

Thematic Area Guide for:

Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action

*Reducing risk, promoting resilience
and aiding recovery*



Camp Coordination and Camp Management



Child
Protection



Education



Food Security
and Agriculture



Health



Housing, Land
and Property



Humanitarian
Mine Action



Livelihoods



Nutrition



Protection



Shelter, Settlement
and Recovery



Water, Sanitation
and Hygiene



Humanitarian Operations
Support Sectors

Acknowledgements

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), available at <www.gbvguidelines.org>. The lead authors were Jeanne Ward and Julie Lafrenière, with support from Sarah Coughtry, Samira Sami and Janey Lawry-White.

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.

The Operations and Task Teams would like to extend a sincere thank you to all those individuals and groups who contributed to the Guidelines revision process from all over the world, particularly the Cluster Lead Agencies and cluster coordinators at global and field levels. We thank you for your input as well as for your ongoing efforts to address GBV in humanitarian settings.

We would like to thank the United States Government for its generous financial support for the revision process.

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 at <www.gbvguidelines.org>. The 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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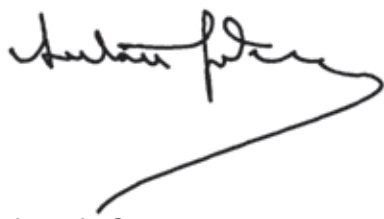
Foreword

All national and international actors responding to a humanitarian emergency have a duty to protect those affected by crisis; this includes protecting them 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: Humanitarians must be aware of the risks of gender-based violence and work to prevent and mitigate them as quickly as possible, coordinating their actions to ensure a comprehensive response.

Camp coordination and camp management (CCCM) actors play an important role in ensuring the safety and security of affected populations. Taking action against gender-based violence is a key element of this. Overcrowding, lack of privacy and unsafe design of site-related services can all contribute to a heightened risk of GBV in camps and camp-like settings, particularly for women and girls. Well-designed settings, on the other hand, help to reduce exposure to violence, improve quality of life and preserve the dignity of displaced populations. Camps that ensure equitable access to services and protection – as well as effective management of information, space, natural resources and livelihoods opportunities – are much better positioned to prevent and mitigate the risks of gender-based violence.

This Thematic Area Guide (TAG) on CCCM 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>). It is a portable tool that provides practical guidance to assist CCCM actors and affected communities to coordinate, plan, implement, monitor and evaluate essential actions for the prevention and mitigation of gender-based violence. The guidance is meant to be applied throughout the entire life cycle of a site – from planning and set-up, to care and maintenance, and through to site closure and longer-term solutions for affected populations. Extensively reviewed and field tested, this guide reflects the combined wisdom and experience of colleagues from the CCCM sector, as well as from the wider humanitarian community.

Promoting and protecting the rights of affected populations – including the right to be safe from gender-based violence – is central to the work of CCCM actors. By implementing this guidance in our work, we can achieve groundbreaking improvements in humanitarian responses. Most important, we will enhance the safety and dignity of those we serve, now and into the future. We owe that to them.



Antonio Guterres,
High Commissioner



Ambassador William Lacy Swing,
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
EA\$E	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



Contents

Acknowledgements.....	ii
Foreword	iii
Acronyms	iv

Part One: Introduction

1. About This Thematic Area Guide	1
2. Overview of Gender-Based Violence	4
3. The Obligation to Address Gender-Based Violence in Humanitarian Work	13

Part Two: Background to Camp Coordination and Camp Management Guidance

1. Content Overview of Camp Coordination and Camp Management Guidance	19
2. Guiding Principles and Approaches for Addressing Gender-Based Violence.....	33

Part Three: Camp Coordination and Camp Management Guidance

Why Addressing Gender-Based Violence is a Critical Concern of the Camp Coordination and Camp Management Sector	39
Addressing Gender-Based Violence throughout the Programme Cycle.....	41
Key GBV Considerations for Assessment, Analysis and Planning.....	41
Key GBV Considerations for Resource Mobilization	44
Key GBV Considerations for Implementation.....	45
Key GBV Considerations for Coordination with Other Humanitarian Sectors.....	54
Key GBV Considerations for Monitoring and Evaluation throughout the Programme Cycle	56
Resources	60



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 camp coordination and camp management (CCCM) 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 CCCM 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: Camp Coordination and Camp Management 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 CCCM 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>>.



**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.*). While some humanitarian sectors (such as health) may undertake response activities related to survivor care and assistance, the overarching focus of this TAG is on essential prevention and mitigation activities that should be undertaken within and across the CCCM 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 CCCM actors.

Part Two provides a background to and summarizes the structure of the CCCM guidance 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 CCCM sector to implement programming that addresses the risk of GBV.

Although this TAG is specifically tailored to the CCCM sector, all humanitarian actors must avoid 'siloe'd' interventions. CCCM 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 CCCM 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'.

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.



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 CCCM; 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 CCCM 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 CCCM programmers—agencies and individuals who can use the information to incorporate GBV prevention and mitigation strategies into the design, implementation, monitoring and evaluation of CCCM interventions. However, it is critical that humanitarian leadership—including governments, humanitarian coordinators, CCCM coordinators and donors—also use this TAG as a reference and advocacy tool to improve the capacity of the CCCM 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.

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

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.



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 within and across the CCCM sector.** This TAG includes recommendations (outlined under ‘Coordination’ in **Part Three**) about how GBV specialists can be mobilized for technical support.

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 CCCM 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.** CCCM 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 CCCM; conducting advocacy to promote the rights of all affected populations; and enlisting females as CCCM 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 CCCM 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, CCCM 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 estab-



lished, 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 CAMP
COORDINATION
AND CAMP
MANAGEMENT
GUIDANCE



1. Content Overview of Camp Coordination and Camp Management Guidance

This section provides an overview of the recommendations detailed in **Part Three: Camp Coordination and Camp Management 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 CCCM 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, ongoing 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>)

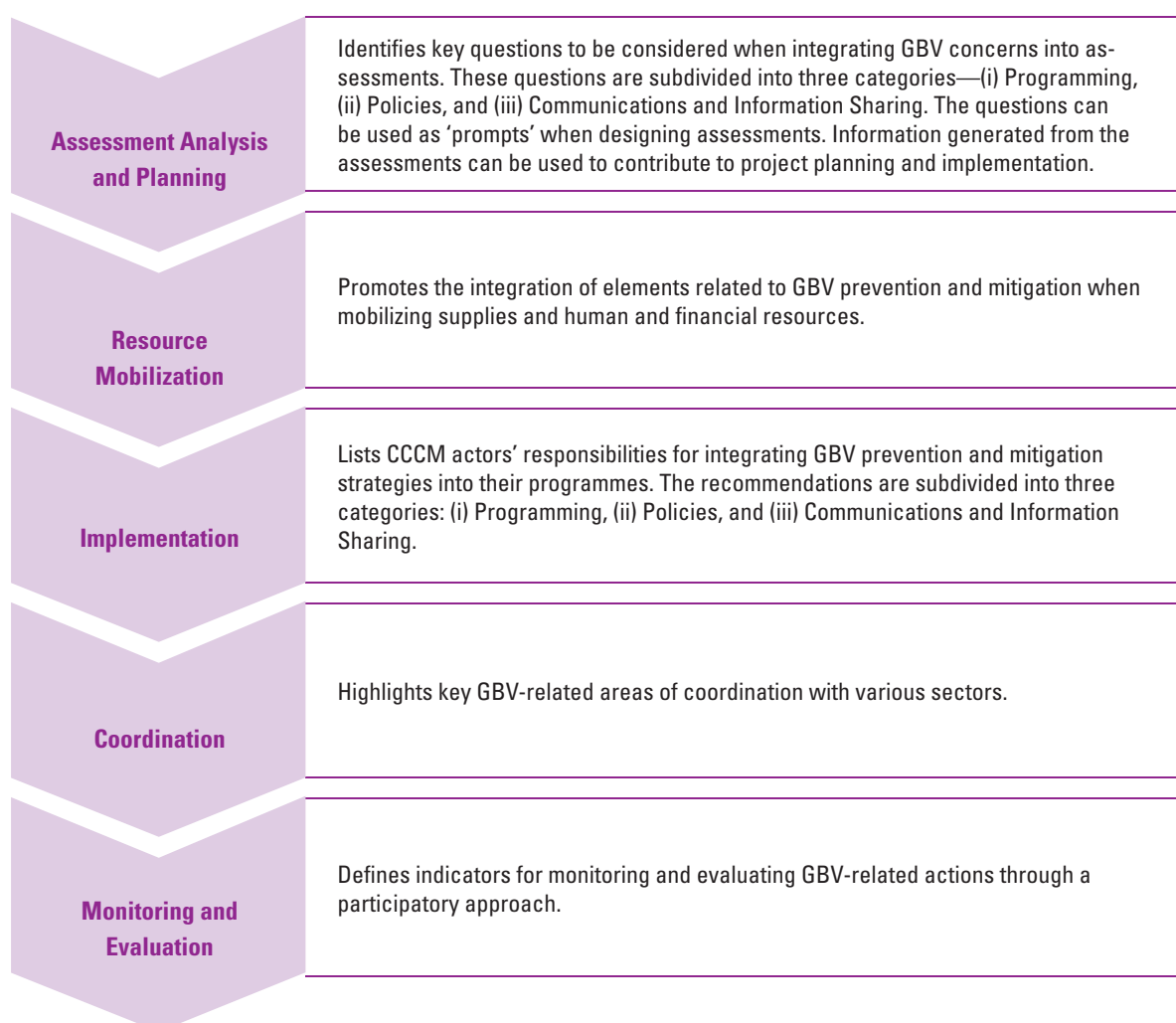
¹ Slow-onset emergencies such as drought may follow a different pattern from rapid-onset disasters. Even so, the risks of GBV and the humanitarian needs of affected populations remain the same. The recommendations in this TAG are applicable to all types of emergency.



In the summary fold-out table, CCCM-specific **minimum commitments**² appear in bold. These minimum commitments represent critical actions that CCCM 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 CCCM 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 and mitigation measures prior to or from the onset of an emergency. **Many risk-reduction interventions can be introduced without conducting an assessment.** For example, CCCM actors can ensure lighting is installed in all communal areas of the site.



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

Who to Assess	<ul style="list-style-type: none"> • Key stakeholders and actors providing services in the community • GBV, gender and diversity specialists • 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
When to Assess	<ul style="list-style-type: none"> • At the outset of programme planning • At regular intervals for monitoring purposes • During ongoing safety and security monitoring
How to Assess	<ul style="list-style-type: none"> • Review available secondary data (existing assessments/studies; qualitative and quantitative information; IDP/refugee registration data; etc.); • Conduct regular consultations with key stakeholders, including relevant grass-roots organizations, civil societies and government agencies • Carry out key informant interviews • Conduct focus group discussions with community members that are age-, gender-, and culturally appropriate (<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, CCCM 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 CCCM 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 CCCM 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 CCCM 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 CCCM-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 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, CCCM actors should:

- ▶ Mobilize human resources by making sure that partners within the CCCM 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 CCCM-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 CCCM 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 in humanitarian settings.
- ▶ Establish GBV-related responsibilities that should be undertaken by all CCCM 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 CCCM 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 and mitigation 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 CCCM 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 CCCM 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 CCCM-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.** CCCM 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.

For all CCCM 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 CCCM 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, CCCM 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 CCCM 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

- 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.

Don'ts

- 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 CCCM coordination mechanisms should also undertake the following:

- ▶ Put in place mechanisms for regularly addressing GBV at CCCM coordination meetings, such as including GBV issues as a regular agenda item and soliciting the involvement of GBV specialists in relevant CCCM 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 CCCM programmes to track their own GBV-related activities (e.g. include



ESSENTIAL TO KNOW

Accessing the Support of GBV Specialists

CCCM coordinators and CCCM 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 CCCM focal point to participate in GBV coordination meetings, and encourage the GBV chair/co-chair (or other GBV coordination group member) to participate in CCCM coordination meetings. Whenever necessary, CCCM coordinators and CCCM 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 CCCM 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 CCCM 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 CCCM sector, however. Efforts to integrate GBV risk-reduction strategies into CCCM responses should be led by CCCM 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, CCCM coordinators and CCCM 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 CCCM programming response.
- ▶ Develop and implement CCCM 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.
- ▶ 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, CCCM 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://cpwng.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 CCCM 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* CCCM M&E tools and processes, in order to improve information collection and analysis without the need for additional data collection mechanisms. CCCM 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 CCCM actors who do not have extensive GBV expertise. However, **it is the responsibility of all CCCM 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 CCCM 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 and mitigation.

Lastly, CCCM 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. CCCM 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.

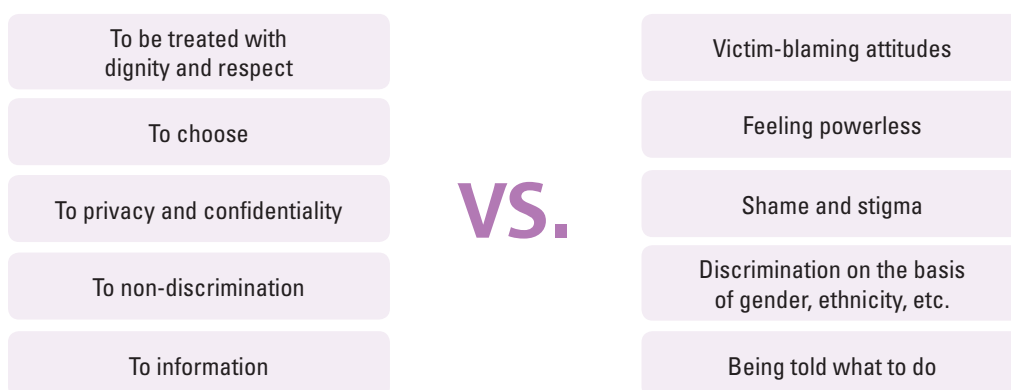
By contrast, the human rights-based approach views affected populations as 'rights-holders', and recognizes that these rights can be realized only by supporting the long-term empowerment of affected populations through sustainable solutions. This approach seeks to attend to rights as well as needs; how 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 and mitigation efforts—both in the short term and in the long term. CCCM actors can apply a systems approach in order to:

- ▶ Strengthen agency/organizational/sectoral commitment to gender equality and GBV-related programming.
- ▶ Improve CCCM 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 CCCM 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 CCCM 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 CCCM 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, CCCM actors can liaise with the Global GBV Area of Responsibility (gbvaor.net) for support in preparing and providing trainings. CCCM actors should also:

- Research relevant CCCM 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

Hersh, M. 2014. 'Philippines: New approach to emergency response fails women and girls'. Refugees International Field Report, <<http://refugeesinternational.org/sites/default/files/Philippines%20GBV%20New%20Approach%20letterhead.pdf>>

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>

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PART THREE
CAMP
COORDINATION
AND CAMP
MANAGEMENT
GUIDANCE



CAMP COORDINATION AND CAMP MANAGEMENT



THIS SECTION APPLIES TO:

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

Why Addressing Gender-Based Violence Is a Critical Concern of the Camp Coordination and Camp Management Sector

Camp managers, coordinators and administrators all share the responsibility of ensuring the safety and security of affected populations during the entire life cycle of a site:¹ from planning and set-up, to care and maintenance, and through to site closure and longer-term solutions for affected populations. Poorly planned camp coordination and camp management (CCCM) processes can heighten risks of GBV in many ways:

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

WHAT THE SPHERE HANDBOOK SAYS:

Standard 1: Strategic Planning

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

Guidance Note 7: Risk, Vulnerability and Hazard Assessments

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

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

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



SEE SUMMARY TABLE ON ESSENTIAL ACTIONS

Essential Actions for <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 within the affected population in all CCCM assessment processes	✓	✓	✓	✓
Analyse the physical safety in and around sites as it relates to risks of GBV (<i>e.g. adherence to Sphere standards; lighting; need for women-, adolescent- and child-friendly spaces; when, where, how and by whom security patrols are conducted; safety of water and distribution sites and whether they accommodate the specific needs of women, girls and other at-risk groups; accessibility for persons with disabilities etc.</i>)	✓	✓	✓	✓
Assess the level of participation and leadership of women, adolescent girls and other at-risk groups in all aspects of site governance and CCCM programming (<i>e.g. ratio of male/female CCCM staff; participation in site committees, governance bodies, and executive boards; etc.</i>)		✓	✓	✓
Analyse whether IDP/refugee registration and profiling are conducted in a manner that respects the rights and needs of women and other at-risk groups, as well as of GBV survivors		✓	✓	✓
Assess awareness of CCCM staff and stakeholders on basic issues related to gender, GBV, women's/human rights, social exclusion and sexuality (<i>including knowledge of where survivors can report risk and access care; linkages between CCCM programming and GBV risk reduction; etc.</i>)	✓	✓	✓	✓
Review existing/proposed community outreach material related to CCCM—specifically communicating with communities (CwC) and feedback mechanisms—to ensure it includes basic information about GBV risk reduction (<i>including prevention, where to report risk and how to access care</i>)	✓	✓	✓	✓
RESOURCE MOBILIZATION				
Identify and pre-position age-, gender-, and culturally appropriate supplies for CCCM that can mitigate risk of GBV (<i>e.g. lighting/torches, partitions where appropriate</i>)	✓	✓		
Develop CCCM proposals that reflect awareness of GBV risks for the affected population and strategies for reducing these risks	✓	✓	✓	✓
Prepare and provide trainings for government, humanitarian workers and volunteers engaged in CCCM work on safe design and implementation of CCCM programming that mitigates risks of GBV	✓	✓	✓	✓
IMPLEMENTATION				
► Programming				
Involve women as staff and administrators in CCCM operations	✓	✓	✓	✓
Involve women, adolescent girls and other at-risk groups as participants and leaders in community-based site governance mechanisms and decision-making structures throughout the entire life cycle of the camp (<i>with due caution where this poses a potential security risk or increases the risk of GBV</i>)	✓	✓	✓	✓
Prioritize GBV risk-reduction activities in camp planning and set-up (<i>e.g. confidential and non-stigmatizing registration; safety of sleeping areas; use of partitions for privacy; designated areas for women-, adolescent- and child-friendly spaces; etc.</i>)	✓	✓		
Prioritize GBV risk-reduction and mitigation strategies during the care and maintenance phase of the camp life cycle (<i>e.g. undertake frequent and regular checks on site security; create complaint and feedback mechanisms for community; etc.</i>)		✓	✓	✓
Support the role of law enforcement and security patrols to prevent and respond to GBV in and around sites throughout the entire camp life cycle (<i>e.g. advocate for adequate numbers of properly trained personnel; work to identify the best safety patrol options with the community; etc.</i>)	✓	✓	✓	✓
Integrate GBV prevention and mitigation into camp closure (<i>e.g. closely monitor GBV risks for returning/resettling/residual populations; work with GBV specialists to ensure continued delivery of services to GBV survivors who are exiting camps; etc.</i>)			✓	✓
► Policies				
Incorporate relevant GBV prevention and mitigation strategies into the policies, standards and guidelines of CCCM programmes (<i>e.g. procedures for food and non-food item distribution; housing policies for at-risk groups; procedures and protocols for sharing protected or confidential information about GBV incidents; agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse; etc.</i>)	✓	✓	✓	✓
Advocate for the integration of GBV risk-reduction strategies into national and local policies and plans related to CCCM, and allocate funding for sustainability (<i>e.g. develop or strengthen policies related to the allocation of law enforcement and security personnel; develop camp closure and exit strategies that take GBV-related risks into consideration; etc.</i>)		✓	✓	✓
► Communications and Information Sharing				
Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure CCCM staff have the basic skills to provide them with information where they can obtain support	✓	✓	✓	✓
Ensure that CCCM programmes sharing information about reports of GBV within the CCCM sector or with partners in the larger humanitarian community abide by safety and ethical standards (<i>e.g. shared information does not reveal the identity of or pose a security risk to individual survivors, their families or the broader community</i>)	✓	✓	✓	✓
Incorporate GBV messages (<i>including prevention, where to report risk and how to access care</i>) into CCCM-related community outreach and awareness-raising activities, using multiple formats to ensure accessibility		✓	✓	✓
COORDINATION				
Ensure GBV risk reduction is a regular item on the agenda in all CCCM-related coordination mechanisms	✓	✓	✓	✓
Undertake coordination with other sectors address GBV risks and ensure protection for women, girls and other at-risk groups	✓	✓	✓	✓
Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a CCCM focal point to regularly participate in GBV 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 CCCM actors in the early stages of an emergency. These minimum commitments will not necessarily be undertaken according to an ideal model for programming; for this reason, they do not always fall first under each subcategory of the summary table. When it is not possible to implement all actions—particularly in the early stages of an emergency—the minimum commitments should be prioritized and the other actions implemented at a later date. For more information about minimum commitments, see **Part Two: Background to Camp Coordination and Camp Management Guidance**.



ESSENTIAL TO KNOW

Defining 'CCCM'

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

(Adapted from **Norwegian Refugee Council. 2008.** 'Prevention of and Response to Gender-Based Violence', ch. 10 in *The Camp Management Toolkit*, <http://www.nrc.no/arch/_img/9178016.pdf>. Also see *CCCM Global Cluster, Revised Toolkit*, forthcoming March 2015, e-version at <www.cmttoolkit.org>.)

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


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

² 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.



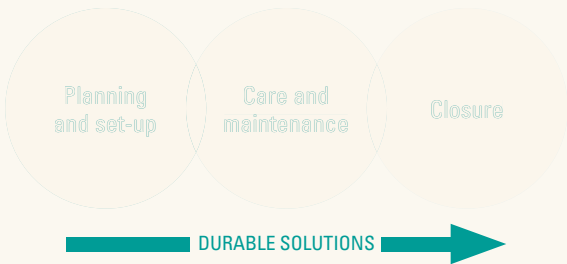
Well-designed camps and camp-like settings help to reduce exposure to GBV, improve quality of life and ensure dignity of displaced populations. Camps should be designed to ensure delivery of, and equitable access to, services and protection. Proper identification of persons at risk, as well as effective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

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


ESSENTIAL TO KNOW

The Camp's Life Cycle

A camp's life cycle can be divided into the three stages noted at right. **This life cycle is taken into consideration in the programme cycle used in this TAG.** It is crucial to include GBV prevention and mitigation activities throughout the entire camp life cycle.



(Adapted from **CCCM Global Cluster**, Revised Toolkit, forthcoming March 2015, e-version at <www.cmttoolkit.org>)

Addressing Gender-Based Violence throughout the Programme Cycle

KEY GBV CONSIDERATIONS FOR ASSESSMENT, ANALYSIS AND PLANNING

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

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 CCCM operations in ways that prevent and mitigate the risk of GBV. 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 Camp Coordination and Camp Management Guidance.**

KEY ASSESSMENT TARGET GROUPS

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

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

Areas Related to CCCM PROGRAMMING

Participation and Leadership

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

Physical Safety in and around Sites

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

(continued)

³ For more information regarding universal design and/or reasonable accommodation, see definitions in **Annex 4** of the comprehensive Guidelines, available at <www.gbvguidelines.org>.



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

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

Registration and Profiling

- n) Are married women, single women, single men, and girls and boys without family members registered individually? Are individuals with different gender identities able to register in a safe and non-stigmatizing way?
- o) Do registration/greeting/transit centres (in both natural disaster and conflict settings) have separate spaces for confidentially speaking with those who may be at particular risk of GBV (*e.g. persons separated from families or without identification who may be at heightened risk of abduction and trafficking*) or those who have disclosed violence?
- Are focal persons and/or GBV specialists available at registration/greeting/transit centres to expedite registration process for survivors and those at risk, and to provide them with information on where to access care and support?

Areas Related to CCCM POLICIES

- a) Are GBV prevention and mitigation strategies incorporated into the policies, standards and guidelines of CCCM programmes?
- Are women, girls and other at-risk groups meaningfully engaged in the development of CCCM policies, standards and guidelines that address their rights and needs, particularly as they relate to GBV? In what ways are they engaged?
 - Has the camp management agency communicated these policies, standards and guidelines to women, girls, boys and men (separately when necessary)?
 - Are CCCM staff properly trained and equipped with the necessary skills to implement these policies?
- b) Do national and local CCCM policies and plans advocate for the integration of GBV-related risk-reduction strategies? Is funding allocated for sustainability of these strategies?
- In situations of cyclical natural disasters, is there a policy provision for a GBV specialist to advise the government on CCCM-related GBV risk reduction? Is there a protection specialist to advise government on common protection risks in camp settings?
 - Are there policies about where and how to establish sites?
 - Are there policies or standards on the construction of women-, adolescent- and child-friendly spaces from the onset of an emergency?
 - Are there policies about the allocation of security/law enforcement personnel to camps and their training in GBV?
 - Do camp closure and exit strategies take GBV-related risks into consideration (*e.g. are those at risk identified so they are not left in camps and/or without durable solutions, etc.*)?

Areas Related to CCCM COMMUNICATIONS and INFORMATION SHARING

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





KEY GBV CONSIDERATIONS FOR RESOURCE MOBILIZATION

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



ESSENTIAL TO KNOW

Beyond Accessing Funds

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

A.

HUMANITARIAN NEEDS OVERVIEW

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

B.

PROJECT RATIONALE/ JUSTIFICATION

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

(continued)



B.

PROJECT RATIONALE/ JUSTIFICATION (continued)

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

C.

PROJECT DESCRIPTION

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



KEY GBV CONSIDERATIONS FOR IMPLEMENTATION

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

Integrating GBV Risk Reduction into CCCM PROGRAMMING

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

⁴ Note: CCCM does not hire camp populations.



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

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

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

! ESSENTIAL TO KNOW

Camp Management Agency

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

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

(Adapted from **Norwegian Refugee Council. 2008.** 'Prevention of and Response to Gender-Based Violence', ch. 10 in *The Camp Management Toolkit*, <http://www.nrc.no/arch/_img/9178016.pdf>. Also see **CCCM Global Cluster**, Revised Toolkit, forthcoming March 2015, e-version at <www.cmttoolkit.org>.)



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



ESSENTIAL TO KNOW

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

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

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

(Adapted from **Seelinger, K.T., and Freccero, J. 2013. *Safe Haven: Sheltering displaced persons from sexual and gender-based violence – Comparative report***. Human Rights Center Sexual Violence Program, University of California, Berkeley, School of Law, <www.law.berkeley.edu/files/HRC/SS_Comparative_web.pdf>)

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

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

(**Child Protection Working Group. 2012. *Minimum Standards for Child Protection in Humanitarian Action***, <http://toolkit.ineesite.org/toolkit/INEEcms/uploads/1103/Minimum-standards-Child_Protection.pdf>. For additional information on child-friendly spaces see: **Global Protection Cluster, IASC Mental Health and Psychosocial Support Reference Group, Global Education Cluster, and International Network of Education in Emergencies. 2011. *Guidelines for Child Friendly Spaces in Emergencies***, <www.unicef.org/protection/Child_Friendly_Spaces_Guidelines_for_Field_Testing.pdf>)





PROMISING PRACTICE

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

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

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

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

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



ESSENTIAL TO KNOW

LGBTI Persons

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

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

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



- Women-, adolescent- and child-friendly spaces and other locations where activities are targeted to women, children and other at-risk groups.

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

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

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



PROMISING PRACTICE

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

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

5. Integrate GBV prevention and mitigation into camp closure.

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



involved in camp closure and return/resettlement/reintegration programmes (with due consideration of the survivor's best interests and in keeping with the principles of GBV reporting and information sharing).

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



ESSENTIAL TO KNOW

Persons with Disabilities

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

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

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

Integrating GBV Risk Reduction into CCCM POLICIES

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

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



- Policies for the provision of separate spaces for interviewing women and girls and other at-risk groups during registration.
- Procedures and protocols for sharing protected or confidential information about GBV incidents.
- Relevant information about agency procedures to report, investigate and take disciplinary action in cases of sexual exploitation and abuse.

► Circulate these widely among CCCM staff, committees and management groups and—where appropriate—in national and local languages to the wider community (using accessible methods such as Braille; sign language; posters with visual content for non-literate persons; announcements at community meetings; etc.). Encourage community members to raise key concerns with site management agencies.

► Advocate for the adoption of CCCM minimum gender commitments as best practice.

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

► Support government and other stakeholders to review CCCM policies and plans and integrate GBV-related measures for safety and security, including:

- Provisions for a GBV specialist to advise government on CCCM-related GBV risk reduction in situations of cyclical natural disasters.
- Where and how to establish sites.
- Allocation of law enforcement and other security personnel.
- The construction of women-, adolescent- and child-friendly spaces from the onset of an emergency.
- Camp closure and exit strategies that take GBV-related risks into consideration.

► Support relevant line ministries in developing implementation strategies for GBV-related policies and plans. Undertake awareness-raising campaigns highlighting how such policies and plans will benefit communities in order to encourage community support and mitigate backlash.

► Work with national authorities and affected populations—including women and other at-risk groups—to develop site closure and exit strategies that take into consideration GBV-related risks.



CCCM COMMUNICATIONS and INFORMATION SHARING**1. Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure CCCM staff have the basic skills to provide them with information on where they can obtain support.**

- ▶ Ensure that all CCCM personnel who engage with affected populations have written information about where to refer survivors for care and support. Regularly update the information about survivor services.

- ▶ Camp managers should ensure all CCCM personnel who engage with affected populations are trained in gender, GBV, women's/human rights, social exclusion, sexuality and psychological first aid (e.g. how to supportively engage with survivors and provide information in an ethical, safe and confidential manner about their rights and options to report risk and access care).

**ESSENTIAL TO KNOW****Referral Pathways**

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

**LESSON LEARNED**

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

(Adapted from **International Organization for Migration. 2010.** 'IOM Haiti Gender-Based Violence', <https://www.iom.int/jahia/webdav/shared/shared/mainsite/published_docs/brochures_and_info_sheets/CCCM_GBV_Strategy.pdf>)

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

- ▶ Develop inter- and intra-agency information-sharing standards that do not reveal the identity of or pose a security risk to individual survivors, their families or the broader community.

3. Incorporate GBV messages into CCCM-related community outreach and awareness-raising activities.

- ▶ Work with GBV specialists to integrate community awareness-raising on GBV into CCCM outreach initiatives (e.g. community dialogues; workshops; meetings with community leaders; GBV messaging; etc.).



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



ESSENTIAL TO KNOW

GBV-Specific Messaging

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



PROMISING PRACTICE

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

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





KEY GBV CONSIDERATIONS FOR

COORDINATION WITH OTHER HUMANITARIAN SECTORS

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

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

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



Child Protection

- ▶ Collaborate with child protection actors on monitoring and addressing site-related GBV issues affecting children

Education

- ▶ Work with education actors to:
 - Plan the location and structure of education programmes (including temporary learning spaces) based on safety concerns for those at risk of GBV
 - Facilitate distribution of sanitary supplies to women and girls of reproductive age, and plan systems for washing and/or disposal of sanitary supplies in educational settings that are consistent with the rights and expressed needs of women and girls
 - Ensure school retention for displaced children and adolescents

Food Security and Agriculture

- ▶ Collaborate with food security and agriculture actors so that distribution locations, times and procedures are designed and implemented in ways that reduce risk of GBV

Health

- ▶ Seek assistance from health actors in planning the location and ensuring accessibility of health facilities based on safety concerns and needs of survivors and those at risk of GBV
- ▶ Coordinate with health actors to assess the availability of and needs for health service delivery and referrals
- ▶ Coordinate with health actors in the implementation and schedule of mobile clinics in evacuation centres and refugee/IDP sites
- ▶ Advocate for the presence of female medical personnel
- ▶ Advocate for facilities and personnel to be well equipped to respond to the needs of GBV survivors

Housing, Land and Property (HLP)

- ▶ Work with HLP actors to:
 - Include questions related to HLP rights and land issues in registration, profiling and intention surveys for both men and women
 - Understand unintended and negative impacts (*e.g. forced evictions and relocation*) of using land, communal sites and public facilities as evacuation/collective centres

Livelihoods

- ▶ Work with livelihoods partners to:
 - Identify safe and unsafe areas within the camp for livelihoods activities
 - Plan the location of income-generating activities based on safety, especially considering access to fuel, water and other key natural resources
 - Assess the impact of livelihoods strategies on the population, in an effort to prevent risky coping behaviour

Nutrition

- ▶ Consult with nutrition actors in planning the location of nutrition facilities based on safety concerns of those at risk of GBV (*e.g. consider, where possible, locating facilities next to women-, adolescent- and child-friendly spaces and/or health facilities in order to facilitate care for survivors*)
- ▶ Where inpatient treatment centres for malnutrition are located off-site and require children to be accompanied by an adult, work with nutrition actors to ensure that the adult is provided with support and assistance to reduce the risk that they will need to exchange sex for food

Protection

- ▶ Work with protection actors to:
 - Provide safe spaces and accommodation for persons at risk of GBV in reception areas and registration sites
 - Monitor and collect data on GBV risks in the environment through regular safety visits and/or audits
 - Support strategies to mitigate these risks (*e.g. lighting in strategic/insecure areas of the camps, security patrols, etc.*)

Shelter, Settlement and Recovery (SS&R)

- ▶ Collaborate with SS&R actors to:
 - Plan and design sites and shelters that reduce the risks of GBV (*e.g. creating accessible safe spaces for women, children and adolescent girls; addressing overcrowding issues; implementing safe distribution of shelter-related NFIs; etc.*)
 - Ensure immediate access to cooking fuel through short-term direct provision
 - Plan and implement shelter upgrades based on the results of safety audits

Water, Sanitation and Hygiene (WASH)

- ▶ Collaborate with WASH actors to:
 - Build safe and accessible water and sanitation facilities that reduce the risks of GBV (*e.g. adequate lighting at WASH facilities; safe distances to water and sanitation points; distribution of relevant NFIs; etc.*)
 - Assist with hygiene promotion outreach activities that integrate GBV messages (*e.g. prevention, where to report risk and how to access care*)
 - Engage receptor/host communities about water-resource usage
 - Facilitate distribution of sanitary supplies to women and girls of reproductive age, and plan systems for washing and/or disposal of sanitary supplies that are consistent with the rights and expressed needs of women and girls
 - Support monitoring of WASH sites for safety, accessibility and instances of GBV





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 CCCM 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 CCCM sector. Several indicators have been taken from the CCCM sector's own guidance and resources (see footnotes below the table). See **Part Two: Background to Camp Coordination and Camp Management 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

Monitoring and Evaluation Indicators				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING						
Inclusion of GBV-related questions in CCCM assessments ⁵	<div># of CCCM assessments that include GBV-related questions* from the GBV Guidelines × 100</div> <div># of CCCM assessments</div> <div><i>* See page 42 for GBV areas of inquiry that can be adapted to questions in assessments</i></div>	Assessment reports or tools (at agency or sector level)	100%	✓	✓	
Female participation in assessments	<div># of assessment respondents who are female × 100</div> <div># of assessment respondents</div> <div>and</div> <div># of assessment team members who are female × 100</div> <div># of assessment team members</div>	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>



				Stage of Programme		
INDICATOR	INDICATOR DEFINITION	POSSIBLE DATA SOURCES	TARGET	BASE-LINE	OUT-PUT	OUT-COME
ASSESSMENT, ANALYSIS AND PLANNING (continued)						
Consultations with the affected population on GBV risk factors in sites <i>Disaggregate consultations by sex and age</i>	Quantitative: $\frac{\text{\# of sites* assessed through consultations with the affected population on GBV risk factors in and around sites} \times 100}{\text{\# of sites}}$ Qualitative: What types of GBV-related risk factors do affected persons experience in and around sites? <i>* Sites can include water points, latrines, food and NFI distribution sites, safe spaces</i>	Organizational records, focus group discussion (FGD), key informant interview (KII), assessment reports	100%	✓	✓	
Staff knowledge of referral pathway for GBV survivors	$\frac{\text{\# of CCCM staff* who, in response to a prompted question, correctly say the referral pathway for GBV survivors} \times 100}{\text{\# of surveyed CCCM staff}}$ <i>* Staff include all employees and volunteers who engage with the affected population</i>	Survey	100%	✓		✓
RESOURCE MOBILIZATION						
Inclusion of GBV risk-reduction in CCCM funding proposals or strategies	$\frac{\text{\# of CCCM funding proposals or strategies that include at least one GBV risk-reduction objective, activity or indicator from the GBV Guidelines} \times 100}{\text{\# of CCCM funding proposals or strategies}}$	Proposal review (at agency or sector level)	100%	✓	✓	
Training of CCCM staff on the GBV Guidelines	$\frac{\text{\# of CCCM staff who participated in a training on the GBV Guidelines} \times 100}{\text{\# of CCCM staff}}$	Training attendance, meeting minutes, survey (at agency or sector level)	100%	✓	✓	
IMPLEMENTATION						
► Programming						
Risk factors of GBV in assessed sites	Quantitative: $\frac{\text{\# of affected persons who report concerns about experiencing GBV when asked about sites* (in and around)} \times 100}{\text{\# of affected persons asked about sites (in and around)}}$ Qualitative: Do affected persons feel safe from GBV when in and around sites? What types of safety concerns does the affected population describe in and around sites? <i>* Sites can include water points, latrines, food and NFI distribution sites, safe spaces</i>	Survey, FGD, KII, participatory community mapping	0%	✓		✓

(continued)

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

(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 (continued)

► Policies

Inclusion of GBV prevention and mitigation strategies in CCCM policies, guidelines or standards	$\frac{\text{\# of CCCM policies, guidelines or standards that include GBV prevention and mitigation strategies from the GBV Guidelines} \times 100}{\text{\# of CCCM policies, guidelines or standards}}$	Desk review (at agency, sector, national or global level)	Determine in the field	✓		✓
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► 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 GBV referral information in CCCM community outreach activities	$\frac{\text{\# of CCCM community outreach activities programmes that include information on where to report risk and access care for GBV survivors} \times 100}{\text{\# of CCCM community outreach activities}}$	Desk review, KII, survey (at agency or sector level)	Determine in the field	✓	✓	

COORDINATION

Coordination of GBV risk-reduction activities with other sectors	$\frac{\text{\# of non-CCCM sectors consulted with to address GBV risk-reduction activities in sites*} \times 100}{\text{\# of existing non-CCCM sectors in a given humanitarian response at site level}}$ <p><i>* See page 55 for list of sectors and GBV risk-reduction activities</i></p>	KII, meeting minutes (at agency or sector level)	Determine in the field	✓	✓	
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RESOURCES

Key Resources

- **Norwegian Refugee Council (NRC). 2008.** 'Prevention of and Response to Gender-Based Violence', ch. 10 in *The Camp Management Toolkit*, <http://www.nrc.no/arch/_img/9178016.pdf>
- **Camp Coordination and Camp Management (CCCM) Global Cluster. Forthcoming March 2015.** Revised Toolkit, <www.cmtoolkit.org>
- **Camp Coordination and Camp Management (CCCM) Global Cluster. 2010.** Collective Centre Guidelines, <www.globalccmcluster.org/tools-and-guidance/publications/collective-centre-guidelines>
- **Gender-Based Violence Area of Responsibility (GBV AoR). 2014.** 'Camp GBV Safety Audit', Annex 36 in *Handbook for Coordinating Gender-Based Violence Interventions in Humanitarian Settings*, <www.unicef.org/protection/files/GBV_Handbook_Long_Version.pdf>
- **International Organization for Migration (IOM) and CCCM Cluster. 2011.** *Standard Operating Procedures for Camp Managers: Prevention and response to GBV in IDP sites, Haiti*, <www.eshelter-cccmhaiti.info/pdf/sop_sgbv_generic_2011.pdf>
- For a checklist to assess gender equality programming, see **Inter-Agency Standing Committee (IASC). 2006.** *Gender Handbook in Humanitarian Action*, <https://interagencystandingcommittee.org/system/files/legacy_files/IASC%20Gender%20Handbook%20%28Feb%202007%29.pdf>

Additional Resources

- **Schulte, J., and Rizvi, Z. 2012.** 'In Search of Safety and Solutions: Somali refugee adolescent girls at Sheder and Aw Barre Camps, Ethiopia'. New York: Women's Refugee Commission, <<http://womensrefugeecommission.org/resources/document/847-in-search-of-safety-and-solutions-somali-refugee-adolescent-girls-at-sheder-and-aw-barre-camps>>
- **United Nations High Commissioner for Refugees (UNHCR). 2011.** 'Working with Lesbian, Gay, Bisexual, Transgender, & Intersex Persons in Forced Displacement'. Switzerland: UNHCR, <www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=4e6073972>
- **House, S., Mahon, T., and Cavill, S. 2012.** *Menstrual Hygiene Matters: A resource for improving menstrual hygiene around the world*, <www.wateraid.org/what-we-do/our-approach/research-and-publications/view-publication?id=02309d73-8e41-4d04-b2ef-6641f6616a4f>
- **Reproductive Health Response in Conflict Consortium. 2004.** *Gender-Based Violence Tools Manual: For assessment & program design, monitoring & evaluation in conflict-affected settings*, <<http://reliefweb.int/report/world/gender-based-violence-tools-manual-assessment-program-design-monitoring-evaluation>>
- **International Committee of the Red Cross (ICRC). 2004.** *Addressing the Needs of Women Affected by Armed Conflict*. Geneva, <www.refworld.org/pdfid/46e943780.pdf>
- **UNHCR. 2006.** *Operational Protection in Camps and Settlements: A reference guide of good practices in the protection of refugees and other persons of concern*, <www.refworld.org/docid/44b381994.html>

