

Thematic Area Guide for:

Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action

Reducing risk, promoting resilience and aiding recovery



Health



Camp Coordination and Camp Management



Child Protection



Education



Food Security and Agriculture



Housing, Land and Property



Humanitarian Mine Action



Livelihoods



Nutrition



Protection



Shelter, Settlement and Recovery



Water, Sanitation and Hygiene



Humanitarian Operations Support Sectors

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The comprehensive Guidelines were revised from the original 2005 IASC *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings*. The revision process was overseen by an Operations Team led by UNICEF. Operations team members were: Mendy Marsh and Erin Patrick (UNICEF), Erin Kenny (UNFPA), Joan Timoney (Women’s Refugee Commission) and Beth Vann (independent consultant), in addition to the authors. The process was further guided by an inter-agency advisory board (‘Task Team’) of 16 organizations including representatives of the global GBV Area of Responsibility (GBV AoR) co-lead agencies—UNICEF and UNFPA—as well as UNHCR, UN Women, the World Food Programme, expert NGOs (the American Refugee Committee, Care International, Catholic Relief Services, ChildFund International, InterAction, International Medical Corps, International Rescue Committee, Oxfam International, Plan International, Refugees International, Save the Children and Women’s Refugee Commission), the U.S. Centers for Disease Control and Prevention and independent consultants with expertise in the field. The considerable dedication and contributions of all these partners has been critical throughout the entire revision process.

The content and design of the revised Guidelines was informed by a highly consultative process that involved the global distribution of multi-lingual surveys in advance of the revision process to help define the focus and identify specific needs and challenges in the field. In addition, detailed inputs and feedback were received from over 200 national and international actors both at headquarters and in-country, representing most regions of the world, over the course of two years and four global reviews. Draft content of the Guidelines was also reviewed and tested at the field level, involving an estimated additional 1,000 individuals across United Nations, INGO and government agencies in nine locations in eight countries.

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A Global Reference Group has been established to help promote the Guidelines and monitor their use. The Reference Group is led by UNICEF and UNFPA and includes as its members: American Refugee Committee, Care International, the U.S. Centers for Disease Control and Prevention, ChildFund International, International Medical Corps, International Organization for Migration, International Rescue Committee, Norwegian Refugee Council, Oxfam, Refugees International, Save the Children, UNHCR and Women’s Refugee Commission.

For more information about the implementation of the revised Guidelines, please visit the GBV Guidelines website <www.gbvguidelines.org>. This website hosts a knowledge repository and provides easy access to the comprehensive Guidelines, the TAGs and related tools, collated case studies and monitoring and evaluation results. Arabic, French and Spanish versions of the Guidelines and associated training and rollout materials are available on this website as well.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the United Nations or partners concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

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Foreword

All national and international actors responding to humanitarian emergencies have a duty to protect those affected by crises. This duty goes beyond the requirement to provide assistance – and it includes protection from gender-based violence. Because no single organization, agency or entity working in an emergency can prevent gender-based violence alone, collective effort is paramount: All humanitarian actors must be aware of the risks of gender-based violence and work to prevent and mitigate these risks as quickly as possible, and to provide care and support to those affected, coordinating their actions to ensure a comprehensive response.

Health actors play a critical role in enhancing the safety and well-being of affected populations. By taking action to prevent and respond to gender-based violence, health actors can help to meet this most basic responsibility. Health services are often the first – and sometimes, the only – point of contact for survivors seeking assistance for gender-based violence. Lack of availability or awareness of health services, staff that are not trained in the guiding principles of working with survivors, inadequate treatment supplies and unsafe access to facilities can prevent survivors from receiving the life-saving services they need. However, when health care programmes implement strategies to address the risks of gender-based violence and meet the needs of survivors – for example, when services are safe, confidential, sensitive, accessible and of good quality – they can have wide-ranging benefits for individuals, families, communities and societies.

This Thematic Area Guide (TAG) on health and gender-based violence is part of the larger comprehensive *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery* (IASC, 2015, available at <www.gbvguidelines.org>). The health TAG is a portable tool that provides practical guidance to assist health actors and affected communities to coordinate, plan, implement, monitor and evaluate essential actions for the prevention of and response to gender-based violence. Extensively reviewed and field tested, the guidance reflects the combined wisdom and experience of colleagues from the health sector, as well as from the wider humanitarian community. It is meant to be used from the preparedness stage of emergency response through to the recovery phase.

Adequate health services are not only vital to ensuring life-saving care for women, girls and other at-risk groups, but they are also a key building block for any setting seeking to overcome the devastation of humanitarian emergencies. By implementing the guidance in this TAG in our work, we can achieve groundbreaking improvements in humanitarian response. Most important, we will enhance the safety and dignity of those we serve, now and into the future. We owe that to them.



M. Chan

Margaret Chan,
Director-General



Acronyms

AAP	Accountability to Affected Populations	GA	General Assembly
AoR	area of responsibility	GBV	gender-based violence
AXO	abandoned explosive ordnance	GBVIMS	Gender-Based Violence Information Management System
CA	camp administration	GPS	Global Positioning System
CAAC	Children and Armed Conflict	HC	humanitarian coordinator
CAAP	Commitments on Accountability to Affected Populations	HCT	humanitarian country team
CaLP	Cash Learning Partnership	HIV	human immunodeficiency virus
CBPF	country-based pooled fund	HLP	housing, land and property
CCCM	camp coordination and camp management	HMA	humanitarian mine action
CCSA	clinical care for sexual assault	HPC	Humanitarian Programme Cycle
CEDAW	Committee on the Elimination of Discrimination against Women	HR	human resources
CERF	Central Emergency Response Fund	HRP	Humanitarian Response Plan
CFW	cash for work	HRW	Human Rights Watch
CIVPOL	Civilian Police	IASC	Inter-Agency Standing Committee
CLA	cluster lead agency	ICLA	Information, Counselling and Legal Assistance
CoC	code of conduct	ICRC	International Committee of the Red Cross
CP	child protection	ICT	information and communication technologies
CPRA	Child Protection Rapid Assessment	ICWG	inter-cluster working group
CPWG	Child Protection Working Group	IDD	Internal Displacement Division
CRC	Convention on the Rights of the Child	IDP	internally displaced person
CwC	communicating with communities	IEC	information, education and communication
DDR	disarmament, demobilization and reintegration	IFRC	International Federation of Red Cross and Red Crescent Societies
DEVAW	Declaration on the Elimination of Violence against Women	IGA	income-generating activity
DFID	Department for International Development	IMC	International Medical Corps
DRC	Danish Refugee Council	IMN	Information Management Network
DRC	Democratic Republic of the Congo	IMS	Information Management System
DTM	Displacement Tracking Matrix	INEE	Inter-Agency Network for Education in Emergencies
EASE	Economic and Social Empowerment	INGO	international non-governmental organization
EC	emergency contraception	IOM	International Organization for Migration
ERC	emergency relief coordinator	IPPF	International Planned Parenthood Federation
ERW	explosive remnants of war	IRC	International Rescue Committee
FAO	Food and Agriculture Organization	IRIN	Integrated Regional Information Network
FGD	focus group discussion	KII	key informant interview
FGM/C	female genital mutilation/cutting	LEGS	Livestock Emergency Guidelines and Standards
FSA	food security and agriculture		



Acronyms (continued)

LGBTI	lesbian, gay, bisexual, transgender and intersex	SGBV	sexual and gender-based violence
M&E	monitoring and evaluation	SOGI	sexual orientation and gender identity
MDG	Millennium Development Goals	SOPs	standard operating procedures
MHPSS	mental health and psychosocial support	SRH	sexual and reproductive health
MIRA	multi-cluster/sector initial rapid assessment	SRP	strategic response plan
MISP	Minimum Initial Service Package	SS&R	shelter, settlement and recovery
MoE	Ministry of Education	STI	sexually transmitted infection
MPP	minimum preparedness package	SWG	Sub-Working Group
MRE	mine risk education	TAG	Thematic Area Guide
MRM	monitoring and reporting mechanism	UNDAC	United Nations Disaster Assessment and Coordination
NFI	non-food item	UNDP	United Nations Development Programme
NGO	non-governmental organization	UNESCO	United Nations Educational, Scientific and Cultural Organization
NRC	Norwegian Refugee Council	UNHCR	United Nations High Commissioner for Refugees
OCHA	Office for the Coordination of Humanitarian Affairs	UNICEF	United Nations Children's Fund
OHCHR	Office of the High Commissioner for Human Rights	UNFPA	United Nations Population Fund
Oxfam	Oxford Famine Relief Campaign	UNMAS	United Nations Mine Action Service
PATH	Program for Appropriate Technology in Health	UNOPS	United Nations Office for Project Services
PEP	post-exposure prophylaxis	USAID	United States Agency for International Development
PFA	psychological first aid	UXO	unexploded ordnance
POC	Protection of Civilians	VAWG	violence against women and girls
PSEA	protection from sexual exploitation and abuse	VSLA	Village Savings and Loan Association
PTA	parent-teacher association	WASH	water, sanitation and hygiene
RC	resident coordinator	WFP	World Food Programme
RDC	relief to development continuum	WHO	World Health Organization
SAFE	Safe Access to Firewood and alternative Energy	WMA	World Medical Association
SC	Security Council	WPE	Women's Protection and Empowerment
		WRC	Women's Refugee Commission



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PART ONE

INTRODUCTION



1. About This Thematic Area Guide

Purpose of This Guide

This Thematic Area Guide (TAG) is excerpted from the comprehensive Inter-Agency Standing Committee *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery* (IASC, 2015).¹ The purpose of this TAG is to assist health actors and communities affected by armed conflict, natural disasters and other humanitarian emergencies to *coordinate, plan, implement, monitor and evaluate essential actions for the prevention and mitigation of gender-based violence (GBV) across the health sector*.²

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

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

1. To **reduce risk** of GBV by implementing GBV prevention and mitigation strategies within the health sector from pre-emergency through to recovery stages;
2. To **promote resilience** by strengthening national and community-based systems that prevent and mitigate GBV, and by enabling survivors³ and those at risk of GBV to access care and support; and
3. To **aid recovery** of communities and societies by supporting local and national capacity to create lasting solutions to the problem of GBV.

¹ The comprehensive Guidelines include guidance for thirteen areas of humanitarian operations, including camp coordination and camp management (CCCM); child protection; education; food security and agriculture (FSA); health; housing, land and property (HLP); humanitarian mine action (HMA); livelihoods; nutrition; protection; shelter, settlement and reconstruction (SS&R); water, sanitation and hygiene (WASH); and humanitarian operations support sectors (e.g. logistics and telecommunications). Unlike this TAG, the comprehensive Guidelines also include annexes with supplemental resources related to GBV prevention, mitigation and response. The annexes are also available as stand-alone documents. The comprehensive Guidelines and stand-alone TAGs and annexes are available at <www.gbvguidelines.org>.

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

³ A survivor is a person who has experienced gender-based violence. The terms 'victim' and 'survivor' can be used interchangeably. 'Victim' is a term often used in the legal and medical sectors, while the term 'survivor' is generally preferred in the psychological and social support sectors because it implies resiliency. This TAG employs the term 'survivor' in order to reinforce the concept of resiliency.



**ESSENTIAL TO KNOW****'Prevention' and 'Mitigation' of GBV**

Throughout this TAG, there is a distinction made between '**prevention**' and '**mitigation**' of GBV. While there will inevitably be overlap between these two areas, **prevention** generally refers to taking action to stop GBV from first occurring (e.g. *scaling up activities that promote gender equality; working with communities, particularly men and boys, to address practices that contribute to GBV; etc.*). **Mitigation** refers to reducing the risk of exposure to GBV (e.g. *ensuring that reports of 'hot spots' are immediately addressed through risk-reduction strategies; ensuring sufficient lighting and security patrols are in place from the onset of establishing displacement camps; etc.*). In addition, some sectors undertake specialized response programming related to survivor care and assistance. The overarching focus on this TAG is on essential prevention, mitigation and response activities that should be undertaken within and across the health sector.

How This Thematic Area Guide is Organized

Part One introduces this TAG, presents an overview of GBV and provides an explanation for why GBV is a protection concern for all health actors.

Part Two provides a background to and summarizes the structure of the health guidance detailed in **Part Three**. It also introduces the guiding principles and approaches that are the foundation for all planning and implementation of GBV-related programming.

Part Three provides specific guidance for the health sector to implement programming that addresses the risk of GBV.

Although this TAG is specifically tailored to the health sector, all humanitarian actors must avoid 'siloed' interventions. Health actors should strive to work with other sectors to ensure coordinated response, and recommendations for coordination are outlined in **Part Three**. It is also recommended that health actors review the content of the comprehensive Guidelines—not just their TAG—in order to familiarize themselves with key GBV prevention, mitigation and response activities of other sectors.

**ESSENTIAL TO KNOW****Assume GBV Is Taking Place**

The actions outlined in this TAG are relevant from the earliest stages of humanitarian intervention and in any emergency setting, regardless of whether the prevalence or incidence of various forms of GBV is 'known' and verified. It is important to remember that **GBV is happening everywhere. It is under-reported worldwide**, due to fears of stigma or retaliation, limited availability or accessibility of trusted service providers, impunity for perpetrators, and lack of awareness of the benefits of seeking care. Waiting for or seeking population-based data on the true magnitude of GBV should not be a priority in an emergency due to safety and ethical challenges in collecting such data. With this in mind, **all humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions based on recommendations in this TAG**, regardless of the presence or absence of concrete 'evidence'.

This TAG draws from many tools, standards, background materials and other resources developed by UN, I/NGO and academic sources. At the end of **Part Three** there is a list of resources specific to health; additional GBV-related resources are provided in **Annex 1** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.



Target Audience

This TAG is designed for national and international health actors operating in settings affected by armed conflict, natural disasters and other humanitarian emergencies, as well as in host countries and/or communities that receive people displaced by emergencies. The principal audience is health programmers—agencies and individuals who can use the information to incorporate GBV prevention and mitigation strategies into the design, implementation, monitoring and evaluation of health interventions. However, it is critical that humanitarian leadership—including governments, humanitarian coordinators, health coordinators and donors—also use this TAG as a reference and advocacy tool to improve the capacity of the health sector to prevent and mitigate GBV.⁴ This TAG can further serve those working in development contexts—particularly contexts affected by cyclical disasters—in planning and preparing for humanitarian action that includes efforts to prevent and mitigate GBV.

! ESSENTIAL TO KNOW

GBV Specialists and GBV Specialized Agencies

Throughout this TAG, there are references to ‘GBV specialists’ and ‘GBV-specialized agencies’. A GBV specialist is someone who has received GBV-specific professional training and/or has considerable experience working on GBV programming. A GBV-specialized agency is one that undertakes targeted programmes for the prevention of and response to GBV. **It is expected that GBV specialists, agencies and inter-agency mechanisms will use this document to assist non-GBV specialists in undertaking prevention and mitigation activities—as well as response services for survivors—within and across the health sector.** This TAG includes recommendations (outlined under ‘Coordination’ in **Part Three**) about how GBV specialists can be mobilized for technical support.

This TAG is primarily targeted to non-GBV specialists—that is, agencies and individuals who work in humanitarian response sectors other than GBV and do not have specific expertise in GBV prevention and response programming, but can nevertheless undertake activities that significantly reduce the risk of GBV for affected populations.⁵

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

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

⁴ Government, humanitarian coordinators, humanitarian country teams/inter-cluster working groups, cluster/sector lead agencies, cluster/sector coordinators and GBV coordination mechanisms can play an especially critical role in supporting the uptake of this TAG as well as the comprehensive Guidelines. For more information about actions to be undertaken by these actors to facilitate implementation of the Guidelines, see ‘Ensuring Implementation of the GBV Guidelines: Responsibilities of key actors’ (available at <www.gbvguidelines.org> as both a stand-alone document and as part of **Part One: Introduction** of the comprehensive Guidelines).

⁵ Affected populations include all those who are adversely affected by an armed conflict, natural disaster or other humanitarian emergency, including those displaced (both internally and across borders) who may still be on the move or have settled into camps, urban areas or rural areas.

2. Overview of Gender-Based Violence

Defining GBV

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

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

The term 'GBV' is most commonly used to underscore how systemic inequality between males and females—which exists in every society in the world—acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. The United Nations Declaration on the Elimination of Violence against Women (DEVAW, 1993) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women." DEVAW emphasizes that the violence is "a manifestation of historically unequal power relations between men and women, which have led to the domination over and discrimination against women by men and to the prevention of the full advancement of women." Gender discrimination is not only a cause of many forms of violence against women and girls but also contributes to the widespread acceptance and invisibility of such violence—so that perpetrators are not held accountable and survivors are discouraged from speaking out and accessing support.

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

! ESSENTIAL TO KNOW

Informed Consent

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



survivor and/or his family members. Many countries do not explicitly recognize sexual violence against men in their laws and/or have laws which criminalize survivors of such violence.

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

! ESSENTIAL TO KNOW

Women, Girls and GBV

Women and girls everywhere are disadvantaged in terms of social power and influence, control of resources, control of their bodies and participation in public life—all as a result of socially determined gender roles and relations. Gender-based violence against women and girls occurs in the context of this imbalance. While health actors must analyse different gendered vulnerabilities that may put men, women, boys and girls at heightened risk of violence and ensure care and support for all survivors, **special attention should be given to females due to their documented greater vulnerabilities to GBV, the overarching discrimination they experience, and their lack of safe and equitable access to humanitarian assistance.** Health actors have an obligation to promote gender equality through humanitarian action in line with the IASC ‘Gender Equality Policy Statement’ (2008). They also have an obligation to support, through targeted action, women’s and girls’ protection, participation and empowerment as articulated in the Women, Peace and Security thematic agenda outlined in United Nations Security Council Resolutions (see **Annex 6** of the comprehensive Guidelines, available at <www.gbvguidelines.org>). While supporting the need for protection of all populations affected by humanitarian crises, this TAG recognizes the heightened vulnerability of women and girls to GBV and provides targeted guidance to address these vulnerabilities—including through strategies that promote gender equality.

Nature and Scope of GBV in Humanitarian Settings

A great deal of attention has centred on monitoring, documenting and addressing sexual violence in conflict—for instance the use of rape or other forms of sexual violence as a weapon of war. Because of its immediate and potentially life-threatening health consequences, coupled with the feasibility of preventing these consequences through medical care, addressing sexual violence is a priority in humanitarian settings. At the same time, there is a growing recognition that affected populations can experience various forms of GBV during conflict and natural disasters, during displacement, and during and following return. In particular, intimate partner violence is increasingly recognized as a critical GBV concern in humanitarian settings.

These additional forms of violence—including intimate partner violence and other forms of domestic violence, forced and/or coerced prostitution, child and/or forced marriage, female genital mutilation/cutting, female infanticide, and trafficking for sexual exploitation and/or forced/domestic labour—must be considered in GBV prevention and mitigation efforts according to the trends in violence and the needs identified in a given setting. (For a list of types of GBV and associated definitions, see **Annex 3** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.)

In all types of GBV, violence is used primarily by males against females to subordinate, disempower, punish or control. The gender of the perpetrator and the victim are central not only to the motivation for the violence, but also to the ways in which society condones or responds to the violence. Whereas violence against men is more likely to be committed by an acquaintance or stranger, women more often experience violence at the hands of those who are well known to them: intimate partners, family members, etc.⁶ In addition, widespread gender discrimination and gender inequality often result in women and girls being exposed to multiple forms of GBV throughout their lives, including 'secondary' GBV as a result of a primary incident (e.g. abuse by those they report to, honor killings following sexual assault, forced marriage to a perpetrator, etc.).

Obtaining prevalence and/or incidence data on GBV in emergencies is not advisable due to the methodological and contextual challenges related to undertaking population-based research on GBV in emergency settings (e.g. security concerns for survivors and researchers, lack of available or accessible response services, etc.). The majority of information about the nature and scope of GBV in humanitarian contexts is derived from qualitative research, anecdotal reports, humanitarian monitoring tools and service delivery statistics. These data suggest that many forms of GBV are significantly aggravated during humanitarian emergencies, as illustrated in the statistics provided below. (See **Annex 5** of the comprehensive Guidelines, available at <www.gbvguidelines.org>, for additional statistics as well as for citations for the data presented below.)

- In the Democratic Republic of the Congo during 2013, UNICEF coordinated with partners to provide services to 12,247 GBV survivors; 3,827—or approximately 30 per cent—were children, of whom 3,748 were girls and 79 were boys (UNICEF DRC, 2013).
- In Pakistan following the 2011 floods, 52 per cent of surveyed communities reported that privacy and safety of women and girls was a key concern. In a 2012 Protection Rapid Assessment with conflict-affected IDPs, interviewed communities reported that a number of women and girls were facing aggravated domestic violence, forced marriage, early marriages and exchange marriages, in addition to other cases of gender-based violence (de la Puente, 2014).
- In Afghanistan, a household survey (2008) showed 87.2 per cent of women reported one form of violence in their lifetime and 62 per cent had experienced multiple forms of violence (de la Puente, 2014).

⁶ In 2013 the World Health Organization and others estimated that as many as 38 per cent of female homicides globally were committed by male partners while the corresponding figure for men was 6 per cent. They also found that whereas males are disproportionately represented among victims of violent death and physical injuries treated in emergency departments, women and girls, children and elderly people disproportionately bear the burden of the nonfatal consequences of physical, sexual and psychological abuse, and neglect, worldwide. (World Health Organization. 2014. *Global Status Report on Violence Prevention 2014*, <www.who.int/violence_injury_prevention/violence/status_report/2014/en>. Also see World Health Organization. 2002. *World Report on Violence and Health*, <<http://whqlibdoc.who.int/hq/2002/9241545615.pdf>>.)

! ESSENTIAL TO KNOW

Women and Natural Disasters

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

(Adapted from **Global Protection Cluster**. n.d. 'Strengthening Protections in Natural Disaster Response: Women and girls' (draft), <www.globalprotectioncluster.org/en/tools-and-guidance/protection-cluster-coordination-toolbox.html>)



- In Liberia, a survey of 1,666 adults found that 32.6 per cent of male combatants experienced sexual violence while 16.5 per cent were forced to be sexual servants (Johnson et al, 2008). Seventy-four per cent of a sample of 388 Liberian refugee women living in camps in Sierra Leone reported being sexually abused prior to being displaced. Fifty-five per cent experienced sexual violence during displacement (IRIN, 2006; IRIN, 2008).
- Of 64 women with disabilities interviewed in post-conflict Northern Uganda, one third reported experiencing some form of GBV and several had children as a result of rape (HRW, 2010).
- In a 2011 assessment, Somali adolescent girls in the Dadaab refugee complex in Kenya explained that they are in many ways 'under attack' from violence that includes verbal and physical harassment; sexual exploitation and abuse in relation to meeting their basic needs; and rape, including in public and by multiple perpetrators. Girls reported feeling particularly vulnerable to violence while accessing scarce services and resources, such as at water points or while collecting firewood outside the camps (UNHCR, 2011).
- In Mali, daughters of displaced families from the North (where female genital mutilation/cutting [FGM/C] is not traditionally practised) were living among host communities in the South (where FGM/C is common). Many of these girls were ostracized for not having undergone FGM/C; this led families from the North to feel pressured to perform FGM/C on their daughters (Plan Mali, April 2013).
- Domestic violence was widely reported to have increased in the aftermath of the 2004 Indian Ocean tsunami. One NGO reported a three-fold increase in cases brought to them (UNFPA, 2011). Studies from the United States, Canada, New Zealand and Australia also suggest a significant increase in intimate partner violence related to natural disasters (Sety, 2012).
- Research undertaken by the Human Rights Documentation Unit and the Burmese Women's Union in 2000 concluded that an estimated 40,000 Burmese women are trafficked each year into Thailand's factories and brothels and as domestic workers (IRIN, 2006).
- The GBV Information Management System (IMS), initiated in Colombia in 2011 to improve survivor access to care, has collected GBV incident data from 7 municipalities. As of mid-2014, 3,499 females (92.6 per cent of whom were 18 years or older) and 437 males (91.8 per cent of whom were 18 years or older) were recorded in the GBVIMS, of whom over 3,000 received assistance (GBVIMS Colombia, 2014).



ESSENTIAL TO KNOW

Protection from Sexual Exploitation and Abuse (PSEA)

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

These responsibilities are at the determination of the Humanitarian Coordinator/Resident Coordinator and individual agencies. As such, detailed guidance on PSEA is outside the authority of this TAG. This TAG nevertheless wholly supports the mandate of the Secretary-General's Bulletin and provides several recommendations on incorporating PSEA strategies into agency policies and community outreach. Detailed guidance is available on the IASC AAP/PSEA Task Force website: <www.pseataaskforce.org>.



Impact of GBV on Individuals and Communities

GBV seriously impacts survivors' immediate sexual, physical and psychological health, and contributes to greater risk of future health problems. Possible sexual health effects include unwanted pregnancies, complications from unsafe abortions, female sexual arousal disorder or male impotence, and sexually transmitted infections, including HIV. Possible physical health effects of GBV include injuries that can cause both acute and chronic illness, impacting neurological, gastrointestinal, muscular, urinary, and reproductive systems. These effects can render the survivor unable to complete otherwise manageable physical and mental labour. Possible mental health problems include depression, anxiety, harmful alcohol and drug use, post-traumatic stress disorder and suicidality.⁷

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

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

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

Contributing Factors to and Causes of GBV

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

Conditions related to humanitarian emergencies may exacerbate the risk of many forms of GBV. However, the **underlying causes** of violence are associated with attitudes, beliefs, norms and structures that promote and/or condone gender-based discrimination and unequal

⁷ For more information on the health effects of GBV on women and children, see **World Health Organization. 1997.** 'Violence Against Women: Health consequences', <www.who.int/gender/violence/v8.pdf>, as well as **UN Women.** 'Virtual Knowledge Centre to End Violence against Women and Girls', <www.endvawnow.org/en/articles/301-consequences-and-costs-.html>. For more information on health effects of sexual violence against men, see **United Nations High Commissioner for Refugees. 2012.** *Working with Men and Boy Survivors of Sexual and Gender-Based Violence in Forced Displacement*, <www.refworld.org/pdfid/5006aa262.pdf>.



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

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





ESSENTIAL TO KNOW

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

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

(Adapted from **United Nations High Commissioner for Refugees. 2009.** 'UNHCR Policy on Refugee Protection and Solutions in Urban Areas', <www.unhcr.org/4ab356ab6.html>)

Key Considerations for At-Risk Groups

In any emergency, there are groups of individuals more vulnerable to harm than other members of the population. This is often because they hold less power in society, are more dependent on others for survival, are less visible to relief workers, or are otherwise marginalized. This TAG uses 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 below will always be at heightened risk of gender-based violence. Even so, they will very often be at heightened risk of harm in humanitarian settings. Whenever possible, efforts to address GBV should be alert to and promote the protection rights and needs of these groups. Targeted work with specific at-risk groups should be in collaboration with agencies that have expertise in addressing their needs. With due consideration for safety, ethics and feasibility, the particular experiences, perspectives and knowledge of at-risk groups should be solicited to inform work throughout all phases of the programme cycle. Specifically, health actors should:

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



Key Considerations for At-Risk Groups

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



Key Considerations for At-Risk Groups (continued)

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



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

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

(Inter-Agency Standing Committee Principals’ statement on the Centrality of Protection in Humanitarian Action, endorsed December 2013 as part of a number of measures that will be adapted by the IASC to ensure more effective protection of people in humanitarian crises.⁸ Available at <www.globalprotectioncluster.org/en/tools-and-guidance/guidance-from-inter-agency-standing-committee.html>)

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

Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations. Inaction and/or poorly designed programmes can also unintentionally cause further harm. Lack of action or ineffective action contribute to a poor foundation for supporting the resilience, health and well-being of survivors, and create barriers to reconstructing affected communities’ lives and livelihoods. In some instances, inaction can serve to perpetuate the cycle of violence: Some survivors of GBV or other forms of violence may later become perpetrators if their medical, psychological and protection needs are not met. In the worst case, inaction can indirectly or inadvertently result in loss of lives.

⁸ The Centrality Statement further recognizes the role of the protection cluster to support protection strategies, including mainstreaming protection throughout all sectors. To support the realization of this, the Global Protection Cluster has committed to providing support and tools to other clusters, both at the global and field level, to help strengthen their capacity for protection mainstreaming. For more information see the **Global Protection Cluster. 2014. Protection Mainstreaming Training Package**, <www.globalprotectioncluster.org/en/areas-of-responsibility/protection-mainstreaming.html>.

The responsibility of humanitarian actors to address GBV is supported by a framework that includes key elements highlighted in the diagram below. (For additional details of elements of the framework, see **Annex 6** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.)



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

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

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



it established, in 2005, a monitoring and reporting mechanism (MRM) on six grave children's rights violations in armed conflict, including rape and sexual violence against children. For more details on the United Nations Security Council resolutions, see **Annex 6** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.

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

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

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

(Excerpted from **Office for the Coordination of Humanitarian Affairs (OCHA)**. 2012. 'OCHA on Message: Humanitarian principles', <https://docs.unocha.org/sites/dms/Documents/OOM_HumPrinciple_English.pdf>)

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

- The right to life with dignity
- The right to receive humanitarian assistance, including protection from violence
- The right to protection and security⁹

Humanitarian standards and guidelines: Various standards and guidelines that reinforce the humanitarian responsibility to address GBV in emergencies have been developed and broadly endorsed by humanitarian actors. Many of these key standards are identified in **Annex 6** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.

! ESSENTIAL TO KNOW

What the Sphere Handbook Says:

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

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

(**Sphere Project**. 2011. *Sphere Handbook: Humanitarian charter and minimum standards in humanitarian response*, <www.sphereproject.org/resources/download-publications/?search=1&keywords=Sphere+Handbook&language=English&category=22&subcat-22=23&subcat-29=0&subcat-31=0&subcat-35=0&subcat-49=0&subcat-56=0&subcat-60=0&subcat-80=0>)

⁹ For more information, see 'The Humanitarian Charter,' available at <www.spherehandbook.org/en/the-humanitarian-charter>.



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PART TWO
BACKGROUND
TO HEALTH
GUIDANCE



1. Content Overview of Health Guidance

This section provides an overview of the recommendations detailed in **Part Three: Health Guidance**. The information below:

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

Summary Fold-Out Table of Essential Actions

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



ESSENTIAL TO KNOW

Emergency Preparedness and Contingency Planning

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

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

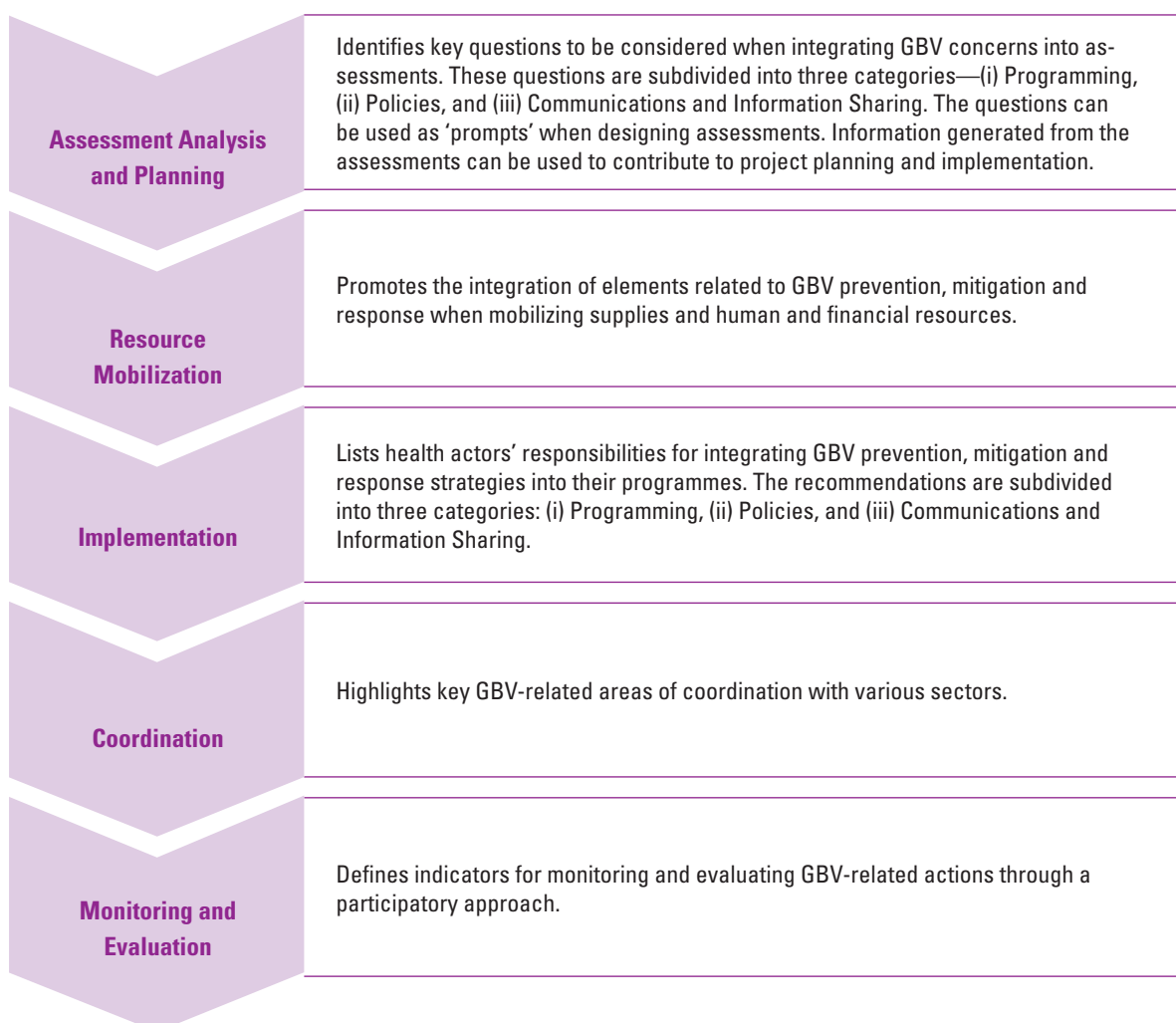
(Quote from **Inter-Agency Standing Committee. 2007. Inter-Agency Contingency Planning Guidelines for Humanitarian Assistance, Revised version**, p.7. <https://interagencystandingcommittee.org/system/files/legacy_files/IA%20CP%20Guidelines%20Publication_%20Final%20version%20Dec%202007.pdf>)

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

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

Essential Actions Outlined according to the Programme Cycle Framework

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



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

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



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

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

(Global Cluster on Early Recovery. 2014. ‘Guidance Note on Inter-Cluster Early Recovery’ [draft], p. 7, <www.humanitarianresponse.info/system/files/documents/files/Guidance%20Note%20on%20inter-cluster%20ER%20draft%20June%202014%20%28no%20Annex%29.pdf>)

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

Element 1: Assessment, Analysis and Planning

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

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



ESSENTIAL TO KNOW

Initiating Risk-Reduction Interventions without Assessments

While assessments are an important foundation for programme design and implementation, they are not required in order to put in place some essential GBV prevention, mitigation and response measures prior to or from the onset of an emergency. **Many risk-reduction interventions can be introduced without conducting an assessment.** For example, health sector actors can implement the Minimum Initial Service Package (MISP) for reproductive health at the onset of every emergency.

In addition to the prompts of what to assess, other key points should be considered when designing assessments:

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

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

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



DOs and DON'Ts for Conducting Assessments That Include GBV-Related Components

DOs

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

DON'Ts

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

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

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

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

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



ESSENTIAL TO KNOW

Investigating GBV-Related Safety and Security Issues When Undertaking Assessments

It is the responsibility of all humanitarian actors to work within a protection framework and understand the safety and security risks that women, girls, men and boys face. Therefore it is extremely important that assessment and monitoring of general safety issues 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. However, **GBV survivors should not be sought out or targeted as a specific group during assessments. GBV-specific assessments—which include investigating specific GBV incidents, interviewing survivors about their specific experiences, or conducting research on the scope of GBV in the population—should be conducted only in collaboration with GBV specialists and/or a GBV-specialized partner or agency.** Training in gender, GBV, women’s/human rights, social exclusion and sexuality—and how these inform assessment practices—should be conducted with relevant health staff. To the extent possible, assessments should be locally designed and led, ideally by relevant local government actors and/or programme administrators and with the participation of the community. When non-GBV specialists receive specific reports of GBV during general assessment activities, they should share the information with GBV specialists according to safe and ethical standards that ensure confidentiality and, if requested by survivors, anonymity of survivors.



Element 2: Resource Mobilization

Resource mobilization most obviously refers to accessing funding in order to implement programming—either through specific donors or linked to coordinated humanitarian funding mechanisms. (For more information on funding mechanisms, see **Annex 7** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.) This TAG aims to reduce the challenges of accessing GBV-related funds by outlining key GBV-related issues to be considered when drafting proposals.

In addition to the health-specific funding points presented under the ‘Resource Mobilization’ subsection of **Part Three**, all humanitarian actors should consider the following general points:

! ESSENTIAL TO KNOW

Recognizing GBV Prevention and Response as Life-Saving

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

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





ESSENTIAL TO KNOW

The IASC Gender Marker

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

(For links between the Gender Marker and GBV prevention and response projects, see **Annex 8** of the comprehensive Guidelines, available at <www.gbvguidelines.org>. For information on the Gender Marker, see: <https://interagencystandingcommittee.org/system/files/legacy_files/IASC%20Gender%20Marker%20Fact%20Sheet.doc>. For information on trends in spending according to the Gender Marker, see **Global Humanitarian Assistance. 2014. Funding Gender in Emergencies: What are the trends?** <www.globalhumanitarianassistance.org/report/funding-gender-emergencies-trends>.)

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

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

Element 3: Implementation

The ‘Implementation’ subsection provides guidance for putting GBV-related risk-reduction responsibilities into practice. The information is intended to:

- ▶ Describe a set of activities that, taken together, establish shared standards and improve the overall quality of GBV-related prevention and mitigation strategies—as well as response services for survivors—in humanitarian settings.
- ▶ Establish GBV-related responsibilities that should be undertaken by all health actors, regardless of available data on GBV incidents.
- ▶ Maximize immediate protection of GBV survivors and persons at risk.
- ▶ Foster longer-term interventions that work towards the elimination of GBV.



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

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

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



ESSENTIAL TO KNOW

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

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

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

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

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

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



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

! ESSENTIAL TO KNOW

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

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

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

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

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

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

PREPARE




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

(continued)



! **ESSENTIAL TO KNOW** (continued)

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

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

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

Dos	Don’ts
<ul style="list-style-type: none"> • Be honest and trustworthy. • Respect people’s right to make their own decisions. • Be aware of and set aside your own biases and prejudices. • Make it clear to affected people that even if they refuse help now, they can still access help in the future. • Respect privacy and keep the person’s story confidential, if this is appropriate. • Behave appropriately by considering the person’s culture, age and gender. 	<ul style="list-style-type: none"> • Don’t exploit your relationship as a helper. • Don’t ask the person for any money or favour for helping them. • Don’t make false promises or give false information. • Don’t exaggerate your skills. • Don’t force help on people and don’t be intrusive or pushy. • Don’t pressure people to tell you their stories. • Don’t share the person’s story with others. • Don’t judge the people for their actions or feelings.

(Adapted from: **World Health Organization, War Trauma Foundation and World Vision International. 2011.** *Psychological First Aid: Guide for field workers*, pp. 53–55, <www.who.int/mental_health/publications/guide_field_workers/en>; and **World Health Organization. 2012.** ‘Mental Health and Psychosocial Support for Conflict-Related Sexual Violence: 10 myths’, <www.who.int/reproductivehealth/publications/violence/rhr12_17/en>. For more information on providing first-line support see **World Health Organization. 2014.** *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A clinical handbook* (Field-testing version), WHO/RHR/14.26, <www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en>.)



Element 4: Coordination

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

The 'Coordination' subsection of **Part Three** provides guidance on key GBV-related areas for cross-sectoral coordination. This guidance targets NGOs, community-based organizations (including National Red Cross/Red Crescent Societies), INGOs and United Nations agencies, national and local governments, and humanitarian coordination leadership—such as line ministries, humanitarian coordinators, sector coordinators and donors. Leaders of health coordination mechanisms should also undertake the following:

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

! ESSENTIAL TO KNOW

Accessing the Support of GBV Specialists

Health coordinators and health actors should identify and work with the chair (and co-chair) of the GBV coordination mechanism where one exists. (Note: GBV coordination mechanisms may be chaired by government actors, NGOs, INGOs and/or United Nations agencies, depending on the context.) They should also encourage a health focal point to participate in GBV coordination meetings, and encourage the GBV chair/co-chair (or other GBV coordination group member) to participate in health coordination meetings. Whenever necessary, health coordinators and health actors should seek out the expertise of GBV specialists to assist with implementing the recommendations presented in this TAG.

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

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

GBV experts neither can nor should have specialized knowledge of the health sector, however. Efforts to integrate GBV risk-reduction strategies into health responses should be led by health actors to ensure that any recommendations from GBV actors are relevant and feasible within the sectoral response.

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



GBV-related activities in the sector's 3/4/5W form used to map out actors, activities and geographic coverage).

- ▶ Submit joint proposals for funding to ensure that GBV has been adequately addressed in health programming response.
- ▶ Develop and implement health work plans with clear milestones that include GBV-related inter-agency actions.
- ▶ Support the development and implementation of sector-wide policies, protocols and other tools that integrate GBV prevention and mitigation, as well as response services for survivors.
- ▶ Form strategic partnerships and networks to conduct advocacy for improved programming and to meet the responsibilities set out in this TAG (with due caution regarding the safety and security risks for humanitarian actors, survivors and those at risk of GBV who speak publicly about the problem of GBV).

! ESSENTIAL TO KNOW

Advocacy

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

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

Element 5: Monitoring and Evaluation

Monitoring and evaluation (M&E) is a critical tool for planning, budgeting resources, measuring performance and improving future humanitarian response. Continuous **routine monitoring** ensures that effective programmes are maintained and accountability to all stakeholders—especially affected populations—is improved. **Periodic evaluations** supplement monitoring data by analyzing in greater depth the strengths and weaknesses of implemented activities, and by measuring improved outcomes in the knowledge, attitudes and behaviour of affected populations and humanitarian workers. Implementing partners and donors can use the information gathered through M&E to share lessons learned among field colleagues and the wider humanitarian community. This TAG primarily focuses on indicators that strengthen health programme monitoring to avoid the collection of GBV incident data and more resource-intensive evaluations. (For general information on M&E, see resources available to guide real-time and final programme evaluations

! ESSENTIAL TO KNOW

GBV Case Reporting

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



such as ALNAP's *Evaluating Humanitarian Action Guide*, <www.alnap.org/eha>. For GBV-specific resources on M&E, see **Annex 1** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.)

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



ESSENTIAL TO KNOW

Ethical Considerations

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

It is crucial that the data not only be collected and reported, but also analysed with the goal of identifying where modifications may be beneficial. In this regard, sometimes 'failing' to meet a target can provide some of the most valuable opportunities for learning. For example, if a programme has aimed for 50 per cent female participation in assessments but falls short of reaching that target, it may consider changing the time and/or location of the consultations, or speaking with the affected community to better understand the barriers to female participation. The knowledge gained through this process has the potential to strengthen health interventions even beyond the actions taken related to GBV. Therefore, indicators should be analysed and reported using a 'GBV lens'. This involves considering the ways in which all information—including information that may not seem 'GBV-related'—could have implications for GBV prevention, mitigation and response.

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



2. Guiding Principles and Approaches for Addressing Gender-Based Violence

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

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



ESSENTIAL TO KNOW

Do No Harm

The concept of '**do no harm**' means that humanitarian organizations must strive to "minimize the harm they may inadvertently be doing by being present and providing assistance." Such unintended negative consequences may be wide-ranging and extremely complex. Health actors can reinforce the 'do no harm' principle in their GBV-related work through careful attention to the human rights-based, survivor-centred, community-based and systems approaches described below.

(Adapted from **Kahn, C., and Lucchi, E. 2009.** 'Are Humanitarians Fuelling Conflicts? Evidence from eastern Chad and Darfur', *Humanitarian Exchange Magazine*, No. 43, <www.odihpn.org/humanitarian-exchange-magazine/issue-43/are-humanitarians-fuelling-conflicts-evidence-from-eastern-chad-and-darfur>)

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

1. Human Rights-Based Approach

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

By contrast, the human rights-based approach views affected populations as 'rights-holders', and recognizes that these rights can be realized only by supporting the long-term empowerment of affected populations through sustainable solutions. This approach seeks to attend to rights as well as needs; how those needs are determined and addressed is informed by legal and



moral obligations and accountability. Humanitarian actors, along with states (where they are functioning), are seen as ‘duty-bearers’ who are bound by their obligations to encourage, empower and assist ‘rights-holders’ in claiming their rights. A human rights-based approach requires those who undertake GBV-related programming to:

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

2. Survivor-Centred Approach



(Excerpted from **GBV AoR. 2010. GBV Coordination Handbook** (provisional edition), p. 20, <www.gbvguidelines.org/tools-resources>)

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

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



! ESSENTIAL TO KNOW

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

1) Safety: The safety and security of the survivor and others, such as her/his children and people who have assisted her/him, must be the number one priority for all actors. Individuals who disclose an incident of GBV or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them.

2) Confidentiality: Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment.

3) Respect: The survivor is the primary actor, and the role of helpers is to facilitate recovery and provide resources for problem-solving. All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor.

4) Non-discrimination: Survivors of violence should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation or any other characteristic.

(Adapted from **United Nations Population Fund. 2012.** 'Module 2' in *Managing Gender-Based Violence Programmes in Emergencies, E-Learning Companion Guide*, <www.unfpa.org/sites/default/files/pub-pdf/GBV%20E-Learning%20Companion%20Guide_ENGLISH.pdf>)

3. Community-Based Approach

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

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

4. Systems Approach

Using a systems approach means analyzing GBV-related issues across an entire organization, sector and/or humanitarian system to come up with a combination of solutions most relevant to the context. The systems approach can be applied to introduce systemic changes that improve GBV prevention, mitigation and response efforts—both in the short term and in the long term. Health actors can apply a systems approach in order to:

- ▶ Strengthen agency/organizational/sectoral commitment to gender equality and GBV-related programming.
- ▶ Improve health actors’ knowledge, attitudes and skills related to gender equality and GBV through sensitization and training.



- ▶ Reach out to organizations to address underlying causes that affect health sector-wide capacity to prevent and mitigate GBV, such as gender imbalance in staffing.
- ▶ Strengthen safety and security for those at risk of GBV through the implementation of infrastructure improvements and the development of GBV-related policies.
- ▶ Ensure adequate monitoring and evaluation of GBV-related programming (adapted from USAID, 2006).



ESSENTIAL TO KNOW

Conducting Trainings

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

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

(For a general list of GBV-specific training tools as well as training tools on related issues, including LGBTI rights and needs, see **Annex 1** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.)

Additional Citations

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Inter-Agency Standing Committee. 2007. *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, <https://interagencystandingcommittee.org/system/files/legacy_files/Guidelines%20IASC%20Mental%20Health%20Psychosocial%20%28with%20index%29.pdf>

Inter-Agency Standing Committee Gender Sub-Working Group (IASC Gender SWG) and GBV Area of Responsibility (GBV AoR). 2010. *Caring for Survivors of Sexual Violence in Emergencies Training Guide*, <www.unicef.in/emergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf>

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PART THREE
HEALTH
GUIDANCE





HEALTH

THIS SECTION APPLIES TO:

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

Why Addressing Gender-Based Violence Is a Critical Concern of the Health Sector

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

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

! ESSENTIAL TO KNOW

Defining 'Health'

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

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

Emergencies put additional stress on health systems that are often already overburdened. Even so, overlooking the physical and mental health implications of GBV is not just a missed opportunity: it can be a violation of medical ethics. Health-care workers may fail to provide necessary—even life-saving—care, such as post-exposure prophylaxis (PEP) for HIV; emergency contraception; treatment for sexually transmitted infections (STIs); mental health and psychosocial support;

◀ SEE SUMMARY TABLE ON ESSENTIAL ACTIONS



Essential Actions for <i>Reducing Risk, Promoting Resilience and Aiding Recovery</i> throughout the Programme Cycle	Stage of Emergency Applicable to Each Action			
	Pre-Emergency/ Preparedness	Emergency	Stabilized Stage	Recovery to Development
ASSESSMENT, ANALYSIS AND PLANNING				
Promote the active participation of women, girls and other at-risk groups in all health assessment processes	✓	✓	✓	✓
Investigate cultural and community perceptions, norms and practices related to GBV and GBV-related health services (e.g. stigma that may prevent survivors from accessing health care; community awareness about the physical and mental health consequences of GBV and benefits of seeking care; existing community supports for survivors; providers' attitudes towards survivors; etc.)	✓	✓	✓	✓
Assess the safety and accessibility of existing GBV-related health services (e.g. safety travelling to/from facilities; cost; language, cultural and or/physical barriers to services, especially for minority groups and persons with disabilities; existence of mobile clinics; etc.)	✓	✓	✓	✓
Assess the quality of existing GBV-related health services (e.g. range of health services provided; privacy and confidentiality; representation of females in clinical and administrator positions; policies and protocols for clinical care of survivors; safe and ethical case documentation and information-sharing processes; availability of appropriate drugs and equipment; etc.)	✓	✓	✓	✓
Assess awareness of specialized (clinical) staff in the provision of targeted care for survivors (including how to provide clinical care for adult and child survivors of sexual assault; how to safely and confidentially document cases of GBV; knowledge and use of multi-sectoral referral pathways; how to provide care for intimate partner violence and other forms of domestic violence; how to provide court testimony when appropriate; etc.)	✓	✓	✓	✓
Assess awareness of all health personnel on basic issues related to gender, GBV, women's/human rights, social exclusion and sexuality	✓	✓	✓	✓
Investigate national and local laws related to GBV that might affect the provision of GBV-related health services (e.g. legal definitions of rape and other forms of GBV; legal age of consent; legal status of abortion and emergency contraception; etc.)	✓	✓		
With the leadership/involvement of the Ministry of Health, assess whether existing national policies and protocols related to the clinical care and referral of GBV are in line with international standards (e.g. post-exposure prophylaxis [PEP]; emergency contraception; abortion/post-abortion care in settings where these services are legal; etc.)	✓	✓		
Review existing/proposed health-related community outreach material to ensure it includes basic information about GBV (including prevention; where to report risk; health effects of GBV; benefits of health treatment; and how to access care)	✓	✓	✓	✓
RESOURCE MOBILIZATION				
Develop proposals for GBV-related health programming that reflect awareness of GBV risks for the affected population and strategies for health sector prevention and response	✓	✓	✓	✓
Pre-position trained staff and appropriate supplies to implement clinical care for GBV survivors in a variety of health delivery systems (e.g. medical drugs, equipment, administrative supplies, mental health and psychosocial support, referrals, etc.)	✓	✓		
Prepare and provide trainings for government, health facility administrators and staff, and community health workers (including traditional birth attendants and traditional healers) on sexual assault-related protocols	✓	✓	✓	✓
IMPLEMENTATION				
► Programming				
Involve women, adolescent girls and other at-risk groups in the design and delivery of health programming (with due caution where this poses a potential security risk or increases the risk of GBV)	✓	✓	✓	✓
Increase the accessibility of health and reproductive health facilities that integrate GBV-related services (e.g. provide safe and confidential escorts to facilities; make opening times convenient; ensure universal access for persons with disabilities; eliminate service fees; etc.)	✓	✓	✓	✓
Implement strategies that maximize the quality of survivor care at health facilities (e.g. implement standardized guidelines for the clinical care of sexual assault; establish private consultation rooms; maintain adequate supplies and medical drugs; provide follow-up services; etc.)		✓	✓	✓
Enhance the capacity of health providers to deliver quality care to survivors through training, support and supervision (and, where feasible, include a GBV caseworker on staff at health facilities)		✓	✓	✓
Implement all health programmes within the framework of sustainability beyond the initial crisis stage (e.g. design plans for rebuilding health centres; provide more frequent and intensive training of health workers; develop longer-term supply management strategies; etc.)			✓	✓
► Policies				
Develop and/or standardize protocols and policies for GBV-related health programming that ensure confidential, compassionate and quality care of survivors and referral pathways for multi-sectoral support	✓	✓	✓	✓
Advocate for the reform of national and local laws and policies that hinder survivors or those at risk of GBV from accessing quality health care and other services, and allocate funding for sustainability	✓		✓	✓
► Communications and Information Sharing				
Ensure that health programmes sharing information about reports of GBV within the health sector or with partners in the larger humanitarian community abide by safety and ethical standards (e.g. shared information does not reveal the identity of or pose a security risk to individual survivors, their family members or the broader community)	✓	✓	✓	✓
Incorporate GBV messages into health-related community outreach and awareness-raising activities (including prevention; where to report risk; health effects of different forms of GBV; benefits of health treatment; and how to access care, using multiple formats to ensure accessibility)		✓	✓	✓
COORDINATION				
Undertake coordination with other sectors to address GBV risks and ensure protection for women, girls and other at-risk groups	✓	✓	✓	✓
Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a health focal point to regularly participate in GBV coordination meetings	✓	✓	✓	✓
MONITORING AND EVALUATION				
Identify, collect and analyse a core set of indicators—disaggregated by sex, age, disability and other relevant vulnerability factors—to monitor GBV risk-reduction activities throughout the programme cycle	✓	✓	✓	✓
Evaluate GBV risk-reduction activities by measuring programme outcomes (including potential adverse effects) and using the data to inform decision-making and ensure accountability		✓	✓	✓

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

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

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

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

Adequate health services are not only vital to ensuring life-saving care for women, girls and other at-risk groups,¹ but they are also a key building block for any setting seeking to overcome the devastation of humanitarian emergency. When health-care programmes are safe, confidential, effectively designed, sensitive, accessible (both in terms of location and physical access) and of good quality, they can:

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

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

¹ For the purposes of this TAG, at-risk groups include those whose particular vulnerabilities may increase their exposure to GBV and other forms of violence: adolescent girls; elderly women; woman and child heads of households; girls and women who bear children of rape and their children born of rape; indigenous people and ethnic and religious minorities; lesbian, gay, bisexual, transgender and intersex (LGBTI) persons; persons living with HIV; persons with disabilities; persons involved in forced and/or coerced prostitution and child victims of sexual exploitation; persons in detention; separated or unaccompanied children and orphans, including children associated with armed forces/groups; and survivors of violence. For a summary of the protection rights and needs of each of these groups, see page 10 of this TAG.

WHAT THE SPHERE HANDBOOK SAYS:

Essential Health Services—Sexual and Reproductive Health Standard 1: Reproductive Health

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

Key Actions:

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

Health Systems Standard 2: Human Resources

Guidance Note 1: Staffing Levels

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

Health Systems Standard 5: Health Information Management

Guidance Note 4: Confidentiality

- ▶ Adequate precautions should be taken to protect the safety of the individual, as well as the data itself. . . . Data that relate to injury caused by torture or other human rights violations

(Sphere Project. 2011. *Sphere Handbook: Humanitarian charter and minimum standards in humanitarian response*, <www.sphereproject.org/resources/download-publications/?search=1&keywords=&language=English&category=22>)





ESSENTIAL TO KNOW

The Minimum Initial Service Package

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

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

Addressing Gender-Based Violence throughout the Programme Cycle



KEY GBV CONSIDERATIONS FOR

ASSESSMENT, ANALYSIS AND PLANNING

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

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

These areas of inquiry are linked to the three main types of responsibilities detailed below under 'Implementation': programming, policies, and communications and information sharing. The information generated from these areas of inquiry should be analysed to inform planning of health programmes in ways that prevent and mitigate the risk of GBV, as well as facilitate response services for survivors. This information may highlight priorities and gaps that need to be addressed when planning new programmes or adjusting existing programmes. For general information on programme planning and on safe and ethical assessment, data management and data sharing, see **Part Two: Background to Health Guidance**.



KEY ASSESSMENT TARGET GROUPS

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

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

Areas Related to Health PROGRAMMING

Participation and Leadership

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

Cultural and Community Perceptions, Norms and Practices

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

Infrastructure

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

(continued)

² For more information regarding universal design and/or reasonable accommodation, see definitions in **Annex 4** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.



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

Services

- j) What is the range of health services provided to support the medical needs of GBV survivors (*e.g. PEP to prevent HIV; emergency contraception; treatment for STIs; pregnancy care; safe access to abortion where it is legal; basic mental health care; etc.*)?
- Are follow-up services available (*e.g. ensuring adherence to the full course of PEP against HIV; voluntary counselling and testing at prescribed intervals; provision of long-term mental health and psychosocial support as needed; etc.*)?
 - Is a trained GBV caseworker available at the health facility to provide care and support to survivors?
- k) Are there agency-specific policies or protocols in place for the clinical care of sexual assault and other forms of GBV?
- Do these policies/protocols adhere to ethical and safety standards (*privacy, confidentiality, respect, non-discrimination and informed consent*)?
 - Do they include: medical history, examination, collection of forensic evidence where possible, treatment, referral and reporting, pregnancy counselling, survivor safety planning, mental health and psychosocial support, record-keeping, and coordination with other sectors and actors?
 - Can these policies/protocols be easily referenced or accessed? Are staff aware of them?
 - Do they include information about providing care and support to male survivors of sexual violence?
 - Are women, girls and other at-risk groups meaningfully engaged in the development of health policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
- l) What referral pathways for GBV survivors are in place in health facilities (*to security/police, safe shelter, mental health and psychosocial support, legal services, community services, etc.*)?
- Are these institutions safe (*i.e. do they not expose the survivor to further risks*)?
 - Is there a system for following up after providing referrals?
- m) What is the documentation process for GBV reports and referrals?
- Are consent forms, medical examination forms and medico-legal certificates physically available in local languages?
 - What are the most prevalent types of GBV being documented?
 - Who is responsible for documentation?
 - Are records kept in a secure place and appropriately coded (*e.g. with unique identifying numbers*) to ensure confidentiality?
- n) What are the methods of information sharing, coordination, feedback, and system improvements among health actors, as well as between health actors and other multi-sectoral service providers?
- Are all actors/organizations aware of each other's activities?
 - How are gaps and problems in service delivery identified?
 - Have Standard Operating Procedures (SOPs) been developed for multi-sectoral prevention and response to GBV? Have health actors signed on to these?
- o) What are health-care workers' attitudes towards GBV survivors and the services provided (*e.g. attitudes towards emergency contraception and abortion care in settings where these services are legal*)? How is this reflected in the type and level of care provided?
- p) Do specialized health staff (*e.g. doctors and nurses who conduct medical examinations of survivors; psychiatrists, psychologists and social workers; etc.*) receive ongoing supervision, and have they been trained on:
- The clinical care of sexual assault, including mental health and psychosocial support?
 - How to identify and treat various other forms of GBV without breaching confidentiality or privacy, or placing patients at additional risk of harm?
 - Providing safe and ethical referrals?
- q) Have community health workers (*including traditional health providers*) been trained on:
- The physical and mental health implications of different types of GBV?
 - How to respond immediately to survivors?
 - Providing safe and ethical referrals?

(continued)



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

Areas Related to Health POLICIES

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

Areas Related to Health COMMUNICATIONS and INFORMATION SHARING

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



LESSON LEARNED

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

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

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

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





KEY GBV CONSIDERATIONS FOR RESOURCE MOBILIZATION

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

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



ESSENTIAL TO KNOW

Beyond Accessing Funds

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



A.

HUMANITARIAN NEEDS OVERVIEW

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

B.

PROJECT RATIONALE/ JUSTIFICATION

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

C.

PROJECT DESCRIPTION

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





KEY GBV CONSIDERATIONS FOR IMPLEMENTATION

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

Integrating GBV Prevention and Response into HEALTH PROGRAMMING

1. Involve women, adolescent girls and other at-risk groups in the design and delivery of health programming *(with due caution in situations where this poses a potential security risk or increases the risk of GBV).*

- ▶ Employ women in clinical and non-clinical staff, administrator and training positions to ensure a gender balance in all aspects of health programming and provision of health care to survivors. Provide them with formal and on-the-job training as well as targeted support to assume leadership and training positions.
- ▶ Ensure the active participation and leadership of women (and where appropriate, adolescent girls) in local health committees and community groups. Be aware of potential tensions that may be caused by attempting to change the role of women and girls in communities and, as necessary, engage in dialogue with males to ensure their support.
- ▶ Employ persons from at-risk groups in health staff, leadership and training positions. Solicit their input to ensure specific issues of vulnerability are adequately represented and addressed in programmes.

2. Increase the accessibility of health and reproductive health facilities that integrate GBV-related services.

- ▶ Maximize safety within and around health facilities. This can include, among other things, installing adequate lighting; employing female guards at facilities; ensuring lockable sex-segregated latrines and washing facilities; and linking with community health workers to provide survivors safe, supportive and confidential escorts to and from facilities.
- ▶ Reduce or eliminate fees for GBV-related services.
- ▶ Make opening times convenient for women, girls and other at-risk groups based on their household duties and school times. Provide 24-hour services for sexual assault when possible.
- ▶ Ensure facilities are universally accessible by older persons and persons with disabilities.
- ▶ Ensure the presence of same-sex, same-language health workers when possible. Provide translators and sign language interpreters who are trained in guiding principles for survivor care.
- ▶ Consider whether to integrate GBV services into existing facilities (especially Primary Health Care and Reproductive Health services) and/or as stand-alone centres. Give due consideration to issues of stigma that may discourage survivors from entering facilities in which they may be easily identified.
- ▶ Introduce mobile clinics to remote areas.



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



ESSENTIAL TO KNOW

Transgender Persons

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

(For more information see: <www.transequality.org>)

3. Implement strategies that maximize the quality of care available to survivors at health facilities.

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

³ See Annex 4 of the comprehensive Guidelines, available at <www.gbvguidelines.org> for a description of informed consent.





ESSENTIAL TO KNOW

Confidentiality

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

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

Key points to keep in mind include:

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

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

(Adapted from **Inter-Agency Working Group on Reproductive Health in Crises. 2010.** *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 revision for field testing*, p. 66, <<http://iawg.net/resource/field-manual>>. For more information about issues of confidentiality when working with child survivors, see **International Rescue Committee and United Nations Children's Fund. 2012.** *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*, <www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf>.)

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





ESSENTIAL TO KNOW

Persons with Disabilities

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

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

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

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

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



ESSENTIAL TO KNOW

Child and Adolescent Survivors

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

Persons interviewing and assisting child and adolescent survivors should:

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

(For more information on working with child survivors see the Child Protection TAG. Also see **International Rescue Committee and United Nations Children's Fund. 2012. Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings**, <www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf>.)



- Ideally, a broad pool of service providers should be trained in specialized GBV services to account for high staff turnover and prevent stigmatization of survivors who access services from a single designated provider.
- Train and provide ongoing supervision to specialized health providers (i.e. doctors and nurses who conduct medical examinations of survivors; psychiatrists, psychologists and social workers) on specific protocols for compassionate and confidential care.
- Ensure health-care providers are informed of relevant laws and policies governing cases of GBV (e.g. abortion laws; process of pursuing legal justice; interactions with the police; police forms; mandated reporting laws; testifying in court; etc.).
- Where feasible, include a GBV caseworker on staff at health facilities to provide care and support to survivors.



ESSENTIAL TO KNOW

Female Genital Mutilation/Cutting

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

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

- ▶ Consider training health providers in identification of sexual violence and other forms of GBV (e.g. systematically asking women, girls and other at-risk groups about experiences of violence/abuse). *Note that health facilities should not conduct routine inquiry until health providers are well trained and experienced in providing services for various forms of GBV; can ensure clients’ privacy, safety and confidentiality; and can receive regular supervision to ensure no harm is caused through identification processes.*



ESSENTIAL TO KNOW

Male Survivors

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

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



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

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

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

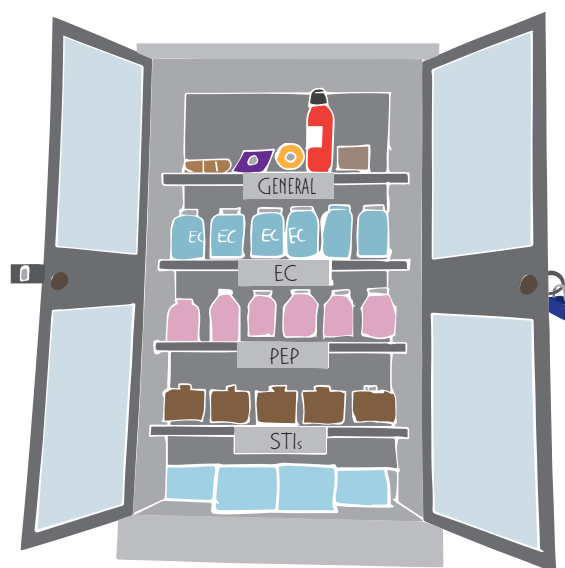
Integrating GBV Prevention and Response into HEALTH POLICIES

1. Develop and/or standardize protocols and policies for GBV-related health programming that ensure confidential, compassionate and quality care of survivors and referral pathways for multi-sectoral support.

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

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

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



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

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



ESSENTIAL TO KNOW

Dual Loyalty and GBV

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

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

(For more information on dual loyalty, see **World Medical Association. 2009. *Medical Ethics Manual***, <www.wma.net/en/30publications/30ethicsmanual/pdf/ethics_manual_en.pdf> and the **Istanbul Protocol**, <www.ohchr.org/Documents/Publications/training8Rev1en.pdf>. See also **Physicians for Human Rights and University of Cape Town. 2002. *Dual Loyalty and Human Rights in Health Professional Practice: Proposed guidelines and institutional mechanisms***, <https://s3.amazonaws.com/PHR_Reports/dualloyalties-2002-report.pdf>.)

Integrating GBV Prevention and Response into HEALTH COMMUNICATIONS AND INFORMATION SHARING

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

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



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

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



ESSENTIAL TO KNOW

Informing Communities about Services

Once health services are established for survivors, providers should inform communities about what to do after experiencing GBV, the benefits of seeking health care, and the location, days and hours of services. Field-tested pictorial templates that are universal and adaptable are available online at <http://iawg.net/resource/template-g>. These templates allow agencies to customize to the socio-cultural context and to insert their own logos and information about the location, days and hours of services. **When undertaking GBV-specific messaging, non-GBV specialists should be sure to work in collaboration with GBV-specialist staff or a GBV-specialized agency.**





PROMISING PRACTICE

Clinic staff in North Darfur distributed emergency contraception (EC) to village midwives, along with a flyer (in Arabic) developed by the MISP Coordinator on the benefits and availability of care for survivors of sexual violence. African Union (AU) commanders in North Darfur were informed by the MISP Coordinator to refer all rape survivors to a local clinic for treatment. The AU civilian police (CIVPOL) patrol also distributed informational flyers. The MISP Coordinator conducted meetings with CIVPOL members about the importance of the clinical management of rape survivors, and traditional birth attendants delivered messages on sexual violence to the community. In West Darfur, midwives were identified as sexual violence protection focal points; internally displaced women could approach these focal points confidentially, and the focal points would refer them to appropriate medical care. In South Darfur, women's health teams conducted community outreach to survivors of sexual violence. Some agencies immediately established women's centres in camps; these centres not only provided a safe place for women and girls, but also provided a space for survivors of sexual violence to receive confidential, holistic care in an environment that minimized any social stigma. The following key strategies helped to make this programme effective and could be adapted by other programmes:

- Information about emergency contraception was distributed by known health-care providers in local languages.
- Police were engaged in referring rape survivors early.
- Education about sexual violence and the care available was distributed by an authoritative staff.
- Different focal points were identified based on who was respected and accessible in the community.

(Adapted from **Women's Refugee Commission. 2006 [revised 2011].** 'Minimum Initial Service Package [MISP] for Reproductive Health in Crisis Situations: A distance learning module', <<http://misp.iawg.net>>.)



KEY GBV CONSIDERATIONS FOR COORDINATION WITH OTHER HUMANITARIAN SECTORS

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

- ▶ Design and conduct health assessments that examine the risks of GBV related to health programming, and strategize with health actors about ways these risks can be mitigated.
- ▶ Provide trainings for health staff (including medical and non-medical personnel) on issues of gender, GBV, women's/human rights, and how to respectfully and supportively engage with survivors and provide compassionate care.
- ▶ Develop a standard referral pathway for GBV survivors who may disclose to health staff, and ensure training for health personnel on how to provide safe, ethical and confidential referrals.
- ▶ Identify existing national health guidelines and protocols for the clinical care of GBV, and advocate as needed to ensure they meet international standards.
- ▶ Conduct training and awareness-raising for the affected community on issues of gender, GBV and women's rights/human rights as they relate to health.

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



Camp Coordination and Camp Management (CCCM)

- ▶ Coordinate with CCCM actors to:
 - Assess the availability of health services and referrals for affected populations
 - Plan the location and ensure the accessibility of health facilities based on safety concerns and needs of survivors and those at risk of GBV
 - As appropriate, implement and establish a schedule for mobile clinics visiting evacuation centres and IDP/refugee sites

Child Protection

- ▶ Enlist support of child protection actors to:
 - Provide training for health workers on child protection, GBV, and mental health and psychosocial support
 - Ensure child-friendly services are available in health facilities for child survivors of GBV

Education

- ▶ Work with education actors to:
 - Integrate information on sexual and reproductive health, family planning, prevention of HIV infection, and GBV into educational curricula and mass communication campaigns in schools
 - Provide sensitization and training for teachers, students, parents and community on health and GBV issues

Food Security and Agriculture

- ▶ Work with food security and agriculture actors to:
 - Provide food assistance, as necessary, to GBV survivors
 - Advocate for flexible delivery times of food rations for hospitalized survivors of GBV

Housing, Land and Property (HLP)

- ▶ Link with HLP actors to reduce unintended and negative impacts of using specific land or communal/public facilities for temporary health-care centres

Livelihoods

- ▶ Work with livelihoods programmers to provide cash-for-work to survivors and those at risk of GBV in health facilities and health outreach initiatives (ensuring equitable pay for women and men)

Nutrition

- ▶ Collaborate with nutrition actors to:
 - Assess and, as necessary, provide nutritional assistance to GBV survivors receiving medical support
 - Where appropriate, establish nutritional services within health centres that deliver at flexible times for hospitalized and/or outpatient survivors of GBV
 - Develop and deliver GBV messages (*e.g. prevention, where to report risk, benefits to health services and how to access care*) to those accessing nutrition services

Protection

- ▶ Work with protection actors to:
 - Address the protection needs of women, girls and other at-risk groups travelling to/from health facilities (linking with law enforcement as necessary)
 - Train protection personnel in health concerns related to GBV and safe and appropriate referral pathways
 - Analyse local laws related to GBV, as well as the health sector's responsibility to support justice for survivors

Shelter, Settlement and Recovery (SS&R)

- ▶ Work with SS&R actors to plan the location and construction of health facilities

Water, Sanitation and Hygiene (WASH)

- ▶ Consult with WASH personnel to ensure health facilities are equipped with safe, private, sex-segregated and accessible facilities (*e.g. toilets, bathing facilities, safe water supply, hygiene facilities, etc.*)





KEY GBV CONSIDERATIONS FOR

MONITORING AND EVALUATION THROUGHOUT THE PROGRAMME CYCLE

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

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

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

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in health assessments⁵	$\frac{\text{\# of health assessments that include GBV-related questions* from the GBV Guidelines} \times 100}{\text{\# of health assessments}}$ <p><i>* See page 42 for GBV areas of inquiry that can be adapted as questions in assessments</i></p>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	$\frac{\text{\# of assessment respondents who are female} \times 100}{\text{\# of assessment respondents and \# of assessment team members who are female} \times 100}$	Assessment reports (at agency or sector level)	50%	✓	✓	

(continued)

⁵ **Inter-Agency Standing Committee. 30 November 2012.** *Reference Module for Cluster Coordination at the Country Level.* IASC Transformative Agenda Reference Document, <https://interagencystandingcommittee.org/system/files/legacy_files/4.%20Reference%20module%20for%20Cluster%20Coordination.pdf>

INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Consultations with the affected population on accessing GBV-related health services⁶ <i>Disaggregate consultations by sex and age</i>	<i>Quantitative:</i> $\frac{\# \text{ of health services conducting consultations with the affected population to discuss access to GBV-related services} \times 100}{\# \text{ of health services}}$ <i>Qualitative:</i> What types of barriers do affected persons experience in accessing GBV-related health services?	Organizational records, focus group discussion (FGD), key informant interview (KII)	100%	✓	✓	
Health facilities with trained clinical staff on clinical care for sexual assault (CCSA) and other forms of GBV <i>Disaggregate trained clinical staff by sex</i>	$\frac{\# \text{ of health facilities with clinical staff who are trained on CCSA and other forms of GBV} \times 100}{\# \text{ of health facilities}}$	Health facility assessment	100%	✓	✓	
RESOURCE MOBILIZATION						
Inclusion of GBV prevention and response in health funding proposals or strategies	$\frac{\# \text{ of health funding proposals or strategies that include at least one GBV risk-reduction objective, activity or indicator from the GBV Guidelines} \times 100}{\# \text{ of health funding proposals or strategies}}$	Proposal review (at agency or sector level)	100%	✓	✓	
Training of health staff on the GBV Guidelines	$\frac{\# \text{ of health staff who participated in a training on the GBV Guidelines} \times 100}{\# \text{ of health staff}}$	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	
Stock availability of pre-positioned supplies for CCSA⁶	$\frac{\# \text{ of CCSA supplies that have stock levels below minimum levels} \times 100}{\# \text{ of CCSA supplies}}$	Planning or procurement records, health facility assessment	0%	✓	✓	

(continued)

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



INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
IMPLEMENTATION						
► Programming						
Female participation prior to programme design⁶	<p><i>Quantitative:</i></p> $\frac{\# \text{ of affected persons consulted before designing a programme who are female} \times 100}{\# \text{ of affected persons consulted before designing a programme}}$ <p><i>Qualitative:</i> How do women and girls perceive their level of participation in the programme design? What enhances women's and girls' participation in the design process? What are barriers to female participation in these processes?</p>	Organizational records, FGD, KII	Determine in the field		✓	
Female staff in health service provision⁶	$\frac{\# \text{ of staff who provide health services who are female} \times 100}{\# \text{ of staff who provide health services}}$	Organizational records	50%	✓	✓	
Risk factors of GBV in and around health centres providing services for CCSA and other forms of GBV	<p><i>Quantitative:</i></p> $\frac{\# \text{ of affected persons who report concerns about experiencing GBV when asked about access to health centres providing services for CCSA and other forms of GBV} \times 100}{\# \text{ of affected persons asked about access to health centres providing services for CCSA and other forms of GBV}}$ <p><i>Qualitative:</i> Do affected persons feel safe from GBV when accessing health centres providing services for CCSA and other forms of GBV? What types of safety concerns does the affected population describe?</p>	Survey, FGD, KII, participatory community mapping	0%	✓		✓
Availability of free services for CCSA and other forms of GBV in health facilities	$\frac{\# \text{ of health facilities with CCSA with no fee for CCSA and other forms of GBV} \times 100}{\# \text{ of health facilities with CCSA}}$	Health facility assessment, KII	0%	✓		✓
Community knowledge of health services for CCSA and other forms of GBV	$\frac{\# \text{ of affected persons who, in response to a prompted question, correctly say where to locate health services for CCSA and other forms of GBV} \times 100}{\# \text{ of surveyed affected persons}}$	Survey	100%	✓		✓
Safe provision of quality CCSA treatment at health facilities	$\frac{\# \text{ of health facilities that can provide* emergency contraceptive pills, post-exposure prophylaxis and sexually transmitted infection (STI) presumptive treatment in a private room} \times 100}{\# \text{ of assessed health facilities}}$ <p><small>* Provision includes supplies, trained staff and World Health Organization (WHO) standardized protocols</small></p>	MISP Needs Assessment Health Facility Questionnaire	Determine in the field	✓		✓

(continued)

INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	Stage of Programme		
				BASE-LINE	OUT-PUT	OUT-COME
IMPLEMENTATION (continued)						
► Programming						
Staff knowledge of Standard Operating Procedures for multi-sectoral care for GBV	$\frac{\text{\# of health staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors} \times 100}{\text{\# of surveyed health staff}}$	Survey	100%	✓	✓	
► Policies						
Existence of a standard referral pathway for GBV survivors	$\frac{\text{\# of health sites with a standard referral pathway for GBV survivors} \times 100}{\text{\# of health sites}}$	KII	100%	✓	✓	
Existence of national policies meeting international standards for CCSA	$\frac{\text{\# of reviewed national policies* that follow WHO standards for CCSA} \times 100}{\text{\# of reviewed national policies}}$ <i>* National policies include, PEP, emergency contraception, abortion/post-abortion care, STI treatment</i>	Desk review	0%	✓		✓
► Communications and Information Sharing						
Staff knowledge of standards for confidential sharing of GBV reports	$\frac{\text{\# of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors} \times 100}{\text{\# of surveyed staff}}$	Survey (at agency or programme level)	100%	✓		✓
Inclusion of information about the location and benefits of timely care for CCSA and other forms of GBV in community outreach activities	$\frac{\text{\# of health community outreach activities programmes that include information about the location and benefits of timely care for CCSA and other forms of GBV} \times 100}{\text{\# of health community outreach activities}}$	Desk review, KII	Determine in the field	✓	✓	
COORDINATION						
Coordination of GBV risk-reduction activities with other sectors	$\frac{\text{\# of non-health sectors consulted with to address GBV risk-reduction activities*} \times 100}{\text{\# of existing non-health sectors in a given humanitarian response}}$ <i>* See page 56 for list of sectors and GBV risk-reduction activities</i>	KII, meeting minutes (at agency or sector level)	Determine in the field	✓	✓	



RESOURCES

Key Resources

Clinical Care for Sexual Assault and other forms of GBV

- **World Health Organization. 2003.** *Guidelines for Medico-Legal Care of Victims of Sexual Violence.* Geneva, <<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>>
- For an example of a medical history and examination form that can be used as a guide when treating survivors of violence against women and girls, see **World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. 2004.** *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons – Revised Edition*, pp. 44–47, <www.who.int/reproductivehealth/publications/emergencies/924159263X/en>
- **International Rescue Committee. 2009 (revised 2014).** *Clinical Care for Sexual Assault Survivors*, <<http://iawg.net/ccsas/ccsas-resources>>. The goal of this training tool is to improve the clinical care of sexual assault survivors in low-resource settings by encouraging compassionate, competent and confidential care in keeping with international standards.
- **United Nations High Commissioner for Refugees, United Nations Population Fund, and World Health Organization. 2009.** 'Clinical Management of Rape Survivors: E-Learning programme', <www.who.int/reproductivehealth/publications/emergencies/9789241598576/en>. The course is a self-instructional, interactive e-learning programme based on the content of the WHO/UNHCR guidance on *Clinical Management of Rape Survivors*, and the training materials used by UNHCR and UNFPA in field-based face-to-face training sessions.
- **World Health Organization. 2013.** *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO clinical and policy guidelines*, <www.who.int/reproductivehealth/publications/violence/9789241548595/en>
- **United Nations Population Fund/United Nations Children's Fund Joint Programme on Female Genital Mutilation/Cutting, 2009.** 'The End Is in Sight: Moving toward the abandonment of female genital mutilation/cutting', <www.unfpa.org/publications/end-sight-2009-annual-report>
- For guidelines for the clinical care of FGM/C designed for application in England and Wales, see **HM Government, 2011.** *Multi-Agency Practice Guidelines: Female Genital Mutilation*, <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf>

- **United Nations Population Fund. 2012.** 'Research, Health Care and Preventive Measures for FGM/C and the Strengthening of Leadership and Research in Africa', <www.unfpa.org/resources/research-health-care-and-preventive-measures-fgmc-and-strengthening-leadership-and>
- **World Health Organization. 2014.** *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A clinical handbook.* WHO/RHR/14.26, Field testing version, September 2014, <www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en>
- **Yeager, J., and Fogel, J. 2006.** 'Male Disclosure of Sexual Abuse and Rape', *Topics in Advanced Practice Nursing eJournal* 2006;6(1), <www.medscape.com/viewarticle/528821>

Minimum Initial Service Package

- **Women's Refugee Commission. 2006 (revised 2011).** 'Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A distance learning module', <<http://misp.iawg.net>>
- **Inter-Agency Working Group on Reproductive Health in Crises. 2010.** *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, <<http://iawg.net/resource/field-manual>>. This field manual includes information on the Minimum Initial Services Package (MISP) and comprehensive reproductive health. One chapter is devoted to gender-based violence, and addresses sexual violence, intimate partner violence, female genital mutilation and child and/or forced marriage.
- **Inter-Agency Working Group on Reproductive Health in Crises. 2011.** *Inter-Agency Reproductive Health Kits for Crisis Situations*, fifth edition, <http://iawg.net/resources/184151_UNFPA_EN.pdf>. The essential drugs, equipment and supplies to implement the MISP have been assembled into a set of specially designed prepackaged kits, the Inter-Agency Reproductive Health Kits. The kits complement the objectives laid out in *Reproductive Health in Humanitarian Settings: An inter-agency field manual*. The resource is also available in French and Spanish.
- **Women's Refugee Commission.** 'Universal and Adaptable Information, Education and Communication (IEC) Templates on the MISP'. In an effort to provide clear and consistent messages on the MISP for Reproductive Health, the Women's Refugee Commission developed information, education and communication (IEC) templates on two of the MISP-related objectives to better inform communities on the importance of seeking care, knowing when and how to seek care, and what services to expect from field agencies. Electronic and hard copies of a facilitator's tool-kit are available from the Women's Refugee Commission: <<http://iawg.net/resource/iec-misp>>



■ Working with Child and Adolescent Survivors

- **International Rescue Committee and United Nations Children's Fund. 2012.** *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*, <www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf>
- **United Nations Population Fund and Save the Children. 2009.** *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*, <www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf>
- **United Nations Population Fund and Save the Children.** *E-Learning Course on Adolescent and Sexual Reproductive Health in Humanitarian Settings*, <<http://iawg.net/resource/interactive-e-learning-course>>. This e-learning course is an introduction to adolescents' sexual and reproductive health needs in humanitarian settings.

Mental Health and Psychosocial Support

- **Inter-Agency Standing Committee. 2010.** *Caring for Survivors Training Guide*, <www.unicefinemergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf>. This training pack can be used to develop multi-sectoral skills (e.g. health, psychosocial, legal/justice and security) and is designed for professional health-care providers, as well as for members of the legal professionals, police, women's groups and other concerned community members, such as community workers, teachers and religious workers. The training includes a facilitator guide for medical management of sexual assault.
- **World Health Organization, United Nations Population Fund, United Nations Children's Fund, and UNAction. 2012.** 'Mental Health and Psychosocial Support for Conflict-Related Sexual Violence: Principles and interventions', <www.who.int/reproductivehealth/publications/violence/rhr12_18/en>
- **Inter-Agency Standing Committee. 2007.** *Guidelines on Mental Health and Psychological Support in Emergency Settings*, <www.who.int/hac/network/interagency/news/mental_health_guidelines_checklist/en>
- **World Health Organization, War Trauma Foundation, and World Vision International. 2011.** 'Psychological First Aid: Guide for field workers'. Available in 10+ languages at <www.who.int/mental_health/publications/guide_field_workers/en>
- **Inter-Agency Standing Committee Reference Group. 2013.** 'Mental Health and Psychosocial Support Assessment Guide'. The purpose of this document is to provide agencies with tools containing key assessment questions that are of common relevance to all actors involved in Mental Health and Psychosocial Support (MHPSS) independent of the phase of the emergency. <www.who.int/mental_health/publications/IASC_reference_group_psychosocial_support_assessment_guide.pdf>
- **World Health Organization, United Nations Population Fund, United Nations High Commissioner for Refugees, United Nations Children's Fund and UNAction, 2012.** 'Mental health and psychosocial support for conflict-related sexual health: 10 myths', <www.unicef.org/protection/files/Policy_brief_10_myths_English_19-7.pdf>

- **Sveaass, N., et al. 2014.** *Mental Health and Gender-Based Violence: Helping survivors of sexual violence in conflict – A training manual*, <<http://hhri-gbv-manual.org>>

Data Collection

- **GBVIMS.** The GBVIMS has been implemented in Burundi, Colombia, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Guinea, Iraq, Kenya, Liberia, Nepal, Sierra Leone, Southern Sudan, Thailand and Uganda. To gain access to the GBVIMS tools and to learn about implementing the GBVIMS, organizations must:
 - Participate in a GBVIMS Orientation in person or via webinar.
 - Submit a brief questionnaire to the Steering Committee to ensure that it is applicable to your context and programme of the requesting organization.
 - Participate in a consultation with a member of the GBVIMS Global Team. This provides access to the expertise of organizations that developed the GBVIMS and have implemented the GBVIMS in multiple countries.

For more information on the GBVIMS, see: <www.gbvims.com>. You can also **watch a short GBVIMS Website Tour:** <https://www.youtube.com/watch?v=8Ziqef2X4aA&utm_source=Listserve+Emails+September&utm_campaign=%20defe51ceea-GBVIMS_Website_Updates10_29_2012&utm_medium=emailwww>

- **World Health Organization. 2007.** *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, <www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf>
- **United Nations Action Guidance Note. 2008.** 'Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries: Dos and don'ts', <www.stoprapienow.org/uploads/advocacyresources/1282164733.pdf>

Standard Operating Procedures

- **Inter-Agency Standing Committee Gender Sub-Working Group. 2008.** *Establishing Gender-Based Violence Standard Operating Procedures (SOPs) for Multisectoral and Inter-Organizational Prevention and Response to Gender-Based Violence in Humanitarian Settings*, <www.gbvguidelines.org/wp-content/uploads/sites/3/2015/03/Gender-Based-Violence-Resource-Tools-2005.pdf>. The guide includes detailed guidance on the process of developing referral pathways and other procedures for GBV prevention and response in humanitarian emergency settings.
- The **GBV SOP Workshop Package** was developed by the Gender-Based Violence Area of Responsibility Global Working Group (GBV AoR) in the Global Protection Cluster. Development of these materials was a collaborative process jointly led by UNHCR's Community Development, Gender Equality and Children Section and UNFPA's Humanitarian Response Branch. The SOP Guide and workshop package can be downloaded from: <www.gbvguidelines.org/resources/gbv-sop-workshop-manual>



Additional Resources

- For an overview of health sector responsibilities in humanitarian settings, see the Conflict/Post-Conflict Module at the **UN Women Virtual Knowledge Centre to End Violence Against Women and Girls**. The Centre website also contains a programming module on Health that does not focus specifically on humanitarian contexts, but nevertheless contains links to many key tools and resources relevant to health-care providers working in emergencies. See: <www.endvawnow.org>.
- For a checklist for ensuring gender-equitable health programming, see **Inter-Agency Standing Committee. 2006. Gender Handbook in Humanitarian Action**, <https://interagencystandingcommittee.org/system/files/legacy_files/IASC%20Gender%20Handbook%20%28Feb%202007%29.pdf>
- **Sphere Project. 2011. Sphere Handbook: Humanitarian charter and minimum standards in humanitarian response**, <www.spherehandbook.org>
- **International Planned Parenthood Federation, 2010. Resource Manual: Improving the health sector response to gender-based violence**, <<https://www.ippfwhr.org/en/publications/improving-the-health-sector-response-to-gender-based-violence>>. This manual provides tools and guidelines that health-care managers can use to improve the health-care responses to gender-based violence in developing countries. It includes practical tools to determine provider attitudes to gender-based violence, legal definitions, the responsibilities of health-care providers and the quality of care.
- **World's Abortion Laws Map**, <<http://worldabortionlaws.com/map>>. Since 1998, the Center for Reproductive Rights has produced the World's Abortion Laws map to visually compare the legal status of abortion across the globe. The interactive map is updated in real time to keep pace with changes in how countries are protecting—or denying—women's reproductive freedom.
- **United Nations High Commissioner for Refugees. 2012. Working with Men and Boy Survivors of Sexual and Gender-Based Violence in Forced Displacement**, <www.refworld.org/docid/5006aa262.html>
- For a documentary from UNAIDS on **Handicap International's work on GBV and HIV** mainstreaming in Kenya during the post-election violence in 2007–2008, see: <www.youtube.com/watch?v=DW8qFVJJtQg&feature=email>



