right person with the right attitude, understanding and skills, being in the right place at the right time. Pay utmost attention to the composition of your team, and allow time to breathe and to deliberate.

Enjoy! At the heart of participation is a meeting of different individuals, cultures, skills, beliefs and values. This is an opportunity to learn and to share experiences; humanitarian aid workers can benefit as much as affected populations.

Confidentiality

What is confidentiality?

- Confidentiality refers to the right of a person to have any information about them treated privately and with respect. Confidentiality is a basic principle of working with survivors of GBV; it is important for restoring the dignity of the survivor and for reducing social stigma and blame. Survivors have the right to keep information about themselves private in the same way every person has the right to privacy regarding personal information, such as health status.
- Information about a GBV incident or case should never be shared publicly. Those involved in responding to GBV should never discuss details of a case outside of their work or with anyone not related to the case.
- People sometimes think that confidentiality means never telling anyone anything about a case. This is not what confidentiality means. For example, a case worker might discuss issues related to a case with her supervisor. She needs to do this in order to get supervision and make sure she is providing the best possible service.
- People involved in a case may discuss details about the case with each other to make sure they are coordinating and meeting all of a survivor's needs and rights.
- At all times, it is essential that we inform a survivor or her caregiver about who will be involved in a case and why. If they object, we must take their objection seriously and look at why they are objecting; they likely have a good reason for objecting, and we need to listen and find out more.

Limited confidentiality

- 'Limited confidentiality' refers to situations in which there may be legal or other obligations that override the individual's right to confidentiality. Such 'limited confidentiality' applies in the following circumstances:
    - When there are concerns about a person's safety and well-being or the safety of others; and/or
    - When it is believed a criminal offence has been committed, and there are laws that obligate reporting to police or other authorities. In situations in which legal requirements override the person's permission, the survivor or her caregiver should be made aware of the legal requirements.

Communicating with survivors about confidentiality

- Guaranteeing confidentiality can be an important way of building trust, particularly with adolescents. However, it is not acceptable to promise confidentiality and then break it. In fact, we should never start a conversation with survivors by promising that we will not tell anyone what they have said. What we *do* explain to them is what the limits of confidentiality are in that context.

- The first step in addressing complex issues of confidentiality, trust and the rights of survivors is to identify what the limits to confidentiality are in your context.
  - How is confidentiality related to cases of GBV being dealt with now?
  - Does it reflect the best interests of child survivors?
- After agreeing between actors about the limits of confidentiality, it is important to make sure this information is communicated to survivors at the beginning of an interview.

Mandatory reporting

- All response actors need to understand the laws and obligations on mandatory reporting of sexual violence and other forms of GBV.
- Mandatory reporting can conflict with ethical principles in working with survivors of GBV, including confidentiality and self-determination. It can be complex: for example, when for example, when mandatory reporting results in an action that is not in the survivor's best interest, such as being removed from her family and placed in an institution or punished.

See related **Info Sheet** on:

Mandatory Reporting of Child Abuse

Dos and Don'ts with GBV Data

Adapted from: Gender-Based Violence Information Management System Steering Group, 'Guidance Note: GBVIMS Dos and Don'ts'; [1] and UN Action Against Sexual Violence in Conflict, 'Dos and Don'ts: Fact Sheet on Sexual Violence,' UN Action, New York, 2008.

Data security

DO store, use, and share GBV data safely and securely.

- ✔ Always check and double check security of data; do not assume data is safe.
- ✔ Assess data protection and ensure major identified gaps are filled before collecting GBV incident information.
- ✔ Store case files in a locked cabinet.
- ✔ Protect electronic files with a password.
- ✔ Only share case-based data to designated persons for clear, necessary reasons.
- ✔ Put a plan in place for destroying paper-based files in the event of evacuation in highly insecure environments.
- ✘ **Don't** assume that data is safe because there are no names on files or the data is only used within your organization (for example, piling case files on a desk or asking a colleague to carry intake forms in an unsealed envelope to another office).
- ✘ **Don't** ignore the importance of creating a sound coding system.

Data sharing

DO establish an Information Sharing Protocol with other organization before data is shared.

- ✔ Establish an Information Sharing Protocol with other actors to determine how data will be shared, protected and used, and for what purpose, before data is shared. This includes with Child Protection Working Groups, MRM and MARA Working Groups, PSEA Networks and any other relevant coordination mechanisms.
- ✘ **Don't** start sharing or asking for GBV data unless proper and agreed upon protocols are in place.

DO share GBV data in the form of aggregated statistics for purposes of identifying trends in GBV incident reporting.

- ✔ When decided as part of an Information Sharing Protocol or when agreed upon with all service providing organizations, it is appropriate and encouraged to share GBV data for purposes of identifying trends in GBV incident reporting, facilitating coordination, improving services and monitoring programmes. Be sure shared data is anonymised,

1 Available at: <www.gbvims.com/wp/wp-content/uploads/GBVIMS-Guidance-Note-Dos-and-Donts-Final.pdf>.

meaning no names, addresses or other directly identifiable information is included. Also, consider that just because such information is not shared, it does not mean data is safe and truly anonymous, respecting survivor confidentiality. For instance, sharing that a disabled child in Block A of the camp reported an incident may be identifying information even though the name is not included. Each and every instance of data sharing should be scrutinized by users to ensure confidentiality and safety for survivors, their communities and the organizations assisting them. Information on individual survivors, including their name and other identifiable information, is often shared for inappropriate reasons and without survivor consent.

✕ **Don't** share or ask for identifiable data (such as name) as a regular practice.

✕ **Don't** publish or share GBV statistics if doing so will cause any security or safety issues for survivors, their communities, organizations or agencies.

DO add context about any shared or published GBV statistics, as appropriate.

✓ Caveats on what GBV data represents must be issued with any analysis of GBV data, including that the statistics are based on the reporting of incidents to a particular type of service provider. Users must emphasise that GBV data cannot provide a clear understanding of incidence or prevalence in a given population. The analysis should also give perspective on the programmatic circumstances and relevant security, cultural and political context during the specified period concerned by the data.

✕ **Don't** publish or share GBV statistics without accompanying contextual analysis.

DO limit the sharing of individual case information to service provision referrals and only with the survivor's informed consent.

✓ There are times when it is necessary to share individual case information through a referral form to facilitate referral and access to a service without the survivor having to repeat the information about the incident already given to the first service provider. Using a survivor-centred approach means that the survivor has control at all times over the information related to the GBV incident. Detailed information about the specific case should only be shared outside the service provider to a specific actor for a determined purpose if the survivor consents. In rare situations, it may be necessary to share a case file, for example:

- If total care/support of a survivor is being transferred because an organization is pulling out or the survivor is moving to a new location where another organization will provide support (with survivor consent); or
- If it is a case of sexual exploitation and abuse involving a child.

✕ **Don't** mandate that service providers submit individual case files (i.e., intake or incident report forms) as routine reporting.

✕ **Don't** share case files without the consent of the survivor and only on extraordinary occasions according to the needs of the survivor.

Reporting

- ✓ **Do assess the risks associated with sharing data.** For example, if an assessment report details allegations of sexual violence by armed groups, is there a risk that the armed groups indicated will retaliate against the community?
- ✓ **Do keep in mind the audience and possible use.** If information on GBV is being shared with the media, donors or policymakers, make sure clear and comprehensive guidance is offered on the interpretation of the information. Briefing notes may help.
- ✓ **Do label all tables, charts and maps appropriately** to avoid being taken out of context, and clearly state the sources for any data cited.
- ✗ **Don't share data that may be linked back to an individual or group of individuals.**
- ✗ **Don't take data at face value:** assess original sources, including their quality/reliability.
- ✗ **Don't assume reported data on GBV or trends in reports represent actual prevalence in GBV.**

Survivor-Centred Principles

A survivor-centred approach to GBV response is based on a set of guiding principles that guide the work of all helpers – no matter what their role is – in all of their interactions with GBV survivors.

Survivor-centred principles are interrelated and mutually reinforcing; for example, confidentiality (principle 2) is essential to promote safety (principle 1) and dignity (principle 3). The principles are described below.

Principle 1: Right to safety

Safety refers to both physical security as well as a sense of psychological and emotional safety. It is important to consider the safety and security needs of each survivor, their family members and those providing care and support.

In the case of conflict-related and politically motivated sexual violence, the security risks may be even greater than usual.

Every person has the right to be protected from further violence. In the case of child survivors, every child has the right to be protected from sexual and other violence; as adults, we all have responsibilities to uphold that right.

Why is safety important?

Individuals who disclose sexual violence or other forms of GBV may be at high risk of further violence from the following people:

- Perpetrators;
- People protecting perpetrators; and
- Members of their own family due to notions of family 'honour'.

Principle 2: Right to confidentiality

Confidentiality promotes safety, trust and empowerment. It reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned.

Why is confidentiality important?

- Confidentiality promotes safety, trust and dignity.
- Confidentiality reflects the belief that survivors, including children, have the right to privacy and to choose who should know about what has happened.
- Breaching confidentiality inappropriately can put the survivor and others at risk of further harm.
- If service providers and other helpers do not respect confidentiality, other survivors will be discouraged from coming forward for help.

Exceptions to confidentiality

In several situations there are exceptions to confidentiality, and it is very important that survivors, including children and their caregivers, are not led to believe that nothing they say will be shared.

Helpers need to understand and communicate the exceptions to confidentiality, such as:

- Situations in which there is the threat of ongoing violence or harm to a child, and the need to protect the child overrides confidentiality;
- Situations in which laws or policies require mandatory reporting of certain types of violence or abuse;
- Situations in which the survivor is at risk of harming themselves or others, including thoughts of suicide; and
- Situations involving sexual exploitation or abuse by humanitarian or peacekeeping personnel.

Principle 3: Dignity and self-determination

GBV is an assault on the dignity and rights of a person, and all those who come into contact with survivors have a role to play in supporting their dignity and self-determination. For example, survivors have the right to choose whether or not to access legal services and other support services.

Failing to respect the dignity, wishes and rights of survivors can increase their feelings of helplessness and shame, reduce the effectiveness of interventions, and cause re-victimization and further harm.

Principle 4: Non-discrimination

All people have the right to the best possible assistance without unfair discrimination on the basis of sex, gender, age, disability, race, colour, language, religious or political beliefs, sexual orientation, status or social class.

Best interests of the child principle

Every child is unique and will be affected differently by violence. Decisions and actions affecting them should reflect what is best for the safety, well-being and development of that particular child.

The primary purpose of intervening is to provide care, support and protection for individual children – not to meet other objectives.

Strategies for ensuring the best interests of the child include the following:

- Take an approach that takes the individual circumstances of each child into account, including their family situation and their particular vulnerabilities and strengths, and prioritize their needs for safety, protection, and physical and mental health above other needs.
- Listen to the voice and perspective of the child and take their wishes into consideration.

- Protect the child from further emotional, psychological and/or physical harm.
- Empower children and families.
- Examine and balance benefits and potentially harmful consequences of each decision or action affecting a child.
- Promote recovery and healing.

See related **Info Sheets** on:

Mandatory Reporting of Child Abuse

Working with Child Survivors of Sexual Abuse

Obtaining Permission from a Child

Sexual Exploitation and Abuse

All forms of sexual exploitation and abuse (SEA) by humanitarian and peacekeeping personnel are a gross violation of human rights and an abuse of a position of power over vulnerable people. SEA can lead to serious and sometimes life-long consequences for those who are victimized and their families. Further, SEA has wider negative impacts: it undermines the integrity and reputation of the UN and other humanitarian actors, and it can threaten the security of staff and operations, hindering UNICEF and the wider UN from achieving its mission.

Although there has been a decrease in reports, incidents of SEA by UN civilian and military personnel against women and children continue to occur. Underreporting of all forms of sexual violence, including SEA, is widely acknowledged. Recently, sexual harassment and sexual assault of humanitarian workers by fellow staff has also been reported publicly.

The problem of sexual exploitation and sexual abuse by humanitarian workers and peacekeepers is not new; allegations surfaced in numerous conflict-affected settings in the 1990s. However, the release of a report detailing serious and widespread misconduct and abuse of children in West Africa by aid workers and peacekeepers in 2002 brought international attention and condemnation to the issue.

In response to the allegations, the Inter-Agency Standing Committee (IASC) established a task force in 2002 and developed six core principles on SEA.[1] These principles are:

- Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- Sexual activity with children (persons under the age of 18) is prohibited regardless of the local age of consent. Mistaken belief in the age of the child is not a defence.
- Exchange of money, employment, goods or services for sex, including favours or other forms of humiliating, degrading or exploitative behaviour is prohibited. This includes the exchange of assistance that is due to beneficiaries.
- Sexual relationships between staff members and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- Where a member of staff develops concerns or suspicions regarding sexual abuse or exploitation by any person, whether in the UN or not, s/he must report such concerns via the prescribed procedure.
- UN staff members are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of this code of conduct.
- Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.

These principles were incorporated into a zero tolerance policy toward SEA perpetrated by UN and partner personnel. This policy is outlined in the Secretary-General's 2003 Bulletin, *Special measures for protection from sexual exploitation and sexual abuse* (ST/SGB/2003/13). The Bulletin serves as a Code of Conduct (CoC) for UN and partner personnel and prohibits sexual relations in the context of one person taking advantage of another person, regardless of the victim's age. It also prohibits all sexual relations with children under 18 years of age.

1 Available at: <www.pseataskforce.org/uploads/tools/sixcoreprinciplesrelatingtosea_iasc_english.doc>.

Transactional sex is banned. Although the policy does not prohibit all sexual relations with members of the local population, most are considered unequal due to the vulnerability of conflict- and disaster-affected people and the relative power held by humanitarian and peacekeeping personnel, and they are therefore "strongly discouraged."

A comprehensive approach to addressing SEA

UNICEF country offices (COs) must undertake multi-dimensional actions to effectively prevent SEA from occurring and to ethically and appropriately respond to all allegations and complaints of SEA involving humanitarian and peacekeeping personnel. Key pillars of action include: (i) management and coordination of CO efforts to address SEA; (ii) effective systems and procedures for confidentially and effectively reporting and responding to SEA allegations and complaints; (iii) proactive prevention measures; and (iv) community outreach and education related to the issue.

Management and coordination

Implementing comprehensive prevention and response to SEA requires strategic and coordinated action, best implemented via a well-resourced CO SEA action plan. This plan must be championed by senior management and must set out clear accountabilities for all managers and staff.

In addition to coordination across CO departments and programmes, inter-agency coordination is a core component of action to prevent and respond to SEA.

Systems for reporting and responding to SEA allegations and complaints

Each and every report or allegation of SEA received by UNICEF must be appropriately followed up on by COs. In the case of allegations involving children, the Notification Alert must be followed.[2] Responding to allegations also involves providing appropriate care, support and protection for survivors, as well as following procedures for internal reporting set out in the Notification Alert.

2 The UNICEF Notification Alert can be found at the end of this Info Sheet. Contact Child Protection in Emergencies Section at Headquarters for additional UNICEF SEA prevention and response resources and training materials.

Preventive measures

Steps can and must be taken to reduce the likelihood of UNICEF or partner staff breaching the code of conduct and perpetrating sexual abuse or exploitation. COs must take steps to mitigate the risk of staff engaging in SEA-related misconduct in the same way that risks of other misconduct, such as theft, are minimized. Preventive action centres on increasing staff compliance with behavioural standards set out in the Secretary-General's Bulletin *Special measures for protection from sexual exploitation and sexual abuse* (ST/SGB/2003/13)[3] and related UNICEF policies. It also involves strengthening organizational practices such as improving staff recruitment and management processes, building safer partnerships and implementing protective programming.

Community outreach and education

Community members have both a need and a right to access information regarding protection from SEA by humanitarian and peacekeeping personnel, as well as the UN's zero tolerance approach toward it. Providing community members with age-, sex- and ability-appropriate information about how to safely report SEA complaints, and initiating efforts to build trust with communities so that people are willing to come forward and make complaints, are both vital for ending impunity for SEA by humanitarian and peacekeeping personnel.

Challenges in preventing and responding to SEA

It is important to be aware of the complexities and challenges inherent in SEA prevention and response. Sexual violence is a sensitive issue, and even in well-resourced, stable settings, there are significant obstacles to reporting and responding to sexual assault, as well as to coordinating multi-stakeholder preventive action. A common challenge across settings is the underreporting of sexual violence. Survivors are often reluctant to report their experience of sexual assault due to feelings of shame, intense social stigma, and victim-blaming attitudes and behaviours from those around them. Survivors who speak out often face the threat of retaliation in the form of further violence or harassment from perpetrators and/or those supporting the perpetrators. This challenge is further exacerbated in humanitarian settings. Although the following list is not exhaustive, it highlights some of key challenges faced in unstable and/or resource-poor emergency contexts.

A lack of appropriate GBV response services: Poor quality or limited access to health, safety and psychosocial services means survivors may be less likely to come forward, increasing the risk of further harm. It can be extremely difficult to provide appropriate care and assistance to survivors of SEA who do come forward when there are limited or poor quality services available. Further, a lack of legal services may prohibit survivors from asserting their legal rights, where these rights exist.

The nature and context of abuse and exploitation: SEA includes a spectrum of activities and behaviours: some involve the use or threat of force or violence, while others do not outwardly appear to be coercive. For example, in some instances of sexual exploitation, survivors may 'consent' to the activity and therefore not consider it abusive. In such cases, there is often an economic incentive to exchange sexual activity for resources for survival and a subsequent disincentive to report: the survivor may not wish to lodge a complaint or have the matter investigated because of the economic consequences it may cause. In these cases, it is not uncommon for survivors to 'disappear' rather than agree to participate in an

3 See the website of the Inter-Agency Standing Committee Protection from Sexual Exploitation and Abuse Taskforce for this and other SEA-related policies and documents: <www.pseataskforce.org/>.

investigation. In other settings, behaviours that are considered culturally or socially acceptable may constitute abuse or exploitation according to the UN definition.

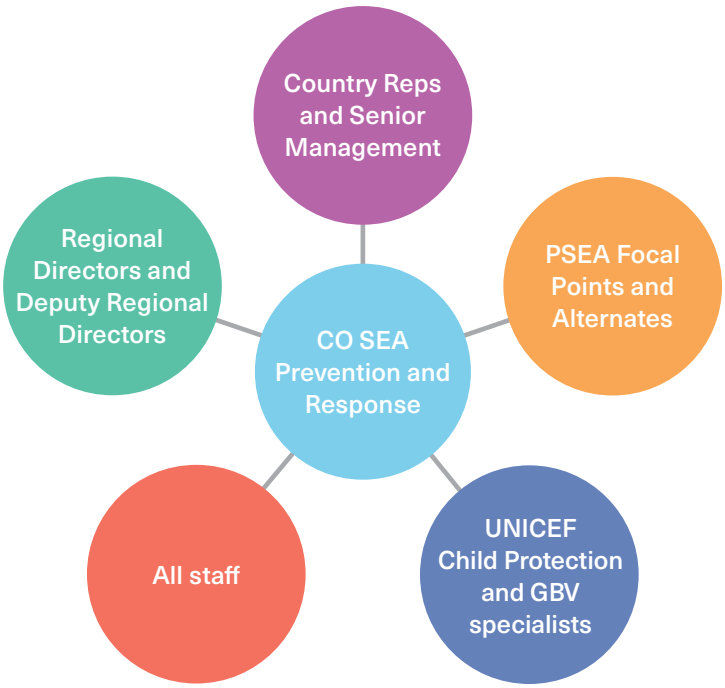
Evidentiary issues: Although the burden of proof is lower for establishing a breach of the UN's code of conduct (as opposed to proving criminal responsibility), it can be very difficult to prove SEA. There are rarely witnesses, and even when there are, they may be afraid of participating in investigations. This problem is compounded in situations where survivors are not the complainant in a case.

Maintaining a survivor-centred approach in conditions of mandatory reporting: A survivor-centred approach to sexual violence affirms the rights of survivors to confidentiality and self-determination – including the right to decide whether or not to formally report the incident. Upholding the full rights of survivors to confidentiality and self-determination is not always possible in the context of mandatory reporting of SEA. Further, maintaining anonymity and safety of survivors and witnesses can also be difficult.

Inconsistent investigative and disciplinary procedures: UN staff, including civilian staff and police, are disciplined by the UN through administrative sanctions, such as fines, dismissal or repatriation, whereas military personnel are disciplined according to the rules of the troop-contributing country. Communities rarely make distinctions between different arms of the UN; therefore, poor practices amongst one organization or entity can reflect badly on the entire UN country mission.

Inadequate resources and technical capacity: Implementing comprehensive SEA prevention and response measures requires resources, specialist knowledge and skills, and adequate capacity – which have not always been prioritized in the past. Further, the issue of SEA has not always been taken seriously by the humanitarian community in some settings.

Accountabilities, roles and responsibilities for preventing and responding to SEA



Senior management staff at all levels are accountable for preventing and responding to SEA. The procedures to report, respond to and monitor allegations of SEA, in line with the Notification Alert, and to take effective actions in preventing SEA, are carried out in coordination with the Division of Human Resources, Supply Division, Office of Internal Audit and Investigation (OIAI) and the Legal Adviser. The specific roles and responsibilities of those offices are identified and explained in other documents.

Regional Directors and Deputy Regional Directors

Regional Directors and Deputy Regional Directors are responsible for:

- Holding in-country management to account regarding their roles and responsibilities for SEA prevention, reporting and response strategies and providing support in identifying adequate resources for implementation;
- Taking appropriate action with regard to onward reporting of alleged cases of SEA, noting in particular the Notification Alert; and
- Supporting the management of external communications concerning an SEA case, particularly media management.

Country Representatives/Heads of Office and other senior managers

UNICEF Country Representatives and senior managers, including Heads of sub or zonal offices, are accountable for taking action to prevent and respond to SEA at country level. This includes operationalizing the four steps for reporting and responding to SEA allegations, noted above.

PSEA Focal Points and Alternates

PSEA Focal Points and Alternates have a significant role in preventing and responding to SEA. They are responsible for:

- Receiving and reporting onward all complaints, reports and questions about alleged acts of SEA committed by UNICEF personnel and personnel of other entities whenever approached;
- Confirming that records are kept, information is held confidentially and appropriate reporting takes place, in line with local reporting procedures; and
- Reporting to the UNICEF Representative or other senior manager, such as the Head of a field office.

The PSEA Focal Point or Alternate is never responsible for questioning or dismissing an allegation, deciding if or how to proceed with an allegation, or making decisions regarding investigations.

UNICEF Child Protection and GBV specialists

Child Protection and GBV staff are often the first to be notified of an SEA incident or allegation. They are also likely to have the expertise and skills to engage with and support victims. Key responsibilities of UNICEF Child Protection and GBV specialists include:

- Supporting PSEA Focal Points, Alternates and other designated staff at field level to identify appropriate referral services and establish protocols for referring victims; and
- Providing guidance and advice to Focal Points and Alternates regarding victims' rights and the best interests of the child throughout the reporting and assistance processes.

UNICEF staff members and related personnel

Regardless of their contractual status, all UNICEF staff and related personnel have the following responsibilities in preventing and responding to SEA:

- Abiding by the standards of behaviour set out in the UN SEA Code of Conduct;
- Reporting all information regarding allegations, suspicions or complaints of SEA to designated Focal Points or supervisors; and
- Contributing to a climate and culture of zero tolerance for SEA in the workplace and community by promoting the rights of women and children to be free from all forms of violence.

Country office checklist for preventing and responding to sexual exploitation and abuse

Reporting	
UNICEF Head of Office is immediately informed of SEA allegations by UN staff or related personnel.	◯
Notification Alert is activated within 24 hours of receipt of an SEA allegation. Allegation is reported using the Significant Incident Report (SIR) for SEA.	◯
Within 12 hours after receiving the SIR, Regional Director makes a decision whether to inform NYHQ.	◯
Where PSEA Task Force has been established by the UNCT, UNICEF informs Task Force as appropriate.	◯
Country Representative consults UNICEF Legal Adviser and other relevant staff to determine the appropriate procedures for reporting to national authorities.	◯
Country Representative reports SEA allegations involving UNICEF staff and related personnel following the Notification Alert and confirms follow-up actions are taken.	◯
Response	
Appropriate information, support, referral and victim assistance are provided or facilitated for child victims of SEA (and adult victims of SEA allegedly perpetrated by UNICEF staff or related personnel) throughout the reporting and investigation process and during follow-up, as needed. Victim assistance includes safety, medical care, psychosocial support, legal services and case management. Relevant Child Protection colleagues are involved in identifying available services and referral procedures for child victims.	◯
OIAI is informed of SEA allegations.	◯

Monitoring	
Mechanisms are in place for monitoring response and follow-up of allegations, including the quality of victim assistance provided by UNICEF and its partners to address the child's safety, health and psychosocial needs, and access to legal assistance. UNICEF's accountability for monitoring SEA response also includes assistance to adult victims of SEA allegedly perpetrated by a UNICEF staff or related personnel.	◯
Mechanisms are in place for monitoring ongoing investigations.	◯
Prevention	
A PSEA Focal Point and Alternate are designated in each CO and each sub or zonal office and are trained on SEA prevention and response.	◯
Focal Points' and Alternates' responsibilities are reflected in Performance Appraisal Reports.	◯
CO is active in inter-agency PSEA Task Force and advocates for establishment of Task Force where it does not exist.	◯
Appropriate linkages are facilitated with other relevant coordination forums.	◯
Victim assistance services are mapped to determine the availability and quality of medical, psychosocial and legal services.	◯
Protocol is established for referring SEA victims.	◯
Victim assistance services are established or strengthened.	◯
PSEA training and capacity-building of partners, peacekeepers and relevant troops is supported.	◯
All staff are trained on SEA and the Code of Conduct.	◯
The Code of Conduct and key UNICEF policies related to SEA reporting, response and prevention are translated into the main local languages and prominently displayed throughout the CO.	◯
SEA awareness is promoted to build staff knowledge and commitment to zero tolerance of SEA.	◯
Senior managers are trained on how to identify and respond to staff stress.	◯
Staff are advised of disciplinary procedures.	◯

Prevention (continued)	
GBV prevention and mitigation strategies are incorporated into the policies, standards and guidelines of sectoral programmes.	◯
Communities, especially children and women, are consulted on how to make community-based complaint mechanisms accessible, safe and confidential.	◯
Community-based complaint mechanisms are established and announced in UNICEF operational areas.	◯
Provisions are in place for anonymous reporting of SEA.	◯
Mechanisms are in place to provide feedback to communities on measures taken to prevent and respond to SEA.	◯

Essential SEA prevention and response resources

- **UNICEF Minimum Operating Standards for Protection from Sexual Exploitation and Abuse (MOS-PSEA):** Contact Child Protection in Emergencies, Programme Division, Headquarters for a copy.
- **UNICEF Notification Alert package:** Reporting Allegations of Sexual Exploitation and Abuse of Children by UN Personnel or by Foreign Military Personnel Associated with a UN Mandate – contact Child Protection in Emergencies, Programme Division, Headquarters for a copy.
- **UNICEF SEA package** (Eng, Fr): Guidance on conducting child interviews for investigations, Child Interview Monitoring Checklist, SEA UNICEF Training presentation – contact Child Protection in Emergencies, Programme Division, Headquarters for a copy.
- **UNICEF's Standard Programme Cooperation Agreement,** available at: <https://intranet.unicef.org/pd/pdc.nsf/caf1cccd04786f1285256c870076516b/b972e7beaf90edba85257e0a0069239e?OpenDocument>.
- **UNICEF Child Safeguarding Policy,** available at: <https://intranet.unicef.org/pd/pdc.nsf/0/B91A2CD30AA64B2685257FE9007254A4/$FILE/CF%20EXD%202016%20006%20Child%20Safeguarding%20Policy.pdf>.
- **Secretary-General's Bulletin on Special measures for protection from sexual exploitation and sexual abuse** (ST/SGB/2003/13), available at: <www.pseataskforce.org/uploads/tools/1327932869.pdf>.
- **IASC Standard Operating Procedures for Community-Based Complaints Mechanisms (CBCMs),** available at: <https://interagencystandingcommittee.org/accountability-affected-populations-including-protection-sexual-exploitation-and-abuse/documents-51>.
- **IASC AAP/PSEA Best Practice Guide on Inter-Agency Community-Based Complaints Mechanisms (CBCMs),** available at: <https://interagencystandingcommittee.org/accountability-affected-populations-including-protection-sexual-exploitation-and-abuse/documents-50>.

UNICEF Notification Alert to Senior Management: Reporting Allegations of Sexual Exploitation and Abuse of Children by UN Personnel or by International Military Personnel Associated with a UN Mandate

Allegations must be reported to UNICEF senior management

- All UNICEF Personnel have a duty to report to UNICEF senior management allegations of sexual exploitation and abuse of children by UN Personnel or by international military personnel associated with a UN mandate. Reports must be made urgently once an allegation is received. The steps for making these reports (including the template form to use) are set out on the following page.
- Reporting allows UNICEF senior management to make sure the Organization is taking appropriate steps to help the children involved, to stop any on-going exploitation and abuse, and to trigger appropriate investigations and possible referrals to law enforcement.

Who must report what, when, and to whom?

- **Who has to report?** "UNICEF Personnel" means, for these purposes, all staff members; UNVs working with UNICEF; people deployed to UNICEF under Stand-by Personnel arrangements or on reimbursable or non-reimbursable loans; interns; personnel deployed to UNICEF through an employment agency or similar arrangements; and individuals who have a consultancy contract with UNICEF.
- **What has to be reported?** Allegations of sexual exploitation and abuse of children by UN Personnel. Given the nature of the actions involved, all allegations should be reported. However, making an allegation in bad faith against someone or embellishing an allegation are strictly prohibited; appropriate steps will be taken against anyone who does so.
    - "Sexual exploitation and abuse" have been defined in various instruments issued by UNICEF and the UN, but all allegations of sexual conduct by UN Personnel with children – including attempted or threatened conduct of a sexual nature – must be reported. This is especially so if the allegation involves actual or threatened violence or inducements such as protection, food, shelter, or the like. An analysis of whether such conduct meets the technical definitions can occur at a later phase of the process.
    - "Children" also has a definition, and all allegations involving someone who appears or claims to be under 18 must be reported.
    - "UN Personnel" means staff members of the UN Secretariat or any UN System Organization (including UNICEF), UNVs working with any such organization, people deployed to a UN System Organization under Stand-by Personnel arrangements or on reimbursable loans, interns, people deployed to a UN System Organization through an employment agency or similar arrangements, gratis personnel, and individuals who have a consultancy contract with a UN System Organization. It also includes the employees or consultants and sub-contractors of UN System Organizations, civil society implementing partners, and contractors or suppliers. In addition, it includes all personnel associated with international or regional military forces operating as part of a UN Peacekeeping Mission or otherwise under a UN mandate. "International military personnel associated with a UN mandate" is self-explanatory.

- **When Must the Allegations be Reported?** Allegations must be reported urgently once they are received. The maximum time frames for reporting are set out in the matrix below.
- **To Whom Must the Report be Made?** The report must be made directly to the head of the UNICEF office where the person making the report is assigned. That might be a Country Office or a zonal- or sub-office. That person then has obligations to report to more senior colleagues within UNICEF and the UN System at country level. The reporting protocols from there are set out in the matrix below.

Special notes:

- If you are in doubt about whether something has to be reported, report it.
- UNICEF expects that our government partners and donors, UNICEF national committees, civil society implementing partners (local and international), vendors and suppliers, and organizations with a corporate consulting contract with UNICEF, and the employees of all of these, will also report such allegations to UNICEF.

Reporting steps

Step 1

Immediately after receiving an allegation of actual, attempted, or threatened, sexual exploitation and abuse of a child by any UN Personnel, UNICEF Personnel must inform the Head of Office where he or she is assigned. The Head of Office must immediately inform the UNICEF Representative in the country, or the acting Representative, if the initial report is made at a sub- or zonal- office. This report should be made by whatever means is fastest and easiest, e.g., in person, by phone, by text, by email.

Step 2

Within 24 hours after he or she receives the report, the UNICEF Representative must report the allegation to the UNICEF Regional Director.

- The report must be made in writing, using the Significant Incident Report (SIR) for Sexual Exploitation and Abuse (SEA). First reports are often incomplete and may contain details that are later found to be inaccurate. The SIR for SEA may be revised later. All information available at the time of making the report must be included except the names and identifying information of the child which must be removed from all written documents and communications; that information (if known) is to be retained at Country Office level under strict confidentiality.
- The SIR for SEA form requires the Representative to report on steps taken to support the child and his/her family. The SIR for SEA also requires the Representative to express a view on whether the allegation is credible.
- In all cases, the Representative must also inform the most-senior UN official in country (e.g., SRSG of UN Mission, or UNCT RC/HC). This report is provided orally, with an email follow up making clear that the allegation has not been assessed or investigated. The SIR for SEA is a confidential internal UNICEF document and is not provided outside UNICEF.

Step 3

Within 12 hours after he/she receives the SIR for SEA, the Regional Director reviews the information and makes a decision, using his or her best judgment, whether to inform NYHQ. If the Regional Director decides to inform NYHQ, this is done by forwarding the SIR for SEA (with the relevant section of the SIR/SEA completed by the Regional Director):

- Deputy Executive Director Programmes with copy to:
  - Deputy Executive Director Management
  - Chief of Staff (OED)
  - Director Programme Division
  - Director EMOPS
  - Associate Director PD (Child Protection)
  - Country Representative

- If the alleged perpetrator is a UNICEF staff member, UNV working with UNICEF, a person deployed to UNICEF under a Stand-by Personnel arrangement or on reimbursable or non-reimbursable loan, an intern, a person deployed to UNICEF through an employment agency or similar arrangements, or a gratis personnel: the SIR for SEA must also be copied to Director DHR; Chief of Investigations, OIAI; and the Legal Adviser NYHQ.

- If the alleged perpetrator is an individual consultant, or an employee or associate of a corporate vendor or supplier or of an institutional or corporate contractors (sometimes referred to as corporate consultants): the SIR for SEA must also be copied to Director SD; Chief of Investigations OIAI; and the Legal Adviser NYHQ.

The Country Representative, upon advice of and with specific guidance from UNICEF Headquarters, informs appropriate Government authorities and, when relevant, contractors or implementing partners.

Addressing GBV-Related Risks in WASH Assessments and Initial Programme Design

Source: Gender-Based Violence Area of Responsibility, 'Tip Sheet: Addressing Gender-based Violence (GBV)-related Risks in WASH Assessments and Initial Programme Design', Global Protection Cluster, n.d.[1]

In emergency settings, the design of WASH programmes and facilities can have a major impact – either positive or negative – on the safety of the affected community, particularly in relation to sexual violence and other forms of GBV. When it comes to GBV risk mitigation, the GBV AoR recommends that the WASH cluster consider the following issues.

Key linkages between WASH and GBV

- Women and girls are often disproportionately affected by WASH issues.
- Bathing facilities and latrines located far from dwellings are often the site of sexual violence attacks, especially after nightfall in settings with insufficient or no lighting.
- Bathing facilities and latrines that lock from the inside and that are separated for females and males can mitigate GBV risk.
- Inadequate or inappropriate sanitary supplies or lack of access to appropriate ways to maintain/wash these materials may limit women's and girls' mobility and increase their vulnerability to GBV.

GBV issues to examine in WASH assessments

- What does the community report in terms of the gender and age divisions of responsibilities for water collection, water storage, water treatment, waste disposal, cleaning, taking care of children's hygiene and maintenance and management of WASH facilities? Is this confirmed through observation of WASH facilities?
- How often must women and girls collect water? What time of day? How many hours a day is spent traveling to and from water sources? Does this prevent girls from attending school?
- What concerns do women and girls have in relation to traveling to water collection points? How do women and girls feel about the route to be travelled to water and sanitation facilities? From their perspective, are the routes used safe for girls and women? How long does it take to walk there? Is the path well lit at night?
- How do women and girls feel about the water and sanitation facilities that they have access to? How likely are women and girls likely to use these water and sanitation facilities? What might keep a woman or girl from using the water and sanitation facilities?
- Do women and girls feel latrines accessible, located in safe areas and adequate in number? Are there separate facilities for males and females that are clearly marked and appropriate distances apart? Are there adequate disposal mechanisms for sanitary supplies in all female latrines?

1 Available at: <www.humanitarianresponse.info/system/files/documents/files/GBV%20Tip%20Sheet%20WASH%20FINAL.pdf>.

From the perspective of women and girls, are water and sanitation facilities secure and designed to ensure privacy? Is there sufficient lighting? Are latrines and bathing facilities equipped with doors that lock from the inside?

Crucial points

- Crucial to the design of any WASH intervention is a **gender-sensitive assessment that consults both males and females about their respective needs and roles** around water and sanitation. Extra steps may be necessary to ensure women's voices can be heard.
- WASH assessments **should not deliberately seek to identify specific incidents or individual survivors.** However, in the event a survivor chooses to disclose and incident of GBV, members of the assessment the team must be aware of available GBV services and prepared to provide referrals in a safe, confidential and non-judgmental manner.
- If an assessor notices a **specific GBV-related concern**, rather than attempt to investigate further, the **appropriate response is to notify someone with experience working on a GBV** (e.g. GBV specialist/expert). If a GBV specialist is not available, the team should note in their findings that additional GBV expertise, resources and possibly a GBV-specific assessment are needed.

From the Sphere Standards (2011)

"People require spaces where they can bathe in privacy and with dignity… The number, location, design, safety, appropriateness and convenience of facilities should be decided in consultation with the users, particularly women, adolescent girls and persons with disabilities. The location of facilities in central, accessible and well-lit areas with good visibility of the surrounding area can contribute to ensuring the safety of users."

"Inappropriate siting of toilets may make women and girls more vulnerable to attack, especially during the night. Ensure that women and girls feel safe when using the toilets provided."

Addressing GBV-Related Risks in Health Assessments and Initial Programme Design

Source: Gender-Based Violence Area of responsibility, 'Tip Sheet: Addressing Gender-based Violence (GBV)-Related Risks in Health Assessments and Initial Programme Design', Global Protection Cluster, (nd).[1]

In the early stages of an emergency, Health cluster assessment questions on GBV should focus on collecting information about availability and quality services, as well as the GBV-related concerns and help-seeking behavior of the community.

Key linkages between Health and GBV

- Timely, appropriate health response to sexual violence is a life-saving intervention. Survivors can reduce the risk of HIV transmission is they seek medical care within 72 hours (3 days) and pregnancy if within 120 hours (5 days) of the assault.
- Health services are often the first – and sometimes only – point of contact with GBV survivors.
- If survivors are treated with dignity, respect and compassion, they are more likely to discuss their experience with service providers, which can lead to better-informed interventions and better outcomes for survivors.

Note: Because sexual violence is always present in emergencies, implementation of the Minimum Initial Services Package (MISP) for reproductive health – which includes clinical care for sexual violence – is a standard responsibility of the Health cluster. These services must be prioritised from the outset of the emergency, regardless of whether or not an assessment has taken place.

GBV issues to examine in Health assessments

Community

- Are women and girls aware of the health consequences of GBV, particularly sexual violence?
- Are women and girls aware of the benefits of seeking healthcare and available services? Do women and girls indicate that survivors can come forward and seek help in a safe, secure, anonymous, and confidential environment?
- Have women and girls been consulted about their health needs, the quality/appropriateness of existing health services and gaps in available services? If so, how?
- Do women and girls report any barriers or prerequisites to accessing healthcare, such as the need for a husband/partner's consent or a police report?
- Do community health workers provide outreach to the community that includes GBV messaging?

1 Available at: <www.humanitarianresponse.info/system/files/documents/files/GBV%20Tip%20Sheet%20Health%20FINAL.pdf>.

Health infrastructure

- How many functioning health facilities provide services for GBV survivors? What services are available? How far away are these facilities from the affected population?
- How available are the drugs – including antibiotics for STI presumptive treatment, emergency contraception, and post-exposure prophylaxis for HIV – equipment and supplies for clinical management of rape survivors (CMR)? What is the procedure for replenishing these supplies?
- Are services for survivors integrated into existing healthcare facilities (so that survivors can seek treatment without being easily identified by the community)?
- Do national medical protocols allow for the provision of clinical care for survivors of sexual violence per WHO's CMR guidelines?
- Are there national and agency-specific policies/protocols that adhere to ethical and safety standards (privacy, confidentiality, respect, non-discrimination, informed consent)?
- What are the laws on abortion? Is it legal/illegal in all cases? Some cases? Are there exceptions for pregnancies that result from rape?
- Are there mandatory reporting laws for certain types of violence or when an incident involves a certain type of survivor (i.e. a child)?

Health facilities

- How many members (or what percentage) of the clinical staff have been trained on CMR? How many of the CMR-trained staff are female?
- Are there female receptionists and interpreters working at the health facility?
- Are there private rooms in health facilities for survivors to be interviewed and examined?
- Do health facilitates have separate male and female latrines that lock from the inside and washing areas, and are in secure locations with adequate path lighting at night?
- What are the potential barriers to survivors' access to GBV-related health services, such as getting to and from the facility, opening times, costs, privacy, confidentiality, language, cultural issues? (See AAAQ framework)
- What referral systems are in place for survivors of GBV (to security/police, safe shelter, psychosocial services, legal, community services, other)? Are these institutions safe (i.e. do not expose the survivor to further risks)?
- Does the facility have a system in place for collecting, storing and analysing data on reported cases of GBV that protects survivor confidentiality? If yes, what system? Are records kept in a secure place and appropriately coded to ensure confidentiality?

Summary of the AAAQ Framework

The "Availability, Accessibility, Acceptability, Quality (AAAQ)" framework is useful for assessing all types of GBV services and particularly for identifying barriers to services that may not be immediately apparent.

Availability refers to the existence of services. Essentially, are services sufficient in terms of quantity and type?

Accessibility includes many components such as:

- **Physical accessibility:** Are facilities located within a reasonable distance? Is the route to and from the facility safe to travel? Are there other forms of physical barriers, such as armed guards outside the facility?
- **Financial accessibility:** How is the service funded? Do users have to pay a fee? If so, is the fee reasonable/manageable given the economic circumstances/means of those who need this type of care?
- **Bureaucratic/administrative accessibility:** Are there procedural steps a survivor must complete before accessing certain services? For example, must s/he report to the police before receiving medical treatment? Are the facilities open at times that are convenient given the daily/weekly rhythm of community members?
- **Social accessibility:** Do service providers respect and practice non-discrimination in the provision of services? Are certain groups excluded from services because of language or communication barriers? Are there female doctors, nurses and (if necessary) interpreters? Are there stigma issues related to a person being seeing in/around a certain facility? Are other responsibilities, such as childcare, affecting certain individuals' ability to access services?
- **Information accessibility:** How is information about services communicated to the community? Is it accessible to those who need it (i.e. is it available in various languages?)? Are there alternatives to printed information in order to reach illiterate members of the community? Is personal information treated confidentially?

Acceptability: Are the services respectful of the culture of individuals, minorities, peoples and communities? Are services designed to respect relevant ethical and professional standards? Do service providers respect confidentiality and informed consent? Are services gender-sensitive? Are there certain characteristics of the service providers (gender, international vs. local staff, etc.) that make the community more/less comfortable accessing services?

Quality: Do service providers possess the necessary skills/training? Are there adequate supplies (drugs that aren't expired, etc.)? Is the environment appropriate? Are the facilities safe and sanitary? Quality also extends to the way people are treated before, during and after accessing services.

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