



Standard Operating Procedures for Gender-Based Violence Prevention and Response

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1 INTRODUCTION

Standard operating procedures (SOPs) are recognized as international best practice during an emergency humanitarian action to boost coordination and quality of gender-based violence (GBV) prevention and response interventions. Developing SOPs in an emergency setting has proven to be essential to promote coordination in service delivery and to boost coordination and enhance the quality of GBV programming for both response and prevention.

This document describes minimum actions to be taken to respect international standards and a survivor-centered approach in caring for GBV survivors within the Syrian humanitarian response. It outlines the guiding principles, procedures, and roles and responsibilities of all actors for the response to and prevention of GBV in this context. By setting out minimum standards to ensure quality, coordination and coherence among organizations and actors, these SOPs aim to facilitate joint action by all actors to respond to, prevent and mitigate GBV within the Syrian humanitarian response, and to improve services offered to GBV survivors and all individuals exposed to GBV.

This SOPs document is not intended as a stand-alone resource. It should be read in conjunction with the documents provided in *Chapter 14: Resources*.

1.1 Background

The SOPs were developed by the Whole of Syria (WoS) Turkey hub GBV Sub-Cluster (GBV SC) for areas reachable through cross-border operations in Syria from Turkey or other locations still under the mandate of the Turkey hub coordination mechanism. The GBV SC is the coordinating body established in 2015 with the objective to strengthen GBV prevention, response and coordination in areas of Syria reachable through cross-border intervention from Turkey. It works to facilitate multi-sectoral, inter-agency actions aimed to prevent GBV, and to ensure the provision of accessible, timely and survivor-centered GBV response services. The GBV SC develops and implements the operational GBV strategy for cross-border Turkey within the broader GBV WoS strategy as outlined in the Humanitarian Response Plan (HRP)¹.

A steering committee was established (comprising two national NGO representatives, one international INGO representative and GBV SC Coordinators) to develop the SOPs, supported by an international consultant. The Steering Committee was comprised of individuals with in-depth knowledge of the existing GBV SC Turkey hub SOPs and practical experience in supporting GBV survivors (including through case management) or supervising a team of people delivering GBV services. They all represented GBV SC members and are signatories to the existing GBV SC SOPs.

An evaluation of the extent to which the humanitarian community in the Syrian crisis had implemented the Inter-Agency Standing Committee's (IASC) *Guidelines for integrating gender-based violence interventions in humanitarian action* found significant gaps in comprehensive, consistent and strategically guided implementation of these guidelines². Based on this evaluation, an initial meeting was held in April 2015 to agree on the main objectives and development process for the SOPs. A first draft of the SOPs was discussed at a workshop in August 2015. During this workshop, partners endorsed the main content and provided additional input. In February 2018, a further review of GBV mainstreaming within the 2018 HRP

¹ See the 'Syria Humanitarian Response Plan 2018: WoS gender based-violence results framework'.

² *Evaluation of Implementation of 2005 IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings in the Syria Crisis Response, 2015.*

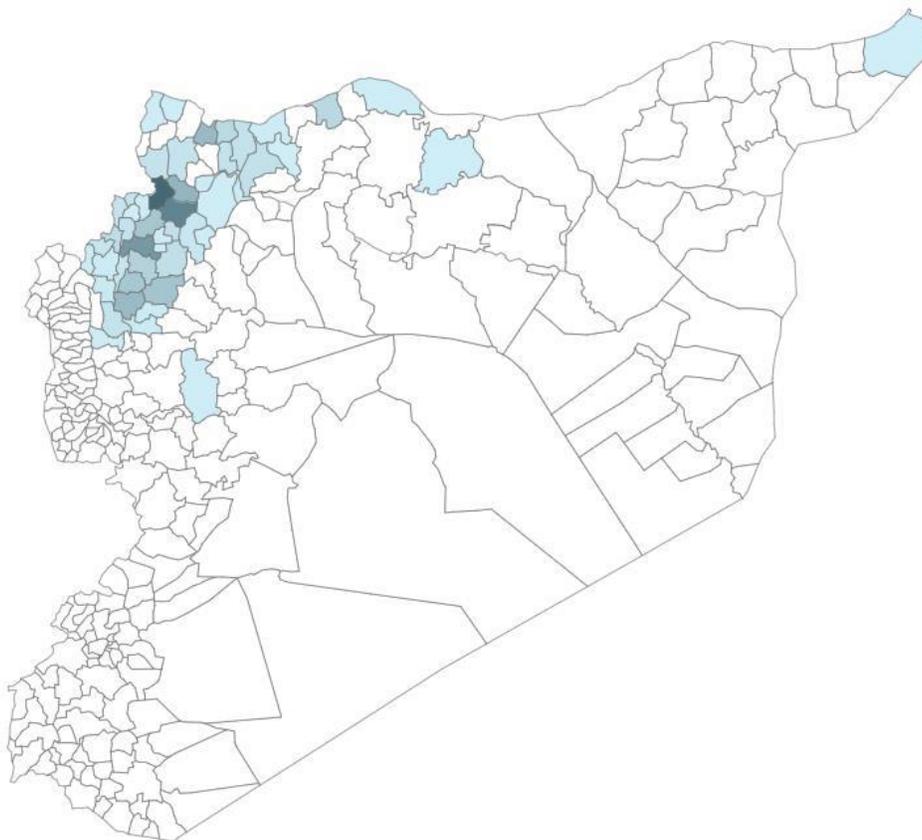
for the WoS concluded that, apart from some references to GBV related risks within some sectors, across the clusters there was limited—and often no—attention to GBV in the HRP.³ A more in-depth review of the SOPs was carried out in September that year to reflect and include many of the contextual changes, as well as to more strongly draw on global guidance. This current version of the SOPs is the result of this most recent review.

1.2 Intended users

The intended users of the SOPs are all humanitarian actors and service providers that are engaged in GBV response and prevention programming in areas of Syria accessible through cross-border operations from Turkey, or other locations still under the mandate of the Turkey hub coordination mechanism.

Figure 1 shows the map of the coverage of GBV services in areas under Turkey hub mandate (Oct 18).

Figure 1: Coverage of GBV services in areas under Turkey hub mandate



³ Apio, *GBV integration into humanitarian action: Review and analysis of GBV mainstreaming within the 2018 humanitarian response plan (HRP) for the whole of Syria*, 2018 (unpublished).

Actors that can be and are signatory to these SOPs are:

- Non-government organizations (NGOs) or United Nations (UN) agencies that deliver GBV services directly or through partners in areas of Syria reachable through cross-border operations from Turkey, and that are members of the GBV Sub-cluster or Health Cluster (Turkey Hub).
- Organizations that operate in areas usually managed from the Turkey Hub, but are currently based elsewhere (e.g., Amman) because of operational constraints to work from Turkey, and that still work in areas under the Turkey Hub GBV SC's mandate.
- Implementing partners of members of the GBV sub-cluster that provide GBV service on behalf of a GBV sub-cluster member.

1.3 Limitations

GBV is a prominent feature of the Syrian conflict. GBV survivors overall, and in particular survivors of sexual violence, face considerable challenges in obtaining support. Service providers also face challenges in providing survivor-centered care. There are therefore a number of limitations with respect to the implementation of the SOPs.

Security concerns. Humanitarian access to people in need in Syria remains constrained by shifting frontlines, administrative and bureaucratic hurdles, violence along access routes, and general safety and security concerns especially in areas under the control of extremist groups. The level of relevance of the SOPs therefore varies according to the area and security situation.

Limited mobility for Syrian people. In many areas controlled by extremist groups, the mobility of women and girls is especially limited. This is due to discriminatory restrictions explicitly imposed to limit their freedom of movement, and because families limit the movement of women and girls outside the homes to protect them from the risks of sexual violence and harassment. In some areas, including camps for internally displaced persons (IDPs), extremist groups limit women's engagement in public life, education and employment, and hinder their access to communal facilities. In some parts of Syria, men are unable to move freely due to fear of arrest at checkpoints. It is therefore increasingly difficult for GBV survivors and other vulnerable people to access the services and support they need.

Limited quality response services. The humanitarian community continues to provide support services to survivors of GBV and prevention and mitigation programming in northern Syria, in areas accessible through cross-border programmes from Turkey. Syrian organizations, with the support of the GBV SC invested in capacity building of their field teams, are now able to provide valuable support services in challenging and volatile contexts. Overall, the challenges related to the quality of response services available to GBV survivors in Syria remain in place, and the quality of services varies across different areas.

Remote management. Due to the restriction of staff movement in and out of northern Syria and the fluidity of the security situation, the majority of the cross-border operations are managed remotely. Restrictions limit the movements of humanitarian workers across the borders with Turkey. This means necessary support for and supervision of staff who provide GBV response services are challenging. Capacity building efforts aimed at increasing the availability of life-saving services are also hindered by this situation.

Limited community awareness of GBV. There is a general poor understanding of GBV within communities. Assessments conducted in 2017⁴ identified a number of barriers to survivors being willing to disclose GBV incidents and being able to access GBV services. These barriers include:

- the social stigma surrounding sexual violence;
- the fear of ‘honor killings’ of women and girls who disclose sexual violence;
- an increased acceptance of early/forced marriage as offering effective social and financial protection for women and girls;
- a continuing belief in the scientific validity of virginity testing; and,
- an increase in the use of negative coping mechanisms (e.g., survival or transactional sex) to alleviate poverty.

The GBV SC therefore also now prioritizes the identification of the key GBV risks in communities.

⁴ GBV AoR, *Voices from Syria 2018: Assessment findings of the humanitarian needs overview*, 2017.

2 GLOSSARY

2.1 Acronyms

AAP	Accountability to affected people
AoR	Area of responsibility
CP	Child protection
GBV	Gender-based violence
GBVIMS	Gender-based violence information management system
GBV SC	Gender-based violence sub-cluster (in Turkey)
HCT	Humanitarian country team
HIV	Human immunodeficiency virus
HRP	Humanitarian response plan
IASC	Inter-Agency Standing Committee
IDP	Internally displaced person
ILAC	International Legal Assistance Consortium
IRC	International Rescue Committee
MHPSS	Mental health and psychosocial support
NFI	Non-food items
NGO	Non-governmental organization
NRC	Norwegian Refugee Council
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PC	Protection Cluster
PFA	Psychological first aid
PSEA	Prevention of sexual exploitation and abuse

PSS	Psychosocial support
RFP	Referral focal point
SEA	Sexual exploitation and abuse
SC	Sub-cluster
SOPs	Standard operating procedures
SSG	Strategic Steering Committee (for Syria)
STIs	Sexually transmitted infections
UN	United Nations
USAID	United States Agency for International Development
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VAWG	Violence against women and girls
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WoS	Whole of Syria

2.2 Definitions

Definitions are provided here to explain key terms used in the SOPs. These definitions draw from a range of GBV resources that are considered international best practice. In all cases, the given definition explains the term's meaning and application as it relates to work to respond to and prevent GBV, but they are not necessarily contextualized to the Syrian humanitarian response.

Actor(s)	Individuals, groups, organizations and institutions involved in preventing and responding to GBV.
Adolescent	Any person between the ages 10 – 19 years old. Early adolescents are 10 – 14. Later adolescents are 15 – 19.
Adult	Any person over the age of 18 years and older.
Advocacy	The deliberate and strategic use of information to bring about change. Advocacy work includes employing strategies to influence decision makers and policies, and to change attitudes, power relations, social relations and institutional functioning.
Assessment	The set of activities necessary to understand a given situation which can include the collection, updating and analysis of data pertaining to a population of concern (needs, capacities, resources etc.), or the general socio-economic conditions in a given location/area.
'At risk' group(s)	Group(s) of individuals more vulnerable to harm than other members of the population because they hold less power, are more dependent on others for survival, are less visible to relief workers, or are otherwise marginalized.
Awareness raising	Activities conducted with the affected community to increase their knowledge of GBV.
Case management	A structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure survivors are informed of all the options available to them; and that issues and problems facing a survivor and their family are identified and followed up in a coordinated way, as well as providing the survivor with emotional support throughout the process.
Child or minor	Any person under the age of 18. Children have evolving capacities depending on their age and developmental stage. In working with children, it is critical to understand these stages, as it will determine the method of communication with individual children.

Child (early) marriage	A child or early child marriage is a formal marriage or informal union before age 18. Even though some countries permit marriage before age 18, international human rights standards classify these as child marriages, reasoning that those under age 18 are unable to give informed consent. Therefore, early marriage is also a form of forced marriage as children are not legally competent to agree to such unions.
Community	A group of people that recognizes itself or is recognized by others as sharing common cultural, religious or other social features, and backgrounds and interests, to form a collective identity with shared goals often in a defined geographical area.
Confidentiality	An ethical principle associated with medical and social service professions. Maintaining confidentiality requires service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. Maintaining confidentiality about abuse means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children or clients who express intent to harm themselves or someone else.
Coordinating agencies	The organizations that take the lead in chairing GBV working groups and ensuring that the minimum prevention and response interventions are put in place. The coordinating agencies are usually selected by the GBV working group and endorsed by the leading United Nations entity in the country.
Counselling	A dynamic process of interaction between two people during which the counselor helps a survivor to identify and process symptoms they experiencing, and to take decisions to help alleviate their suffering. It involves active listening, giving comfort in an atmosphere of empathy, and helping survivors to work out what to do about their problems with a focus on empowering them. In GBV cases, the counsellor provides access to information, resources and services, ensures the respect of individual rights, and facilitates access to services and community resources and support.
Disclosure	The process of revealing information about a GBV experience or incident. Disclosure in the context of GBV abuse refers specifically to how a person (e.g., caregiver, health worker, social worker, member of a women's group, friend, teacher) learns about a GBV directly from a survivor. The terms "identification" and "involuntary disclose" are commonly used in the case of children when they are too young to speak about the incident and when a third person identifies the violence.

Emergency	A term describing a state. It is a managerial term, demanding decision and follow-up in terms of extraordinary measures. A 'state of emergency' demands to 'be declared' or imposed by somebody in authority, who, at a certain moment, will also lift it. Thus, it is usually defined in time and space, it requires threshold values to be recognized, and it implies rules of engagement and an exit strategy
Empowerment of women	The goal and practice of women gaining power and control over their own lives. It can involve awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources, and actions to transform the structures and institutions that reinforce and perpetuate gender discrimination and inequality.
Focal point	The role of designated staff who represent their organization, community structures and/or their sector, and who participate in meeting and coordination activities related to GBV. It also refers to individuals within services and associations who have been appointed as contact persons for GBV cases.
Gender	Gender refers to the behaviors, social attributes and opportunities associated with being a particular sex. It can also refer to relationships between the sexes. These attributes, opportunities and relationships are socially constructed. They are learned through gender socialization. They are context and time specific, and changeable. Gender determines what is expected, allowed and valued in a person in a given context. In most societies, there are differences and inequalities between genders with regard to assigned responsibilities, activities, access to and control over resources, and decision-making. There are also dominant views on how a person should display their gender based on assumptions of gender linked to sex assigned at birth.
Gender-based violence	Any form of violence, including physical and verbal abuse, related to social and cultural expectations of gender roles, often for the purpose of sustaining social power. It can include intimidation, bullying, the use of language to harass or undermine, and the use of physical force. Gender-based violence can affect both men and women. The term is most often used to underscore the fact that structural, gender-based power differentials between males and females around the world place females at risk of multiple forms of violence. The term is also used by some actors to describe violence against non-gender confirming persons and non-dominant sexual orientations.
Gender based violence Information Management Services	A system for collecting, storing and sharing key information on GBV incidents. It helps harmonize data collection on GBV in humanitarian settings, to provide a simple system for GBV project managers to collect, store and analyze their data, and to enable the safe and ethical sharing of reported GBV incident data. The system is intended to both assist service providers to better understand the GBV cases being reported, and to enable actors to share data internally across project sites and externally with other agencies for broader trends analysis and improved GBV coordination.

Health/Medical care	Care for survivors of GBV for injuries and mental health, as well as for sexual reproductive health issues. For survivors of sexual violence the essential components of medical care are documentation and treatment of injuries, collection of forensic evidence, evaluation for and prevention of sexually transmitted infections, evaluation for risk of pregnancy, prevention of pregnancy, psychosocial support, and counseling.
Humanitarian worker	An employee or volunteer, whether internationally or nationally recruited, or formally or informally retained from the beneficiary community, engaged by a humanitarian agency to conduct the activities of that agency.
Information management	The manner in which an organization's information concerning GBV is handled or controlled. It usually includes different stages of processing information such as collection, storage, analysis and reporting/sharing in a way that ensures security and confidentiality of the data, of the survivors and of the actors providing GBV services
Informed assent	The expressed willingness to participate in services. This applies to younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services. Informed assent is therefore the expressed willingness of the child to participate in services.
Informed consent	Approval or assent, particularly and especially after thoughtful consideration. Free and informed consent is given based upon a clear appreciation and understanding of facts, implications and future consequences of an action. In order to give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given, and be able to evaluate and understand the consequences of an action. They must also be aware of and have the power to exercise their right to refuse to engage in an action and/or to not be coerced. Children are generally considered unable to provide informed consent because they may not have the ability and/or experience to anticipate the implications of an action, and because they may not understand or be empowered to exercise their right to refuse. There are also instances where consent might not be possible due to cognitive impairments and/or physical, sensory or intellectual disabilities.
Mandatory reporting	Laws and policies that mandate certain agencies and/or persons to report actual or suspected child abuse. Mandatory reporting may also be applied in cases where a person is a threat to themselves or another person. Mandatory reporting is a responsibility for humanitarian actors who hear about and/or receive a report of sexual exploitation or abuse committed by a humanitarian actor against a member of the affected population.

Non-specialist	A person or agency that works in humanitarian response sectors other than GBV and that does not have specific expertise in GBV prevention and response programming. Non-GBV specialists include WASH, camp coordination and camp management, educators, livelihoods specialists and other humanitarian service providers
Perpetrator	A person, group or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against their will.
Person with disability	Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.
Prevention	Taking action to stop GBV from first occurring or preventing it from further occurring (e.g. activities that promote gender equality, working men and boys to address gender attitudes that contribute to GBV).
Protection	Activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and spirit of human rights, refugee and international humanitarian law.
Psychological first aid	Humane, supportive and practical assistance to survivors of GBV. This includes listening but not pressuring people to talk, providing information on available support services, and helping to access basic needs (e.g., food, water).
Psychosocial	A term used to emphasize the interaction between the psychological aspects of human beings and their environment or social surroundings. Psychological aspects are related to our functioning, such as our thoughts, emotions and behavior. Social surroundings concern a person's relationships, family and community networks, cultural traditions and economic status, including life tasks such as school or work.
Psychosocial support	Services and assistance aimed at addressing the harmful emotional, psychological and social effects of GBV. Psychosocial support can include improving a survivor's wellbeing by bringing healing, restoring the normalcy of life for the survivor, and protecting survivors from the accumulation of distressful and harmful events.
Psychosocial and recreational activities	Community self-help and resilience strategies to support survivors and those vulnerable to GBV, such as through women's groups.

Response	Providing services and support to reduce the harmful consequences of GBV, and to prevent further injury, suffering or harm. These can include health and medical care, mental health and psychosocial support, legal assistance, case management, and education and vocational training opportunities.
Referral pathway	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.
Safety audit	A tool used in visits to emergency-affected areas to compare conditions against a set of pre-selected indicators about general and specific living conditions of communities and people in order to improve safety and security.
Sexual violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. Sexual violence includes, at least, rape and attempted rape, sexual abuse and sexual exploitation.
Sexual exploitation and abuse	Any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of forced and/or coerced prostitution can fall under this category.
Specialist	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. GBV specialists include health practitioners, community psychosocial support workers, case managers and GBV technical persons.
Survivor	A person who has experienced GBV. The terms 'victim' and 'survivor' are often used interchangeably. Victim is a term more often used in the legal and medical sectors. Survivor is the term generally preferred in the psychological and social support sectors because it implies resiliency.
Survivor-centered approach	A survivor-centered approach means that the survivor's rights, needs and wishes are prioritized when designing and developing GBV-related responses and programming.

2.3 Incident type definitions

For the purpose of these SOPs and to enhance harmonization of definitions and language, the Gender-Based Violence Information Management System (GBVIMS) categories are used throughout this document to describe GBV incident types.⁵ These are internationally agreed definitions and some examples may not be relevant to the Syrian context. Local and national legal systems may define these terms differently and/or may have other legally recognized forms of GBV that are not universally accepted as GBV. The definitions in the SOPs should be used by signatories to the SOPs for data collection, analysis and future dissemination.

The GBVIMS refers to six core types of GBV.

Rape	Non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape.
Sexual assault	Any form of non-consensual sexual contact that does not result in or include penetration. Examples include attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. Female genital mutilation (FGM) is an act of violence that impacts sexual organs, and as such should be classified as sexual assault.
Physical assault	An act of physical violence that is not sexual in nature. Examples include hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.
Forced marriage	The marriage of an individual against her or his will. Child or 'early' marriage is a formal marriage or informal union before age 18. Even though some countries permit marriage before age 18, international human rights standards classify these as child or 'early' marriages, reasoning that those under age 18 are unable to give informed consent. Therefore, child and 'early' marriage is a form of forced marriage as children are not legally competent to agree to such unions.
Denial of resources, opportunities or services	Denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. "Economic abuse" is generally included in this category

⁵ For more information, refer to <http://www.gbvims.com>.

Psychological / Emotional abuse	Infliction of mental or emotional pain or injury. Examples include threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things etc.
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These are other useful definitions for types of GBV that, although not considered as core GBVIMS classifications, are frequently used in local contexts to provide a more comprehensive picture of GBV and to inform the humanitarian response.

Child sexual abuse	Generally used to refer to any sexual activity between a child and closely related family member (incest) or between a child and an adult or elder child from outside the family. It involves either explicit force or indirect coercion. It includes different forms of sexual violence.
Domestic violence	A term used to describe violence that takes place within the home or family between family members, including intimate partners.
Harmful traditional and cultural practices	Social and religious customs and traditions that can be harmful to a person's mental or physical health. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group (e.g., women). These harmful traditional practices include female genital mutilation (FGM), forced feeding of women, child marriage, taboos or practices that prevent women from controlling their own fertility, nutritional taboos and traditional birth practices, son preference and its implications for the status of the girl child, female infanticide, early pregnancy and dowry price. Other harmful traditional practices affecting children include binding, scarring, burning, branding, violent initiation rites, fattening, forced marriage, so-called "honor" crimes and dowry-related violence, exorcism, sorcery or witchcraft.
Intimate partner violence	A term used to describe violence that takes place between intimate partners (spouses, boyfriend/girlfriend). It is behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors. This type of violence may also include the denial of resources, opportunities or services. The definition of an intimate partner can also extend to a sex worker, and intimate partner violence therefore can include violence committed against sex workers by paying clients.

Sexual exploitation	Any actual or attempted abuse of a person in a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another (e.g., sex in exchange of food or mobbing). The perpetration of sexual exploitation by humanitarian actors against members of beneficiary communities in return for aid and services is a current concern.
Sexual slavery	This term indicates whether an incident of sexual abuse was perpetrated while the survivor was being forcibly transported (i.e., being trafficked), being forced to join an armed group (i.e., forced conscription), or being held against their will including abduction and kidnapping.
Transactional sex	This is sex that is defined by the power relationship between the survivor and perpetrator, as well as the circumstances surrounding the incident. For instance, when access to resources is limited, individuals might be compelled by circumstance to resort to transactional sex to help advance their education, gain employment or business opportunities, or simply to meet basic survival needs. This practice is sometimes referred to as 'survival sex' as well. It also includes accepting sex, and tolerating physical or sexual violence in order to sustain relationships that provide critical income.

3 GUIDING PRINCIPLES

The survivor-centered approach can guide professionals—regardless of their role—in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which a GBV survivor's rights are respected, safety is ensured, and the survivor is treated with dignity and respect. The approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person's capacity to make decisions about possible interventions.⁶

Signatories to these SOPs agree to adhere to and promote the guiding principles specified in this document. These guiding principles are in addition to the core humanitarian principles referenced in Annex I.

3.1 Organizational GBV capacity and programming

Organizations that are signatories to these SOPs agree to adhere to a set of guiding principles aimed at ensuring staff are committed to integrating GBV into their work and are adequately skilled to do so; and aimed at ensuring their programmes are gender sensitive, collaborative and participatory.

Organizations should:

- Integrate and mainstream GBV interventions into all programmes and all sectors.
- Establish and maintain carefully coordinated multi-sectoral and inter-organizational interventions for GBV prevention and response.
- Extend the fullest cooperation and assistance between organizations and institutions in preventing and responding to GBV. This includes sharing situation analyses and assessment information to avoid duplication and to maximize a shared understanding of situations.
- Engage the community fully in understanding and promoting gender equality and gender power relations that protect and respect the rights of women and girls.
- Ensure equal and active participation by women and men, girls and boys in assessing, planning, implementing, monitoring, and evaluating programmes through the systematic use of participatory methods.
- Ensure accountability at all levels to local communities and among all humanitarian actors working in any sector.
- Ensure all staff understand and adhere to ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies.⁷
- Ensure all staff, contractors and volunteers involved in prevention of and response to GBV understand and sign a code of conduct or similar document setting out the same standards of conduct.⁸

⁶ IASC, *Guidelines for integrating gender-based violence interventions in humanitarian action: Reducing risk, promoting resilience and aiding recovery*, 2015, p.47.

⁷ See WHO, *Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*, 2007.

⁸ See *Annex II: Sample Code of Conduct*.

3.2 Multi-sectoral response

It is the responsibility of all humanitarian actors to identify ways to deliver services and aid safely. All humanitarian service providers have a role in mitigating the risks of GBV and its consequences.

The new *Standard terms of reference for humanitarian country teams*⁹ outlines four mandatory responsibilities for humanitarian country teams (HCTs):

1. A collective approach for ensuring that protection is central to humanitarian action, including developing and implementing a common HCT strategy on protection.
2. A collective approach to Accountability to Affected People (AAP) for engaging with, ensuring feedback to and adjusting the response based on the views of affected people.
3. A collective mechanism and approach to Protection from Sexual Exploitation and Abuse (PSEA) by humanitarian workers, including a Code of Conduct, aligned with any other mechanisms in place to deal with this issue.
4. A collective approach to addressing sexual and gender based violence (SGBV).

The Strategic Steering Group (SSG) for Syria also endorsed and emphasized a responsibility for 'all organizations involved in humanitarian response to protect those affected by the crisis from GBV, even if there is no data or proof of GBV happening in country'.¹⁰

This group promotes multi-sectoral responsibility, shared by all humanitarian organizations and actors working in the WoS, to prevent and mitigate GBV throughout the response, and to hold sectors and organizations accountable for mitigating the risk of GBV in their specific sectors. The SSG also encourages organizations to engage substantively with the donor community on GBV needs, and to be led by examples that show dedication to eradicate all forms of GBV with the humanitarian community and affected populations.

3.3 Care for GBV survivors

Signatories to these SOPs agree to adhere to a set of guiding principles aimed at minimizing harm to the GBV survivor and maximizing efficiency of GBV prevention and response interventions.

The four principles to care for GBV survivors and the related skills are considered essential for a survivor-centered GBV humanitarian intervention. Service delivery informed by the principles of safety, confidentiality, dignity and non-discrimination fosters empowerment and control for survivors, and promotes a survivor's safety, wellbeing and recovery.

Organizations should ensure all staff receive training so they can apply the relevant skills to uphold these four principles.

Table 1 provides details of the four guiding principles and skills to care for GBV survivors.

⁹ IASC, *Standard terms of reference for humanitarian country teams*, 2017.

¹⁰ SSG, *GBV priorities paper*, 2017.

Table 1: Four guiding principles and skills to care for GBV survivors

GUIDING PRINCIPLE	SKILLS
<p>RIGHT TO SAFETY</p> <p>The safety and security of the survivor and others, such as their children and people who have assisted them, must be the number one priority for all actors.</p> <p>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.</p>	<ul style="list-style-type: none"> • Conduct conversations, assessments and interviews in a quiet and private place. • Assess the safety of the survivor and promote security measures the survivor believes should be taken. • Only take action with the informed consent of the survivor.
<p>RIGHT TO CONFIDENTIALITY</p> <p>Confidentiality reflects the belief that people have the right to choose to whom they will or will not tell their story.</p> <p>Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned.</p> <p>Confidentiality promotes safety, trust and empowerment.</p>	<ul style="list-style-type: none"> • Share only relevant information and do not share the name, identifying information or story of survivors with others. • If you need to share information with professionals (i.e., for referrals), you may only do so if the survivor has given their consent. • Keep records in a secure location at all times. Do not include identifying information on records. Files should be identified by a number or code, and not by an individual's name.
<p>RIGHT TO DIGNITY AND SELF-DETERMINATION</p> <p>The survivor is the primary actor. The role of helpers is to facilitate recovery and provide resources for problem solving.</p> <p>All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor.</p>	<ul style="list-style-type: none"> • Respect the strength and capacities of the survivor to cope with what has happened to them. • Show that you believe the survivor, that you don't question or blame the survivor, and that you respect their privacy. • Provide emotional support to the survivor. Show sensitivity, understanding and willingness to listen to their concerns and story with a caring attitude. • Do not make judgments. • Provide the survivor with information about available services and the quality of these services. • Allow the survivor to make choices about the care and support they want. Avoid advising the survivor. • Be clear about your role and about the type of support and assistance you can offer. Never make promises that you cannot keep.

	<ul style="list-style-type: none"> • Make sure you are well informed about the options for referral (e.g., medical, psychosocial, economic, judicial), including what services are available, the quality of these services and the safety for survivors when accessing these services. • Consider the possibility of accompanying the survivor throughout the process, if necessary. • Ensure attention to survivors' various needs, including medical and psychosocial needs, material needs and the need for safety and security.
<p>RIGHT TO NON-DISCRIMINATION</p> <p>Survivors of violence should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation or any other characteristic.</p>	<ul style="list-style-type: none"> • Treat all survivors equally and in a dignified way. • Do not make assumptions about the history or background of a survivor. • Be aware of your own prejudices and opinions about GBV, and do not let these influence the way you treat a survivor. • Ensure you have been trained on human rights, humanitarian principles, and relevant agency non-discrimination policies.

3.4 Adopting a survivor-centered approach

The GBV guiding principles are inextricably linked to the overarching humanitarian responsibility to provide protection and assistance to those affected by a crisis. They are embodied in a GBV intervention strategy that promotes a survivor-centered approach. The survivor-centered approach can guide all humanitarian workers to respond appropriately to persons who have experienced GBV.

A survivor-centered approach involves designing and developing programming that ensures the rights and needs of GBV survivors come first and foremost. This means the survivor should be placed at the center of each step of the response process, and that every decision should be driven by the survivor's needs, wishes and capacities.

The survivor-centered approach aims to create a supportive environment in which a survivor's rights are respected and in which the survivor is treated with dignity and respect. This approach helps promote a survivor's recovery and empower them to make decisions about possible recovery interventions.

The survivor-centered approach is considered essential for the following reasons:

- To protect survivors from further harm
- To provide survivors with the opportunity to talk about their concerns without pressure
- To assist survivors in making choices and in seeking help if they want help
- To cope with the fear that they may have about negative reactions (from the community or their family) or being blamed for the violence
- To provide basic PSS to the survivor
- To give back to the survivor the control they may have lost during the GBV incident

3.5 Care for child survivors

All actors involved in GBV intervention should apply the above principles to children. Service providers caring for child survivors of sexual abuse should adhere to a common set of additional principles to guide decision-making and overall quality of care. These guiding principles ensure all actors are accountable to minimum standards for behavior and action. They ensure children and families receive the best care possible.

Table 2 provides details of the guiding principles to care for child survivors.

Table 2: Guiding principles to care for child survivors

GUIDING PRINCIPLES TO CARE FOR CHILD SURVIVORS	
Work according to the best interests of the child	<p>This important principle should be applied both to decisions relating to individual children and to broader policy matters and decisions relating to groups of children.</p> <p>In each and every decision affecting children, the various possible solutions must be considered and due weight must be given to the child's best interests. The decision about how to establish a child's best interests can often be difficult, and no single answer may be obviously and indisputably correct. There are many factors that have to be considered, including age, sex, cultural background, general environment and past experiences of the child.</p> <p>Any interpretation of this principle must be made in the spirit of the Convention on the Rights of Children, and must give due regard to expert advice from both legal and child development perspectives.</p>
Ensure the safety of the child, and their right to life, survival and development	<p>Ensuring the physical and emotional safety of children is critical during care and treatment. All case actions taken on behalf of a child must safeguard a child's physical and emotional wellbeing in the short term and in the long term.</p>
Comfort the child	<p>Children who disclose sexual or other types of abuse require comfort, respect and support from all service providers. Service providers should believe children who disclose abuse and never blame them in any way for the abuse they have experienced.</p>
Ensure appropriate confidentiality	<p>Information about a child's experience of abuse should be collected, used, shared and stored in a confidential manner. This means ensuring:</p> <ul style="list-style-type: none"> • the confidential collection of information during interviews; • that sharing information happens in line with local laws and policies and on a need-to-know basis, and only after obtaining permission from the child and/or caregiver; and, • that case information is stored securely.

	<p>In some places where service providers are required under local law to report child abuse to the local authorities, mandatory reporting procedures should be communicated to the children and their caregivers at the beginning of service delivery.¹¹ In situations where a child’s health or safety is at risk, limits to confidentiality exist in order to protect the child.</p>
<p>Involve the child in decision-making</p>	<p>Children have the right to participate in decisions that have implications in their lives.</p> <p>The level of a child’s participation in decision-making should be appropriate to the child’s level of maturity and age. Listening to children’s ideas and opinions should not interfere with caregivers’ rights and responsibilities to express their views on matters affecting their children.</p> <p>While service providers may not always be able to follow the child’s wishes (based on best interest considerations), they should always respect, empower and support children, and deal with their concerns in a transparent manner. In cases where a child’s wishes cannot be prioritized, the reasons should be explained to the child.</p>
<p>Treat every child fairly and equally</p>	<p>All children should be offered the same high-quality care and treatment, regardless of their race, religion, gender, family situation or the status of their caregivers, cultural background, financial situation, or unique abilities or disabilities. No child should be treated unfairly for any reason. This ensures all children are given opportunities to reach their maximum potential.</p>
<p>Strengthen children’s resiliencies</p>	<p>Each child has unique capacities and strengths, and possesses the capacity to heal. Service providers can assist child survivors to recover by:</p> <ul style="list-style-type: none"> • treating them with dignity and encouraging others to do the same; • helping them participate in family and community life; and, • helping them build and maintain healthy relationships.

¹¹ Mandatory reporting is not currently relevant in the Syrian context because the legal system is not operating.

4 DISCLOSURE PROCEDURES

This chapter provides guidance to all humanitarian actors on how to respond when a survivor discloses a GBV incident.

A survivor may disclose a GBV incident to anyone they choose. They may disclose their experience to a trusted family member or friend, or to a humanitarian worker. The person to whom a survivor discloses their experience has a responsibility to provide support and assistance, according to the wishes of the survivor.

All humanitarian services providers have an obligation to provide support and assistance to GBV survivors who disclose an experience of GBV. Any humanitarian worker or service provider who receives disclosure of a GBV incident from a survivor should follow the disclosure guidelines set out in this chapter.

4.1 Definitions

It is important to understand the definition of the term disclosure and how it differs from identification.

Disclosure. The term disclosure refers to an adult survivor's choice to share with someone they have experienced GBV. Survivors have the right to disclose an incident to anyone. They may disclose their experience to a trusted family member or friend, or seek help from an individual or organization in the community. They have the right to disclose as little or as much of what happened to them, and to choose when to disclose information.

Identification. The term identification refers to the situation where other people (e.g., friends) inform a service provider that another person has experienced GBV.

Humanitarian actors who are not GBV specialists should NOT attempt to identify survivors of GBV. This could put survivors and staff/volunteers at risk. In the case where a humanitarian actor who is not a GBV specialist receives a report identifying someone as having experienced violence, they should contact a GBV specialist who has experience in implementing appropriate follow-up.

4.2 Impacts

GBV seriously affects a survivor's immediate sexual, physical and psychological health, and contributes to greater risk of future health problems. Possible sexual health consequences include unwanted pregnancies, complications from unsafe abortions, female sexual arousal disorder or male impotence, and sexually transmitted infections (STIs) including HIV. Possible physical health effects of GBV include injuries that can cause both acute and chronic illness, and that can affect neurological, gastrointestinal, muscular, urinary and reproductive systems. Possible mental health consequences of GBV include depression, anxiety, harmful alcohol and drug use, post-traumatic stress disorder and suicide.

GBV can also have long-term physical, economic and social consequences on the survivors and on their families and communities. Survivors may suffer further because of the stigma associated with GBV. Community and family ostracism may place the survivor at greater social and economic disadvantage. The physical and psychological consequences of GBV can inhibit a survivor's functioning and wellbeing both personally and in their relationships with family members and others (e.g., work colleagues). The consequences of GBV can also affect relationships in the community, such as the relationship between the survivor's family and the community, or the community's attitudes towards children born because of rape.

GBV can affect child survival and development by raising infant mortality rates, lowering birth weights, contributing to malnutrition and affecting school participation. Child marriage, a particular type of GBV, can also expose a girl to risks of intimate partner violence (IPV), HIV and other STIs, and reproductive and birth complications. It also restricts their freedom and in many cases denies them access to education.

Many of these effects are hard to link directly to GBV because they are not always easily recognizable by health and other service providers as related to a specific GBV incident. 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 a society’s ability to heal from humanitarian emergencies.

There are additional and specific impacts of sexual abuse for children that require specialized knowledge and skills to identify and address.¹²

4.3 Affected groups

The majority of cases of GBV are perpetrated by males against females. Adult women and adolescent girls constitute the primary vulnerable groups who are at high risk of experiencing a GBV incident.

Men and boys can and do experience GBV especially conflict-related sexual violence. This can include violence perpetrated by a stranger or by somebody known to the survivor. GBV against men and boys is most often perpetrated by other men and boys. In the Syrian context, GBV is mostly used in detention settings to humiliate those who hold different political opinions.

Globally, women and girls are disadvantaged in terms of social power and influence, access to and control of resources, control of their bodies, and participation in public life. This disadvantage is not the result of the natural organization of men and women in cultures according to biological or physical truths. Rather, it is the result of socially constructed and socially normalized gender roles and relations in and through which women and girls are located as inferior to, subservient to and weaker than men and boys. GBV against women and girls occurs within the context of this imbalance and often in order to sustain this imbalance.

The genders of the perpetrator and the survivor in any GBV incident are central to the motivation for the violence. They also determine if and how individuals, organizations and governments respond to a specific incidence of GBV and to general incidents of GBV in a society. In many cases, the location of women and girls as ‘naturally’ inferior and subservient to men and boys results in a response that further stigmatizes or punishes the female survivor, and/or views the violence that has occurred as acceptable and normal behavior by males against females. This is especially the case in societies where husbands have or are seen to have legal ownership over their wives and daughters.

Women and girls often experience violence at the hands of people they know well, including an intimate partner or a family member. They are often subjected to multiple forms of GBV throughout their lives. They often also experience ‘secondary GBV’—violence perpetrated against them in response to the violence they have already suffered. Secondary GBV can include so-called ‘honor killings’, abuse by those they report to, and forced marriage to a perpetrator.

While humanitarian actors should be open to working with men and boys as survivors (and perpetrators) of GBV, signatories to these SOPs are encouraged to focus on the needs of women and girls in their GBV

¹² See *Annex III: Consequences of sexual abuse for children*.

programming. Enhancing strategies to empower women and girls and to prevent GBV, with a particular focus on adolescent girls, is a key objective of the HRP in Syria.¹³

The GBV Area of Responsibility (AoR) identifies four distinct objectives as part of its strategy to address the needs of adolescent girls in the WoS¹⁴:

1. Generate knowledge, data and evidence on the needs of and varying impacts on adolescent girls to inform programme design, track progress and document lessons on girls programming.
2. Promote holistic adolescent friendly reproductive health and specialized GBV services to address the needs of adolescent girls.
3. Increase adolescent girls' access to appropriate reproductive health services, GBV specialized services and empowerment activities.
4. Engage with other actors to ensure needs and consideration of adolescent girls are part of the response.

4.4 Preparing to receive survivors

All organizations should be prepared to receive disclosures of GBV. Each service organization, including humanitarian organizations that do not provide GBV specialized services, should at a minimum:

- Train all staff on GBV guiding principles and standard operating procedures relevant to their specialization.
- Ensure all staff know the GBV referral focal points (RFPs) for their district and how to access the referral pathways online using the request form available at this [link](#). For further information, refer to section 5.4 in the SOPs.

4.5 Adopting a survivor-centered approach

When responding to a disclosure of a GBV incident, it is important to act in ways that respect the safety, dignity and rights of the survivor. All persons involved in humanitarian response should learn how to promote a survivor-centered approach as part of their readiness to respond to disclosures of GBV by survivors.

It is important to facilitate the initial conversation with a survivor carefully. The initial information and messages provided to survivors could influence whether they go on to disclose their experiences and access further care. Please refer to *Annex IV: Techniques for Helping GBV Survivors* for more guidance.

Table 3 summarizes some skills to promote a survivor-centered response to GBV disclosures.

¹³ GBV SC, *Syria HRP 2018: Gender based violence (GBV) sub-cluster work plan*, 2018.

¹⁴ GBV SC, *Listen, engage and empower: A strategy to address the needs of adolescent girls in the whole of Syria*, 2017.

Table 3: Skills to promote a survivor-centered response to GBV disclosures

WHAT TO DO	WHAT NOT TO DO
Do believe them.	Do not trivialize or minimize the violence. Not taking a survivor’s story seriously can serve as a barrier for a survivor to seek help.
Do reassure them that the incident of GBV is not their fault. They are not the person who is in the wrong.	Do not judge them and what they tell you.
Do say that it is positive that they have talked to someone about the incident.	Do not carry out proactive identification activities (e.g., looking for GBV survivors, asking about past abuse, pushing for disclosure).
Do be honest and trustworthy.	Do not exploit your relationship as a helper by asking for money or favors.
Do listen to what they have to say and take anything they say seriously.	Do not expect them to make decisions quickly.
Do affirm the person’s strength in disclosing the incident.	Do not blame the GBV survivor.
Do allow the person to take back some sense of control in their life by allowing them to make decisions on what to say and do.	Do not make unrealistic promises or give false information.
Do be aware of and set aside your own biases and prejudices.	Do not exaggerate your skills. For example, do not ask survivors to look in depth at how they are feeling, as this is work that should only be undertaken by a professional trained in psychosocial care.
Do make it clear to the survivor that even if they refuse help now, they can still access help in the future.	Do not be intrusive or pushy, and do not ask the survivor to tell details of what happened to them.
Do respect privacy and keep the person’s story confidential. Try to have the conversation in a private place.	Do not pressure the survivor to tell you their story.
Do behave appropriately by considering the person’s culture, age and gender.	Do not ask for proof or evidence to corroborate the incident of GBV.

Do help the survivor to plan for safety. This may prove difficult in conflict situations, but efforts should be made to improve the survivor's safety.	Do not do nothing.
Do inform them about all available options for services, and the benefits and potential consequences of accessing them.	Do not tell them what do to or take decision on their behalf.

4.6 Disclosure procedures

This section provides guidance to humanitarian actors and service providers on what to do when a GBV survivor discloses a GBV incident. It is common for humanitarian actors who are working in non-GBV areas (e.g., WASH, livelihoods) to be the entry point to GBV referral pathways for survivors who disclose a GBV incident and who require and consent to referral. It is therefore important that all humanitarian actors understand and comply with these disclosure procedures.

When a humanitarian actor receives a disclosure of GBV from a survivor, they should be able to provide the survivor with:

- psychosocial first aid;
- information on services that may be able to assist the survivor;
- details on how to access these services; and,
- appropriate support to help the survivor access these services.

While dealing with a survivor, if at any point a humanitarian actor who is not a GBV specialist is unsure about how to proceed, they should consult with a GBV specialist without disclosing identifiable information about the survivor's situation. If a GBV specialist is not available, the humanitarian actor should apply the GBV guiding principles outlined in Chapter 2 of these SOPs.

The humanitarian actor should inform the survivor about all the available options and support based on their needs and availability in their location. The full range of choices for support services should be presented to the survivor regardless of personal beliefs. The role of the humanitarian actor is to give accurate and honest information without promising things they cannot provide and without unrealistically raising expectations

Humanitarian actors should know that sharing any information about a GBV incident may pose serious and potentially life-threatening consequences for the survivor and for those helping them. They should share only essential information on how service providers can get in touch with the survivor and important safety issues relating to the survivor's situation.

Table 4 explains the disclosure procedure steps for all humanitarian actors.

Table 4: Disclosure procedure steps for all humanitarian actors

PROCEDURE	ACTIONS	RESOURCES
Prepare	<ul style="list-style-type: none"> • Be aware of available services. • Know how to communicate with survivors in a survivor-centered manner. • Increase your knowledge and skills as a non GBV practitioner. 	GBV Pocket Guide ¹⁵
Welcome	<ul style="list-style-type: none"> • Find a safe and quiet space to talk. • Ensure they are not left alone. • Ask the survivor what their immediate concerns are • Assess the security and safety of the survivor, evaluating this together. • Remove the person from immediate danger if it is safe to do so. • If they are in danger, identify together actions to help them (e.g., key people to contact, safer locations). • Try to keep the person safe. • If the survivor is very distressed, help them to calm down. • Ask what the survivor needs to be comfortable (clothing, blanket, food, water etc.). • Ask if you can provide help. 	
Listen	<ul style="list-style-type: none"> • Act in a respectful manner to build trust with the survivor and listen to them. • Allow the survivor to disclose their distress and seek help. • Do not pressure the person to talk and do not expect them to display particular emotional reactions. • Listen in case they want to talk about what happened. • Listen actively (e.g., give your full attention, gently nod your head, make eye contact, use appropriate body language). • Assure the survivor it is not their fault. • Inform them it is common to feel strong negative emotions in these situations. 	Annex VI: Techniques for Helping GBV survivors

¹⁵ See https://gbvguidelines.org/wp/wp-content/uploads/2018/03/GBV_PocketGuide021718.pdf.

<p>Provide information</p>	<ul style="list-style-type: none"> • Inform the survivor they are entitled to protection from violence, abuse and exploitation, and to receive care and support. • Inform them of the services available, and the benefits and consequence of the available options. • Use language they will understand. • Inform the survivor of a realistic timeframe within which services can be expected. • If you do not know, contact the service provider or the GBV SC to inquire. • For sexual violence survivors, provide information on health services. • Explain to the survivor the importance of seeking health care within 72 hours to minimize risks of sexually transmitted diseases (including HIV/AIDS) and unwanted pregnancies. • For adult survivors, inform them they have the right to decide what services they wish to receive and with whom they wish to share information. • Give the survivor time to take breaks and ask for clarifications. • Respect the survivor's right to decide what support they need. • Do not give advice or your opinion on what the survivor should do. 	<p>Annex V: Survivor-centered tips.</p>
<p>Referral</p>	<ul style="list-style-type: none"> • If the survivor requests access to services, follow the SOPs for procedures for referral. 	<p>Chapter 5 in the SOPs</p>
<p>Close</p>	<ul style="list-style-type: none"> • Finish the disclosure in a positive way • Reaffirm they are entitled to protection from violence, abuse and exploitation, and to receive care and support. • Reaffirm it is not their fault. • Reaffirm it is common to feel strong negative emotions in these situations. • Reaffirm they have the right to live free from violence and risk of violence. 	

5 REFERRAL PROCEDURES

This chapter provides guidance to humanitarian actors on how to refer GBV survivors after disclosure.

Providing information to survivors in an ethical, safe and confidential manner about their rights and options to access care is a cornerstone element of a survivor-centered referral system by which survivors can access the mix of services and support appropriate to their needs and wishes. Quality referral pathways are of paramount importance to enable timely interventions in response to survivors' multiple needs.

Referral roles and responsibilities are assigned according to an individual's professional position and level of professional responsibility. The referral pathways differ for humanitarian actors who are GBV specialists and humanitarian actors who are not. All humanitarian actors provide information on the services available, how to access them, and refer survivors to services. GBV specialists provide additional support and services directly to survivors, including case management.

Any humanitarian worker or service provider who is asked for information about GBV support services should follow the referral guidelines set out in this chapter

5.1 Types of referrals

Referrals can happen in many different directions amongst different actors.

Table 5 indicates types of possible referrals.

Table 5: Types of referrals

FROM	TO	TYPE OF REFERRAL
Any humanitarian actor or community members	GBV case management actors	Professional care and GBV case management
GBV case management actors	GBV case management actors	It may be more appropriate for another GBV specialist to provide case management (e.g., in another area).
GBV case management actors	Multi-sectoral response services	To provide timely and quality care to GBV survivors such as medical services. Refer to Chapter 7 for more information about multi-sectoral response services. According to the survivor's needs and initial assessment, care should be provided and comprehensive information about other services and the consequences and benefits of accessing them should be given. At this point, the survivor will be referred to additional services of his/her choice and based on her/his needs.

GBV case management actors	Other services	During or following the period of time when a survivor is receiving care from specialists, they may also be in need of additional services not directly GBV-related (e.g. food assistance, shelter, NFI, education, etc.) as part of their case management action plan. GBV case management actors will refer survivors to the relevant agencies, and follow up if they are acting as case managers for the survivor.
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5.2 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. It promotes safety, trust and empowerment. It is an important part of the survivor-centered approach, and should be given consideration at all times.

Confidentiality might need to be broken in certain circumstances. These are:

- If the survivor is an adult who threatens their own life or who is directly threatening the safety of others, in which case referrals to lifesaving services can be sought.
- If the survivor is a child, when there are concerns for his/her health or safety.
- When there are mandatory reporting policies for cases of sexual exploitation and abuse that involve humanitarian workers.

A survivor should be informed about any exception to confidentiality.

5.3 Informed consent

Informed consent refers to the giving of approval after careful consideration. In order to give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given, and must be able to evaluate and understand the consequences of an action.

Informed consent is a crucial step in providing quality care and response to a GBV survivor. The purpose of documenting the GBV incident and gaining the survivor’s consent to share the information with other organizations and/or services is to facilitate protective measures and the healing process of the survivor through appropriate referrals. Informed consent is an important step in recognizing the fundamental rights of the individual of taking care of their own life. It places the survivor at the center of the healing process. It empowers them to decide what to do about their life and body.

Asking for informed consent means asking the survivor for permission to undertake any action (e.g., a referral, a medical exam) and to share information about them with others (e.g., referral services). Informed consent should be voluntarily and given freely by the survivor based upon their clear appreciation and understanding of the facts, implications and future consequences of any action that will be undertaken.

All humanitarian actors must explain to the survivor any steps involved in the offered service, as well as inform them about additional available services according to their needs. This must include explaining in detail any potential negative aspects (e.g., cost, distance, lack of female staff) or consequences, as well as potential benefits related to accessing the services.

Under no circumstances should the survivor be pressured to consent to any examination, conversation, assessment, interview or other intervention with which they do not feel comfortable. A survivor can also at any time decide to stop an intervention (e.g. during a medical examination).

Table 6 summarizes the steps to ensure informed consent.

Table 6: Steps to ensure informed consent

STEPS TO ENSURE INFORMED CONSENT	
Step 1: Provide all information	<p>To ensure consent is truly informed consent, a humanitarian actor must provide all possible information and options available to the survivor.</p> <p>They must explain what is going to happen to the survivor after the referral.</p> <p>They must also explain to the survivor that they have the right to decline or refuse any part of any services.</p>
Step 2: Ensure the survivor understands the implications of any referral	<p>Explain the benefits and risks of the service to the survivor.</p> <p>GBV survivors have a right to control how information about their case is shared with other agencies or individuals, and should understand the implications for sharing information so that they can make decisions based on full knowledge before the information is shared.</p>
Step 3: Explain the limitations to confidentiality	<p>Make the survivor aware that their information may need to be shared with others who can provide additional services.</p>
Step 4: Ask for consent	<p>Ask the survivor if they give consent for you to contact other services and to pass on their name.</p> <p>For non-specialized providers, this can be done verbally. A written document is not advisable, especially if confidentiality procedures are not known or cannot be followed.</p> <p>During case management, written consent should be obtained as much as possible</p>
Step 5: Check limitations of consent	<p>After being made aware of any risks or implications of sharing information about their situation, the survivor has the right to place limitations on the types of information to be shared, and to specify which organizations can and cannot be given the information.</p>

5.3.1 Informed consent form

An 'Informed Consent Form' (Annex VI) should be used by GBV specialists within the framework of case management when referring the survivor to specialized GBV services. When possible and relevant, the survivor should sign the form to indicate they understand and agree to the care they choose. Before a

survivor signs a consent form, the GBV actor should confirm the survivor understands how the provider will use, store and disseminate the information. Service providers should also sign the form.

Asking for a signature may not always be appropriate, especially if the existence of such a form signed by the survivor poses risks to their safety. Alternative options are for the provider to sign a form confirming consent was given. For those who cannot sign, a thumbprint or “X” may be appropriate, otherwise verbal consent must be obtained. If an informed consent form is not available for a survivor to sign, verbal informed consent must be obtained.

If the survivor does not consent to sharing information, information cannot be shared with outside organizations. Even if a survivor does not provide their consent to share information with other organizations, they are still entitled to receive appropriate and timely care.

The generally accepted approach to obtaining informed consent is as follows:

- Read aloud to the survivor the consent statement included in the standard informed consent form, allowing time for the survivor to ask questions and seek clarification of individual points.
- After explaining the key points, ask the survivor to repeat back in their own words why they think consent is being requested, what they think they will gain from providing consent, what they have agreed to consent to, what the potential consequences of giving consent might be, and what would happen if they refuse to give consent. This will allow the service provider to assess the survivor’s understanding of each issue and if necessary, reinforce anything that was not clearly understood and/or correct any misunderstanding.

5.3.2 Informed consent for survivors with disabilities

Persons with disabilities are not a homogenous group. Some may have long-term disabilities, whereas others may have short-term disabilities. Their disabilities might be physical, sensory, intellectual and/or psychosocial. Gaining informed consent from persons with disabilities can sometimes be difficult depending on the type and extent of their disabilities. Perceptions about the capacity of a person with a disability and the level of control the caregiver may have over the person also present barriers to gaining truly informed consent from GBV survivors with disabilities.

The Convention on the Rights of Persons with Disabilities states that an individual cannot lose their legal capacity to make decisions simply because they have a disability.¹⁶ It is therefore important to assume initially that all adult GBV survivors with disabilities can provide informed consent, and to follow the same procedures as described above. Some additions¹⁷ to these procedures are:

- Asking the survivor if they want some support to help them give informed consent.
- Adapting communication methods to match those preferred by and effective for the survivor.
- Taking more time to ask questions to ensure the survivor understands everything, including possible consequences of accessing services.
- Checking to ensure they are not being coerced or forced to make decisions.

¹⁶ See <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>.

¹⁷ For more details of how to ensure a GBV survivor with disabilities has the capacity to give informed consent, refer to pp.139-146.

5.3.3 Informed consent/assent for child survivors

Generally, children who have experienced GBV do not disclose it directly. Identification is more common. Identification occurs, for example, when someone witnesses child sexual abuse or when the child contracts a STI or becomes pregnant.

As a general principle, permission to proceed with providing assistance is sought from both the child and their caregiver (e.g., parent) unless it is deemed inappropriate to involve the caregiver. Permission to proceed with case management and other care and treatment actions (e.g., referrals) is sought by obtaining 'informed consent' from caregivers of older children and/or 'informed assent' from younger children.

Informed consent and informed assent are similar, but not exactly the same.

- *Informed consent* is the voluntary agreement of an individual who has the legal capacity to give consent. To provide "informed consent" the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent.
- *Informed assent* is the expressed willingness to participate in services.

Table 7 provides a summary of the guidelines for obtaining informed consent/assent from children.

Table 7: Summary of guidelines for obtaining informed consent/assent from children

AGE GROUP	CHILD	CAREGIVER	IF NO CAREGIVER OR NOT IN THE CHILD'S BEST INTEREST	MEANS
0-5	-	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent
6-11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, Written consent
12-14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight.	Written assent, Written consent
15-18	Informed consent	Obtain informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

5.4 Obtaining referral pathways

Due to a strict Information Sharing Protocol, the GBV SC cannot openly share the referral pathways developed by the GBV SC. However, all humanitarian actors should know how to refer a GBV survivor for support. It is very important to take prompt action in order for the GBV survivor to access quality and timely care. Timely referrals can save lives and prevent further harm and medical consequences in some case of sexual violence and other severe cases.

The GBV SC has developed a system of 'referral focal points' (RFPs) at the district level. These are service phones of organizations that provide GBV case management. The list of RFPs is available in *Annex VII: List of Referral Focal Points*. This list is a public document and can be accessed by all humanitarian actors. All actors can call any number on the list to receive direct support for the GBV survivor, and/or to receive relevant information and assistance to refer the survivor to a GBV specialist.

5.4.1 Obtaining referral pathways for GBV specialists signatories to the SOPs

GBV specialists who are signatory to these SOPs receive the referral pathways, updated on a quarterly basis, directly. They will proceed with case management as described in Chapter 6 of the SOPs, or refer the case to another GBV specialist (e.g., in a different area).

5.4.2 Obtaining referral pathways for humanitarian actors

Any humanitarian actor can access referral pathways for a certain location by submitting a request to the GBV SC coordination team using the on-line referral form (<https://form.jotform.com/81003717264955>) or by contacting the GBV SC service number (+90 – 537 267 7138). The GBV SC coordinators will send referral pathways within a maximum of 48 hours.

5.4.3 Obtaining referral pathways for other non-humanitarian entities

Other non-humanitarian entities—such as human right organizations, camp management, stabilization actors, private clinics and private companies carrying out development work—may need to refer GBV survivors to specialized GBV service providers. They can request referral pathways by directly contacting GBV SC coordinators and explaining the reasons for the request. Referral pathways will be shared on a case by case basis.

5.5 Survivor referral options

If the survivor decides to access support, any humanitarian actor should inform the survivor they have two options:

1. The survivor can contact or go directly to the GBV case management actor.
2. The humanitarian actor can help the survivor access the services by making a referral.

The choice of option should always be made in consultation with the survivor. If they choose the first option, the role of the humanitarian actor is to provide the survivor with information on where services are available, including sharing the list of RFPs. If they choose the second option, the humanitarian actor should do this after obtaining informed consent and with full respect of the survivor's rights and dignity.

Table 8 explains the options for referring a survivor for humanitarian actors who are not GBV actors providing case management.

Table 8: Options for survivors' referral for humanitarian actors who are not GBV actors providing case management

CHOICE	APPROPRIATE SITUATION	WHAT TO DO
Accompany the survivor	Emergency or urgent GBV cases	Accompany the survivor to the relevant service provider.
Referral by phone using the RFPs (<i>Annex VII: List of Referral Focal Points</i>)	Emergency, urgent or moderate cases if accompanying the survivor is not possible or is not in their best interest.	Any humanitarian actor can call any number in the focal point list to receive direct support for the GBV survivor, or relevant information and assistance to refer the survivor to a GBV specialist.
Referral by phone using the Referral Pathway (<i>Annex II</i>)	Emergency, urgent or moderate cases if accompanying the survivor is not possible or is not in their best interests.	Any humanitarian actor can contact GBV actors providing case management using the referral pathway (see session 5.4.2 on how to obtain referral pathways).
Referral by email or messaging application (using either the RFP list or the Referral Pathways)	For moderate risk cases	When using email for referral, it should only be sent to the relevant focal point, and others who are not involved in managing the case should not be copied.

After the humanitarian actor has obtained informed verbal consent to make the referral to a GBV actor providing case management, and after the referral has been made, this is the end of responsibility for this actor. The responsibility for case management now rests with the GBV actor who has received the referral.

5.6 Remote management referral

Working in a remote management setting is challenging. When evaluating services to which a survivor will be referred via remote management, it is important to carefully consider the following criteria prior to referral:

- **Presence.** Is the service regularly available and fully function on the ground?
- **Geographical location.** Does the service reach the population it is meant to serve?
- **Accessibility.** Can survivors and/or communities access this service freely, safely and confidentially?
- **Accountability.** Who is responsible for following up this service?

5.7 Non-availability of services

It might be the case that one or more services are not available or not accessible at a given time. It is important not to raise unrealistic expectations for a survivor about what services and support they may be able to receive. It is therefore important all actors maintain up-to-date knowledge about what community and GBV specialized services are operating in their areas. When GBV specialized services are not

available, a survivor should still have access to information to ensure their safety and basic emotional support. As the situation in the field is very fluid and service availability may change quite fast, humanitarian actors should seek to remain updated on GBV specialized services available. Referral pathways produced by the GBV SC are updated on a quarterly basis.

5.8 Refusal of services

GBV survivors must never be forced or coerced into receiving support or services. The survivor has the right to refuse any support or service that is available or offered. The following are some guidelines for what to say and do when a survivor refuses a particular service:

- Assure the survivor it is their right to refuse any service.
- Explain to the survivor that their refusal right now does not affect in any way their right to request or access that service at some time in the future.
- Confirm the survivor understands the consequences of not accessing the service.
- Identify if there are any safety risks that may be the reasons the survivor has refused the service.
- For GBV case management actors, and with the agreement and in consultation with the survivor, build a safety plan that includes identifying ways to eliminate or mitigate the risks of future GBV.

6 CASE MANAGEMENT

GBV case management is a structured method for providing help to a survivor. It involves one organization, usually a PSS or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process. The goal of case management is to empower the survivor (and, where appropriate, their caregiver), by giving them increased awareness of the choices they have and assisting them to make informed decisions about GBV.

A case management-based referral system allows survivors to be active participants in defining their needs and deciding what options best meet those needs. It is useful for persons with complex and multiple needs who seek access to services from a range of service providers, organizations and groups.

6.1 Competencies

Case management is a specialized service provided by agencies with specific GBV expertise. Case managers play an important advocacy role to ensure survivors receive needed services, to monitor the provision of services, and to follow-up with the survivor throughout the process.

Due to the insecure and complex context where these SOPs apply, case management actors need to consider the following:

- Always comply with the guiding principles described in Chapter 2 in the SOPs.
- Case management procedures can be highly complex and detailed. Focus on the basics and keep the whole process simple.
- Focus on the services you can offer without raising expectations unrealistically.
- Concentrate on the survivor's immediate needs, skills and capacities when the situation is particularly insecure. This will involve, for example, conducting safety planning and providing contacts for essential services.
- Ensure timeliness of the response. Minimizing the time it takes to arrange all services is important so survivors are supported as quickly as possible.
- Ensure that case management is provided by trained, well supervised and experienced staff who have the time and resources to carry out their work.
- Case management should take place as much as possible in safe and confidential spaces.
- Avoid home visits to survivors. If safe spaces are not available or accessible, identify another community or service provider center.

6.2 Procedures

Table 9 provides further details on the actions for case management after informed consent from the GBV survivor has been obtained.

Table 9: Actions for case management

STEPS	CASE MANAGEMENT ACTIONS
<p>STEP 1: Introduction and Engagement</p>	<p>Case management always begins with disclosure and/or referral, including obtaining informed consent from the GBV survivor. For disclosures and referrals, case managers should follow the steps outlined in Chapter 4 and Chapter 5 in the SOPs.</p>
<p>STEP 2: Assessment</p> <p><i>Why has the survivor come for help?</i></p> <p><i>Is the survivor at immediate risk?</i></p> <p><i>What has happened?</i></p> <p><i>How does the survivor see the situation?</i></p>	<p>The case manager should properly evaluate the safety and security of the survivor to identify if there is any risk to the survivor. A safety plan might also be discussed with the survivor to ensure adequate security measures are in place.¹⁸</p> <p>Conducting an initial assessment involves listening to survivor’s story, helping them identify needs, and carefully and confidentially documenting information without raising unachievable expectations. Active listening is one of the most powerful elements of this process.</p> <p>The following information should be prioritized during the assessment and documented¹⁹ when appropriate:</p> <ul style="list-style-type: none"> • Type and circumstances of the GBV incident. • Survivor personal and background information (age, where they live, marital status, occupation etc.). • Information about the perpetrator(s)—occupation, relationship to the survivor, age etc., but not necessarily identity. • Information about other services the survivor has sought or accessed after the incident. <p>During the assessment, the case manager also evaluates the survivor’s capacities and resources. The caseworker and the survivor might identify supportive networks including family members.</p>
<p>STEP 3: Action plan</p> <p><i>How can the survivor’s needs be addressed?</i></p>	<p>The survivor with the help of the case manager develops action plans.</p> <p>To help a survivor plan how to meet their needs and improve their situation, the case manager should give relevant information about all services available without creating expectations that cannot be met.</p> <p>The case manager should help the survivor identify their options and help them make informed decisions about what they want to do.</p>

¹⁸ See Annex IX: Safety Checklist and Safety Planning

¹⁹ See Annex X: Standard GBVIMS Intake Form.

<p><i>Which actions can be prioritized and who can provide them?</i></p>	<p>A timeframe should be agreed for the plan of action.</p>
<p>STEP 4: Implement the plan</p> <p><i>How can a survivor be assisted to achieve their goals?</i></p> <p><i>How can the survivor access services and opportunities?</i></p>	<p>This step involves putting the agreed plan into action. This involves direct service delivery, referral to other services, advocacy on behalf of the survivor, and supporting the survivor throughout the process.</p> <p>The action plan is a road map. The case manager is the navigator, helping the survivor manoeuvre through the steps in the plan.</p> <p>The case manager needs to be knowledgeable on GBV referral pathways.</p> <p>It is important to note that while the referred service (or agency) is responsible for providing a specific service, the case manager maintains overall responsibility for following up on the case plan. All referrals should happen based on the informed consent of the survivor.</p>
<p>STEP 5: Follow-up and review</p> <p><i>Is the survivor's wellbeing improving?</i></p> <p><i>Are they feeling better?</i></p>	<p>This step involves following-up with the survivor and the different services to make sure the survivor is getting the help and services they need. It also involves monitoring and evaluating that the survivor's medical and psychosocial needs have been met, and/or identifying with the survivor any barriers to achieving the action plan's outcomes.</p> <p>During the follow-up stage, the survivor in consultation with the case manager might identify additional needs and new actions points which should be added to the case plan.</p>
<p>STEP 6: Case closure</p> <p><i>Is the survivor able to take care of their life alone?</i></p> <p><i>Have the needs of the survivor been met?</i></p>	<p>The survivor, in consultation with the case manager, decides when to close their case. The timing of the closure will depend on when the needs of the survivor have been met and when the survivor is satisfied with the outcome of the healing process.</p>

6.3 Vulnerable groups

In certain cases, case management procedures may need to adapt to specific needs of individuals, especially those who are part of a distinct vulnerable group. GBV specialists should ensure they have the skills and knowledge, as well as the willingness, to be able to adapt their case management procedures to meet these needs.

6.3.1 Adolescent girls

Adolescent girls are often overlooked in humanitarian response. They nevertheless face greater risks than any other population group. They are especially at risk because of their low social and economic status in many societies. They may be reluctant to share details of what has happened because of fear of being punished, shame and social stigma. They may believe that what has happened to them is normal. They may feel extremely vulnerable, especially if the perpetrator is somebody on whom they rely for basic living needs (e.g., a male family member). They may also be at further risk of violence if it is discovered that they are accessing services and support for GBV.

Adolescent girls have been identified in Syria as particularly vulnerable group to sexual violence and to child marriage leading to early pregnancy. A strategic framework to address the specific needs of adolescent girls in Syria focusing GBV and reproductive health has therefore been identified and developed to better respond to the needs of adolescent girls inside Syria.²⁰ The aim of this strategy is to strengthen and expand on existing programming for adolescent girls in Syria.²¹

When managing a case of GBV for an adolescent girl, the following points should be considered:

- Assess the safety of the survivor, including how easy it is for the perpetrator to have access to her and what support she might expect from her family.
- Recognize that she may be feeling confused, guilty, scared and sad. Her emotional state may affect what she is willing to disclose and to whom she is willing to talk.
- Recognize that she may not understand what has happened to her, and she may not be aware of the possible consequences of sexual violence including pregnancy and STIs.
- Use simple language to explain what services are available, including the possible consequences of accessing these services.
- Pay attention to the development stage of the girl. The ability of a survivor to explain what has happened and to make decisions about services she wishes to access can differ greatly depending on her age and level of education.

Adolescent girls also face the unique GBV risk of child marriage. The management of such a case requires a highly sensitive approach to ensure the girl is allowed to make decisions and not placed at risk of further harm. Regardless of the position a GBV specialist holds on child marriage, they should never intervene to stop the marriage. The best approach is to understand the situation of the girl and what she wants to do.

There are two types of case management of child marriage: management of an imminent marriage and management of an existing marriage. Table 10 shows the case management responses to child marriage.

Table 10: Case management response for child marriage

FOR IMMINENT RISK CASES	FOR GIRLS WHO ARE ALREADY MARRIED
Get consent to work with the girl.	
Assess: How does she feel about the marriage?	Assess her needs.

²⁰ GBV AoR, *Listen, engage and empower: A strategy to address the needs of adolescent girls in the whole of Syria*, 2017.

²¹ The four primary objectives of this strategy are outlined in section 4.3.

Provide information to the girl about the consequences of marriage.		
Identify with her a supportive family member or other trusted adult.		Provide information about the services available and make referrals.
With the girl's consent, engage the supportive family member or other trusted adult.		Carry out safety planning.
If person identified is parent or caregiver.	If person identified is not parent or caregiver.	
Discuss pro and cons of child marriage.	If safe to do so and with the girl's consent, support the identified person to have a conversation with the decision-maker in the family.	
Provide information to the identified persons on the consequences of child marriage.		
If marriage is likely to go forward, focus on risk reduction.		
Assess the girl's concerns and questions, and potential risks related to her safety and health.		
Carry out safety planning.		
Provide information about services and referrals.		
Help her identify a supportive person in her life.		
Help her identify positive coping strategies.		
With her consent, engage—or continue to engage—a supportive adult.		

6.3.2 Child survivors

Providing care for survivors of GBV who are children is particularly challenging. It requires qualified and trained staff with appropriate competencies and attitudes, working to clear guidelines.²²

The following points should be considered when managing a case of GBV involving a child survivor:

- The best interests of the child should always be prioritized.

²² Core knowledge, attitude and communication competencies for staff working with child survivors can be found in chapters 1 to 3 of IRC & UNICEF, 2012.

- Communication with child survivors should use child-friendly techniques to encourage them to express themselves.²³
- If the child survivor wishes, they can privately talk with a social worker or counsellor.
- Where both child protection and GBV actors are available, child survivors under the age of 14 should be referred to child protection actors for case management.
- Where both child protection and GBV actors are available and equally trained on how to care for child survivors, boys between 14 and 18 years of age should be assisted with case management by child protection actors; while for girls of the same age case management should be provided by GBV specialists.
- After the initial assessment provided, referrals should be made to specific organizations skilled in working with child survivors.
- The parents or caregiver of the child and the child should always be informed about the next steps and available services, and about risks and benefits of accessing them.
- If the case manager and caregiver are unable to come to an agreement about the provision of services, and if it is the case manager's opinion that the caregiver is not acting in support of the child's best interest, the service providing organization may need to intervene.
- Action needs to be taken if there are suspicions the perpetrator is a family or household member or the caregiver is in disagreement with the services providers.
- For children under the age of 14, when parents and/or caregivers are suspected to be perpetrators or complicit in children's abuse, involving an adult that the child trusts, such as a relative, should be prioritized. The child should be supported to identify an adult whom they trust. It is acceptable to proceed with only the child's permission only in cases when the life and/or safety of the child is at risk and therefore immediate support is needed.

In such circumstance, the following guidelines also apply:

- Service providers should follow a decision-making process that first considers the child's safety and best interest of the child.
- Supervisors and specialists of GBV Sub-Clusters should be consulted in the decision-making to determine the best course of action when possible.
- Where it is not possible to consult specialists, specific safety measures should be taken, relevant to the context, and regular follow up might be required.
- The whole family should be referred to family wellbeing activities and/or women center programmes and/or child friendly spaces in the area if available.

6.3.3 People with disabilities

The intersection of gender and disability increases the risk of violence for women, girls, men and boys with disabilities, as well as their caregivers. In the same way that gender inequality is the root cause of violence against women and girls (VAWG), so too inequality associated with disability is the root cause of violence against persons with disabilities.

When managing cases of GBV affecting persons with disabilities, it is important to keep in mind that the survivor may have communication and physical barriers that prevent them from clearly explaining what has happened and what they wish to access in terms of services and support. Their dependency on their caregiver may affect what they can disclose as well as what services they can access, especially if the

²³ See *Annex XI: Best practices to communicate with children*.

caregiver controls what the survivor can do, including the choices they can make. Maintaining confidentiality at all times can be difficult because the GBV incident may have been reported by somebody else in the community, and not by the caregiver nor by the survivor. It is therefore important to emphasize survivor-centered techniques when talking to a GBV survivor with disabilities, including taking time to watch and listen, always talking directly to the survivor, paying attention to how the survivor wishes to communicate, and not putting pressure on the survivor to disclose or agree to anything.

The following points should be considered when managing a case of GBV for a person with disabilities:

- Assume an adult survivor with a disability has the capacity to provide informed consent independently.
- Always ask the survivor if they would like support to make an informed decision.
- Use a variety of communication methods to ensure the survivor can communicate well and understand.
- Ask questions to check the survivor has understood information and consequences related to accessing services.
- Be aware of the power dynamics between the survivor and their caregiver to ensure the survivor is not being coerced into making decisions.
- If required, ask the survivor if they will agree to involve somebody they trust to help them, and let the survivor identify who this person is.
- Ensure any decisions you make with or for the survivor are in the best interests of the survivor and empower them to take control of their healing.

6.3.4 Older Women

Research studies²⁴ demonstrate how aging is not a factor that protects women from GBV, especially in displacement situations. Older women undergo multiple forms of discriminations, on the basis of gender and age. Age-specific factors, such as physical vulnerability, displacement, possible illness, isolation, dementia, lack of social connections or dependence on relatives or neighbors, put older women at greater risk of violence compared with women of younger age. Older women who experience violence are more likely to have severe consequences such as fear, anger, depression, exacerbation of existing illness, confusion, severe psychosocial distress and life-threatening injuries. Further, they are especially vulnerable to economic abuse, in particular, they experience obstacles as they attempt to secure inheritance and property rights, and face greater challenges in accessing information on available services. Older women could also internalize and normalize abuse and violence with the time, or not recognize abusive behavior like domestic violence.

For older widows, discrimination compounds the effects of a lifetime of poverty and gender discrimination. This can result in extreme impoverishment and isolation, both for the widows themselves and any dependents they care for. Their situation is worsened by a lack of knowledge of their legal rights such as inheritance, of how to access appropriate information and where to seek impartial advice and guidance

When managing a case of GBV for an elderly woman, the following points should be considered:

- Use simple language to explain what services are available, including the possible consequences of accessing these services.

²⁴ AAAS Scientific Responsibility, Human Rights and Law Program, *Age is no protection: Prevalence of gender based violence among men and women over 49 years of age in five situations of protracted displacement*, July 2017

- Pay attention to the mental status of the survivor. The ability of a survivor to explain what has happened and to make decisions about services she wishes to access can differ greatly depending on her status.
- If required, ask the survivors if they will agree to involve somebody they trust to help them, and let the survivor identify who this person is.
- Sensitize outreach and mobile team on inclusion of older women in information provision and GBV awareness sessions.

6.3.5 Male survivors

In humanitarian settings, men and boys are also at risk of sexual violence. This may be perpetrated by other men within the context of armed or ethnic conflict to emasculate men or to disempower families and communities. Boys may be at risk of sexual abuse, usually perpetrated by family members or other men who are known to the boy. Young men and boys also regularly face GBV aimed at 'punishing' them for and 'correcting' behaviors and characteristics they display that are considered by others (often other boys and men) to be insufficiently masculine and/or overtly feminine according to the gender norms of the culture.

Many male survivors of sexual violence do not report the incident because of extreme shame. Many face additional barriers to accessing care because traditional notions of normative masculinity do not promote self-care and healing as practices for men. Instead, male survivors may turn to negative coping mechanisms (e.g., drug and alcohol abuse).

Organizations primarily set up to provide services to women and girls, and/or that do so through women and girls safe spaces, will need to have clear procedures for how to respond to any disclosures from men. Protocols need to be in place for referring the case to a service provider with appropriate service entry points for men (e.g., a health actor who has been trained in clinical care for male survivors, or another protection or mental health actor). If such options are not available, the organization can work with the survivor in an alternative location, such as a nearby health clinic.

The following points should be considered when managing a case of a male survivor of sexual violence:

- Be aware that the man or boy may believe they have been 'turned into' a homosexual if the sexual violence was perpetrated by another man. They may be concerned about their future ability to enjoy a 'normal' heterosexuality.
- Do not make any assumptions about the sexuality of the survivor.
- Recognize they may be in denial about what has happened, and so their story of the experience may not be consistent or accurate.
- Do not make any judgements about negative coping mechanisms they may have adopted.
- Reassure them of their strength. Telling them they are strong and brave for disclosing the GBV incident. This can help revalidate their sense of masculinity and be part of their healing.

6.4 Documentation

GBV documentation refers to the collection of data of individual GBV incidents (including action plans and follow up actions) by a case management organization. Case management agencies with appropriate expertise on the subject and information management procedures in place should document GBV cases in

order to enhance quality of services to survivors. In the absence of the GBV Information Management System (GBVIMS), the GBV SC introduced a simplified GBV incident tracking sheet²⁵

Each organization might adopt a different system for GBV documentation. In doing so, organizations should take the following recommendations into account:

- Agency staff charged with collecting the initial intake information from the survivor should be appropriately trained on how to fill out the forms and how to act in accordance with the guiding principles.
- The consent form, which normally includes names, should be stored separately from other documents. When possible, a coding system should be utilized for survivors' and staff's names. Each case file should be stored separately.
- Completed intake forms should never be transferred or shared between agencies in order to maintain the safety, security and confidentiality of information.
- Information should only be printed if absolutely necessary.
- All printed material should be destroyed when it is no longer needed. A contingency plan should be considered for dealing with printed materials in case of evacuation.
- Information should not be emailed unless absolutely necessary. Any emails should never contain personal names nor contacts.
- Access to information should be controlled within every agency. This includes establishing clear responsibility for which staff can access or use survivor information, and limiting access to computers used to store confidential data.
- Information stored electronically should be password protected.

A system for GBV documentation should be set up if a GBV service is offered by the organization.

²⁵ See *Annex XII*: GBV incident tracking sheet

7 MULTI SECTORAL SUPPORT TO GBV SURVIVORS

Not all GBV survivors want or need assistance. Many survivors of GBV will recover without specialist support. For some, services such as social supports, psychological first aid (PFA) and clinical health interventions will be of benefit.

These services are delivered through a multi-sectoral approach in line with international standards and protocols. All providers must abide by the principles described in Chapter 2 of these SOPs. Sector-specific tasks, roles and goals towards GBV survivors differ according to the nature of each service, but all providers share roles and responsibilities in dealing with survivors of GBV.²⁶

In general, the following are the main services which make up a holistic GBV response:

- Immediate material assistance
- Safety and security options
- Health/Medical care
- Mental health and psychosocial support (MHPSS)
- Legal/Justice assistance
- Long-term assistance

7.1 Immediate assistance

Survivors may need basic assistance to ensure their immediate wellbeing, safety and security. Case managers and other GBV service providers can help by providing or arranging such assistance.

When providing immediate assistance, consideration should be given to the following:

- Assistance should never stigmatize GBV survivors by identifying them as survivors in the specific services they receive or at the locations in which services are provided.
- Assistance should not expose survivors to additional risks (e.g., domestic violence or robbery after receiving cash or vouchers).
- Assistance should be provided by other sectors based on the case manager's assessment and evaluation of the survivor's needs and context. The case manager will still be the responsible person for ensuring quality of assistance and follow-up in line with a survivor-centered approach.
- Material assistance, such as emergency food, non-food items (NFIs) and shelter should be provided through quality and timely referrals.
- Assistance should be considered part of the healing process, aimed at addressing immediate needs related to the GBV incident, within a specific timespan, and in line with the action plan agreed between the case manager and the survivor.
- Assistance should be guided by the principles of confidentiality, safety, respect and non-discrimination.

Agencies providing immediate assistance to meet survivors' basic needs should follow the guiding principles described in Chapter 2 of the SOPs.

²⁶ See *Annex XIII: Sector-specific tasks, roles and goals towards GBV survivors*.

GBV actors should regularly liaise with other sectors and service providers to be informed about activities and criteria for accessing other forms of assistance. GBV actors should also provide training for other sectors and agencies to ensure all humanitarian actors are aware of GBV core concepts and risk mitigation measures in humanitarian programming.

7.2 Health/medical care

Health care providers play a crucial role in providing immediate and lifesaving care for GBV survivors. They provide treatment related to rape, sexual assault and other types of GBV to prevent further harm and health consequences of the GBV.

A coordinated, survivor-centered approach to the health/medical response to GBV follows the principles of safety, confidentiality, respect and non-discrimination. Following a survivor-centered approach is at the core of all health assistance to protect GBV survivors.

Health providers need to know the protocol relevant to the care of GBV survivors in accordance with internationally approved standards for the clinical management of rape (CMR) survivors.²⁷ They should be trained on GBV core concepts, GBV guiding principles and providing clinical care for survivors of sexual violence. They should also understand and inform GBV survivors about the importance of other potentially needed services including legal and social services.

Service providers offering medical care to GBV survivors that are signatory to these SOPs should implement the standards set out in the GBV SC Turkey's *Guidelines for health staff caring for gender-based violence survivors*.²⁸ These guidelines are based on the internationally recognized WHO guidelines and have been adapted to the Syria context. These guidelines have been endorsed by the members of the Health Cluster and GBV SC in Turkey who are responsible for cross-border operations into Syria.

Table 11 provides a summary of the steps involved in the provision of CMR for women, men, boys and girls who have been raped in emergency settings.

Table 11: Steps for clinical management of rape

STEPS	SURVIVOR-CENTERED APPROACH
STEP 1: Preparing the survivor for an examination	Introduce yourself. Limit the number of people in the room to the minimum necessary. If the survivor wishes, ensure that a trained support person or trained health worker of the same sex accompanies the survivor throughout the examination. Ask if they also want to have a specific person present (e.g., family member or friend). Determine the best way to communicate and adapt to the survivor's communication skill level and language. Avoid medical terminology and jargon.

²⁷ WHO et al, *Clinical management of rape: Developing protocol for use with refugees and internally displaced persons*, 2004.

²⁸ GBV SC, *Guidelines for health staff caring for gender-based violence survivors: Including protocol for clinical management of rape*, 2016.

	<p>Obtain informed consent (or a parent’s informed consent in the case of a child).</p> <p>Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you will give. Make sure the survivor understands everything.</p> <p>Reassure the survivor they are in control of the examination. Explain that they can refuse any aspect of the examination they do not wish to undergo, and that this will not affect their access to treatment or care.</p> <p>Reassure the survivor that the examination findings will be kept confidential unless the survivor decides to bring criminal charges.</p> <p>Apply psychological first aid.</p> <p>Ask the survivor if they have any questions.</p>
<p>STEP 2: Taking the history</p>	<p>If the history-taking is conducted in the treatment room, cover the medical instruments until they are needed.</p> <p>Before taking the history, review any documents or paperwork brought by the survivor. Do not ask questions that have already been asked and documented by other people involved in the case.</p> <p>Avoid any distraction or interruption during the history-taking.</p> <p>Make sure the survivor feels comfortable. Use a calm tone. If culturally appropriate, maintain eye contact. Be aware of the survivor’s body language and your own.</p> <p>Be systematic. Proceed at the survivor’s own pace. Be thorough, but don’t force the survivor.</p> <p>Let the survivor tell their story the way they want to. Document the incident in the survivor’s own words.</p> <p>Avoid questions that suggest blame (e.g., What were you doing there alone?).</p> <p>Be compassionate and non-judgmental.</p> <p>Explain what you are going to do at every step.</p>
<p>STEP 3: Collecting forensic evidence</p>	<p>The main purpose of the examination of a rape survivor is to determine what medical care should be provided. If applicable, forensic evidence may also be collected to help the survivor pursue legal redress.</p> <p>The survivor may choose not to have evidence collected. Respect their choice.</p> <p>Forensic evidence can be collected only if:</p> <ul style="list-style-type: none"> • timing is appropriate (e.g., less than 72 hours or more than 72 hours in contexts where the local law accepts evidence from more than 72 hours); • samples can be analyzed in the local context; • informed consent is obtained; and, • the chain of evidence can be maintained.

	In areas of Syria reachable through cross-border programmes, most medical facilities are not able to collect forensic evidence at this moment, as they do not meet the above requirements and/or would, by doing so, put the survivor and/or medical staff in danger.			
STEP 4: Performing a physical examination	<p>The primary objective of the physical examination is to determine what medical care should be provided to the survivor.²⁹</p> <p>Work systematically according to the medical examination form.</p> <p>Use the survivor’s history to guide the exam to prioritize the survivor’s needs and wishes, to identify and document injuries, and to help guide follow-up care and referrals.</p> <p>Make sure the equipment and supplies are prepared.</p> <p>Always look at the survivor first before you touch them, and take note of their appearance and mental state.</p> <p>Always tell the survivor what you are going to do and ask their permission before you do it.</p> <p>Assure the survivor they are in control, can ask questions, and can stop the examination at any time.</p>			
STEP 5: Prescribing treatment	What you prescribe will depend on when the survivor presents to your health facility, what the survivor experienced, and if the survivor is pregnant.			
	<i>Treatment</i>	<i>Within 72 hours</i>	<i>72 - 120 hours</i>	<i>After 120 hours</i>
	Prevent sexually transmitted infections (STIs) (gonorrhea, chlamydia, syphilis)	Yes	Yes	Yes
	Prevent HIV transmission (post-exposure prophylaxis)	Yes	No	No
	Prevent pregnancy (emergency contraception pill)	Yes	Yes	No
	Provide wound care	Yes	Yes ³⁰	Yes
	Prevent tetanus	Yes	Yes	Yes
	Prevent Hepatitis B	Yes	Yes	Yes

²⁹ Most survivors do not present with visible genital injury. Studies indicate that less than 30% of pre-menopausal women have genital injuries and less than 50% of postmenopausal women have genital injuries from forced sex (WHO, *Guidelines for medico-legal care for victims of sexual violence*, 2003). Absence of genital injury does not mean a survivor has not been raped. It is not the responsibility of the health provider to establish whether rape occurred.

³⁰ Wounds that require suturing should be sutured within 24 hours. After this time they will have to heal by second intention or delayed primary suture.

	Provide mental health care	Yes	Yes	Yes
STEP 6: Psychological first aid and counselling	<p>All survivors of GBV should be offered psychological support.</p> <p>Be aware that emotional reactions of survivors in response to GBV are very personal.</p> <p>In caring for survivors of GBV, it's important to be attentive to signs/manifestations of psychological distress/disorder and look, listen, and link.</p> <p>In assessing psychological support needed, identify:</p> <ul style="list-style-type: none"> • protective factors • risk factors <p>negative and positive coping mechanisms</p> <p>Counselling must take place from the first contact with the patient, including counselling for specific issues such as pregnancy and STIs.</p> <p>Tell the survivor they can return to the health service at any time if they have questions or other health problems.</p>			
STEP 7: Medical certificates	<p>Medical care of a survivor of rape includes preparing a medical certificate. It is the responsibility of the health care provider who examines the survivor to make sure the certificate is completed.</p> <p>Only the survivor has the right to decide whether and when to use this document.</p>			
STEP 8: Follow up care	<p>All survivors of GBV will benefit from follow-up medical and psychological care.</p> <p>With the unstable situation inside Syria, it is possible the survivor will not or cannot return for follow-up. Therefore provide maximum input during the first visit, as it may be the only visit.</p>			

This summary will help GBV service providers who are not qualified medical staff understand the type of medical assistance and clinical management that GBV survivors may need, as well as the steps involved in delivering this. Healthcare service providers and medical practitioners who provide treatment to GBV survivors must refer to and follow the detailed guidelines in full, and not rely on this summary.

All humanitarian actors should pay particular attention to the importance of referring survivors of sexual violence to health and medical service providers in a timely and confidential manner. All humanitarian actors should be able to explain to survivors the importance of receiving medical treatment within 72 hours to minimize the risk of HIV/AIDS and within 120 hours to prevent unwanted pregnancy, while also explaining the benefits of seeking medical care (e.g. for treatment of STIs) even when accessed after 120 hours.

7.2.1 Special considerations for child survivors

GBV is always a brutal and intrusive act which impacts heavily on children, on their current stage of development, and possibly also on later stages of development. There are specific protocols for the CMR involving children. Some of these are:

- Find out about specific local laws in your setting that determine who can give consent for minors.

- The child should never be examined against his or her will, whatever the age, unless the child is in a life-threatening situation.
- Take special care in determining who is present during the interview and examination.
- Remember that it is possible that a family member is the perpetrator of the abuse. Always ask the child who he or she would like to be present, and respect his or her wishes.
- Assure the child that he or she is not in any trouble.
- Never restrain or force a frightened, resistant child to complete an examination.
- Remind children often that they are safe and they are not to blame.
- Do not respond in harmful ways to children's' stress reactions (e.g. beating, abandonment, belittling, mocking).

7.2.2 Special considerations for male survivors

Men and boys experience some forms of GBV, most notably conflict-related sexual violence. Male survivors are less likely than women to report an incident of sexual violence, because of extreme embarrassment, shame, criminalization of same sex-relationships and slowness of institutions and health workers to recognize the extent of the problem. The needs of male survivors are often similar to those of females, but oftentimes the subject is even more sensitive and many providers are uncomfortable. Male survivors may feel guilty if they had an erection and ejaculated during forced anal intercourse.

7.2.3 Virginity testing

Among Syrian communities, 'virginity testing' is still practiced due to an ingrained cultural belief that the test can confirm if a woman or girl has had sexual relations before marriage. In some cases, girls and women approach medical facilities to ask for such a test. Virginity testing is, however, not a useful clinical tool as forensic evidence. It is not a reliable method to determine if a woman or girl has ever had sexual intercourse. Virginity is also not a medical condition, therefore a medical assessment is not necessary or useful, and it is in fact potentially discomfoting and harmful.

Virginity testing constitutes discrimination against women and girls as it has the effect or purpose of denying them their rights on a basis of equality with men and boys. The practice goes against the medical and humanitarian ethical code of conduct because it breaks the principles of true informed consent and of patient confidentiality, and because it goes against the do-no-harm approach to clinical care. Virginity testing constitutes a form of sexual violence. It should never be performed by medical professionals or in medical settings.³¹

7.3 Mental health and psychosocial support

Mental health and psychosocial support (MHPSS) is a composite term used to describe any type of support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental distress. This includes providing PFA and linking survivors with other services, psychosocial interventions (such as groups activities), and, where indicated, specialist mental health care. It also includes engaging the broader community to play a role in protecting dignity, promoting psychosocial wellbeing, and preventing mental health problems associated with GBV and the stigmatization/isolation of the survivor.

³¹ For further information, see the GBV SC's *Virginity testing: Evidence-based guidance note*.

All MHPSS activities with survivors and communities must adhere to the GBV guiding principles of confidentiality, safety, respect and non-discrimination. It is never acceptable to share information about a survivor’s case without their explicit informed consent.

All MHPSS actors who interview or have direct contact with survivors should:

- be familiar with the guiding principles and be able to put them into practice;
- be familiar with GBV core concepts and definitions; and,
- assess immediate safety and security risks of the survivor.

Table 12 provides summary guidance on how MHPSS actors should interact with survivors.

Table 12: MHPSS interaction

DO	DON'T
Welcome the survivor and make them feel at ease	Do not blame or judge them
Listen to the survivor and ask only non-intrusive, relevant and non-judgmental questions for clarification only.	Do not press the survivor for more information than they are ready to give.
Reassure the survivor that GBV is always the fault of the perpetrator and never the fault of the survivor.	Do not justify the perpetrator's' action or ask the survivor to forgive or forget the perpetrator.
Give honest and complete information about services and facilities available, as well as the potential consequences and benefits in accessing these.	Do not use technical jargon or medical language.
Empower the survivor by helping them make informed decisions.	Do not tell the survivor what to do. Do not provide examples of other cases that might influence their choice.

Figure 2 shows the four levels of MHPSS care for GBV survivors linked to the survivor's mental state and the care provider.³²

Figure 2: Four levels of MHPSS care for GBV survivors

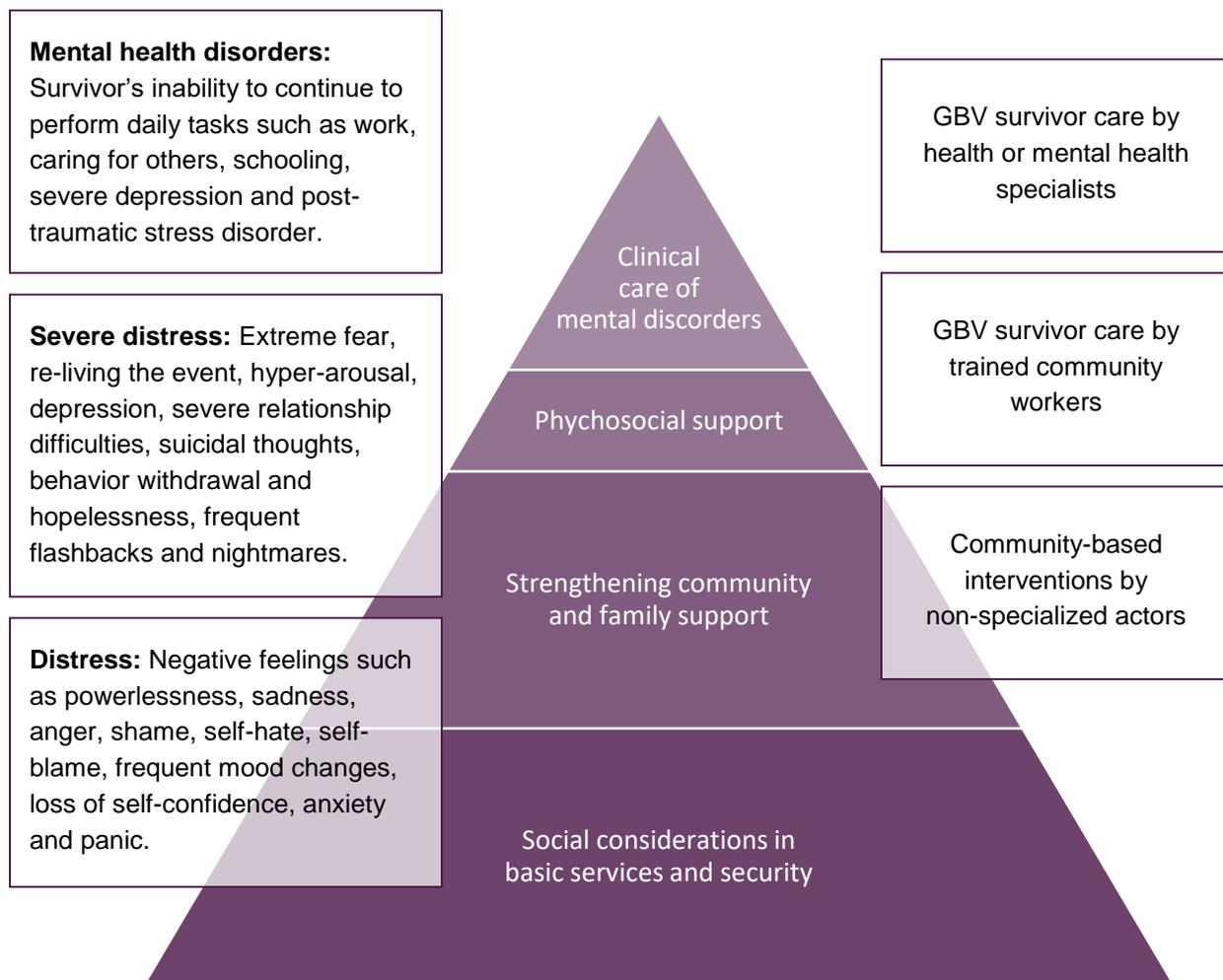


Figure 2 shows the importance of ensuring, firstly, that the basic services and security needs of GBV survivors are addressed. Then, from the perspective of MHPSS, the most appropriate support for GBV survivors is generally family and community-based interventions by non-specialized actors to support survivors when they are distressed. Some GBV survivors require more specialized psychosocial support, and some may need clinical care.

Response services for GBV survivors focus primarily on the top three levels.³³

³² Adapted from the MHPSS Pyramid in IASC, *IASC guidelines on mental health and psychosocial support in emergency settings*, 2007.

³³ Ibid.

Level 2: Strengthening community and family support. Provided by service providers and community members, the support is intended for community members who are able to maintain their mental health and psychosocial wellbeing through receiving help from their community and family. It seeks to respond to immediate, non-complex psychological distress, and to prevent further severe forms of distress and mental health disorders. It can include working with community leaders, setting up safe spaces for those at risk of GBV and their family members (especially women and adolescent girls), GBV awareness-raising activities, promoting women and girls groups and age-tailored activities including self-help and resilience initiatives, livelihoods activities, and facilitating community-mobilization activities (including women's and men's support groups, dialogue groups and community education and advocacy). Typically, GBV survivors are referred to or join community activities without other participants or facilitators knowing about GBV incidents. This confidentiality provides some protection to survivors against stigmatization.

Level 3: Psychosocial support by trained workers. Provided by psychosocial workers and trained GBV staff who are able to give PFA to the survivors as part of their care, and who know how to protect and promote survivors' rights to dignity through informed consent, confidentiality and privacy. The support seeks to respond to survivor's emotional issues and psychological distress. It can include providing basic emotional support, providing opportunities for survivors to discuss their experiences, discouraging negative coping mechanisms, providing one to one or group PSS sessions and encouraging participation in everyday activities. In the application of these SOPs, this service is usually provided together with and in the framework of case management.

Level 4: Clinical care of mental disorders. Provided by trained local health workers, and international medical organizations. This support is intended for survivors with mental disorders such as post-traumatic stress disorders.³⁴ It seeks to respond to severe behavioral and emotional disorders, including psychoses. It can include the prescription of psychiatric drugs, as well as a combination of biological, social and psychological interventions.

7.4 Safety and security options

Security and safety are the responsibility of all actors and staff. All service providers should prioritize the safety and security of survivors, their families and workers providing care.

A safety and security assessment is part of GBV case management and service delivery.³⁵ While considering all the options below, GBV case managers, service providers and survivors should always assess the related security risks.

To ensure the safety of GBV survivors the following processes are recommended:

- Find strategies that enable the survivor to stay safely with their family when appropriate (e.g., helping the survivor find a resourceful and trustful family member).

³⁴ It is important to make the distinction between distress and disorder. Survivors with a disorder will most likely not be able to cope on their own. They will need specialized professional help (e.g., mental health evaluation and treatment). Survivors suffering from distress or extreme distress will also benefit from emotional and social support, although they may also be able to rely on their own coping mechanisms and capacities.

³⁵ See *Annex IX: Safety Checklist and Safety Planning*.

- Identify temporary shelter for the survivor³⁶ (i.e., a safe, secure and accessible place where they can rest temporarily) with the survivor's family members or in other nearby and accessible locations.³⁷
- Provide financial support and transport to the safe location whenever possible.
- Involve non-offending caregivers in the healing process, especially when the aggressor is one of the parents of a child GBV survivor.
- Ensure more frequent and regular follow-up on cases where the survivor is particularly at risk if no alternative relocation solutions could be found.
- For cases at risk of repeat or escalating domestic violence, help the survivor establish a safety plan whereby they can identify mechanisms to decrease trigger points that cause or lead to the aggression (e.g. not being at home alone when the husband comes back from home; inviting other family members when discussing important issues). In such cases, be very cautious never to blame the survivor.
- Identify a safe place to meet the GBV survivor for follow-up visits and agree a trusted person to contact in case the survivor is not reachable.
- Provide GBV survivors with information about the whole healing and referral process highlighting potential consequences and benefits of accessing services.
- Engage other sectors to meet in a timely manner other immediate needs raised by the survivor that may further expose them to harm and violence.
- Train staff involved in GBV case management in how to identify suicidal thoughts in survivors.
- Train and ensure all staff comply with an organization's security procedures while on duty.
- Ensure staff engage the community in respecting the core humanitarian principles.³⁸
- Ensure your organization has a clear code of conduct and that your staff know it.

Due to the dramatic disruption of the legal system in areas where this SOP applies, security actors such as police, are not included in the referral pathways.

7.5 Legal and justice assistance

Justice options can include providing legal counseling, assistance and representation for a GBV survivor who wishes to press charges against the perpetrator or in cases related to personal status (e.g., custody law issues, divorce, alimony). Due to the insecurity, uncertainty and judicial vacuum in the area where these SOPs apply, justice assistance is however currently limited.³⁹

It is important that service providers present survivors with full and up-to-date information to allow them to make informed decisions about which institutions to access, especially since the systems in place are subject to sudden changes. Referrals should prioritize humanitarian protection actors that can give more information about what systems are in place in different communities and advise survivors based on the

³⁶ A temporary safe shelter should not be confused with women and girls' safe spaces.

³⁷ Actors abiding by these SOPs are strongly discouraged from setting up formal safe shelters in the Syrian context, because it will be not possible to ensure the safety and confidentiality of such places, and security for residents and staff will likely not be guaranteed.

³⁸ See *Annex I: The Humanitarian principles or 'principles of humanitarian action'*.

³⁹ In Syria and surrounding countries, several international and national organizations are collecting information about GBV incidents, as well as other human rights violations, for advocacy and/or human rights violations monitoring purposes. Survivors may wish to be referred to these organizations, and these organizations may refer cases to humanitarian actors who are signatory to these SOPs. When referring survivors to human rights advocacy/monitoring organizations, it is important to explain clearly to the survivor the type of work the organization delivers and whether there are any immediate benefits survivors can expect from the referral.

Syrian law regarding GBV before they decide to access any justice system. No automatic referrals to legal institutions should be made.

With respect to justice assistance, signatories to these SOPs should:

- Be aware of the legal and justice context in Syria.⁴⁰
- Consider the emerging legal systems put in place in the different areas of the Syrian territory.
- Lay the groundwork for improved access to justice for GBV survivors by putting in place quality health and psychosocial services, and by establishing quality case management and referral systems. These aspects of emergency programming can help facilitate the process for GBV survivors who request legal assistance in the future.
- Inform GBV survivors about procedures, potential consequences and benefits on how they might seek formal justice in the near future (forensic evidence, medical certificate etc.) without making promises that cannot be met.
- Enquire and evaluate whether there are other forms of cultural and informal justice systems the survivor might want to access. While not encouraging traditional informal justice procedures such as mediation, if a survivor decides to access such processes, it is a duty of a case manager to inform the survivor about how such processes work and the associated risks.

The right to protection of the individual survivor should have priority over the society's need for justice, except when the survivor specifically desires justice.

With respect to other forms of legal assistance, signatories to these SOPs should:

- Ensure health care providers hand over a medical certificate to GBV survivors who have received medical support.
- Support efforts to ensure documentation of property ownership and civil documentation to help mitigate GBV through providing more security, especially for women and IDPs, with respect to accommodation and access to services.⁴¹

7.6 Long-term assistance

The resilience of a GBV survivor, including their coping mechanisms, differ from one individual to another. The medical and psychosocial consequences of having experienced a GBV incident might affect the survivor throughout their life. It might affect the survivor's wellbeing, community relations and societal participation for many years.

During the initial assessment phase and the development of an action plan (as described in Chapter 6), GBV actors and survivors should agree on some common long-term objectives. It is essential that a GBV actor is clear about the limits of the assistance that can be provided. GBV actors should not make unrealistic promises. The focus should be on helping survivors to reactivate their coping mechanisms and safety nets for taking care of themselves.

Some options that might be available to provide long-term assistance to a survivor include:

⁴⁰ ILAC, *Rule or law assessment report: Syria 2017*, 2017.

⁴¹ NRC, *Displacement, housing, land and property and access to civil documentation in the North West of the Syrian Arab Republic*, 2017.

- Helping the survivor liaise with organizations providing long-term activities and opportunities to help them fully reintegrate into their communities, empower them and give them tools to protect themselves in the future.
- Referrals to organizations offering age-tailored vocational and skill-training opportunities, formal and non-formal educational programmes, safe income-generating activities, livelihood activities and cash assistance. Provision of cash assistance should be tailored to the survivor's needs, should adhere to do no harm principle and should follow international guidance⁴².
- Referrals to families and communities as part of promoting resilience. Community reintegration is an essential part of a survivor's recovery process, for adults as well as children. In the areas where these SOPs apply, GBV case management actors will find it essential to support survivors to reintegrate with families and communities for ongoing support because availability and access to ongoing services for survivors are extremely limited. These kinds of referrals are more informal. They must be guided by the survivor who will decide what and if to disclose information to anyone. This type of referral requires special attention to confidentiality.

The case manager maintains a responsibility to follow up on these services to ensure that assistance does not further stigmatize survivors.

It is clear the benefits of creating opportunities for women and girls are wide-ranging and transformational; for women and girls to have the opportunity to fulfil their potential, for their children, for their communities. However, in order for women and girls to be able to access these opportunities and fully participate in and benefit from interventions, it is essential we confront the biggest obstacle to their health, education, economic status and overall well-being: violence.

In order for programming to benefit women and girls, it is essential to pay attention to safety, both safety from violence and the safety to participate in programmes and activities that benefit them, and to ensure they are able to use the benefits of those activities in their own interests. In this sense, response and prevention, protection and empowerment are highly inter-related.

⁴² IRC, Mercy Corps, Women's Refugee Commission, *Toolkit for Optimizing Cash-based Interventions for Protection from Gender-based Violence: Mainstreaming GBV Considerations in CBIs and Utilizing Cash in GBV Response*, 2018

8 PREVENTION AND RISK MITIGATION

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.⁴³

Preventing GBV involves identifying and mitigating factors that make certain members of the community vulnerable to this kind of violence, and designing a range of strategies that improve protection for all. As with all programmes to combat GBV, prevention strategies are most effective when all humanitarian actors work together, and with communities, to design, implement and evaluate them.

Risk reduction activities are actions that aim to reduce the risks that vulnerable persons (especially women and girls) face in emergency and post-emergency contexts, and to protect those who have already experienced violence from further harm.

This process cannot be done without engaging and mobilizing the community to become aware of gender roles and stereotypes, men’s power over women, and how the community’s silence about this power imbalance perpetuates VAWG.

8.1 For GBV service providers

Table 13 provides some general recommendations for GBV service providers on how to set up a GBV prevention intervention. The list of activities is not exhaustive. Activities should be developed based on the local context and culture, the risks involved in running activities, and the expertise and capacities of the implementing GBV actors.

Table 13: Recommendations for a GBV prevention intervention

PHASES	AIMS	ACTIONS
Phase 1: Identify concerns and risks	To understand the local attitudes towards and practices of gender roles and discrimination through specific assessments, and the situation-specific factors that contribute to or increase the risks for GBV in a given area.	<p>Carry out safety audits on a regular basis and use them to inform actions and programming.</p> <p>Carry out participatory assessments with women and girls to understand their issues and concerns.</p> <p>Involve women and girls in planning and decision-making to address their safety and security concerns through evaluation exercises.</p> <p>Set up feedback and community complaints mechanisms to inform intervention programmes on specific issues and concerns.</p>

⁴³ IASC, *Guidelines for integrating gender-based violence interventions in humanitarian action: Reducing risk, promoting resilience and aiding recovery*, 2015, p.33.

PHASES	AIMS	ACTIONS
<p>Phase 2: Raise awareness and share information</p>	<p>To increase the community's understanding about gender roles, human (and women) rights, GBV causes and consequences, and services available to GBV survivors, in order to promote social change and increase awareness (especially amongst women and girls) on where to seek help.</p>	<p>Run awareness-raising sessions using the GBV SC's toolkit.⁴⁴</p> <p>Promote harmonization of information, education and communication materials.</p> <p>Encourage use of creativity to stimulate discussions in groups, and to stimulate critical thinking rather than telling people what to think.</p> <p>Strengthen people's understanding of GBV issues using interactive and thought-provoking exercises, and roles plays to challenge myths and stereotypes around women's and men's roles.</p> <p>Facilitate focus groups discussions, campaigns and door-to-door visits to address specific topics according to the age, sex and type of audience. Topics should be selected based on the previous risk identification.</p> <p>Facilitate specialized training for health care providers, psychosocial actors, women's groups, community leaders, local authorities (if appropriate), other humanitarian agencies, school personnel and parents' associations on GBV core concepts, GBV guiding principles and IASC GBV guidelines.</p> <p>Ensure all staff and implementing partners are informed and aware of the zero tolerance policy on PSEA.⁴⁵</p> <p>Disseminate information on the availability and value of services for GBV survivors, these SOPs, and IASC guidelines.</p> <p>Create channels to disseminate clear information and age-appropriate GBV messages to different groups within the affected population.</p>

⁴⁴ GBV SC, *Hearing and being voices in Syria: Working together to raise awareness on gender-based violence*, 2018.

⁴⁵ Immediate PSEA involves the following minimum actions:

- Screening job applicants and recruiting staff who will not perpetrate SEA.
- Ensuring all actors understand the definition of SEA, expected standards of behavior, and their obligation to prevent SEA.
- Putting systems in place to respond to allegations, to enforce codes of conduct and standards, and to ensure there are consequences for those who perpetrate SEA.
- Educating communities on their entitlements and rights, the zero tolerance approach to SEA, and how to report complaints.
- Decreasing the vulnerability of those at higher risk of SEA through ensuring access to resources to meet basic needs and implementing livelihood programmes.

PHASES	AIMS	ACTIONS
<p>Phase 3: Take action and empower</p>	<p>To translate awareness and knowledge acquired in the previous phase into practice. During this phase individuals and groups can create change. In this phase GBV actors should engage even more people from all circles of influence and reach a critical mass for changing community norms.</p>	<p>Build networks among community groups and associations, and enhance collaboration and coordination among them.</p> <p>Empower women and girls through specific age-tailored activities in order to engage them in the community life, build safety nets and promote their resilience.</p> <p>Rebuild family and community structures, and support systems to design effective services and facilities.</p> <p>Meet the basic needs of women and girls through the distribution of NFI and age-tailored dignity kits.</p> <p>Advocate on behalf of civilian communities for protection from GBV.</p> <p>Raise funds for GBV programming.</p> <p>Set up safe spaces and age-tailored women and girls' activities so they can feel confident and safe to share concerns and risks.</p> <p>Engage men and boys in transformative learning to change gender attitudes and behaviors.⁴⁶</p>

8.1.1 GBV assessments and research

The highly sensitive nature of GBV, especially sexual violence, means that specific attention must be given to how to conduct assessments and research for gathering GBV data. When people are asked to participate in assessments or research, they may be prompted or required to admit to and discuss extremely sensitive and painful issues that are cultural, social and often highly personal.

Before commencing a GBV assessment or research project, consideration must be given to the ethics of the methodology and the safety of the participants. Failure to do so can result in harm to the physical, psychological and social well-being of those who participate and can even put lives at risk.

⁴⁶ See GBV SC, *Syria HRP 2018: Gender based violence (GBV) sub-cluster work plan*, 2018; and IRC, *Preventing violence against women and girls: Engaging men through accountable practice*, 2013.

Table 14 shows the eight ethical and safety recommendations that apply when collecting information about sexual violence.

Table 14: Ethical and safety recommendations that apply when collecting information about sexual violence

TOPIC	DESCRIPTION
1. Risks and benefits	The benefits to respondents or communities of documenting sexual violence must be greater than the risks to respondents and communities.
2. Methodology	Information gathering and documentation must be done in a manner that presents the least risk to respondents, is methodologically sound, and builds on current experience and good practice.
3. Referral services	Basic care and support for survivors/victims must be available locally before commencing any activity that may involve individuals disclosing information about their experiences of sexual violence.
4. Safety	The safety and security of all those involved in information gathering about sexual violence is of paramount concern and in emergency settings in particular should be continuously monitored.
5. Confidentiality	The confidentiality of individuals who provide information about sexual violence must be protected at all times.
6. Informed consent	Anyone providing information about sexual violence must give informed consent before participating in the data gathering activity.
7. Information gathering team	All members of the data collection team must be carefully selected and receive relevant and sufficient specialized training and ongoing support.
8. Children	Additional safeguards must be put into place if children (i.e., those under 18 years) are to be the subject of information gathering.

8.1.2 Community engagement

In order to ensure full engagement with the local community for prevention and risk mitigation activities, GBV service providers should:

- Select and provide coaching to focal points in collaboration with the community and follow protection criteria to help plan, design, and implement activities.
- Identify local resources and engage people from the community who can support the overall implementation of preventions activities (including recreational activities).
- Map out local representatives from key institutions (e.g., health care providers, religious leaders, teachers).

8.1.3 Women and girls' safe spaces

Women and girls' safe spaces (WGSS) are formal or informal places where women and girls feel physically and emotionally safe, and where they enjoy the freedom to express themselves without the fear of judgment or harm. They are areas where women and girls can socialize and re-build their social networks, receive social support, acquire contextually relevant skills, access safe and non-stigmatizing multi-sectorial GBV response services (psychosocial, legal, medical), and receive information on issues relating to women's rights, health and services.

Women and girls in Syria face increased isolation and restrictions on their movement because of the crisis. WGSS provide opportunities for women and girls to meet other women and girls, to share experiences and receive education. They offer IDPs opportunities to access services they may otherwise not have access to because the community in which they now live deems they are not entitled to access existing services. The provision of WGSS is therefore a key strategy for the protection and empowerment of women and girls affected by the conflict in Syria.⁴⁷

WGSS also fulfil the needs for specialized GBV response services. Through these spaces, GBV actors often provide case management to GBV survivors along with awareness raising other GBV prevention activities. Recent assessments⁴⁸ found out that, where they exist, WGSS are the primary and often the only place women and girls visit to seek support in case they have been subject to GBV.

These spaces are especially important for reaching adolescent girls in Syria who experience particular vulnerabilities due to, among other factors, increased risks of suffering sexual violence and child marriage. The GBV SC has produced a distance-learning toolkit to make WGSS friendlier for adolescent girls. This toolkit was disseminated and has been used by partner organizations in remote sessions with staff in Syria. The GBV SC is committed to continue to conduct trainings on WGSS standards and on how to promote more inclusive approaches to accommodate women and girls.

The creation of these spaces in Syria should follow the six guiding principles for establishing WGSS⁴⁹:

1. Leadership and empowerment of women and girls
2. Client/survivor centered
3. Safe and accessible
4. Community involvement
5. Coordinated and multi-sectoral
6. Tailored

They should aim to provide age appropriate psychosocial and recreational activities (including livelihood training). WGSS also play an important role in the prevention of, awareness raising about and responses to GBV. All WGSS staff should therefore have a clear understanding of these SOPs, especially the referral pathways and prevention activities.

⁴⁷ See GBV SC, *Syria HRP 2018: Gender based violence (GBV) sub-cluster work plan*, 2018; WoS, *Syria humanitarian response plan 2018: WoS gender based violence (GBV) results framework*, 2018.

⁴⁸ FGDs conducted in the framework of the 2019 HNO.

⁴⁹ UNFPA, *Women and girls' safe spaces: A guidance note based on lessons learned from the Syrian crisis*, 2015, pp. 7-9.

8.1.4 GBV awareness-raising toolkit

The GBV SC has developed a GBV awareness-raising toolkit to help streamline activities aimed at increasing knowledge about GBV prevention and responses within Syrian communities. The toolkit includes activities for women, adolescent girls, men and adolescent boys that promote the following key GBV messages:

- Key Message A: The root cause of GBV is gender inequality
- Key Message B: Knowledge of and access to GBV services can save lives
- Key Message C: Mutual support can help prevent GBV and ensure good responses to GBV
- Key Message D: Child marriage is a form of GBV
- Key Message E: Domestic violence is a form of GBV
- Key Message F: It is not shameful to discuss sexuality and sexual violence
- Key message G: Virginity testing is a form of GBV

For each key message there are three activities for each of the target groups. The activities are organized into four full programmes—one for each of the target groups.

8.1.5 Dignity kits

The GBV SC supports the use of dignity kits in the context of GBV programming in Syria to help women and girls maintain their dignity during the humanitarian crisis.⁵⁰ These kits contain hygiene and sanitary items, including sanitary pads, underwear, hand soap, toothbrushes and toothpaste.

Organizations that are planning to distribute dignity kits should:

- liaise with the GBV SC to coordinate the location and target population;
- coordinate with other actors covering the same areas to avoid duplication of materials;
- assess the specific needs of women and girls in partnership with local communities to identify what items to include in the dignity kits;
- prioritize the use of dignity kits that are procured and assembled locally
- distribute the dignity kits at regular intervals throughout an emergency; and,
- consider IDPs as beneficiaries.

8.2 For other humanitarian sectors

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.⁵¹

The responsibility for preventing and mitigating the risks of GBV is a shared one amongst all humanitarian actors.

⁵⁰ GBV SC, *Dignity kits: Guidance note*, 2015.

⁵¹ IASC, *Guidelines for integrating gender-based violence interventions in humanitarian action: Reducing risk, promoting resilience and aiding recovery*, 2015, p.14.

Addressing GBV is considered life-saving and meets multiple humanitarian donor guidelines and criteria. In spite of this, GBV prevention, mitigation and response are rarely prioritized from the outset of an emergency.

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. 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.⁵²

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 equality) and develop evidence-based programming and tailored assistance.

Integrating GBV prevention and mitigation into humanitarian action requires anticipating, contextualizing and addressing factors that may contribute to GBV. Whenever possible, efforts to address GBV should be alert to and promote the protection of the rights and needs of ‘at risk’ groups.

Table 15 outlines the GBV protection mainstreaming recommendations for other humanitarian sectors.

Table 15: GBV mainstreaming recommendations

PHASES	MAINSTREAMING RECOMMENDATIONS
<p>Overall recommendations</p> <p>Preventing and mitigating GBV involves promoting gender equality and promoting beliefs and norms that foster respectful, non-violent gender norms.</p> <p>Safety, respect, confidentiality and non-discrimination in relation to survivors and those at risk are vital considerations.</p> <p>GBV related interventions should be context-specific.</p> <p>Participation and partnership are cornerstones.</p>	
<p>Phase 1: Assessment and analysis planning</p>	<p>Identify key questions to be considered when integrating GBV concerns into assessments. These questions can be subdivided into three categories:</p> <ul style="list-style-type: none"> • Programming • Policies • Communications and information sharing.

⁵² 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.

PHASES	MAINSTREAMING RECOMMENDATIONS
	<p>The questions can be used as prompts when designing assessments. Information generated from the assessments can be used to contribute to project planning and implementation.</p>
<p>Phase 2: Resource mobilization</p>	<p>Promote the integration of elements related to GBV prevention and mitigation (and, for some sectors, response services for survivors) when mobilizing supplies and human and financial resources.</p>
<p>Phase 3: Implementation</p>	<p>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.</p> <p>Implement programmes that reflect awareness of the particular GBV risks faced by women, girls and other at-risk groups, and address their rights and needs related to safety and security.</p> <p>Integrate GBV prevention and mitigation (and, for some sectors, response for survivors) into activities.</p> <p>Incorporate GBV prevention and mitigation strategies into programme policies, standards and guidelines from the earliest stages of the emergency.</p> <p>Support the integration of GBV risk-reduction strategies into national and local development policies and plans, and allocate funding for sustainability.</p> <p>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.</p> <p>Work with GBV specialists in order to identify safe, confidential and appropriate systems in sector-specific community outreach and awareness-raising activities; and to develop information-sharing standards that promote confidentiality and ensure anonymity of survivors.</p> <p>Receive training on issues of gender, GBV, women's/human rights, social exclusion, sexuality and PFA.</p>
<p>Phase 4: Coordination</p>	<p>Sector coordinators and sector actors should identify and work with the chair (and co-chair) of the GBV coordination mechanism.</p> <p>GBV specialists can ensure the integration of protection principles and GBV risk-reduction strategies into ongoing humanitarian programming. These specialists can advise, assist and support coordination efforts through specific activities, such as:</p> <ul style="list-style-type: none"> • conducting GBV-specific assessments; • ensuring appropriate services are in place for survivors; • developing referral systems and pathways; • providing case management for GBV survivors; and,

PHASES	MAINSTREAMING RECOMMENDATIONS
	<ul style="list-style-type: none"> developing trainings for sector actors on gender, GBV, women's/human rights, on how to respectfully and supportively engage with survivors. <p>Efforts to integrate GBV risk-reduction strategies into different sectoral responses should be led by sector actors to ensure any recommendations from GBV actors are relevant and feasible within the sectoral response.</p>
Phase 5: Monitoring and evaluation	For a number of ethical and practical reasons these SOPs do not recommend to use the number of reported cases as an indicator of success. As general rule, GBV specialists should undertake data collection of cases of GBV.

8.2.1 Links to sector-specific guidelines on GBV prevention and mitigation

Table 16 provides links for sector-specific guidelines on mainstreaming GBV prevention and mitigation into humanitarian work.

Table 16: Sector-specific guidelines on GBV prevention and mitigation

SECTOR	LINK
Camp Coordination and Management	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-CCCM-08_26_2015.pdf
Child Protection	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-child-protection-08_26_2015.pdf
Education	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-EDUCATION-08_26_2015.pdf
Food Security and Agriculture	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-FSA-08_26_2015.pdf
Health	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-health-08_26_2015.pdf
Housing, Land and Property	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-HLP-08_26_2015.pdf
Humanitarian Mine Action	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-HMA-08_26_2015.pdf
Livelihoods	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-livelihood-08_26_2015.pdf

Nutrition	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-nutrition-08_26_2015.pdf
Protection	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-protection-08_26_2015.pdf
Shelter, Settlement and Recovery	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-shelter-08-26-2015.pdf
Water, Sanitation and Hygiene	http://gbvguidelines.org/wp-content/uploads/2015/09/TAG-wash-08_26_2015.pdf

8.3 Sexual exploitation and abuse

PSEA is an important aspect of GBV prevention. All signatories to these SOPs must implement policies and/or practices to ensure PSEA linked to humanitarian programmes. This includes PSEA against affected populations committed by those responsible for implementing these programmes.

Identified risks of sexual exploitation and abuse (SEA) for women and girls linked to humanitarian programmes⁵³ include, among others:

- Sexual harassment and abuse when going unaccompanied to receive aid distributions
- Sexual exploitation at schools
- Harassment when receiving health services
- Sexual exploitation by landlords in return for rent
- Sexual exploitation of children working near distribution sites

Policies and practices for PSEA should cover:

- Establishing confidential reporting mechanisms
- Establishing safe and ethical responses when incidents of SEA are reported and/or occur
- Ensuring SEA survivors have access to specialized GBV support services (including case management)
- Ensuring the distribution of NFI incorporates child safeguarding standards
- Ensuring the distribution of NFI is aligned to protect beneficiaries from SEA

8.4 Vulnerable groups

Prevention and response work should aim to reach and include specific vulnerable groups. Within the Syrian context, these are women and girls, widowed, divorced and separated women and girls, female-headed households and people with disabilities.

Women and girls are disproportionately affected by GBV, especially child marriage, sexual violence and domestic violence. Because women and girls in Syria are seen to be inherently vulnerable and in need of a male protector, this limits the ability of this group to be able to access services freely and without approval

⁵³ GBV AoR, *Voices from Syria 2018: Assessment findings of the humanitarian needs overview*, 2017, pp.60-62.

of a father, husband or other male relative. Displaced women and girls who are living in camps and other settlements are especially vulnerable.

Being a widow or divorced is highly stigmatized in Syrian society. Divorced and separated women and girls in particular are viewed as responsible for the failure of their marriage and therefore 'bad'. Many may also lack civil documentation or property-related documents. This affects the ability of widowed, divorced and separated women and girls to move freely and access services. This group is nevertheless at particular risk of a number of GBV types, including forced marriage, polygamy, sexual violence and economic violence.

Women and girls who are alone, or with young children, are at risk of violence, extreme poverty, negative coping mechanisms (including survival sex), and SEA linked to humanitarian distribution work.

People with disabilities are seen to be inherently unable to protect themselves or to make decisions. This limits their ability to access services freely. Communication and physical disabilities mean the person often needs to rely on others to help them express what has happened and to access services. In displacement situations, there is a risk that a person with a disability will be separated from their primary caregiver.

9 EMERGENCY RESPONSE

Escalating violence in Syria means targeted communities that fall within the areas under the mandate of the Turkey hub coordination mechanism have been and continue to be subject to displacement, violence (torture, detention, abduction, sexual violence etc.), deepening poverty and lack of access to services. Within this context, cases of GBV are likely to increase. Disruptions to or closures of services means fewer safe opportunities for survivors to disclose cases of GBV and less protection for survivors. Adolescent girls are already at greater risk of child marriage. Displacement caused by hostilities in the region further expose women and adolescent girls to risks of sexual violence, domestic violence and exploitation. This situation calls for consideration of an emergency plan for the prevention of and response to GBV.

In 2016, the coordinators and members of the Turkey Hub PC, together with the GBV, Child Protection (CP) and Mine Action Sub-Clusters, developed an Emergency Response Model to promote an integrated, standardized and quick response to GBV and other protection concerns in an emergency context.⁵⁴ This emergency response model enhances field coordination and provides minimum service packages in an integrated manner to affected communities. A mixed-modality approach, with both static service points and mobile outreach teams, is used. Due to the dynamic nature of the Syrian context, this approach supports affected populations with multiple entry points to protection services and also supports Cluster members continue to deliver services in rapidly-changing circumstances.

PC and SC members in the field, following the emergency response model, prioritize the following activities:

1. Mobile outreach teams: PFA, information sharing/awareness raising on different protection aspects including CP, GBV and MA, counselling, referrals, protection monitoring, and identification of separated and unaccompanied children and those without appropriate care.
2. Static service points: PSS, information and referrals, in addition to provision of case management for child protection and GBV.
3. Dignity kit distributions: providing dignity kits to women and girls.
4. Risk Education: providing explosive hazards risk education with a specific focus on IDPs, with the deployment of mobile risk education teams and the distribution of risk education material including through the overall humanitarian response.
5. Rapid protection monitoring: identify protection risks, as well as other urgent needs to inform the overall response and any related advocacy.

⁵⁴ Turkey Hub Protection Cluster, *Emergency response model*, 2016.

Table 17 shows the roles and responsibilities of different actors within the PC and SCs for activating, responding and reporting through the PC and SC emergency response model.

Table 17: Roles, responsibilities and timelines for the PC and SC emergency response plan

ROLES	RESPONSIBILITIES	TIMEFRAME
PC coordinator	Shares information received from United Nations Office for the Coordination of Humanitarian Affairs (OCHA) about the emergency situation with PC members	Immediately
PC and GBV SC coordinators	Develop and share the emergency tool populated with specific data including contact details and messages	12 hours
PC members	Identify and share needs, gaps and challenges with the PC and SC coordinators	Throughout the emergency
PC and GBV SC members	Report on the provision of services and number of people in need reached based on a pre-determined schedule	48 hours 1 week 1 month
PC Information management officer	Develops dashboards of the response based on a pre-determined schedule, and shares these with PC and SC members (and more broadly to OCHA, donors, WoS PC etc...)	72 hours 10 days End of first month

The Emergency Response Tool referenced in

Table 17 includes:

- Contact details of focal points (organizations selected by PC coordinators for the coordination of specific protection response in the field).
- A reporting sheet that each organization must populate with type of services provided, activities implemented, location, age and gender disaggregated number of people in need reached, and the modality of service delivery (in a static facility or through mobile outreach).
- Referral pathway and GBV guidance for referrals.
- Emergency Response Packages
- Key awareness raising messages.

A standard version of the Emergency Response Tool has been developed to assist with the overall coordination of the emergency response.⁵⁵ Whenever an emergency erupts, the PC and GBV SC coordinators must review this tool, and populate it with information and data relevant to the specific emergency context.

⁵⁵ Turkey Hub Protection Cluster, *Emergency response reporting tool*, 2018.

10 CLOSURE OF GBV PROGRAMMES

There are times when an existing GBV programme may need to close. Ideally, this should only happen in an emergency context when there is no further need for the programme, and where health and other related services have been restored. In practice, GBV programmes have to close early because of funding restriction, security issues and operational restrictions.

The GBV SC developed dedicated guidelines and promotes the ethical closure of GBV programmes⁵⁶ through requiring the development of an exit strategy that adheres to the following guidelines:

- It should be built in from the beginning of a programme.
- It should ensure a smooth process that does not negatively affect the community.
- It should ensure duty of care for staff.
- It should do no harm to beneficiaries, especially survivors of GBV.

Closure actions and timeframe will depend on the reasons for the phasing out (emergency or planned closure). However, in general terms, organizations that need to close GBV programmes should:

- coordinate with the GBV SC to maximize the success of the above guidelines;
- consult with other organizations to identify possible replacement services;
- support capacity building for other local actors who can continue to provide services;
- consult with both staff and beneficiaries about the closure;
- communicate the closure to key stakeholders;
- ensure ethical and secure management of data;
- stop the intake of cases; and,
- explore all possible options to ensure case management can continue (e.g., handover to another case management organization, referral to other organizations in other areas, remote support).

⁵⁶ GBV SC, *Guidance note on ethical closure of GBV programmes*, 2018.

11 COMMUNICATIONS

It is important to communicate key elements of the SOPs, to ensure relevant groups have sufficient information to be able to carry out their responsibilities and access services. It is equally important that GBV actors keep informed about the knowledge that community members, especially women and girls, have about these key elements.

The key elements of the SOPs that should be shared with communities are:

- Where to go for help at different levels (i.e., referral pathways).
- What to expect in terms of roles and responsibilities of different humanitarian actors.
- Limitations and risks in accessing services.
- Guidelines on confidentiality after disclosure.
- GBV Guiding Principles.

Target groups within communities for this communications include:

- Service providers
- Humanitarian actors
- Camp management
- Local councils
- Women's networks
- Teachers
- Religious leaders

GBV actors signatory to these SOPs agree to:

- Inform beneficiaries (especially women and girls) on the services available to GBV survivors.
- Raise awareness about the referral pathways and what to expect when accessing services through specific activities (e.g., focus group discussions, training sessions, workshops).
- Harmonize messages and communication materials in coordination and collaboration with the GBV SC.⁵⁷
- Provide messages that are culturally acceptable and in a format that protects individuals accessing these services from risk of harm.
- Integrate modules on referral pathways into other GBV related training (e.g. case management of rape).

⁵⁷ See, for example, the GBV SC toolkit on GBV awareness raising.

12 DATA MANAGEMENT PROTOCOLS

This chapter explains the protocol for ensuring the protection of GBV data. It also explains the types of information that should be shared to better coordinate and inform GBV prevention and response activities.⁵⁸

12.1 Data protection

It is important that organizations assess their existing data security and develop a customized data protection protocol for GBV programmes. This is a vital part of ensuring confidentiality for the survivor and eliminating the risk of exposing them to further violence by parties who may gain access to information about their case, including what they have said and about whom (e.g., perpetrators).

The following general rules apply to GBV data protection for organizations⁵⁹:

- All staff in contact with the data have a strong understanding of the sensitive nature of the data, and the importance of data confidentiality and security.
- Staff have been asked to identify security risks specific to their context and to think through the possible implications for clients, their families and communities, and for the organization, if data gets into the wrong hands.
- Staff understand that all cases will be allocated a code based upon an agreed standard coding format, and that the code should be used to refer to the case either verbally or on paper, in place of any identifiable information such as name.
- Clients and/or their caregivers need to give informed consent to gather and store their data before any information is recorded.
- Staff are aware that when obtaining informed consent, clients may highlight particular information they do not want shared with certain people, and that this must be recorded and respected.
- Signed paper consent forms must be kept in a locked filing cabinet.
- Information must not be passed on to a third party without the informed consent of clients and/or their caregiver(s).
- Staff who are working with GBV data are aware of the importance of being vigilant as to who is entering the room where they work and for what purpose.
- Staff who work with GBV data have signed a data protection agreement.⁶⁰

The collection of GBV data for all cases requires the completion of two key paper-based forms:

1. The intake form. This form must be marked with an incident ID and organized by incident ID. See *Annex X: Standard GBVIMS Intake Form*.
2. The consent form. This form must be organized by month/year and stored in binders. See *Annex VI: Informed Consent Form*.

Additional GBV data may be stored and filed on paper or electronically. Different rules apply.

For GBV data stored and filed:

- Paper documentation for each incident must be stored in its own individual file.

⁵⁸ This section does not refer to documentation of GBV individual cases described in Chapter 6 (section 6.4).

⁵⁹ A full checklist is provided in *Annex XV: Data Protection Checklist*.

⁶⁰ See *Annex XVI: Sample Data Protection Agreement for Staff*.

- Paper documentation must be clearly labeled with the incident number.
- The names of clients must not be written on the outside of paper files.
- Paper files must be kept in a locked cabinet or drawer that is accessible only to responsible individuals specified by the site manager.
- No one else should be given independent access to the paper files without permission.
- Rooms containing paper and electronic information must be locked securely when the staff leave the room.

For GBV data stored and filed electronically:

- All computers used for data storage must be password protected.
- All applicable staff must be made aware that information should be transferred by encrypted and password-protected files whether this is by internet or memory sticks.
- At least two backups must exist:
 - One stored in the location of the database and backed up each day data is entered.
 - One sent out for secure storage in a designated off-site location (e.g., to GBV Program Coordinator once a month). Staff responsible for the data at the second site must follow the same data protection protocols.

12.2 Information sharing

Information management is critical to effective GBV prevention and responses. Careful attention nevertheless needs to be paid to how information is collected and shared. The highly sensitive nature of GBV poses a unique set of challenges for information management especially in the geographical area where these SOPs apply. A range of ethical and safety issues must be considered and addressed prior to the commencement of data collection or sharing activity.⁶¹ These include:

- Information about specific incidents of GBV should not be shared.
- Special care should be taken when distributing information.
- All guiding principles associated with ethical and safe information collection must be upheld.
- No identifying information should be included in any of the data summaries.
- Information that is private, which could identify individuals or particular communities, or that could endanger members of the affected population or staff members, should not be disclosed publicly.

Information that should be shared includes:

- Services mapping matrices
- Research and assessment documents
- Information, education and communications materials
- Standard GBV resources (e.g., international guidelines)

Table 18 provides recommendations on the sharing of quantitative and qualitative information.

⁶¹ For more information, refer to WHO, *Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*, 2007 and IASC, 2005.

Table 18: Recommendations for sharing information

QUANTITATIVE INFORMATION	QUALITATIVE INFORMATION
<p>Only aggregated data at district level of Syria should be shared.</p> <p>This aggregated data should be shared only among GBV actors and within the GBV SC framework.</p> <p>Each agency sharing aggregate data should have a trained responsible person for completing this task.</p>	<p>Organizations should share the results of their assessments in a timely and accessible manner with the community, the coordination group and other relevant organizations.</p> <p>Encourage the dissemination of qualitative data (e.g., rapid assessments, safety audit results, situation analyses) to promote a better understanding of the local context through the coordination bodies.</p> <p>Advocate for harmonization of assessment tools for focus groups discussions, safety audits, service mappings, key informant interviews etc.</p>

13 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.*⁶²

The GBV SC is the coordinating body with the objective to strengthen GBV prevention and response in areas of Syria reachable through cross-border intervention from Turkey. As described in the introduction to these SOPs, it works to facilitate multi-sectoral, inter-agency actions aimed to prevent GBV, and to ensure the provision of accessible, timely and survivor-centered GBV response services. The GBV SC is chaired by UNFPA and Global Communities. It is a sub-cluster of the PC which is chaired by UNHCR and IRC. Members include UN agencies, international and national NGOs.

Membership is free and open to all humanitarian organizations involved in GBV prevention and response under the goal of reducing risks and mitigating consequences of GBV experienced by women, girls, boys and men in North of Syria. This includes UN agencies, international and national NGOs (Syrian and Turkish) and international organizations. Organizations are encouraged to be represented by technical staff in GBV and women's empowerment. Organizations wishing to join the GBV SC will follow the same procedure highlighted in the PC Terms of Reference. The GBV and CP Sub-Clusters collaborate and harmonize intervention on overlapping issues, such as sexual abuse on children.

The GBV SC meets monthly in Gaziantep. Information is shared at least monthly between members of the GBV SC through dissemination of meeting minutes. Issues and problems needing action from other clusters are identified in these minutes. In collaboration with International Organization for Migration, the GBV SC leads the Gender Focal Points Network. Focal Points are trained in GBV risk mitigation and support their cluster in this work.

The GBV SC will continue to support coordination among GBV actors by undertaking the following actions:

- It will focus on making prevention and response services more inclusive, with special attention to the needs and capacities of adolescent girls and of people with disabilities.
- It will collaborate with other sectors to make services safer and more accessible for women and girls.
- In collaboration with WoS, it will produce a number of products and maps to support the analysis of the GBV response, as well as to identify gaps and geographic priorities.
- It will continue to be represented at the Inter-Cluster Coordination Group in the Humanitarian Leadership Group and in other humanitarian forums for interagency initiatives, including multi-sectoral assessments, protection monitoring and emergency response plans.
- It will continue to provide information, guidance, training and whenever possible conduct meetings in Arabic and English.
- It will focus on defining more specific criteria for the categorization of GBV SC members on the basis of their on-going GBV programmes and services to better delineate a strategy of engagement, technical support and capacity building for each group.
- It will support the development of harmonized and consistent awareness raising messages and dissemination approaches.

⁶² IASC, *Guidelines for integrating gender-based violence interventions in humanitarian action: Reducing risk, promoting resilience and aiding recovery*, 2015, p.42.

- It will look at initiatives to introduce ‘engaging men and boys’ approaches in prevention activities.
- It will coordinate joint initiatives to mark campaigns, such as the 16 Days of Activism against GBV.
- It will continue to provide prevention and empowerment activities both through WGSS and mobile teams.
- It will support its partners with guidance on how to ensure the participation of girls in decision-making and how to better hear their voices on their vision and needs in GBV programmes.
- It will contribute to the development of advocacy messages, position papers and advocacy products and will support their dissemination

GBV specialists can ensure the integration of protection principles and GBV risk-reduction strategies into ongoing humanitarian programming. These specialists can advise, assist and support coordination efforts through specific activities, such as conducting GBV-specific assessments, ensuring appropriate services are in place for survivors, developing referral systems and pathways, providing case management for GBV survivors, developing trainings for sector actors on gender, GBV, women’s/human rights, and how to respectfully and supportively engage with survivors.

14 RESOURCES

Content from the following resources has helped inform the development of the GBV SC SOPs and the content of this SOPs document. Many of these resources are referenced in this document.

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UNFPA. (2008). *Addressing violence against women and girls in sexual and reproductive health services: a review of knowledge assets*.

---. (2015). *Women and girls' safe spaces: A guidance note based on lessons learned from the Syrian crisis*.

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WHO. (2003). *Guidelines for medico-legal care for victims of sexual violence*.

---. (2007). *Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*.

---. (2011). *Psychological first aid*.

WHO, UNFPA & UNHCR. (2004). *Clinical management of rape: Developing protocol for use with refugees and internally displaced persons*.

WoS. (2018). *Syria humanitarian response plan 2018: WoS gender based violence (GBV) results framework*.

ANNEX I: THE HUMANITARIAN PRINCIPLES OR 'PRINCIPLES OF HUMANITARIAN ACTION'

1. **Humanity/ The humanitarian imperative:** Human suffering must be addressed wherever it is found, with particular attention to the most vulnerable in the population, such as children, women, the displaced and the elderly. The dignity and rights of all those in need of humanitarian assistance must be respected and protected. The humanitarian imperative implies a right to receive humanitarian assistance and a right to offer it. At times, humanitarian access to civilian populations is denied by authorities for political or security reasons. Humanitarian agencies must maintain their ability to obtain and sustain access to all vulnerable populations and to negotiate such access with all parties to the conflict.
2. **Neutrality:** Humanitarian agencies must not take sides in the hostilities or in controversies based on political, racial, religious or ideological identity (non-partisanship/independence). Transparency and openness are key issues to keep neutrality. Neutrality for an organization that has taken on a rights-based approach must not, however, be an obstacle to tackling human rights violations. Neutrality is not a justification for condoning impunity or turning a blind eye to egregious human rights abuses. It does not negate the need for some form of action, whether through strategic advocacy, simple presence, political demarches, local negotiations, etc. Neutrality also requires that humanitarian actors be clear about the specific and limited circumstances in which military assets can be used: only as a last resort (where there is no comparable civilian alternative); the operation as a whole must remain under the overall authority and control of the responsible humanitarian organization; and any use of military assets should be clearly limited in time and scale. The military and civil defense assets of belligerent forces should never be used to support humanitarian activities.
3. **Impartiality:** aid is delivered to all those who are suffering; the guiding principle is only their need and the corresponding right. Human rights are the basis and the framework for an assessment of needs. This principle includes both the proportionality to need (where resources are not sufficient, priority is always given to those most affected) as well as the principle of non-discrimination (no one should be discriminated against based on their sex, age, ethnicity, identity, etc.), and that there should not be subjective distinction.
4. **Independence:** Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor might hold with regard to areas where humanitarian action is being implemented.

Finally, although aid can become part of the dynamics of the conflict and may even prolong it, humanitarian organizations must strive to “do no harm” or to minimize the harm they may be inadvertently doing simply by being present and providing assistance. Humanitarian actors need to be aware of this and take steps to minimize the harm when, for example, aid is used as an instrument of war by denying access or attacking convoys; aid is an indirect part of the dynamics of the conflict because it creates jobs, gives incomes in form of taxes, leaves no or little responsibility on the state for social welfare, etc.; or aid exacerbates the root causes of the conflict by securing rebel activities. To minimize possible longer term harm, humanitarian organizations should provide assistance in ways that are supportive of recovery and long-term development. This is also referred as an additional principles “**Do no/less harm**”.

ANNEX II: SAMPLE CODE OF CONDUCT

All actors involved in prevention of and response to GBV should understand and sign a Code of Conduct or a similar document⁶³, setting out professional standards of conduct. Humanitarian agencies have a duty of care to beneficiaries and a responsibility to ensure that beneficiaries are treated with dignity and respect and that certain minimum standards of behavior are observed.

In order to prevent sexual exploitation and abuse, the following core principles must be incorporated into humanitarian agency codes of conduct:

- Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defense.
- Exchange of money, employment, goods, or services for sex, including sexual favors or other forms of humiliating, degrading, or exploitative behavior is prohibited. This includes exchange of assistance that is due to beneficiaries.
- Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, s/he must report such concerns via established agency reporting mechanisms.
- Humanitarian workers are obliged to create and maintain an environment which prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems which maintain this environment.

To ensure the maximum effectiveness of the Code of Conduct, it should be posted in clear view in the public areas of each actor's office/center, introduced and explained, signed by all staff and kept in employee files.

All posted and distributed copies of the Code of Conduct should be translated into the appropriate language of use for the field area.

⁶³ See the Secretary-General's Bulletin on 'Special measures for protection from sexual exploitation and sexual abuse' (ST/SGB/2003/13) available at <http://www.pseataaskforce.org/uploads/tools/1327932869.pdf>; and other examples of codes of conducts available at <http://www.pseataaskforce.org/en/tools>.

ANNEX III: CONSEQUENCES OF SEXUAL ABUSE FOR CHILDREN

Many (especially small) children will not say anything about sexual abuse they have experienced. This often stems from their fear of the perpetrator. Often, the perpetrator has told them the abuse is normal or that something bad will happen if they react or say anything. Also, children sometimes don't understand that the abuse is wrong.

However, most children will show reactions after the abuse or violence. These behavioral reactions may be an indicator of abuse. While the presence of these indicators may raise concern, it does not always mean a child has been sexually abused. Especially in conflict-affected settings, many children might show temporarily reactions to stress that might be similar to the reactions described below. Therefore, a careful assessment of the child and their circumstances is necessary.

In a later stage of development when they fully understand what happened and develop their own sexuality, many children develop reactions and psychosocial problems as a backlash of the earlier abuse.

Common behavioral reactions

The following are some of the most common consequences of sexual violence on children:

Inappropriate sexualized behavior

When children are sexually assaulted, their sense of what is right and wrong becomes distorted. What they had previously learnt about bodies and sexual activity becomes invalid. When a child is raped by someone in their family, they may believe they will get attention by being sexual with another person. If children have experienced sexual feelings (common in children who have been sexually assaulted), they are likely to try and recreate those reactions. They may begin to act out sexually with other children to try and make sense of what has happened to them. In some circumstances, the trouble they may get into as a result of this behavior might confirm their view of themselves as dirty and bad.

Sexualized behavior is, to a certain extent, part of normal child development. However, when it occurs at greater frequency or at an earlier age than would be developmentally appropriate, when it is accompanied by coercion (the child forcing another child to engage in sexual acts) or when it is associated with emotional distress, it can be an indicator of sexual abuse.

Wetting/Soiling

Many young children lose bladder and/or bowel control following sexual violence. It can be frustrating for parents, and humiliating and embarrassing for children.

All children wet from time to time when they are sick, stressed or anxious. Children who have been sexually assaulted will often bed wet every night and sometimes more than once a night. Bedwetting can be linked to feelings and may be a result of nightmares. Extreme fear can cause loss of bladder control and may serve the purpose of waking a child from a terrifying dream. Bedwetting can also result from feelings of helplessness when children feel a loss of ownership and power over their body when it has been used by someone more powerful than they are.

Nightmares

All children have bad dreams from time to time, but children who have experienced sexual assault often have nightmares every night sometimes more than once. They may have recurring dreams that are all the more frightening because they know what is coming. Nightmares can make children terrified of the dark leading to difficult behaviors. Their dreams are likely to reflect their fears and their sense of lack of control. Asking them to tell their dreams can help them talk about what has happened.

Persistent Pains

Lots of children develop aches and pains that have no physical cause. These will often have a connection to an aspect of the assault. Sometimes if a child has experienced physical pain during the assaults, their body can retain the memory of this pain. Children may also think that something is broken inside of them. Repeated pain can also be a way for children to gain the extra love and attention they need at the time. Sometimes emotions manifest themselves physically for children because they do not have the ability to put it into words.

Clinginess

Previously independent children often cling closely to their parents or caretakers after sexual assault. This is communication of their need to be reassured by the caregiver that they are lovable and secure. In these cases, children are attempting to rebuild a sense of safety and trust through their relationships with close adults. They are trying to restore a sense of good touch by demanding affection and cuddles. In essence, they are trying to heal their wounds. Constant physical and verbal demands can be difficult for parents but can be modified by identifying what the child needs and putting limits on when and how they are met. Talking about a child's fears can help reduce clinginess.

Aggression

Aggression in children after sexual assault tends to be related to fear and anger. It can be a direct communication that states, "I am never going to be hurt again." Anger is a normal response and can be part of the recovery process from any terrifying event. It needs to be expressed in a safe and constructive way with firm limits against hurting oneself or others. To do this, anger needs to be acknowledged and recognized by the child and the adult. A child needs to learn how to control and express their anger in acceptable ways. Adults can help children learn skills in controlling and managing their anger without aggression.

Aggression causes the child more problems as their aggression prevents other people from seeing or understanding the child's needs. It stems from fear and a need to protect themselves from further hurt. This can be evident in boys who may believe they were weak because they did not fight off the offender. Sometimes they can try to make themselves feel more powerful by hurting other children or animals.

Being aggressive can also cause children to punish themselves and confirm their low self-esteem because they have no friends and are always in trouble.

Other consequences of sexual violence on children

Consequences of sexual violence on children can be wide-ranging and diverse. Other consequences include resuming behaviors from earlier stages of their development or stopping newly acquired behaviors (e.g., toilet trained children may regress to wetting), withdrawal from family and friends, difficulties

concentrating at school, lack of interest in daily activities, severe fear of strangers, risk-taking, and changes in beliefs and values (especially among adolescents). Secondary effects (e.g., social isolation and stigmatization, dropping out of school, lack of marriage and employment opportunities) can compound the initial harm done by the sexual violence and undermine their long-term development. If sexual violence is not addressed and/or continues for a long time, it risks undermining children's emotional, social and cognitive development.

Coping mechanisms of children:

Just like with adults, different factors have an impact on coping, resilience and recovery of children after sexual violence and abuse.

Generally, children have a large set of resources to adapt to change after difficult or stressful experiences. In fact, children generally demonstrate a huge resilience and have the capacity 'to bounce back'.

More than adults, children need the support of parents, siblings, extended family and friends to feel protected and to deal with the impact of sexual violence. Attachment to stable and supportive caregivers is a fundamental building block for a healthy development, including the development of coping mechanisms. A safe environment of a family – which implies that no one of the family is complicit in the abuse—will help the child-survivor to play, deal with their emotions and thoughts, and recover from the violence.

Factors related to the community, culture and religion will also have an impact on the coping, resilience and recovery of children. Positive community attitudes towards sexual violence can help to protect children against further harm and help them in their recovery. Positive religious and traditional rituals, such as cleansing or healing rituals, can also promote recovery.

ANNEX IV: TECHNIQUES FOR HELPING GBV SURVIVORS

Some people who experience GBV may be very anxious or upset. They may feel confused or overwhelmed, and may have some physical reactions such as shaking or trembling, difficulty breathing or feeling their heart pounding. The following are some techniques to help very distressed people to feel calm:

- Keep your tone of voice calm and soft.
- If culturally appropriate, try to maintain some eye contact with the person as you talk with them.
- Remind the person that you are there to help them. Remind them that they are safe, if it is true.
- If someone feels unreal or disconnected from their surroundings, it may help them to make contact with their current environment and themselves. You can do this by asking them to:
 - Place and feel their feet on the floor.
 - Tap their fingers or hands on their lap.
 - Notice some non-distressing things in their environment, such as things they can see, hear or feel. Have them tell you what they see and hear.
 - Encourage the person to breathe and take her own pace.

Talking to GBV survivors in ways that reassure them and support them are vital. The following messages are intended for anyone who comes into contact with GBV survivors in their work. The information here is very basic and does not replace training for working with survivors of GBV.

Very important things to say (not necessarily in this order):

- “I’m very sorry this happened to you.”
- “You are not alone. Help is available for you.”
- “It is not your fault.” (That she/he was raped.)
- “How can I help you?”
- “I can give you some important information that will help you make decisions about what you want to do next, but the decisions and choices are yours.”
- “If you have questions that I cannot answer, I will do my best to find the information and speak to you again very soon.”

About health

- “It is very important for you to get medical care after a sexual assault, as soon as possible.”
- “It is possible to get medication to prevent pregnancy, sexually transmitted infections, and other harmful diseases, in addition to treating injuries.”
- “The medication to prevent pregnancies must be taken as soon as possible, within 5 days of the incident.”
- “There is medication to prevent HIV. This must be taken as soon as possible, within 72 hours/3 days of the incident.”
- “If the incident happened more than 5 days ago, it is still important for you to seek medical care.”
- “I can help you find a health clinic that can give you the health treatment you need and answer your questions.”
- “You do NOT need a police report to receive medical care, only if you want to report the crime to Police.”

About emotional support, counseling and follow up

- “It is normal to feel very emotional after rape. Many survivors cannot stop thinking about it, have nightmares about it, and cannot eat and sleep normally. You are not crazy. These are normal reactions to a terrible event.”
- “There are people who can help you heal emotionally and get the help that you need. I can help you contact these people.”

About safety

- “Do you feel in danger or need help for safety?”

ANNEX V: SURVIVOR-CENTERED TIPS

Make use of Psychological First Aid (PFA) techniques to facilitate building trust and create a safe and confidential environment during the initial assessment and interview.

SURVIVOR-CENTERED ATTITUDES	SURVIVOR-CENTERED TIPS
<p>Avoid specialized medical or legal language. Be careful to avoid using words that the survivor may not understand or that may increase anxiety.</p>	<ul style="list-style-type: none"> • “Let me explain what happens now...” • “Do you have any questions? Would you like me to go over the next steps we talked about to check that we both understand what happens after this?”
<p>Do not rush to fill silence with words. Some survivors need to sit quietly and process the event. After a few moments, acknowledge the silence.</p>	<ul style="list-style-type: none"> • “I can see this is not easy to put into words.” • “Sometimes it feels easier not to talk.” • “Sometimes it may feel better to be silent.”
<p>Acknowledge that you are a stranger, a new person in her/his life.</p>	<ul style="list-style-type: none"> • “I know we have just met, it may be uncomfortable for you to tell me about what happened to you, but I am here for you, to listen to you and make sure you are okay.”
<p>Reassure the survivor that you will be patient and that They does not need to hurry through her/his story.</p>	<ul style="list-style-type: none"> • “We can take as long as you need.” • “I’ll wait.” • “That’s okay, take your time.”
<p>Use simple support statements when needed:</p>	<ul style="list-style-type: none"> • “I’m glad you came here.” • “It’s good you are telling me these things.” • “What would it take for you to feel safe here.”? • “It is common to have those feelings. Many women in your situation feel that way.” • “If you want to stop at any time we can, just tell me.” • “If you think of something else you want to talk about, we can stop what we’re doing and I can listen. Tell me if you remember anything else.” • “You’re here, you have survived.”
<p>Clearly acknowledge that the survivor is not at fault and ensure that your attitude is supportive, not blaming</p>	<ul style="list-style-type: none"> • “What happened was not your fault.”

SURVIVOR-CENTERED ATTITUDES	SURVIVOR-CENTERED TIPS
<p>Provide a safe space for emotional expression. If the interview comes to a halt with shouting or expressions of rage, for example, point out the behavior and ask how you can help the survivor feel more comfortable.</p>	<ul style="list-style-type: none"> • “I see this is difficult for you, would you like to take a break?” • “Anger is normal, what can we do to release this feeling ”
<p>Provide empathy and support by reflecting back to the person what They is doing (e.g. crying, expressing anger) and ask how you can help.</p>	<ul style="list-style-type: none"> • “I see you are angry. You have a right to be angry. Please tell me what I can do to help you feel better.” • “I see you are crying, we can wait until you are ready to talk. Is there anything that I can do to help you?”

ANNEX VI. INFORMED CONSENT FORM



CONFIDENTIAL

Form 1: Consent for Release of Information

This form should be read to the client or guardian in their first language. It should be clearly explained to the client that they can choose any or none of the options listed.

I, _____, give my permission for (Name of Organization) to share information about the incident I have reported to them as explained below:

1.

I understand that in giving my authorization below, I am giving (Name of Organization) permission to share the specific case information from my incident report with the service provider(s) I have indicated, so that I can receive help with safety, health, psychosocial, and/or legal needs.

I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I request.

I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency / focal point listed below.

I would like information released to the following:

(Tick all that apply, and specify name, facility and agency/organization as applicable)

YES NO

Security Services (specify):

Psychosocial Services (specify):

Health/Medical Services (specify):

Safe House / Shelter (specify):

Legal Assistance Services (specify):

Livelihoods Services (specify):

Other (specify type of service, name, and agency):

Authorization to be marked by client (or parent/guardian if client is under 18):

Yes No

2.

I have been informed and understand that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to me or the incident. There will be no way for someone to identify me based on the information that is shared. I understand that shared information will be treated with confidentiality and respect.

Authorization to be marked by client (or parent/guardian if client is under 18):

Yes No

Signature/Thumbprint of client: _____

(or parent/guardian if client is under 18)

INFORMATION FOR CASE MANAGEMENT (OPTIONAL-DELETE IF NOT NECESSARY)

Client's Name: _____

Name of Caregiver (if client is a minor): _____

Contact Number: _____

Address: _____

ANNEX VII: REFERRAL FOCAL POINTS

REFERRAL FOCAL POINTS LIST

District	Organization	Service Phone Number	Service Email
	GBV SC Service Number	0090 537 267 7138	referral.GBVSC@gmail.com
JABAL SAMAN	Masrrat	00963 952 451430	case.mg@masrrat.com
AL MARR'A	SRD	00963 954 510463	srdreferral@gmail.com
AL MARR'A	ISWA	00963 935 450274	ref.gbv@iswa-turkey.org
ARIHA	Space of Peace	00963 964 779504	Complain@spaceofpeace.org
AFRIN	Bahar	0090 536 692 9419	haf-pro-casem@baharorganization.org
JISR ASHOGHOUR	Hope Revival	0090 555 070 7182	r.protection@hope-revival.ngo
ALBAB	IhsanRD	0090 534 226 4609	refferalalbab@gmail.com
JARABULUS	IhsanRD	0090 534 228 0296	refferaljarabulus@gmail.com
HARIM	Global Communities	0090 538 863 5786	
HARIM	MRFS	0090 538 861 2740	serviceforall.harim@gmail.com
IDLEB	Shafak	0090 538 862 7653	protection.services@shafak.org
AZAZ	WVI	0090 539 627 2638	gbvsyria@gmail.com
IDLEB	Syria Relief	00963 946 977204	refferal.idleb@syriarelief.org.uk

REMEMBER

1. **Contact the GBV SC Service Number (+90 537 267 7138)** for any information regarding referrals and to request a Referral Pathway;
2. Report any incorrect information or non-functioning numbers/irresponsive email addresses to the GBV SC referral email referral.GBVSC@gmail.com;
3. In addition to reaching out to the referral focal points, you can **request the Referral Pathway** for the district where you received GBV disclosure, by **filling in the online request form at this [link](#)**.
4. Referrals happen both towards and from GBV case management actors. This means that as much as you can reach out to the Focal Points listed below, GBV case management actors may reach out to your sector to refer GBV survivors who may need a holistic and inter-sector approach.
5. The GBV SC is available to provide trainings to Cluster members to improve the capacity to respond to GBV disclosure through an ethical and respectful approach. Feel free to contact the GBV SC coordination team at rkhamis@unfpa.org, fboniardi@globalcommunities.org, aali@ihsanrd.org

ANNEX VIII: STATEMENT OF CONFIDENTIALITY

Referral pathway information is confidential. This includes contact information of focal points and service providers.

The transmission is sent in trust, for the sole purpose of delivery to the intended recipient and with the sole aim of referring the GBV survivor(s) to service providers. The information about both the GBV survivor(s) and the GBV service provider's information is confidential. All contents are intended solely for the addressee and staff immediately involved in making the referral.

Care shall be taken to ensure that unauthorized individuals do not overhear any discussion of confidential information, and that documents containing confidential information are not left in the open or inadvertently shared. Unauthorized disclosure of confidential or privileged information is a serious violation of this policy.

Any referral of a GBV survivor is based on the GBV guiding principles. These principles are set out in Chapter 2 of the *Standard Operating Procedures for Gender-Based Violence Prevention and Response*, and are attached to this email.

Please reply to this message stating that you understand and accept the terms set out in this email.

If you have received this transmission in error, any use, reproduction or dissemination of this transmission is strictly prohibited.

Thank you very much for your work and cooperation.

ANNEX IX: SAFETY CHECKLIST AND SAFETY PLANNING

A humanitarian actor will not be able to stop violence from happening. However, it is possible to make use of general guidelines, as well as some danger signs, to assess as much as possible the vulnerability of the survivor.

A safety checklist is an effective tool to assess the survivor's safety. If the survivor or the person to whom he survivor has disclosed the GBV tick one of the boxes, a safety plan should be developed.

Safety checklist

Check each item that the survivor identifies as a threat to her safety.

- History of causing serious injury**—Check here if the perpetrator has caused one or more life threatening injuries to the survivor or their children in the past, besides the episode of violence disclosed.
- Frequent violence**—Check here if violence is frequent, occurring more than once per month.
- Threats of killing the survivor or self**—Check here if the perpetrator has threatened to kill anybody, including the survivor or self.
- History of violence**—Check here if the perpetrator has a history of other types of violence.
- Weapons**—Check if the perpetrator owns or has access to weapons and has used them or threatened to use them in past assaults.
- Presence/location of the perpetrator**—Check here if the perpetrator lives in the same location as the survivor, contacts the survivor regularly, and/or closely monitors the survivor's activities.
- Drug or alcohol abuse**—Check here if the perpetrator drinks or uses drugs..
- Presence of potential triggers**—Check here if there is a current or upcoming event that could trigger or lead to violence (e.g., survivor has to fetch water, survivor seeks help in a facility).

On a scale of 1 to 5 (5 = perfectly safe, 1 = not safe at all), how safe do you feel?



1

2



3

4



5

Safety Plan

Client Code:	Incident Code:	Caseworker #:	Date of meeting:

Safety concerns

<i>Question</i>	<i>Notes</i>
What are your fears, and why?	
Do you fear anybody in particular?	
Do you fear for the safety of your children and/or other family members?	
Where and when do you feel unsafe, and why?	
Do you know the perpetrator(s)?	
Is the violence ongoing?	

Support systems

<i>Question</i>	<i>Notes</i>
What have you been doing since the incident to keep yourself safe from the perpetrator and others?	
Is this something you can continue to do?	
What support or assistance do you need to continue to use these strategies?	

In the places you feel unsafe, are there any strategies for avoiding these places or for mitigating the risks of violence in those places?	
Are there family members, community members or community leaders you trust?	
Do they know about what has happened?	
Would they provide support to you if they knew about what had happened?	
In an emergency, is there somewhere you can access as a temporary safe space?	
Do you have access to a phone you can use to contact somebody for support if you need to?	

Safety Plan

Complete this safety plan using the exact words of the survivor.

<i>Statement</i>	<i>Notes</i>
When I feel unsafe and need to find safety, I will do the following: I will go to... I will talk to...	
If I have to leave home quickly, I will go to...	

ANNEX X: STANDARD GBVIMS INTAKE FORM



GBVIMS INTAKE AND INITIAL ASSESSMENT FORM CONFIDENTIAL

INSTRUCTIONS

1. This form must be filled out by a case manager, health practitioner, social worker or other authorized person providing services to the survivor.
2. Note that questions followed by an asterisk* must remain on the intake form and must be answered. These questions are a part of a minimum essential dataset on GBV. Some questions are followed by both an asterisk* and a circleO; these are customizable, and the italicized text of these fields is intended to be adapted to each context and can be modified. Questions that are unmarked may be modified by your agency or removed if they are not necessary for your program and/or case management.
3. Unless otherwise specified, always mark only one response field for each question.
4. Please feel free to add as many questions to this form as needed in your context and/or attach additional pages with continued narrative, if needed.

Before beginning the interview, please be sure to remind your client that all information given will be kept confidential, and that they may choose to decline to answer any of the following questions.

1-ADMINISTRATIVE INFORMATION		
Incident ID*:	Survivor code:	Caseworker code:
Date of interview (day/month/year)*:		Date of incident (day/month/year)*:
<input type="checkbox"/> Reported by the survivor or reported by survivor's escort and survivor is present at reporting* (These incidents will be entered into the Incident Recorder)		
<input type="checkbox"/> Reported by someone other than the survivor and survivor is not present at reporting (These incidents will not be entered into the Incident Recorder)		

2-SURVIVOR INFORMATION

Date of birth (approximate if necessary)*:		Sex*: <input type="checkbox"/> Female <input type="checkbox"/> Male	Clan or ethnicity:	
Country of origin*○:				
<input type="checkbox"/> Country names here		<input type="checkbox"/> Etc.	<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> Etc.		<input type="checkbox"/> Etc.		
Nationality (If different than country of origin):			Religion:	
Current civil/marital status*:				
<input type="checkbox"/> Single		<input type="checkbox"/> Divorced/Separated		
<input type="checkbox"/> Married/Cohabiting		<input type="checkbox"/> Widowed		
Number and age of children and other dependants:				
Occupation:				
Displacement status at time of report*:				
<input type="checkbox"/> Resident	<input type="checkbox"/> IDP	<input type="checkbox"/> Refugee	<input type="checkbox"/> Stateless Person	
<input type="checkbox"/> Returnee	<input type="checkbox"/> Foreign National	<input type="checkbox"/> Asylum Seeker	<input type="checkbox"/> N/A	
Is the client a Person with Disabilities?*				
<input type="checkbox"/> No	<input type="checkbox"/> Mental disability	<input type="checkbox"/> Physical disability	<input type="checkbox"/> Stateless Person	
Is the client an Unaccompanied Minor, Separated Child, or Other Vulnerable Child?*				
<input type="checkbox"/> No	<input type="checkbox"/> Unaccompanied Minor	<input type="checkbox"/> Separated Child	<input type="checkbox"/> Other Vulnerable Child	
Sub-Section for Child Survivors (less than 18 years old)				
If the survivor is a child (less than 18yrs) does he/she live alone?				
<input type="checkbox"/> Yes		<input type="checkbox"/> No (if "No", answer the next three questions)		
If the survivor lives with someone, what is the relation between her/him and the caretaker?				
<input type="checkbox"/> Parent / Guardian	<input type="checkbox"/> Relative	<input type="checkbox"/> Spouse/Cohabiting	<input type="checkbox"/> Other:_____	
What is the caretaker's current marital status?				
<input type="checkbox"/> Single	<input type="checkbox"/> Married/Cohabiting	<input type="checkbox"/> Divorced/Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Unknown/Not Applicable
What is the caretaker's primary occupation:				

3-DETAILS OF THE INCIDENT

Account of the incident/Description of the incident (summarize the details of the incident in client's words)

Stage of displacement at time of incident*:

- Not Displaced/Home Community
 During Flight
 During Return/Transit
 Other: _____
 Pre-displacement
 During Refuge
 Post-displacement

Time of day that incident took place*:

- Morning (sunrise to noon)
 Afternoon (noon to sunset)
 Evening/night (sunset to sunrise)
 Unknown/Not Applicable

Incident location/Where the incident took place*○:

(Customize location options by adding new, or removing tick boxes according to your location)

- Bush / Forest
 Garden / Cultivated Field
 School
 Road
 Client's Home
 Perpetrator's Home
 Other (give details) _____

Area where incident occurred*○:

- Area names here
 Etc.
 Etc.
 Etc.
 Other (specify) :

Sub-Area where incident occurred*○:

- Sub-area names here
 Etc.
 Etc.
 Etc.
 Etc.
 Other (specify) :

Camp/Town/Site:

- Camp/Town/Site names here
 Etc.
 Etc.
 Etc.
 Other (specify) :

3-DETAILS OF THE INCIDENT (CONT'D)

Type of Incident Violence*:

(Please refer to the GBVIMS GBV Classification Tool and select only ONE)

- Rape (includes gang rape, marital rape)
- Sexual Assault (includes attempted rape and all sexual violence/abuse without penetration, and female genital mutilation/cutting)
- Physical Assault (includes hitting, slapping, kicking, shoving, etc. that are not sexual in nature)
- Forced Marriage (includes early marriage)
- Denial of Resources, Opportunities or Services
- Psychological / Emotional Abuse
- Non-GBV (specify)

Note: these incidents will not be entered into the incident recorder

1. **Did the reported incident involve penetration?**
If yes → classify the incident as "Rape".
If no → proceed to the next incident type on the list.
2. **Did the reported incident involve unwanted sexual contact?**
If yes → classify the incident as "Sexual Assault".
If no → proceed to the next incident type on the list.
3. **Did the reported incident involve physical assault?**
If yes → classify the incident as "Physical Assault".
If no → proceed to the next incident type on the list.
4. **Was the incident an act of forced marriage?**
If yes → classify the incident as "Forced Marriage".
If no → proceed to the next incident type on the list.
5. **Did the reported incident involve the denial of resources, opportunities or services?**
If yes → classify the incident as "Denial of Resources, Opportunities or Services".
If no → proceed to the next incident type on the list.
6. **Did the reported incident involve psychological/emotional abuse?**
If yes → classify the incident as "Psychological / Emotional Abuse".
If no → proceed to the next incident type on the list.
7. **Is the reported incident a case of GBV?**
If yes → Start over at number 1 and try again to reclassify the incident (If you have tried to classify the incident multiple times, ask your supervisor to help you classify this incident).
If no → classify the incident as "Non-GBV"

Was this incident a Harmful Traditional Practice*○?

- No Type of practice
- Type of practice Type of practice
- Type of practice Type of practice

Were money, goods, benefits, and/or services exchanged in relation to this incident*?

- Yes No

Type of abduction at time of the incident*:

- None Forced Conscription Trafficked Other Abduction/Kidnapping

3-DETAILS OF THE INCIDENT (CONT'D)

Has the client reported this incident anywhere else?*

(If yes, select the type of service provider and write the name of the provider where the client reported);
(Select all that apply).

- No
- Health/Medical Services _____
- Psychosocial/Counseling Services _____
- Police/Other Security Actor _____
- Legal Assistance Services _____
- Livelihoods Program _____
- Safe House/Shelter _____
- Other (specify) _____

Has the client had any previous incidents of GBV perpetrated against them?*

- Yes
- No

If yes, include a brief description:

4-ALLEGED PERPETRATOR INFORMATION

Number of alleged perpetrator(s)*:

- 1
 2
 3
 More than 3
 Unknown

Sex of alleged perpetrator(s)*:

- Female
 Male
 Both female and male perpetrators

Nationality of alleged perpetrator:

Clan or ethnicity of alleged perpetrator:

Age group of alleged perpetrator* (if known or can be estimated):

- 0-11
 12-17
 18-25
 26-40
 41-60
 60+
 Unknown

Alleged perpetrator relationship with survivor *:

(Select the first ONE that applies)

- Intimate partner/Former partner
 Primary caregiver
 Family other than spouse or caregiver
 Supervisor/Employer
 Schoolmate
 Teacher/School official
 Service Provider
 Cotenant/Housemate
 Family Friend/Neighbor
 Other refugee/IDP/Returnee
 Other resident community member
 Other
 No relation
 Unknown

Main occupation of alleged perpetrator (if known)*○:

(Customize occupation options by adding new, or removing tick boxes according to your location)

- | | | |
|---|--|--|
| <input type="checkbox"/> Farmer | <input type="checkbox"/> Trader/Business Owner | <input type="checkbox"/> Religious Leader |
| <input type="checkbox"/> Student | <input type="checkbox"/> Non-State Armed Actor/Rebel/Militia | <input type="checkbox"/> Teacher |
| <input type="checkbox"/> Civil Servant | <input type="checkbox"/> Security Official | <input type="checkbox"/> UN Staff |
| <input type="checkbox"/> Police | <input type="checkbox"/> Camp or Community Leader | <input type="checkbox"/> NGO Staff |
| <input type="checkbox"/> State Military | <input type="checkbox"/> CBO Staff | <input type="checkbox"/> Community Volunteer |
| <input type="checkbox"/> Health Worker | <input type="checkbox"/> Other | <input type="checkbox"/> Unknown |

5-PLANNED ACTION / ACTION TAKEN:

Any action / activity regarding this report.

Who referred the client to you?*

- | | |
|---|--|
| <input type="checkbox"/> Health/Medical Services | <input type="checkbox"/> Teacher/School Official |
| <input type="checkbox"/> Psychosocial/Counseling Services | <input type="checkbox"/> Community or Camp Leader |
| <input type="checkbox"/> Police/Other Security Actor | <input type="checkbox"/> Safe House/Shelter |
| <input type="checkbox"/> Legal Assistance Services | <input type="checkbox"/> Other Humanitarian or Development Actor |
| <input type="checkbox"/> Livelihoods Program | <input type="checkbox"/> Other Government Service |
| <input type="checkbox"/> Self Referral/First Point of Contact | <input type="checkbox"/> Other (specify) _____ |

Did you refer the client to a safe house/safe shelter?*

- Yes No

If 'No', why not?*

- Service provided by your agency
 Services already received from another agency
 Service not applicable
 Referral declined by survivor
 Service unavailable

Date reported or future appointment date (day/ month/year) and Time:

Name and Location:

Notes (including action taken or recommended action to be taken):

Did you refer the client to health / medical services?*

- Yes No

If 'No', why not?*

- Service provided by your agency
 Services already received from another agency
 Service not applicable
 Referral declined by survivor
 Service unavailable

Date reported or future appointment Date and Time:

Name and Location:

Follow-up Appointment Date and Time:

Notes (including action taken or recommended action to be taken):

5-PLANNED ACTION / ACTION TAKEN (CONT'D):

Any action / activity regarding this report.

<p>Did you refer the client to psychosocial services?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken)</p>
<p>Did you refer the client to legal assistance services?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken)</p>
<p>Did you refer the client to the police or other type of security actor?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken)</p>
<p>Did you refer the client to a livelihoods program?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken)</p>

6 - ASSESSMENT POINT

Describe the emotional state of the client at the beginning of the interview:

Describe the emotional state of the client at the end of the interview:

Will the client be safe when she or he leaves?

Yes No

If no give reason:

Who will give the client emotional support?

6 - ASSESSMENT POINT (CONT'D)

What actions were taken to ensure client's safety?

Other relevant information:

If raped, have you explained the possible consequences of rape to the client (if over 14 years of age)?

Yes No

Have you explained the possible consequences of rape to the client's caregiver (if the client is under the age of 14)?

Yes No

Did the client give their consent to share their non-identifiable in your reports?

Yes No

ANNEX XI: BEST PRACTICES TO COMMUNICATE WITH CHILDREN

Any service provider talking with children affected by abuse should adhere to these guiding principles, regardless of the purpose of the communication, in order to ensure that children are not further traumatized during communications with service providers:

1. Be nurturing, comforting and supportive

Children who have been sexually abused most likely will come to your attention through a caregiver or another adult; abused children rarely seek help on their own. Children may not understand what is happening to them or they may experience fear, embarrassment or shame about the abuse, which affects their willingness and ability to talk to service providers. Your initial reaction will impact their sense of safety and willingness to talk, as well as their psychological well-being. A positive, supportive response will help abused children feel better, while a negative response (such as not believing the child or getting angry with the child) could cause them further harm.

2. Reassure the child

Children need to be reassured that they are not at fault for what has happened to them and that they are believed. Children rarely lie about being sexually abused and service providers should make every effort to encourage them to share their experiences. Healing statements such as “I believe you” and “It’s not your fault” are essential to communicate at the outset of disclosure and throughout care and treatment. Direct service providers communicating with child survivors need to find opportunities to tell them that they are brave for talking about the abuse and that they are not to blame for what they have experienced. It is required for service providers to tell children that they are not responsible for the abuse and to emphasize that they are there to help them begin the healing process.

3. Do NO harm: be careful not to traumatize the child further

Service providers should monitor any interactions that might upset or further traumatize the child. Do not become angry with a child, force a child to answer a question that he or she is not ready to answer, force a child to speak about the sexual abuse before he/she is ready, or have the child repeat her/his story of abuse multiple times to different people. Staff should try to limit activities and communication that cause the child distress.

4. Speak so children understand

Every effort should be made to communicate appropriately with children; information must be presented to them in ways and language that they understand, based on their age and developmental stage.

5. Help children feel safe

Find a safe space, one that is private, quiet and away from any potential danger. Offer children the choice to have a trusted adult present, or not while you talk with them. Do not force a child to speak to, or in front of, someone they appear not to trust. Do not include the person suspected of abusing the child in the

interview. Tell the child the truth—even when it is emotionally difficult. If you don't know the answer to a question, tell the child, "I don't know." Honesty and openness develop trust and help children feel safe.

6. Tell children why you are talking with them

Every time a service provider sits down to communicate with a child survivor, she should take the time to explain to the child the purpose of the meeting. It is important to explain to the child why the service provider wants to speak with them, and what will be asked to the child and his/her caregiver. At every step of the process, explain to children what is happening to help secure their physical and emotional well-being.

7. Use appropriate people

In principle, only female service providers and interpreters should speak with girls about sexual abuse. Male child survivors should be offered the choice (if possible) to talk with a female or male provider, as some boys will feel more comfortable with a female service provider. The best practice is to ask the child if he or she would prefer to have male or female trained staff on hand.

8. Pay attention to non-verbal communication

It is important to pay attention to both the child's and your own non-verbal communication during any interaction. Children may demonstrate that they are distressed by crying, shaking or hiding their face, or changing their body posture. Curling into a ball, for example, is an indication to the adult working with the child to take a break or stop the interview altogether. Conversely, adults communicate non-verbally as well. If your body becomes tense or if you appear to be uninterested in the child's story, he or she may interpret your non-verbal behavior in negative ways, thus affecting his or her trust and willingness to talk.

9. Respect children's opinions, beliefs and thoughts

Children have a right to express their opinions, beliefs and thoughts about what has happened to them as well as any decisions made on their behalf. Service providers are responsible for communicating to children that they have the right to share (or not to share) their thoughts and opinions. Empower the child so he/she is in control of what happens during communication exchanges. The child should be free to answer "I don't know" or to stop speaking with a service provider if he/she is in distress. The child's right to participation includes the right to choose not to participate.

Other things to think about when you communicate with a child

- Make sure the child feels comfortable when you have a conversation. Do an assessment or conduct an interview. Sit at the same level as the child. Tell him/her that it is ok to be shy or afraid, not to know the answer to questions, etc.
- Be aware of the environment: is there something in the room that can distract a child (television, radio, noise, other people, a poster on the wall?). Allow a child to first look around and ask questions about the room before you start the conversation, assessment or interview.
- Keep in mind that often the child's answers will depend on who is present in the room.
- Avoid the use of technical terms; use the words the child uses; adapt your questions if the child does not understand you.
- Only ask one question at the time, keep questions simple.
- Avoid negatives (Didn't you go there earlier?).

- Use concrete terms over general terms ('a knife' instead of 'a weapon').
- Avoid asking children to speculate (*what would have happened if...*).
- Never ask exactly the same question more than once. This can make a child think the answer was incorrect, which can lead to inconsistent answers.
- Never force a child to speak, never threaten that something bad will happen when s/he refuses to speak (if you do so, you may repeat the manipulative style of the perpetrator).
- Interactions should be kept to age-appropriate times: 30 minutes for children under 9, 45 minutes for children between 10 to 14; 1 hour maximum for teenagers.

Developmentally appropriate communication

The level of development of a child is influenced by many factors. In addition to the age of the child, other aspects of the environment have a significant impact on a child's developmental level, such as education, culture, nutrition, access to health care, social and family interactions or stressors (like war or violence) and their consequences (psychosocial and mental health problems, displacement).

The way we talk to an infant is different than the way we talk to a child in school age or an adolescent. Therefore:

- Always use language adapted to the child's developmental stage.
- Children's understanding of time, space and size is dependent on their level of development. Only older children should be asked to estimate these quantities in terms of concrete units. School-aged children can probably compare quantities to other quantities they know. Younger children can only say that something is 'big' or 'small' or 'long' or 'short'.
- Do not ask children under 10 (school age) to answer questions that involve abstract ideas like 'justice' or 'love'. Young children (younger than adolescents) cannot think in the abstract.
- Typical responses from young children are "No", or "I don't remember". They may give vague responses such as "to talk about bad things" or "to say what the man did," but they may fail to elaborate.
- With older children and adolescents, general questions often produce some information about sexual assault. These general questions are less useful with young children.

ANNEX XII: GBV INCIDENT TRACKING SHEET

Organization Name نوع الحدث	Age groups الفئات العمرية						Grand Total المجموع الكلي
	0-11		12-17		Above 18		
	Male	Female	Male	Female	Male	Female	
Forced Marriage الزواج القسري					0	0	0
Early marriage الزواج المبكر	0	0	0	0			0
Denial of resources opportunities & services by Family member الحرمان من الموارد والفرص والخدمات من قبل فرد من أفراد العائلة	0	0	0	0	0	0	0
Denial of resources opportunities & services by intimate partner الحرمان من الموارد والفرص والخدمات من قبل الشريك الحميم			0	0	0	0	0
Rape by intimate partner الاغتصاب من قبل الشريك الحميم			0	0	0	0	0
Rape by family member الاغتصاب من قبل فرد من أفراد العائلة	0	0	0	0	0	0	0
Rape by other الاغتصاب من قبل آخرين	0	0	0	0	0	0	0
Sexual Assault by intimate partners الاعتداء الجنسي من قبل الشريك الحميم			0	0	0	0	0
Sexual Assault by family member الاعتداء الجنسي من قبل فرد من أفراد العائلة	0	0	0	0	0	0	0
Sexual Assault by other الاعتداء الجنسي من قبل آخرين	0	0	0	0	0	0	0
Psychological/Emotional Abuse by intimate partner الإساءة النفسية/العاطفية من قبل الشريك الحميم			0	0	0	0	0
Psychological/Emotional Abuse by family member الإساءة النفسية/العاطفية من قبل فرد من أفراد العائلة	0	0	0	0	0	0	0
Psychological/Emotional Abuse by other الإساءة النفسية/العاطفية من قبل آخرين	0	0	0	0	0	0	0
Physical Assault by intimate partner الإعتداء الجسدي من قبل الشريك الحميم			0	0	0	0	0
Physical Assault by family member الإعتداء الجسدي من قبل فرد من أفراد العائلة	0	0	0	0	0	0	0
Physical Assault by other الإعتداء الجسدي من قبل آخرين	0	0	0	0	0	0	0
Grand Total المجموع الكلي	0	0	0	0	0	0	0

ANNEX XIII: SECTOR-SPECIFIC TASKS, ROLES AND GOALS TOWARDS GBV SURVIVORS

Remember that:

- Also within one group, different professionals can have different responsibilities (e.g. a protection officer of an NGO has not the same responsibility as a police officer or a lawyer, a nurse has not the same tasks as a doctor...)
- Some tasks and responsibilities may overlap.

The Health Group:

- Ask detailed questions about what happened during the incident
- Ask detailed questions about injuries
- Conduct a medical examination of a survivor
- Document injuries and collect forensic evidence
- Provide emergency contraception, and treatment for injuries and STIs
- Provide a medical certificate
- Provide testimony in court
- Provide information about possible health consequences of sexual violence

The Psychosocial Support Group:

- Where trained professionals are available conduct individual counselling or group counselling and if the survivor appears unusually distressed or is unable to function in daily life, conduct a mental health assessment of the survivor
- Provide skill-training for survivors
- Provide material support to survivors (clothes, food...)*
- Facilitate access to income-generating activities for survivors*
- Ensure that existing clinical mental health services can deal with disorders resulting from sexual violence
- Work with the community to reduce stigma and discrimination against survivors of sexual violence and to mobilize the community to support and protect survivors from further harm

The Protection/Security Group:

- Take detailed statements from survivors, establish facts
- Investigate cases of sexual violence
- Ensure same-sex police officer conducting interviews of survivors or provide a choice to the survivor of the sex of the police officer
- Arrest perpetrators of sexual violence
- File charges with the court
- Identify relevant national laws and policies regarding sexual violence
- Identify traditional systems in the community for protection, problem-solving and/or justice
- Identify high-risk areas in the setting, e.g. where sexual violence incidents occur, where women and girls perceive safety and security risks, etc.
- Establish strategies for improving security to prevent incidents and to protect survivors who want to report incidents.
- Provide information about legal and judicial remedies to survivors
- Provide shelter to survivors
- Share de-identified data about sexual violence cases with other sectors

The Legal Justice Group:

- Provide information about legal justice mechanisms to survivors
- Provide legal counselling and representation to survivors
- Monitor court cases
- Assist survivors in bringing their case to court
- Take detailed statements from a survivor; establish facts
- File charges with the court
- Apply the relevant national laws regarding sexual violence
- Inform survivors about their rights and possibilities for legal action

Roles and goals of everyone dealing with survivors of sexual violence:

- Consider the safety of the survivor
- Provide information about support options to the survivor and manage expectations
- Ensure referral to the appropriate services
- Treat the survivor with dignity, ensure confidentiality
- Show sensitivity, understanding and willingness to listen to the concerns and, if appropriate, the story of the survivor
- Coordinate support with other sectors

Adapted from, UNICEF; Caring For Survivors - General and Psychosocial Module Handouts for Participants

ANNEX XIV: GBV STAFF CORE COMPETENCIES FRAMEWORK

Introduction

There is no clear pathway currently to becoming a GBV expert. The GBV expert's career pathway may involve moving from being a service provider (midwife, counselor, or lawyer) into managing a GBV programme with an NGO or coordinating a GBV working group. GBV coordinators can and are recruited without GBV programme management experience and sometimes move from coordination into programme management positions. Many GBV Programme Managers do not move into interagency GBV coordination positions at all and still others become GBV advisors, technical specialists, or a myriad of other positions – all of which fall under the category of “GBV Expert.” One position is not “higher” than another. As there is currently no agreed upon standards of what training or experience is needed to become a GBV specialist, this competency document strives to outline core competencies needed.

GBV Outreach worker

The GBV Outreach worker is the face and the voice of an organization's programme and services within the community. S/he has to know the community where we work, and at the same time knowing our programme and our GBV approach. S/he should be familiar with the GBV basic concepts and types and know how to do and how to behave when s/he meet a survivor or a vulnerable women or girl. Moreover s/he should be able to engage the community in activities. These staffs have a clear understanding of how to handle disclosure of GBV and how to make referrals in a survivor centered way.

GBV Case Manager / Response officer

Is the person directly involved in service provision to survivors. Most of the time will be offering case management and psychosocial support, but it can even offer basic emotional support, legal support, referral, according to the structure of the programme and specifically to the response strategy of the programme. This person can have different background (social worker, counselor, health worker, lawyer etc.) but to be considered a GBV expert, s/he needs to have additional experience or training specific on GBV programming and services. If the person is not already experienced, s/he will need continuous support and supervision by a GBV Manager or Specialist.

GBV Prevention officer / staff working in community or women centers

Under this category fall the staff who engage women and girls, or community more in general (even men and boys), in activities aimed to prevent GBV, women and girls empowerment, and spread information. Main activities could be community mobilization, develop GBV awareness activities and material and implement it, engage community in workshop, trainings on GBV, spreading information within the community about GBV and the services available for survivors. These persons will ideally combine excellent communication skills within the community they work in, and a good understanding of GBV, the root causes, contributing factors within the community they serve, and effective prevention techniques. These staffs have a clear understanding of how to handle disclosure of GBV and how to make referrals in a survivor centered way.

GBV Programme Managers

In general, GBV programme managers run the programmes and projects that make up the GBV prevention and response in humanitarian emergencies. These programmes may be focused on healthcare, legal response, livelihoods, or many other areas. A GBV Programme Manager plans, organizes, implements and coordinates all activities that make up GBV programme. GBV Programme Managers can work at NGOs, INGOs, CBOs, United Nations agencies, and government agencies.

Interagency GBV Coordinators⁶⁴

In the current humanitarian response mechanisms, the “cluster approach” offers an explicit structure in which GBV coordination can be established. The GBV AoR, which along with three other AoRs works through the Global Protection Cluster, is charged with ensuring good coordination of multi-sectoral interventions for GBV in humanitarian situations. At the country level, the Protection Cluster usually works with a specific GBV coordination body (mechanism), often called “GBV sub-cluster” or “GBV working group”.

COMPETENCES	GBV OUTREACH WORKER	GBV CASE MANAGER/ RESPONSE OFFICER	GBV PREVENTION OFFICER/WGSS WORKER	GBV PROGRAMME MANAGER/SPECIALIST	INTERAGENCY GBV COORDINATOR
CORE COMPETENCES					
Understands and applies survivor-centered approach	X	X	X	X	X
Applies the GBV Guiding Principles including: <ul style="list-style-type: none"> • Safety • Confidentiality • Respect • Non discrimination 	X	X	X	X	X
Believes in gender equality and applies, promotes and integrates gender analysis into humanitarian programming	X	X	X	X	X

⁶⁴ The Competences of GBV Programme manager/Specialist and Interagency GBV Coordinators, are mostly taken from the GBV Area of Responsibility document “Core Competences for GBV Programme Managers and Coordinators in Humanitarian Settings”, GBV AoR, Learning Task Team, December 2014. The entire document, with additional details and specifics for each Core Competence discussed, can be found at <http://gbvaor.net/wp-content/uploads/sites/3/2015/04/Core-Competencies.pdf>

Uses emotional intelligence includes having and showing empathy and active listening and respectful communication	X	X	X	X	X
PROFESSIONAL COMPETENCES					
Demonstrates knowledge of and ability to implement multi-sectorial response to GBV (includes health, psychosocial, security and legal response)				X	X
Has a detailed knowledge of GBV Case Management and is familiar with the tools		X		X	X
Understands the principles of GBV case management and can apply to GBV programmes	X	X	X	X	X
Demonstrates knowledge of and engages effectively with the humanitarian architecture				X	X
Demonstrates knowledge of current GBV prevention theory and identifies and applies appropriate GBV prevention and behavior change strategies at different stages of the humanitarian response			X	X	X
Critically analyzes context, trends and vulnerabilities related to GBV				X	X
Demonstrates knowledge of prevention of sexual exploitation and abuse responsibilities within the humanitarian response and supports implementation	X	X	X	X	X
Locates, adapts, and applies key GBV tools to context including: <ul style="list-style-type: none"> • GBV Coordination Handbook • GBV IMS • WHO Ethical and Safety Recommendations for Researching, documenting and monitoring sexual violence in Emergencies • IASC Guidelines for gender-based violence interventions in humanitarian settings 		X	X	X	X
Applies critical thinking and problem solving to create innovative GBV programming				X	X
Effectively manages GBV programme and projects				X	
Effectively supervises and builds capacity of GBV personnel				X	

Understands and applies concepts of adult learning to build capacity of GBV personnel				X	X
Applies participatory approaches to engaging with and mobilizing communities	X	X	X	X	
Provides strategic planning for GBV prevention and response		X	X	X	X
Understands how to make appeals for funding for GBV prevention and response				X	X
Advocates for GBV prevention and response and in support of GBV survivors		X	X	X	X
Supports other sectors to mainstream GBV prevention and response		X	X	X	X
Understands ethical issues with regards to collecting data and conducts ethical safe GBV assessments		X	X	X	X
Understands, critical issues around GBV data; manages, shares, and uses GBV case data in confidential, safe, and effective manner	X	X	X	X	X
Facilitates a collaborative environment to promote effective coordination	X	X	X	X	X
Fosters effective communication	X	X	X	X	X
Able to collect, compile, analyze data collected during activities		X	X	X	
Able to compile qualitative and quantitative data in reports				X	X
GBV IMS (where applicable): familiar with the Intake Forms		X		X	X
GBV IMS (where applicable): familiar with data storage and analysis (IR)				X	X
GBV IM (where applicable): familiar with the Information Sharing Protocol (ISP)				X	X
BEHAVIOURAL COMPETENCES					
Adapts and Copes with Pressure	X	X	X	X	X
Shows Leadership				X	X
Negotiation and Advocacy	X	X	X	X	X

ANNEX XV: DATA PROTECTION CHECKLIST

For GBV programs to assess their existing data security and develop a customized data protection protocol.

This checklist is designed to be an **active document** that complements your existing Data Protection Protocols. At the time of establishing the GBVIMS, programs should adapt the template Data Protection Protocols for their context. Similarly, Program and Site Managers are encouraged to adapt this checklist to match their Data Protection Protocols. Managers should then review the checklist on a regular basis to ensure that their Data Protection Protocols are being followed.

General data protection

- Staff have been asked to identify security risks specific to their context and to explicitly think through the possible implications for clients, their families and communities, and for the organization, if data gets into the wrong hands. All staff in contact with the data have a strong understanding of the sensitive nature of the data, the importance of data confidentiality and security.
- Staff understand that all cases will be allocated a code based upon an agreed standard coding format, and that the code should be used to refer to the case either verbally or on paper, in place of any identifiable information such as name.
- Clients and/or their caregivers are giving their informed consent for the agency/agencies to gather and store their data before any information is recorded. Staff are aware that when obtaining informed consent, clients may highlight particular information that they do not want shared with certain people, and that this must be recorded and respected. Signed paper consent forms are being kept in a locked filing cabinet.
- Information is not being passed to a third party without the informed consent of clients and/or their caregivers.
- All staff working with data sign the data protection checklist/agreement as part of their hiring process

Paper file security

- Paper documentation for each incident is stored in its own individual file, clearly labeled with the incident number. Names of clients are NOT on the outside of the paper files.
- Paper files are being kept in a locked cabinet / drawer, accessible only to responsible individuals specified by the Site Manager. No one else should be given independent access to the paper files without permission.
- Rooms containing paper and electronic information are being locked securely when the staff leave the room. All staff are aware of the importance of being vigilant as to who is entering the room where they work and for what purpose.

Electronic data security

- All computers being used for data storage are password protected.
- All applicable staff are aware that information should be transferred by encrypted and password-protected files whether this is by internet or memory sticks.
- At least two backups exist – one stored in the location of the database and backed up each day data is entered, and the second sent for secure storage in a designated off-site location (for example: the database copy sent to GBV Program Coordinator once a month). Staff responsible for the data at the second site must follow the same Data Protection Protocols. The reason for having an off-site back-up is so that the main database can be restored in case of technical problems, or destroyed in an emergency evacuation without this meaning the loss of all electronic data. Typically, the on-site back up is an external hard drive which is kept locked in a filing cabinet, and the off-site back up is done through emailing the database to the designated receiver (most likely GBV Coordinator) as an encrypted, password-protected file.

ANNEX XVI: SAMPLE DATA PROTECTION AGREEMENT FOR STAFF

Data protection and data security is the responsibility of every member of staff who works with survivors or has access to survivor information. Staff should be clear about why they are collecting data and should not collect or share any personal information other than in accordance with best practices and international standards.

Data on gender-based violence is particularly sensitive. It should only be processed, with the individual's explicit, written consent, adhering to the principles of 'need to know.'

Please read and comply with the following guidance (please initial each point and sign below):

- _____ I agree to follow the guidelines in the GBVIMS Data Security Protocol for all GBV data.
- _____ I will not access the GBVIMS or the Primero database or other client files when I am at home or in a public, non-private setting.
- _____ I will not share any GBV data (individual or aggregate) with anyone outside of IRC and not without the express written permission of the survivor and following the proper protocols at my office. Inter-agency data sharing must go through/be approved by a central focal point, for example, the WPE Coordinator.
- _____ I know that survivors have a right to access their personal information therefore I will be accurate and measured in what I write about survivors and other members of IRC or other agencies.
- _____ I will keep all paper files containing personal information locked in a secure location (lockable filing cabinet, safe) per the office protocol.
- _____ I will not share my log-in information or passwords for the GBVIMS or Primero database.

Staff Signature _____

Date _____

ANNEX XVII: MINIMUM CRITERIA TO BE PART OF THE REFERRAL PATHWAY

All criteria listed here constitute the minimum criteria a service provider must have to be part of the referral pathways. Compliance with all criteria will be mandatory and a prerequisite to be part of the referral pathways.

	MINIMUM CRITERIA	REQUIREMENTS
1	PRESENCE	To be part of the referral pathway, organizations are required to have operational presence in the area of Syria reachable from the cross-border operation from Turkey, as well as access to affected population either directly or through implementing partners.
2	LEGAL STATUS	Referral pathways only comprise those organizations that for legal status are defined as a NGO or a humanitarian organization/service provider and those that, for mandate, have as first responsibility to respond to needs of the affected population.
3	ADHERANCE TO HUMANITARIAN PRINCIPLES	To be part of the referral pathway, an organization (and its implementing partners) must have a Code of Conduct and PSEA policy in place.
4	COMMITMENT	Senior management of an organization must: <ul style="list-style-type: none"> • endorse the SOPs; • ensure adherence to the minimum standards in GBV prevention and response; • guarantee that GBV guiding principles, minimum criteria and information sharing protocol are well understood and respected among staff; and, • ensure relevant personnel inside the organization are kept aware of and comply with the SOPs and referral pathways.
5	MEMBERSHIP	Organizations (and their implementing partners) that: <ul style="list-style-type: none"> • are part of the GBV SC and that deliver GBV response services; and/or, • are part of Health Cluster and that deliver CMR or more general clinical care for GBV survivors

6	SERVICE DELIVERY	<p>Services included in the referral pathway are:</p> <ul style="list-style-type: none"> • Case management for GBV survivors • CMR for GBV survivors • Mental health for GBV survivors • Focused PSS for GBV survivors • Safe shelters for GBV survivors • Women & girls' safe spaces • Psychosocial support and recreational activities • PFA • Vocational training, livelihood and economic empowering programmes for GBV survivors or women at risk • Material assistance for GBV survivors (e.g., cash, shelter, NFI, dignity k, hygiene kits)
7	CAPACITIES	<p>To make and receive the referral of GBV survivors, organizations need to have following capacities:</p> <ul style="list-style-type: none"> • Structure (i.e., dedicated personnel, tools, internet or phone connection) • Infrastructure (i.e., specialized centers, confidential space) • Technical expertise (i.e., trained and experienced management, trained services providers, access to training) <p>If for a specific and temporary situation those capacities are not available, organizations need to aim at ensuring adherence to the SOPs as much as possible. When GBV guiding principles cannot be guaranteed due to the lack of capacities, organizations should not deliver GBV response services.</p>
8	HUMAN RESOURCES	<p>To ensure good quality of services, organizations should have trained and dedicated staff for GBV response services.</p> <p>To be part of the referral pathway, organizations must provide at least two Managerial Focal Points and two Service Focal Point through the service-mapping tool.</p>
9	MINIMUM STANDARDS	<p>The referral of GBV survivors and the delivery of services are based on the minimum standards described in these SOPs. To be part of the referral pathways, organizations must agree with and endorse the content of the SOPs.</p>
10	KNOWLEDGE	<p>GBV services providers should have been trained in their areas of expertise and be professionally prepared to deal with GBV survivors.</p>

ANNEX XVIII: GBV REFERRAL PATHWAY

مسار الإحالة في حالات العنف القائم على النوع الاجتماعي - المنطقة:

GBV REFERRAL PATHWAY - District

Confidential | سري

Call/WhatsApp the GBV SC at 00905372677138 for any information about referrals, including for any questions on how to make a referral; if any information in the referral pathways is incorrect or the service is not available; or to request additional referral pathways. The GBV SC will always be available to support you as needed.

اتصل او ارسل رسالة نصية على الواتس أب للكتلة الفرعية للعنف القائم على النوع الاجتماعي على الرقم 00905372677138 من أجل أي معلومة تخص الإحالة. متضمنة أي أسئلة عن كيفية القيام بالإحالة، في حال كانت أي من المعلومات ضمن مسارات الإحالة غير صحيحة أو كانت الخدمة غير متوفرة، أو لطلب مسارات إحالة إضافية. فإن الكتلة الفرعية للعنف القائم على النوع الاجتماعي ستكون جاهزة دائما لدعمك عند الحاجة

In case different services providers are available in the location where the survivor was identified, choose the one that is most accessible and convenient for you. In case no service is available in the location where the survivor was identified, please consider the nearest service or the most accessible. Distance from the service provider should not be a reason for not referring, consider that many service providers offer mobile services or can provide transportation. MAKE SURE THAT YOU REFER ALL CASES

في حال توفر عدة مزودي خدمة في الموقع الذي تم التعرف فيه على الناجية، اختر المزود الأكثر ملائمة وقابلية للوصول بالنسبة لك. في حال عدم توفر في الموقع الذي تم التعرف فيه على الناجية، يرجى اختيار الخدمة الأقرب والأكثر قابلية للوصول. إن المسافة عن مزود الخدمة لا يجب أن تكون سبباً لعدم القيام بالإحالة، يرجى أخذ العلم أن العديد من مزودي الخدمة يقدمون خدمات متنقلة ويمكنهم تأمين المواصلات. يرجى تحويل كافة الحالات.

إخبار أحد ما والسعي للحصول عن المساعدة (الإفصاح)

TELLING SOMEONE AND SEEKING HELP (DISCLOSING)

يقوم الناجي بإخبار العائلة، الأصدقاء أو أعضاء المجتمع ومزودي الخدمة، أو مركز تسجيل اللاجئين، ويقوم الشخص التي تم إبلاغه بمرافقة الناجي إلى مركز العلاج الأولي الطبي/ النفسي الاجتماعي أو مدير الحالة.

مبادرة الناجي بالإبلاغ طوعية إلى مركز العلاج الأولي الطبي/الصحي/النفسي الاجتماعي، أو مدير الحالة

Survivor tells about the GBV incident to family, friends, community member, general service provider or at refugee registration services, that person accompanies survivor to the health or case manager /psychosocial "entry point".

Survivor self-reports a GBV incident to a medical/health or case manager/psychosocial "entry point".

IMMEDIATE RESPONSE:

الاستجابة المبدئية:

- Provide a safe, caring environment and respect the confidentiality and wishes of survivor.
- Provide reliable and comprehensive information on available services and support to survivor.
- If agreed and requested by survivor, obtain informed consent and make referral.
- When family/guardians make a decision on behalf of the child, ensure the best interest of the child is given priority. Preferably, the accompanying adult should be selected by the child.
- Accompany the survivor to assist his/her in accessing services.
- For survivor of sexual violence, ensure immediate (within 72 hours) access to medical care.
- Remember: **Recent sexual violence is a medical EMERGENCY!**

- تأمين بيئة آمنة، تقدم الرعاية وتحترم سرية ورغبات الناجين.
- تقديم معلومات موثوقة وشاملة عن الدعم والخدمات المتاحة للناجين.
- قم بالإحالة بعد الحصول على الموافقة الطوعية من قبل الناجي/ة وبناءً على طلبه/ها.
- عندما تقدم العائلة أو ولي الأمر على اتخاذ قرار بالنيابة عن الطفل، تأكد من إعطاء الأولوية للمصلحة الفضلى للطفل.
- يفضل ان يكون المرافق البالغ قد تم اختياره من قبل الطفل نفسه.
- مرافقة الناجي/ة لمساعدته/ها في الحصول على الخدمات.
- في حالات الناجين من العنف الجنسي، تأكد من حصول الناجي/ة على الرعاية الطبية الفورية خلال 72 ساعة.
- تذكر: حالات العنف الجنسي الحديثة تعتبر حالات طبية طارئة (إسعافية).

التدبير السريري للاغتصاب

إدارة الحالة والدعم النفسي والاجتماعي المخصص

Clinical Management of Rape

GBV Case management and Focused PSS

حالياً في منطقة العمليات قد تكون خدمات الأمن والخدمات القانونية قد لا تتوفر خدمات مرتكزة على الناجين لذلك لم يتم تضمينها في مسارات الإحالة

N.B. Currently, in the area of operation security and legal services may not be available or able to offer survivor-centered services, therefore are not part of this referral pathway.

بعد الاستجابة الفورية تتم المتابعة وتقديم الخدمات الأخرى

وذلك مع مرور الزمن وبناءً على خيارات الناجين وقد تتضمن كل من التالي:

After immediate response, follow-up and Refer to other available services

Based on survivor's choices additional services to refer to can include any of the following:

الرعاية الصحية (متضمنة الصحة العقلية والصحة الإنجابية)	خدمات أخرى (حماية عامة وحماية طفل)	الاحتياجات الأساسية (مواد غير غذائية, دعم نقدي, سبل حفظ الكرامة... الخ)
Health (Including Mental Health and Reproductive Health)	Other (Protection and Child Protection) Services	Basic Services (Cash, NFI, Dignity Kits etc..)

المراكز | Centers

المساحات الآمنة للنساء والفتيات	المساحات الصديقة للطفل	المراكز المجتمعية
Women Girls Safe Spaces	Child Friendly Spaces	Community Centers

ANNEX XIX: GUIDELINES FOR OBTAINING INFORMED CONSENT/INFORMED ASSENT FROM CHILDREN AND CAREGIVERS

The age at which parental consent is needed for a child depends on the laws of the country. This means that when the child is under the age of legal consent, caregiver consent is required. In the absence of any clear laws or adherence to laws, children under the age of 15 require caregiver consent as a general rule.

Infants and Toddlers (ages 0–5)

Informed consent for children in this age range should be sought from the child's caregiver or another trusted adult in the child's life, not from the child. If no such person is present, the service provider (case worker, child protection worker, health worker, etc.) may need to provide consent for the child, in support of actions that support their health and well-being. Very young children are not sufficiently capable of making decisions about care and treatment. For children in this age range, informed assent will not be sought. The service provider should still seek to explain to the child all that is happening, in very basic and appropriate ways.

Younger Children (ages 6–11)

Typically, children in this age range are neither legally able nor sufficiently mature enough to provide their informed consent for participating in services. However, they are able to provide their informed assent or "willingness" to participate. Children in this age range should be asked their permission to proceed with services and actions which affect them directly. This permission can be provided orally by the child, and documented as such on the informed consent form. For children in this age range, written parental/caregiver informed consent is required, along with the child's informed assent. If it is not possible to obtain informed consent from a parent or caregiver, then another trusted adult, identified by the child, who can be safely brought into care and treatment decisions should be approached to consent for the child.

Younger Adolescents (ages 12–14)

Children in this age range have evolving capacities and more advanced cognitive development, and, therefore, may be mature enough to make decisions on and provide informed assent and/ or consent for continuing with services. In standard practice, the caseworker should seek the child's written informed assent to participate in services, as well as the parent/caregiver's written informed consent. However, if it is deemed unsafe and/or not in the child's best interest to involve the caregiver, the caseworker should try to identify another trusted adult in the child's life to provide informed consent, along with the child's written assent. If this is not possible, a child's informed assent may carry due weight if the caseworker assesses the child to be mature enough, and the caseworker can proceed with care and treatment under the guidance and support of his/her supervisor. In these situations, caseworkers should consult with their supervisors for guidance.

Older Adolescents (ages 15–17)

Older adolescents, ages 15 years and above, are generally considered mature enough to make decisions. In addition, 15-year-olds are often legally allowed to make decisions about their own care and treatment, especially for social and reproductive health care services. This means that older adolescents can give their informed consent or assent in accordance with local laws. Ideally, supportive and non-offending caregivers are also included in care and treatment decision-making from the outset and provide their informed consent as well. However, decisions for involving caregivers should be made with the child directly in accordance with local laws and policies. If the adolescent (and caregiver) agrees to proceed, the caseworker documents their informed consent using a client consent form or documenting on the case record that they have obtained verbal consent to proceed with case management services.

Special Situations

If it is not in the best interest of the child to include a caregiver in the informed consent process, the caseworker needs to identify whether there is a trusted adult in the child's life who can provide consent. If there is no other trusted adult to provide consent, the caseworker needs to determine the child's capacity in decision-making based on their age and level of maturity.

If a child under 15 does not assent but caregivers do OR if both the child and caregiver do not consent OR the child above 15 does not consent, the caseworker needs to decide on a case-by-case basis and based on the child's age, level of maturity, cultural/traditional factors, the presence of caregivers (supportive), and the urgency of care needs, whether it is appropriate to go against the wishes of the child and/or caregiver to proceed with case management and assisting the child so that they can receive needed urgent care and treatment services.

ANNEX XX: HUMAN RIGHTS AND MEDICAL CARE FOR SURVIVORS OF RAPE

Rape is a form of sexual violence, a public health problem and a human rights violation. Rape in war is internationally recognized as a war crime and a crime against humanity, but is also characterized as a form of torture and, in certain circumstances, as genocide. All individuals, including actual and potential victims of sexual violence, are entitled to the protection of, and respect for, their human rights, such as the right to life, liberty and security of the person, the right to be free from torture and inhuman, cruel or degrading treatment, and the right to health. Health care providers should respect the human rights of people who have been raped.

Right to health: Survivors of rape and other forms of sexual abuse have a right to receive good quality health services, including reproductive health care to manage the physical and psychological consequences of the abuse, including prevention and management of pregnancy and STIs. It is critical that health services do not in any way "revictimize" rape survivors.

Right to human dignity: Persons who have been raped should receive treatment consistent with the dignity and respect they are owed as human beings. In the context of health services, this means, as a minimum, providing equitable access to quality medical care, ensuring patients' privacy and the confidentiality of their medical information, informing patients and obtaining their consent before any medical intervention, and providing a safe clinical environment. Furthermore, health services should be provided in the mother tongue of the survivor or in a language she or he understands.

Right to non-discrimination: Laws, policies, and practices related to access to services should not discriminate against a person who has been raped on any grounds, including race, sex, color, or national or social origin. For example, providers should not deny services to women belonging to a particular ethnic group.

Right to self-determination: Providers should not force or pressure survivors to have any examination or treatment against their will. Decisions about receiving health care and treatment (e.g. emergency contraception and pregnancy termination, if the law allows) are personal ones that can only be made by the patient herself. In this context, it is essential that the survivor receives appropriate information to allow her to make informed choices. Survivors also have a right to decide whether, and by whom, they want to be accompanied when they receive information, are examined or obtain other services. These choices must be respected by the health care provider.

Right to information: Information should be provided to each client in an individualized way. For example, if a woman is pregnant as a result of rape, the health provider should discuss with her all the options legally available to her (e.g. abortion, keeping the child, adoption). The full range of choices must be presented regardless of the individual beliefs of the health provider, so that the survivor is able to make an informed choice.

Right to privacy: Conditions should be created to ensure privacy for people who have been sexually abused. Other than an individual accompanying the survivor at her request, only people whose involvement is necessary in order to deliver medical care should be present during the examination.

Right to confidentiality: All medical and health status information related to survivors should be kept confidential and private, including from members of their family. Health staff may disclose information about the health of the survivor only to people who need to be involved in the medical examination and treatment,

or with the express consent of the survivor. In cases where a charge has been laid with the police or other, the relevant information from the examination will need to be conveyed.

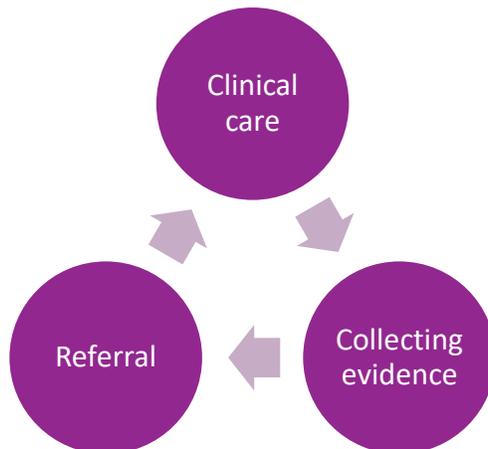
WHO, Clinical Management of Rape Survivors, 2004

ANNEX XXI: CORE HEALTH CARE ELEMENTS

Clinical Care

- Taking a detailed history of the incident
- Performing and documenting a thorough physical examination
- Providing treatment for injuries
- Evaluating the patient for sexually transmitted infections and providing preventive care
- Pregnancy prevention
- Providing supportive counselling and psychosocial support
- Following-up through subsequent visits

Please note: The first 72 hours following a rape can be critical to the survivor's physical health. Certain lifesaving medical treatments are only effective if administered during this short window. Informational and educational materials should emphasize the importance of seeking medical care as soon as possible following an incident of sexual violence. Waiting too long could have serious, and even fatal, implications.



Referral

Good quality, compassionate care means providing:

- Referrals for additional assistance and services
- Information on possible additional services that survivors might want:
- Psychosocial support
- Security
- Legal aid
- Livelihood programmes

Service providers should provide information about what services are available and where/how the survivor can access them. However, a survivor should never be pressured into seeking additional services. It is up to the individual survivor to decide to take the referral.

Collecting Evidence

- Collecting evidence to support a criminal investigation, as appropriate to the context
- May include collection of forensic material (from the survivor's body and/or clothing), photographs of injuries, etc.
- In some cases, the evidence may be kept for a period of time, in case the survivor decides to pursue legal action at a later date.

IMPORTANT! The health sector response to sexual violence does not include the determination of whether rape has occurred. The role of the health care provider is to indicate all examination findings objectively and accurately and to provide treatment.

Adapted from UNFPA, Managing gender-based violence programmes in emergencies, 2012.