Cox's Bazar GBV Sub-Sector

Interagency Gender-Based Violence (GBV)

Standard Operating Procedure (SOP)

Cox's Bazar Bangladesh

Standard Operating Procedures for GBV Interventions in Humanitarian Settings

STANDARD OPERATING PROCEDURES

FOR GBV INTERVENTIONS IN HUMANITARIAN SETTINGS[1]

PREFACE

Gender-based violence (GBV) is a serious violation of human rights and a life-threatening health and protection issue. When people are forcibly displaced, they face heightened risks of physical, sexual, and psychological violence, including rape, sexual abuse, and trafficking. Although anyone—women, girls, and boys—can fall victim to violence based on their sex or gender, women and girls are particularly vulnerable. It is estimated that one in three women will experience sexual or physical violence in their lifetime.

The aim of this SOP is to outline a set of standards on GBV response, risk mitigation and responses to be met at minimum level by all stakeholders and facilities. In doing so, the service standard identifies measurable input, processes and output criteria that need to be applied to make GBV interventions uniform across all levels.

GBV SOPs serve as a powerful tool for achieving shared ownership among local, national, and international actors. They facilitate coordination and implementation of safe and accessible GBV case managements, medical, legal, safety and security, MHPSS, referrals as well as GBV prevention and risk mitigation interventions. It also addresses linkages among sectors that extend beyond the basics of GBV response, aiming for comprehensive GBV programming.

The document is the result of extensive consultation workshops with government ministries, national and international NGOs, academic institutions, and women's civil society organizations.

Therefore, we call upon all government and non-government actors, as well as development partners, to foster collaborative efforts and synergy, and to collectively work towards the prevention and elimination of all forms of GBV — with a view to ensuring the full participation and equitable benefit of women and children.

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

Contents

Acronyms

AAP - Accountability to Affected Populations

AGD - Age, Gender, Diversity

CBO - Community-Based Organization

CEDAW - Convention on the Elimination of All Forms of Discrimination against Women

CM - Case Management

CMR - Clinical Management of Rape

CP - Child Protection

CPSS - Child Protection Sub-Sector

CSO - Civil Society Organizations

DSW - Department of Social Welfare

DV - Domestic Violence

FGM/C - Female Genital Mutilation/Cutting

FIR - First Incident Report

GBV - Gender-Based Violence

GBVIMS - Gender-Based Violence Information Management System

GBVSS - Gender-Based Violence Sub-Sector

IDP - Internally Displaced Person

IM - Information Management

IPV - Intimate Partner Violence

ISNA - Inter Sectoral Needs Analysis

ISCG - Inter Sector Coordination Group

IGO - Inter-Governmental Organization

JRP - Joint Response Plan

LGBTIQ+ - Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, and Others

MHH - Menstrual Health and Hygiene

MHM - Menstrual Hygiene Management

MHPSS - Mental Health and Psychosocial Support

MSNA - Multi-Sector Needs Analysis

NGO - Non-Governmental Organization

PFA - Psychological First Aid

PoC - Persons of Concern

PSEA - Protection from Sexual Exploitation and Abuse

SEA - Sexual Exploitation and Abuse

SGBV - Sexual and Gender-Based Violence

SOGIESC - Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics

SOP - Standard Operating Procedures

SRH - Sexual and Reproductive Health

SRHR - Sexual Reproductive Health and Rights

SV - Sexual Violence

UN - United Nations

UNFPA - United Nations Population Fund

UNHCR - United Nations High Commissioner for Refugees

VAWG - Violence Against Women and Girls

WFS - Women-Friendly Spaces

WGSS - Women and Girls Safe Spaces

WHO - World Health Organization

Definitions

Common terms and definitions used in this document are defined below and listed in alphabetical order.[2] These terms and definitions are not legal definitions, nor are they intended as such. The definitions of many of the types of violence provided here are based on commonly accepted global standards. Local and national legal systems may define these terms differently and/or may have other legally recognized forms of GBV that are not universally accepted as GBV. When developing the SOPs, the list of definitions should be revised and aligned with terminology used in context.

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

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

Adolescent: Any person between the ages of 10-19 years old. Adolescence can be broken down into the following sub-group: pre-adolescence (9–10), early adolescence (10–14), middle adolescence (15–17) and late adolescence (18–19).[3]

Adult: Any person 18 years and older.

Advocacy: The deliberate and strategic use of information, initiated by individuals or groups of individuals, to bring about change. Advocacy includes employing strategies to influence decision makers and policies with a view to changing attitudes, power relations, social relations and institutional functioning to improve the situation for groups of individuals who share similar problems.[4]

Affected people: For UNHCR, the terms affected people and affected populations, common in inter-agency settings, generally refer to persons of concern to UNHCR, in line with the

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

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

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

organization's mandate for refugees, asylum-seekers, refugee returnees, stateless people and the internally displaced. In many situations, affected people may also refer to communities hosting persons of concern to UNHCR.[5]

Assessment: Assessments can be defined as the set of activities necessary to understand a given situation. They include the collection, updating and analysis of data pertaining to the population of concern (needs, capacities, resources, etc.) as well as the state of infrastructure and general socio-economic conditions in a given location/area. In humanitarian settings, NGOs and United Nations agencies often carry out assessments to identify community needs and gaps in coordination and then use this information to design effective interventions.[6]

Asylum seekers: An individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which the claim is submitted. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee was initially an asylum-seeker.[7]

Case action plan: The case document that outlines the main needs of the survivor and goals and strategies for meeting their needs and improving their current condition.[8]

Case conference (or meeting): Case conferences are meetings with the survivor, concerned support people in the survivor's life as appropriate and service providers involved in the survivor's care when the survivor's needs are not being met in a timely or appropriate manner. The survivor should be invited but is not required to participate. The purpose of the case conference is to identify or clarify ongoing issues regarding her care. Case conferences provide an opportunity to review activities, including progress and barriers towards goals; map roles and responsibilities; resolve conflicts or strategize solutions and adjust action plans.[9]

Case documentation: This is information related to the provision of case management services. Generally, this information includes dates of services; the specific service provider; a brief description of the situation and the person's responses to the subject matter; relevant action

[5] UNHCR, Master Glossary of Terms .
[6] IASC GBV Guidelines (2015), p. 338.
[7] UNHCR, Master glossary of terms
[8] Inter-Agency GBV Case Management Guidelines (2017), p.243
[9] Ibid, p. 243.

plans and follow-up appointment information. Case documentation also includes dates and reasons for closing the person's case.[10]

Caseworker: This term describes an individual working within a service-providing agency who is responsible for providing case management services to clients. This means that caseworkers are trained appropriately in client-centered case management; they are supervised by senior programme staff and adhere to a specific set of systems and guiding principles designed to promote health, hope and healing for their clients. Caseworkers are also commonly referred to as social workers and case managers, among other terms.[11]

Child: Every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier.[12]

Denial of resources, opportunities or services: Denial of rightful access to economic resources/assets or livelihoods opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. "Economic abuse" is included in this category. Some acts of confinement may also fall under this category.[13]

Disclosure: The process of revealing information. Disclosure in the context of this document refers to a survivor voluntarily sharing with someone that she has experienced or is experiencing gender-based violence.[14]

Disability: An evolving concept that results from the interactions between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.[15]

Domestic violence (DV): Although DV and intimate partner violence (IPV) are sometimes used interchangeably, there are important distinctions between them. "Domestic violence" is a term used to describe violence that takes place within the home or family between intimate partners

[10] Ibid, p. 243.
[11] Ibid, p. 244.
[12] United Nations Convention on the Rights of the Child, Art.1.
[13] IASC GBV Guidelines (2015), p. 335.
[14] Inter-Agency GBV Case Management Guidelines (2017), p. 244.
[15] Convention on the rights of persons with disabilities, Preamble.

as well as between other family members.[16] "Intimate partner violence" applies specifically to violence occurring between intimate partners (married, cohabiting, boyfriend/girlfriend or other close relationships) and is defined by WHO as 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. See definition of intimate partner violence.

Disaster: A serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses that exceed the ability of the affected community or society to cope using its own resources. Disasters can be slow-onset (such as drought or socio-economic decline) or sudden-onset (such as earthquakes, floods or sudden conflict situations).[17]

Economic abuse: An aspect of abuse where abusers control victims' finances to prevent them from accessing resources, working or maintaining control of earnings, achieving self-sufficiency and gaining financial independence.[18]

Emergency: An event or series of events that represents a critical threat to the health, safety, security or wellbeing of a community or other large group of people, usually over a wide area.[19]

Emotional abuse (also referred to as psychological abuse): Infliction of mental or emotional pain or injury. Examples include threats of physical or sexual violence, intimidation, humiliation, forced isolation, social exclusion, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc. "Sexual harassment" is included in this category of GBV.[20]

Empowerment of women and girls: The empowerment of women and girls concerns women and girls gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources and actions to

[16] The Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) Art.3.
[17] UNDRR, Sendai Framework Terminology on Disaster Risk Reduction
[18] IASC GBV Guidelines (2015), p. 321.
[19] Humanitarian Coalition. What is a humanitarian-emergency
[20] IASC GBV Guidelines (2015), p. 321.

transform the structures and institutions that reinforce and perpetuate gender discrimination and inequality.[21]

Female genital mutilation/cutting (FGM/C): Refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.[22]

Female infanticide and sex-selective abortion: Sex selection can take place before a pregnancy is established, during pregnancy through prenatal sex detection and selective abortion or following birth through infanticide (the killing of a baby) or child neglect. Sex selection is sometimes used for family balancing purposes but far more typically occurs because of a systematic preference for boys.[23]

Forced marriage and child (also referred to as early) marriage: Forced marriage is the marriage of an individual against her or his will. Child marriage is a formal marriage or informal union before age 18. Even though some countries permit marriage under the age of 18, international human rights standards classify these as forced marriages because those under age 18 are unable to give informed consent for these actions. Therefore, child marriage is a form of forced marriage as children are not legally competent to agree to such unions.[24]

Gender: Refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context- and time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities and power relations. Gender is part of the broader socio-cultural context.[25]

Gender-based violence (GBV): An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and

[21] UNWOMEN, Gender Equality Glossary
[22] IASC GBV Guidelines (2015) , p.321.
[23] Ibid, p.321.
[24] Ibid, p. 321.
[25] Ibid, p. 325.

females. The term "gender-based violence" is primarily used to underscore the fact that structural, gender-based power differentials between males and females around the world place females at risk for multiple forms of violence.[26]

As agreed in the *Declaration on the Elimination of Violence against Women* (1993), this includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life. The term is also used by some actors to describe some forms of sexual violence against males and /or targeted violence against people, especially women and girls, with diverse sexual orientations and gender identities (see SOGIESC definition, below), in these cases when referencing violence related to gender-inequitable norms of masculinity and/or norms of gender identity.

Gender-based violence (GBV) case management: GBV case management, which is based on social work case management, is a structured method for providing help to a survivor.[27] It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way and providing the survivor with emotional support throughout the process. GBV case management services require specialized intervention from a range of service providers to meet a survivor's immediate needs and support long-term recovery. Effective GBV case management ensures adherence to the GBV Guiding Principles. Case management for child survivors will be guided by the best interests of the child.

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

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

Gender equality: Refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men are the same but that women's and men's rights, responsibilities and opportunities do not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men

[26] Ibid, p. 322.
[27] Inter-Agency GBV Case Management Guidelines (2017), p. 243.

are taken into consideration, recognizing the diversity of different groups of women and men. Gender equality is not a women's issue but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a precondition for and indicator of sustainable people-centered development.[28]

Gender equity: Refers to fairness and justice in the distribution of benefits and responsibilities between women and men, according to their respective needs. It is considered part of the process of achieving gender equality and may include equal treatment (or treatment that is different but considered equivalent) in terms of rights, benefits, obligations and opportunities.[29]

Gender mainstreaming: A strategy that aims to bring about gender equality and advance women's rights by building gender capacity and accountability in all aspects of an organization's policies and activities, thereby contributing to a profound organizational transformation. It involves making gender perspectives – what women and men do and the resources and decision-making processes they have access to – more central to all policy development, research, advocacy, development, implementation and monitoring of norms and standards, and planning, implementation and monitoring of projects.[30]

Gender roles: A set of social and behavioral expectations or beliefs about how members of a culture should behave according to their biological sex; the distinct roles and responsibilities of men, women and other genders in a given culture. Gender roles vary among different societies and cultures, classes, ages and during different periods in history. Gender-specific roles and responsibilities are often conditioned by household structure, access to resources, specific impacts of the global economy and other locally relevant factors such as ecological conditions.[31]

Gender relations: The ways in which a culture or society defines rights, responsibilities and the identities of men and women in relation to one another.[32]

Harmful traditional practices: Cultural, social and religious customs and traditions that can be harmful to a person's mental or physical health. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women and girls. These harmful traditional

[28] IASC GBV Guidelines (2015), p. 325.
[29] Ibid, p. 325.
[30] Ibid, p. 325.
[31] Ibid, p. 325.
[32] Ibid, p. 325.

practices may include female genital mutilation/cutting (FGM/C); forced feeding of women; child marriage; the various taboos or practices that prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price. Other harmful traditional practices include binding, scarring, burning, branding, violent initiation rites, fattening, forced marriage, killings in the name of honor, dowry-related violence, exorcism or "witchcraft".[33]

Host community: A community that hosts large populations of refugees or internally displaced persons, whether in camps, integrated into households or independently.[34]

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

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

Informed assent: Willingness to participate in services expressed by younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services. [35] Consent from parents/guardians is not necessary where it is not in the best interests of the child to share information with their parents/guardians or where the parents/guardians are not reachable. The information provided and the way in which

[33] Ibid, p. 322.
[34] UNHCR, Master Glossary of Terms
[35] Inter-Agency GBV Case Management Guidelines p. 245.

consent/assent is expressed must be appropriate to the age and capacity of the child and to the particular circumstances in which it is given.[36]

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

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

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

Internally displaced people (IDP): Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters and who have not crossed an internationally recognized state border. "Internally displaced persons" is an interchangeable term.[37]

Intimate partner violence (IPV): Although IPV and domestic violence (DV) are sometimes used interchangeably, there are important distinctions between them. "Intimate partner violence" applies specifically to violence occurring between intimate partners (married, cohabiting,

[36] UNHCR Best interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child (2021), p 13.
[37] Policy on UNHCR's Engagement in Situations of Forced Displacement (2019), p.10.

boyfriend/girlfriend or other close relationships)[38] and is defined by WHO as 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. "Domestic violence" is a term used to describe violence that takes place within the home or family between intimate partners as well as between other family members. See definition of domestic violence.

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

Mandatory reporting: This refers to state laws and policies that mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected forms of interpersonal violence (e.g. physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).[39] Mandatory reporting may also be applied in cases where a person is a threat to themselves or another person. Mandatory reporting is a responsibility for humanitarian actors who hear about and/or receive a report of sexual exploitation or abuse committed by a humanitarian actor against a member of the affected population.

Menstrual health and hygiene (MHH): Menstrual health and hygiene (MHH) encompasses both menstrual hygiene management (MHM) and the broader systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment and rights.[40] These systematic factors have been summarized by UNICEF as accurate and timely knowledge, available, safe and affordable materials, informed and comfortable professionals, referral and access to health services, sanitation and washing facilities, positive social norms, safe and hygienic disposal and advocacy and policy.

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

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[38] IASC GBV Guidelines (2015), p 321.

[39] Inter-Agency GBV Case Management Guidelines, p 246.

[40] Global Water Security and Sanitation Partnership, Menstrual Health and Hygiene Resource Package, Tools and Resources for Task Teams (2021), p 13.

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

Mental health and psychosocial support (MHPSS): A composite term used in these guidelines to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders.[41] An MHPSS approach is a way to engage with and analyze a situation and provide a response, taking into account both psychological and social elements. This may include support interventions in the health sector, education, community services, protection and other sectors.

Migrants: There is no universally accepted definition of the term migrant, and the term is not defined by international law. Traditionally, the word migrant (or, more accurately, international migrant) has been used to refer to people who choose to move across international borders, not because of a direct threat of persecution, serious harm or death, but exclusively for other reasons, such as to improve their conditions by pursuing work or education opportunities or to reunite with family. Migrants in this sense of the word – unlike refugees – continue in principle to enjoy the protection of their own government, even when they are abroad. If they return, they will continue to receive that protection. Nevertheless, the word migrant is used by some actors as an umbrella term to refer to any person who moves within a country or across a border, temporarily or permanently and for a variety of reasons. In this sense, the term covers legally defined categories such as migrant workers and smuggled migrants, as well as others whose status or means of movement is not specifically defined under international law, such as international students. UNHCR recommends that – except in very specific contexts (notably statistical: see below) – the word migrant should not be used as a catchall term to refer to refugees or to people who are likely to be in need of international protection, such as asylum-seekers. To do so risks undermining access to the specific legal protections that States are obliged to provide to refugees.[42]

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

Nexus: A "nexus approach", "nexus programming" or "the nexus" is shorthand for the concept of a "humanitarian-development nexus" or a "humanitarian-development-peace nexus". It focuses

[41] IASC Guidelines on mental health and psychosocial support in emergency settings, 2007. p. 1.
[42] UNHCR, Master Glossary of Terms

on the work needed to coherently address people's vulnerability before, during and after crises. It is an approach or framework that takes into account both the immediate and long-term needs of affected populations and enhances opportunities for peace. Other understandings of the nexus go further, to include a full range of diplomatic and security measures.[43]

Perpetrator: Person, group or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will.[44]

Physical assault: An act of physical violence that is not sexual in nature.[45] Examples include hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.

Prevention: Generally, refers to taking action to stop GBV from first occurring (e.g. scaling up activities that promote gender equality; working with communities, particularly men and boys, to address practices that contribute to GBV, etc.).[46]

Protection from sexual exploitation and abuse (PSEA): As highlighted in the Secretary-General's "Bulletin on special measures for protection from sexual exploitation and sexual abuse" (ST/SGB/2003/13), PSEA relates specifically to the responsibilities of international humanitarian, development and peacekeeping actors to prevent incidents of sexual exploitation and abuse committed by United Nations, NGO and inter-governmental (IGO) personnel against the affected population, to set up confidential reporting mechanisms and to take safe and ethical action as quickly as possible when incidents do occur.[47]

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.[48]

[43] Oxfam, The Humanitarian-Development Nexus: What does it mean for multi-mandated organizations? (2019).
[44] Inter-Agency GBV Case Management Guidelines (2017), p. 246.
[45] IASC GBV Guidelines (2015), p.346.
[46] Ibid, p.11.
[47] Ibid, p. 326.
[48] Inter-Agency GBV Case Management Guidelines , p. 246.

Rape:[49] Physically forced or otherwise coerced penetration, even if slight, of the vagina, anus or mouth with a penis or other body part. It also includes penetration of the vagina or anus with an object. Rape includes marital rape and anal rape/sodomy. The attempt to do so is known as attempted rape.[50] Rape of a person by two or more perpetrators is known as gang rape.[51]

Refugee: Any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion or because of conflict, generalized violence or other circumstances that have seriously disturbed public order, is outside the country of her or his nationality and is unable to or, owing to such fear, is unwilling to avail herself or himself of the protection of that country. This person, as a result, requires international protection.[52]

Resettlement: The selection and transfer of refugees from a State in which they have sought treaty protection to a third State that has agreed to admit them – as refugees – with permanent residence status. The status provided ensures protection against refoulement and provides resettled refugees and their dependents with access to rights similar to those enjoyed by nationals. Resettlement also carries with it the opportunity to eventually become a naturalized citizen of the resettlement country. As such, resettlement is a mechanism for refugee protection, a durable solution and an example of international burden and responsibility sharing.[53]

Response: Response refers to immediate interventions that address survivors' physical safety, health concerns, psychosocial needs and access to justice, in line with the survivor-centered approach and the GBV Guiding Principles.[54] The provision of multisectoral services and assistance to all GBV survivors contributes to ensuring people's safety, improving physical, mental, sexual and reproductive health and facilitating access to justice. All GBV survivors, including survivors of sexual exploitation and abuse (SEA) perpetrated by humanitarian workers, have the right to immediate life-saving protection and GBV services. Survivors of SEA should be

[49] This definition of rape is consistent with the IASC GBV Guidelines (2015). The GBV Information Management System (GBVIMS), however, defines rape as "non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object." These are the two definitions used by GBV specialized actors, whereas health actors might use a World Health Organization definition. Please see section 1.3.2.1 for the GBVIMS Incident Type definitions.

[50] In the GBV Information Management System (GBVIMS), attempted rape is included under "sexual assault".

[51] IASC GBV Guidelines (2015) , p. 322.

[52] UNHCR, Master Glossary of Terms

[53] UNHCR Integration Handbook

[54] The Inter-Agency Minimum Standards for GBV in Emergencies (2019), p.16.

treated equally as survivors of other forms of GBV. Working with perpetrators of GBV is not the responsibility of GBV response programming.

Returnee: A former refugee or IDP who has returned to their country of origin but has not yet been fully (re)integrated.[55]

Risk mitigation: Refers to a process and specific interventions to mitigate risks in all phases of humanitarian programming. It includes actions that are taken in each humanitarian sector and area of work to reduce risks and exposure to GBV and improve safety as part of an agency-wide mainstreaming approach. Cross-sectoral coordination is essential to ensure a comprehensive approach.[56]

Safeguarding: A set of policies, procedures and practices employed to actively prevent harm, abuse and distress.[57] Broadly, it means preventing harm to people – and the environment – in the delivery of development and humanitarian assistance, including taking all reasonable steps to prevent sexual exploitation, abuse and harassment from occurring; to protect people, especially vulnerable adults and children, from that harm; and to respond appropriately when harm does occur.[58]

Sexual abuse: The actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.[59]

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.

Sexual exploitation: Any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another.[60]

[55] UNHCR, Master Glossary of Terms
[56] UNHCR Policy on GBV Prevention, Risk Mitigation and Response (2020), p.9
[57] Save the Children. Safeguarding Children
[58] Resource & Support Hub. What is Safeguarding
[59] IASC GBV Guidelines (2015), p.344.
[60] Ibid, p. 344.

Sexual exploitation and abuse (SEA): A common acronym in the humanitarian world referring to acts of sexual exploitation and sexual abuse committed by United Nations, NGO and inter-government (IGO) personnel against the affected population.[61]

Sexual harassment: Unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature.[62]

Sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC): Umbrella term for all people whose sexual orientations, gender identities, gender expressions and/or sex characteristics place them outside culturally mainstream categories. Sometimes used interchangeably with "LGBTIQ+".[63]

Sexual violence: For the purposes of these guidelines, sexual violence includes, at least, rape/attempted rape, sexual abuse and sexual exploitation. Sexual violence is "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of the relationship to the victim, in any setting, including but not limited to home and work". Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse and forced abortion.[64]

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

Stateless Person: Someone who is "not considered as a national by any State under the operation of its law"[65] and is thus someone without any nationality or citizenship anywhere.[66]

Survivor (see also "Victim"): A person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably. "Victim" is a term often used in the legal and

[61] Ibid, p. 344.
[62] Ibid, p. 344.
[63] IOM, Full Glossary of Terms
[64] IASC GBV Guidelines (2015), p.344.
[65] As defined in article 1(1) of the 1954 Convention relating to the Status of Stateless Persons, a definition considered by the International Law Commission to form part of customary international law.
[66] Guidance Note of the Secretary General, The United Nations and Statelessness (2011),

medical sectors. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency.[67]

Trafficking in persons is "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs."[68]

Victim (see also "Survivor"): A person who has experienced gender-based violence. The term recognizes that a violation against one's human rights has occurred. The terms "victim" and "survivor" can be used interchangeably. "Victim" is a term often used in the legal and medical sectors and in the context of trafficking in persons as the term "victim of trafficking" is linked to a legal definition. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency.[69]

Violence against women and girls (VAWG): Article 1 of the United Nations Declaration on the Elimination of Violence Against Women (1993) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".

Article 2 continues: "Violence against women shall be understood to encompass, but not be limited to, the following: (a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in

[67] IASC GBV Guidelines (2015), p.348.o
[68] Ibid, p. 323, citing United Nations (2000), Protocol to prevent, suppress and punish trafficking in persons, especially women and children
[69] Ibid, p.348.

women and forced prostitution; (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs."[70]

The Secretary-General's in-depth study on all forms of violence against women (2006) highlights that the term "women" is used broadly to cover females of all ages, including girls under the age of 18.[71]

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

[70] Ibid, p. 323, citing United Nations General Assembly. December 1993. "Declaration on the Elimination of Violence against Women ,

[71] Ibid, p. 323, citing United Nations Secretary-General. 2006. The secretary-general's in-depth study on all forms of violence against women,

1. SECTION 1: INTRODUCTION

These Inter-Agency Gender-Based Violence (GBV) Standard Operating Procedures (SOPs) are developed/revised to facilitate joint action by all actors involved in the humanitarian efforts to prevent and respond to GBV - a life-threatening protection, health, and human rights issue that can have a devastating impact on survivors, families and communities. At particular risk to GBV are women and children, people living with disabilities, and elderly persons of concern (POC).

The SOPs comprise sets of internationally recognized best practices aimed at ensuring the coordination and quality of comprehensive GBV programming. They are developed by the representatives of the GBVSS partner organizations in consultation with a diverse range of government and other humanitarian actors to describe the procedures, roles and responsibilities for each actor involved in GBV prevention, mitigation and response. They are designed for actors to be able to deliver GBV services in line with the "Minimum Standards for GBV in Emergencies,"[72] and to hold each other accountable to address the specialized and intersectional needs of GBV survivors.

These GBV Standard Operating Procedures (GBV SOPs) have been developed to facilitate collaborative action to address GBV in the context of Rohingya Refugee Camps and the host communities in Cox's Bazar Bangladesh.

These GBV SOPs will be updated every two years to reflect changes in the context and needs. If preliminary GBV SOPs have been developed, it is important to expand the GBV SOPs to be comprehensive.

Agencies, institutions, and organizations participating in the development and implementation of these SOPs are listed under Annex 3. Participation here denotes endorsement and compliance with guidance included herein.

1.1. Purpose

The interagency GBV SOPs serves as a technical guidance document that applies to GBV prevention, mitigation and response interventions. It aims to ensure accessible and acceptable GBV services that meet the diverse service needs of GBV survivors from the first point of contact.

[72] The Interagency Minimum Standards for GBV in Emergency

The purpose of the SOPs is to provide guidance that facilitates joint action by all actors involved in the Rohingya humanitarian effort to address GBV in line with the international standards and best practices.

This SOP document is an agreement of cooperation among the respective sectors, ministries, agencies, and Non-Governmental Organisations (NGOs) /Community Based Organisations (CBOs) to ensure an effective response to, and coordination of, services for survivors of GBV and are designed to be used together with established guidelines and other good practice materials related to prevention of and response to GBV.

They include guiding principles, procedures, roles and responsibilities and minimum actions to be taken by all actors operating in camp and host community settings. They also detail which organisations and/or community groups are responsible for actions in the four main response sectors: health, psychological, legal/justice and security, while elaborating approaches and core competencies to prevent GBV and support any survivor of GBV.

Intended users, who are also signatory of these SOPs are all non-governmental organizations (NGOs) and the United Nations (UN) agencies that deliver GBV services directly or indirectly or through local partners in the Rohingya humanitarian response, and that are a member of GBV Sub-Sector and/or Health Sector.

GBV Service Facilities

It is mandatory for all GBV-SS partners to provide information to the GBV-SS detailing the GBV facilities and services they provide as well as the GBV prevention and risk mitigation activities they are implementing. This applies to both JRP partners as well as those who are not part of the Joint Response Plan (JRP). This enables the GBV-SS to provide GBV partners with activity and partner mapping for the purposes of coordinating, rationalizing and streamlining activities.

1.2. Settings and affected populations

These GBV SOPs have been developed for use in humanitarian settings in the Rohingya refugee camps and the host communities in Cox's Bazar and Bhasan Char island in Bangladesh.

These SOPs apply to field level prevention, risk mitigation and responses to any form of GBV. They are relevant to all refugee camps in Cox's Bazar and the adjacent host communities. The

SOPs will be updated and expanded to reflect the changing dynamics in the protracted humanitarian crisis context of Cox's Bazar. Throughout this document, the female voice is used ('her', 'she') solely for simplicity and ease. The entire SOP should be taken to apply to any survivor of GBV, women, girls, boys, men and non-binary people.

- **National definitions, legislation, and policy related to GBV in Bangladesh**

The Bangladeshi Constitution provides for equality of all citizens and states, 'All citizens are equal before the law and are entitled to equal protection of the law.' The Constitution specifically prohibits discrimination based on sex and states, 'Women shall have equal rights with men in all spheres of the State and public life.' Equal rights for education and employment are provided.

Sexual crimes are addressed in the Penal Code of 1860. Section 375 of the Penal Code defines 'rape' as sexual intercourse taking place without the will or consent of, or by obtaining consent with false promises, with any women under the age of 14. Marital rape is not criminalized, provided the wife is aged over 13 years. However, the more recent Women and Children Repression Prevention Act, 2000, expands the protection to girls under 16 years, stating that - if a man engages in sexual intercourse with a woman, who is not his wife, without her consent, or by obtaining her consent through intimidation or deception, or with or without her consent if she is under the age of 16, he shall be deemed to have committed rape against that woman.

Bangladesh is a signatory to the UN Convention on the Elimination of All Forms of Discrimination against Women, 1979. As well as some constitutional provisions and the penal code, domestic laws and regulations upholding the rights of women in Bangladesh, both generally and regarding violence against women specifically, include the Human Trafficking Deterrence and Suppression Act 2012; the Hindu Marriage Registration Act 2012; the National Women's Development Policy 2011; the Domestic Violence (Prevention and Protection) Act 2010; the Citizenship Amendment Act 2009; the Acid Crime Prevention and Acid Crime Control Acts 2002; the Prevention of Women and Children Repression Act 2000; the Suppression of Violence against Women and Children Act 2000; and the Dowry Prohibition Act 1980. The draft Dowry Prohibition Act 2017 was approved by the Cabinet in January 2017 and included punishment provisions for inciting suicide (see dowry-related violence).

In its Concluding observations on the eighth periodic report of Bangladesh, dated November 2016, the UN Convention on the Elimination of Discrimination against Women (CEDAW) welcomed legislative reforms, and efforts to improve institutional and policy framework aimed at accelerating the elimination of discrimination against women and promoting gender equality, including:

- The Amendment to the Labor Act (2013), which increased the maternity leave to 6 months;
- Persons with Disabilities Rights and Protection Act (2013), which also provides for the rights of women with disabilities;
- The Prevention and Suppression of Human Trafficking Act (2012);
- The Seventh National Five-Year Plan (2016-2020) to implement the Government's Vision 2021, which includes the promotion of women's rights;
- The Domestic Workers Protection and Welfare Policy, which provides legal protection, including access to social benefits, maternity leave and establishes the minimum age of employment in domestic work at 14 years, in 2015;
- The Gender Equity Strategy, in 2014;
- The Climate Change and Gender Action Plan, in 2013;
- The National Action Plan for Implementation of the National Women Development Policy, in 2013;
- The National Action Plan to Prevent Violence against Women and Children (2013-2025);
- The Domestic Violence (Prevention and Protection) Rules, in 2013;
- The National Plan of Action on Combatting Human Trafficking (2012-2014);
- The National Action Plan for Adolescent Sexual and Reproductive Health (2011-2016)[73].

[73] UN Committee on the Elimination of Discrimination against Women (CEDAW), 'Concluding observations on the eighth periodic report of Bangladesh,' (paragraphs 4-5),18 November 2016, CEDAW/C/BGD/CO/8, available at http://www.refworld.org/docid/583864444.html. 9 November 2018

1.3. Terms

- General terms

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

- Gender-based violence terms

GBV[74] is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many – but not all – forms of GBV are illegal and criminal acts in national laws and policies.

Around the world, GBV has a greater impact on women and girls than on men and boys.

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

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

The term "GBV" is most commonly used to underscore how systemic inequality between male and female persons, which exists in every society in the world, acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. The term "gender-based violence" also includes sexual violence committed with the explicit purpose of reinforcing gender-inequitable norms of masculinity and femininity.

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

GBV incident type definitions

Gender-based violence encompasses many different types of violence. When each GBV actor has a different understanding of how a type of GBV is defined, challenges in communication and analysis can result. Differing definitions may cause inaccurate information to be reported about the scope and impact of GBV risks. To address this issue, the GBV Information Management System (GBVIMS) developed an incident classification system that helps to define and standardize different types of GBV for documentation and trend analysis.

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

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

The six core GBV types were created for data collection and statistical analysis of GBV.[75] They should be used only in reference to GBV incidents, even though some of the definitions may be applicable to other forms of violence that are not gender-based.

- **Rape:**[76] non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.
- **Sexual Assault**: any form of non-consensual sexual contact that does not result in or include penetration. Examples include attempted rape, as well as unwanted kissing, fondling or touching of genitalia and buttocks. FGM/C is an act of violence that impacts

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

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

sexual organs and as such should be classified as sexual assault. This incident type does not include rape, i.e. where penetration has occurred.

- **Physical Assault**: an act of physical violence that is not sexual in nature. Examples include hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. This incident type does not include FGM/C.
- **Forced/Early[77] Marriage**: the marriage of an individual against her or his will.
- **Denial of Resources, Opportunities or Services**: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.
- **Psychological / Emotional Abuse**: infliction of mental or emotional pain or injury. Examples include threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

Intimate partner violence (often referred as domestic violence) is the most common context in which GBV is perpetrated in the Rohingya Refugee Camps of Bangladesh.

2. SECTION 2: GUIDING PRINCIPLES FOR GBV PROGRAMMING

2.1. GBV Guiding Principles and Approaches

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

- **Humanitarian principles:** The humanitarian principles of humanity, impartiality, independence and neutrality are essential to maintaining access to affected populations and ensuring an effective humanitarian response.[78]

[77]

[78] See, e.g. www.unocha.org/sites/unocha/files/OOM_Humanitarian%20Principles_Eng.pdf

- **"Do no harm" approach:** A "do no harm" approach involves taking all measures necessary to avoid exposing people to further harm as a result of the actions of humanitarian actors.[79]
- **Accountability to affected populations[80]** (AAP) refers to the "commitments and mechanisms that humanitarian agencies have put in place to ensure that communities are meaningfully and continuously involved in decisions that directly impact their lives". Humanitarian actors have a duty to make sure that assistance generates the best possible outcomes for all groups who are affected by a crisis, including those who may be less visible.[81]

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

- **Survivor-centered approach[82]:** A survivor-centered approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured and they are treated with dignity and respect. A survivor-centered approach is based on the following guiding principles:
    a. **Safety:** Ensure the safety of the survivor, their family, and the service provider at all times.

o Remember that the survivor may be frightened and need to be assured of their safety. It is important not to ask questions or perform services that could threaten a survivor's safety, or the safety of people helping the survivor (family, friends, and community service or health workers).
o Always be aware of the security risks a survivor of sexual violence might face. Hold all conversations, assessments, and interviews in a safe setting.

[79] See, e.g. Inter-Agency Minimum Standards for GBV in Emergencies (2019).

[80] The 'P' in AAP may also refer to 'People'.

[81] AAP focuses on the rights, dignity and protection of an affected community in its entirety. AAP is about meaningful engagement, working with communities and actively seeking and putting forward the voices of the most vulnerable. It requires humanitarian actors to identify and address the needs and vulnerabilities of members of affected communities and it equally requires them to recognize and harness the capacities, knowledge and aspirations of those communities. Community members must be engaged and empowered throughout all stages of the humanitarian programme cycle, not only to be a part of decision-making but to be equal partners helping to drive the process. Humanitarian actors aim to achieve this by taking account, giving account and being held to account.

[82] GBV SOPs Resource Package (2023)

- Try, as much as the context and your position allow you to assess the safety of the survivor (Does the survivor have a safe place to go to? Will the perpetrator confront the survivor?).
- Inform yourself about all options for referral available to the survivor.

b. **Confidentiality:** Always respect the privacy of the affected person(s) and their families.

- Survivors have the right to choose to whom they will or will not tell their story and any information about them should only be shared with their informed consent.[83] If the survivor gives their informed and specific consent, share only pertinent and relevant information with others to help the survivor, such as referring for services
- Never share a survivor's information without their permission
- All written information about survivors must be maintained in secure, locked files and password protected when electronic records are used

c. **Respect:** Respect the wishes, choices, rights and dignity of the survivor.

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

d. **Non-discrimination:** Treat survivors with equal and fair treatment at all times.

- Ensure non-discrimination in all interactions with survivors and all service providers. Survivors of violence should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation, or any other characteristic.
- Be respectful and maintain a non-judgmental manner. Do not laugh or show any disrespect for the individual or his/her culture, family, or situation.
- Always consider whether services meet the needs of child survivors, survivors living with a disability and gender non-conforming survivors.

- **Rights-based approach:** A rights-based approach seeks to analyze and address the root causes of discrimination and inequality to ensure that everyone has the right to live with

[83] There are some limitations to confidentiality, including when there are concerns about the immediate physical safety of survivors or risk to others, or in the case of mandatory reporting requirements. See section 3.3.3 on mandatory reporting for more information.

freedom and dignity, safe from violence, exploitation and abuse, in accordance with principles of human rights law.

- **Community-based approach:** A community-based approach ensures that affected populations are engaged actively as partners in developing strategies related to their protection and the provision of humanitarian assistance. This approach involves direct involvement of women, girls and other at-risk groups at all stages in the humanitarian response to identify protection risks and solutions and build on existing community-based protection mechanisms.
- **Age, gender, diversity (AGD)**:[84] Age, gender and diversity factors influence how forced displacement and statelessness impact people; understanding and analysing how these factors impact people's experience is necessary for an effective response.
- **Child-centered approach**: A child-centered approach creates a supportive environment in which children are involved in all matters that affect them, including building on their capacities/strengths, and they are part of the decision-making process. A child-centred approach ensures programmes that are adjusted and tailored towards the child's unique needs and capacities. Child-centered and child-focused are terms used interchangeably.
- **Best interests of the child**: In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration[85] in all decisions affecting them. It concerns securing their physical and emotional safety—in other words, the child's wellbeing— throughout their care and treatment.
- **Ensure the safety of the child:** 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 and long terms.
- **Comfort the child:** Children who disclose sexual abuse require comfort, encouragement, and support from service providers, who must have received training to handle the disclosure of child sex abuse appropriately.
- **Ensure confidentiality:** Information about a child's experience of abuse should be collected, used, shared, and stored confidentially.

[84] UNHCR Age, Gender and Diversity Policy (2018), 2018, pp. 5-6.
[85] Convention on right of the Child, Art.3.

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

It is important to emphasize that:

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

3. SECTION 3: GBV RESPONSE PROGRAMMING

Safe access to GBV services (see SOPs development guide for groups facing barriers to access)[86]

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

- Location of the services.
- Mobility restrictions
- Language barriers.
- Perception/stigma of the service in the community.
- Stigma around accessing GBV services.
- Lack of acceptable and accessible services i.e. wash facilities considering the specialized needs of women and girls
- Access to dignity/ menstrual materials and supplies at the service location.

[86] IASC GBV pocket guide (2015)

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

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

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

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

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

3.1. Overview of GBV response services[87]

Essential issues to consider

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

It is necessary that women, adolescent girls, women-led organizations and representatives of groups of persons who experience discrimination (e.g. women and girls with disabilities, older women, etc.) participate in the GBV SOPs development process to support risk assessment for

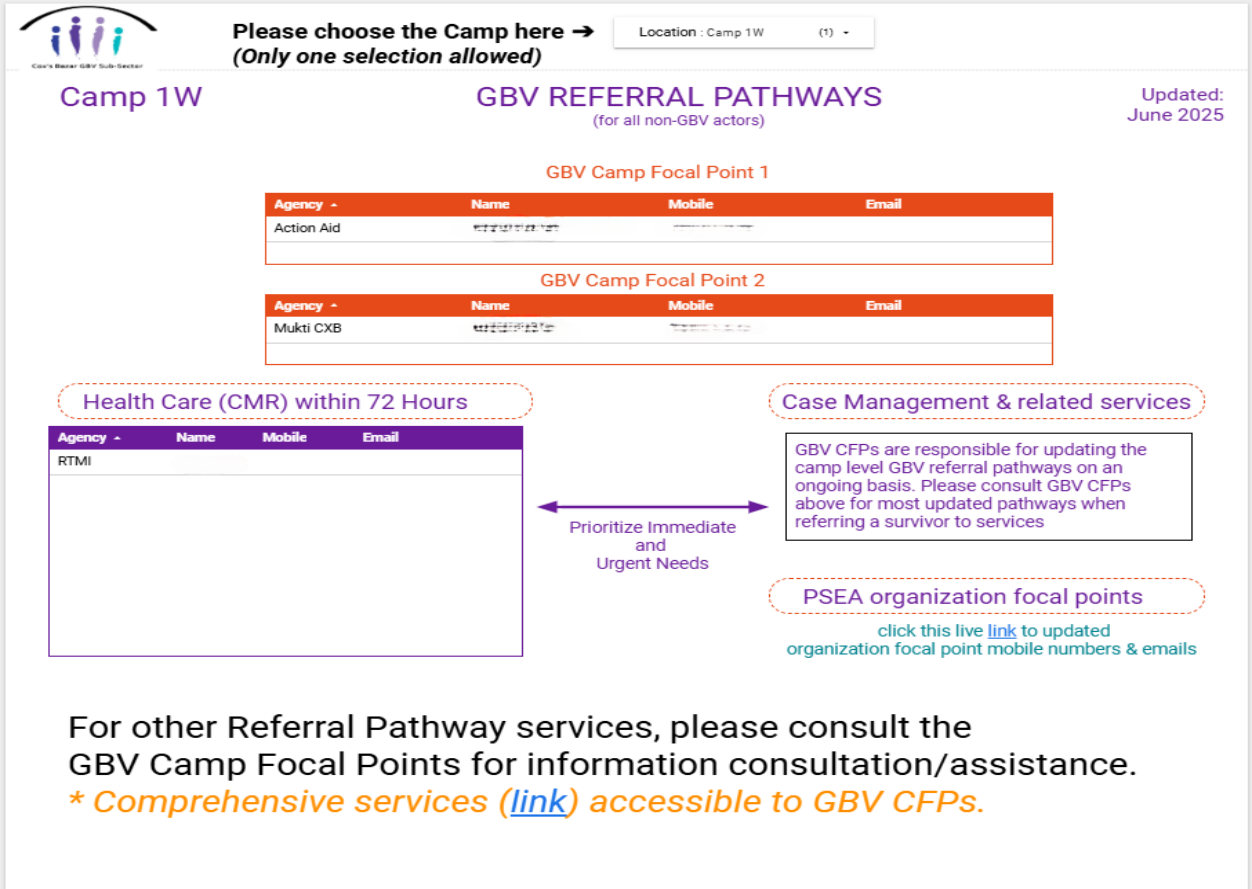
[87] All programme sections in the GBV SOPs are based on Inter-Agency Minimum Standards for GBV in Emergencies (2019) unless otherwise noted. Additional information on each service and how it should be delivered is available in the GBV minimum standards and other resources referenced (e.g. Inter-Agency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

each of the services listed below. Access to, and safety and effectiveness of, GBV services depends on women's and adolescent girls' input.

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

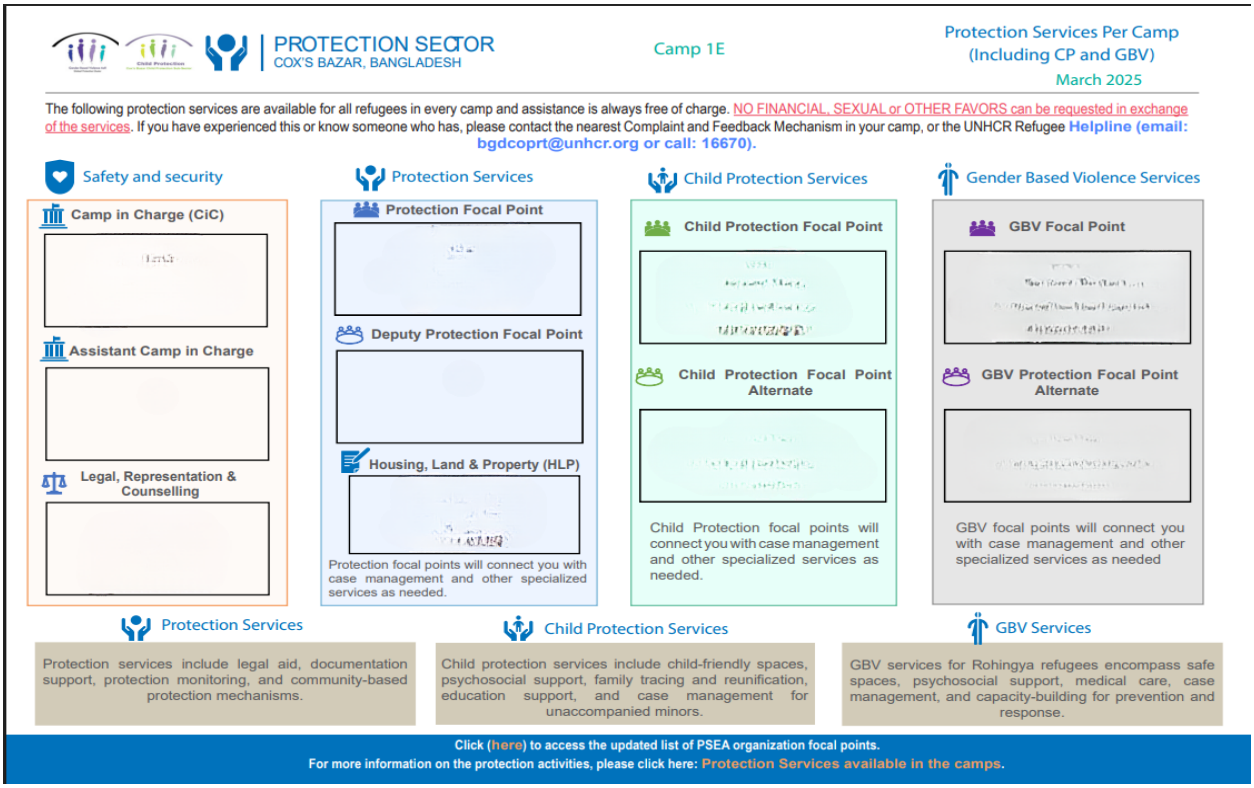
GBV SOPs and referral pathways among health, protection and other safety and security actors and GBV programme actors must uphold a survivor's right to choose where and when to disclose and facilitate timely access to health care and other services.[88]

Example of a GBV Referral Pathways for all non-GBV actors (live at GBVSS website updated regularly)



[88] Rohingya Refugee Response Bangladesh

Example of a Joint Protection Referral Pathways including CPSS & GBVSS (updated on monthly basis)



GBV response services in Cox's Bazar typically include:

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

- **Legal (informal and formal) and law enforcement services** that can promote or help survivors to claim their legal rights and protections, including but not limited to legal aid services.

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

- Education and livelihood opportunities to support survivors and their families to live independently and in safety and with dignity.
- Protection actors and the UNHCR hotline provide survivors with accurate guidance and support for queries related to resettlement. For matters involving entitlements (eg. separate ration cards), relocation to other camps or other documentation-related assistance, survivors should be referred to site management as well for appropriate support. Additionally, GBV actors must ensure timely referrals to all relevant sectoral actors to address the survivor's basic needs with dignity and care.

Referral pathways should be comprehensive, up to date and include services to all survivors regardless of their age, gender and diverse characteristics, including male survivors. However, there is a need to maintain female-only spaces and services to support women and girl survivors of GBV. Many services developed for women and girls will not be appropriate for male survivors. Further, providing support for male survivors through some GBV services will make them less safe and accessible for women and girls and could act as a deterrent for both female and male survivors in accessing care. Hence, it is important that services and referrals for male survivors are included in GBV referral pathways and detailed in standard operating procedures and that information on this is shared with all relevant actors.[89]

3.2. Risk analysis to promote safe implementation of GBV response programming

Essential issues to consider

During the SOPs development process, the coordination leads, and coordination partners should confirm that service providers have considered risks in the design and implementation of GBV response services. If there is no evidence that risks have been considered, it may be

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

useful for the GBV coordination mechanism to undertake programmatic risk analysis as part of determining whether the service should be included in the SOPs referral pathway. The programmatic risk analysis can also assist GBV partners to understand potential safety and ethical issues in the wider community that must be collectively addressed to support survivor-centered care.

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

All GBV-related services and interventions should be based on *programmatic risk analysis,* which examines whether certain safety and ethical considerations are currently in place. While the primary focus of programmatic risk assessment is survivor safety, it is also important to consider the safety of those delivering services. This includes understanding the risks of backlash and intimidation; targeting of staff at the workplace as well as to and from work; potential pressure from community and family to stop doing the work; and other contextual risk factors for GBV programme staff and volunteers.

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

3.3. Referral and Reporting Systems

- **Disclosure and Reporting**

A survivor has the freedom and the right to disclose an incident to anyone. They may disclose their experience to a trusted family member, friend and/or a relevant member of staff. They may seek help from an individual or organization in the community.

Any service provider contacted by a survivor and received a disclosure has a responsibility to give correct and accurate information about services available. Survivors should only be

interviewed by those providing them with direct assistance (ideally psychosocial/health/case management actors who can provide immediate emotional or medical support). This will save them the need to repeat their story in multiple interviews- that may lead to re-traumatization if not handled appropriately. As such, all GBV service providers should ask only relevant questions and should not encourage the survivor to disclose details beyond those that are 100% necessary to provide the service. Service providers should not pressure a survivor to share information that they are not comfortable sharing.

- **Disclosure to non-GBV specialized service providers**

If a survivor discloses a GBV incident to a non-GBV specialized actor, the actor should refer to the survivor safely and appropriately, based on a solid understanding of the referral system available services and mandatory reporting policies.

- Non-GBV actors should not interview a survivor. When they receive a disclosure from a survivor, the non-specialized actor should refer the survivor to the available specialized services[90]. For that it is important that they understand the existing referral system and the GBV guiding principles so that they can inform the survivor about available resources, obtain consent and refer the survivor safely, timely and appropriately. All non-GBV actors should receive mandatory training on GBV core concepts and survivor centered approach, enabling them to understand (1) how to support a survivor safely and ethically in the event of a disclosure, including through psychological first aid (PFA);[91] and (2) how to relay information on available GBV services.
- Non-specialized actors should ask for the survivor's informed consent[92] to contact a primary focal point on the GBV referral pathway (GBV CFP in case of the Rohingya response in Cox's Bazar) and facilitate contact between service provider and survivor. For example - if a service provider/non-specialized actor receives a report about a GBV incident affecting a third party (e.g., the sibling of a beneficiary or a neighbor) or if they

[90] GBV Referral Pathway (Live Update)
[91] IASC GBV pocket guide (2015)
[92] Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent (age 18+). It is a term that is widely used in health and social services and is intended to protect the rights of the survivor and ensure that they are fully aware of the limitations, risks (and benefits) of receiving services.

suspect a case of GBV based on their observations: they **will not make any referrals as they have no consent from the survivor.**

- Frontline workers should limit themselves to providing accurate information about what services are available and the contact details of GBV camp focal point and encourage the beneficiary to pass this information along to the GBV survivor or woman/girl at risk. In this way, they can extend support to her/him in her/his decision to seek help.
- This limitation can be frustrating where cases are urgent, but referrals made without the consent of the survivor directly affected can cause further harm and stigmatize the survivor. In cases of immediate risk/threats to the life and situation of children, frontline workers are encouraged to contact the case management agencies immediately in their areas, refer to the information they have received, and seek technical advice on how to proceed. **Frontline workers should not undertake investigations on the legitimacy of referrals.**
- For cases involving child survivors, non-specialized actors should take into consideration informed assent/consent from child survivors (depending on their age and level of maturity) and the informed consent of caregivers (where relevant and not against the child's best interest).

Special considerations for children

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

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

See section 3.4.3.2 on child protection.

- **Reporting Requirements Related to Sexual Exploitation and Abuse (SEA)**

Sexual Exploitation and Abuse (SEA) by aid workers is a serious problem that directly contradicts the principles of humanitarian action. Perpetrators exploit unequal power relationships through the use of physical force or other means of coercion—for example, threats, the promise of food or services, withholding aid, giving preferential treatment—to obtain sexual acts from a more vulnerable person. Not only does SEA inflict harm on those whom we are mandated to protect, but it also jeopardizes the credibility and reputation of all humanitarian organizations.

Making a Complaint

According to the Secretary General Bulletin, which serves as the United Nation's (UN) Code of Conduct for the prevention of sexual exploitation and abuse (PSEA), all UN Staff, humanitarian workers, and anyone who has entered into a partnership or cooperation agreement with the UN, including contractors, volunteers, and day laborers must report any suspicion of SEA. A complaint can be made by or on behalf of a survivor. Complaints should be submitted on the SEA Complaints Form (see Annex) and should include as much information as possible regarding the survivor, the incident including date and time of report and the alleged perpetrator.

Referral and Investigation:

The receiving organization (irrespective of its membership status within the PSEA Network), will log the complaint and refer it to the PSEA focal person of the concerned Agency no later than 36 hours after receiving the information. The concerned Agency is the Agency with which the alleged perpetrator holds a contract (i.e., an employee of an Agency's Implementing Partner or contractor).

The concerned Agency is then responsible for following its internal PSEA procedures to conduct an investigation and provide feedback to the PSEA Network Coordinator on the status of the complaint.

If the complaint does not provide sufficient information to refer to the case (for example, if the affiliation of the alleged perpetrator is unknown), the PSEA Coordinator will convene a small committee of 3-4 PSEA Network members to gather further information.

Confidentiality:

The PSEA Network will ensure that all data is safe and secure and will implement appropriate procedures to maintain data confidentiality.

Before recording a complaint, the complainant should be informed of the mandatory reporting rule, and the PSEA Network's confidentiality policy and consent should be obtained for the information to be made available to others within the Complaints Management System (the PSEA Network Coordinators, the PSEA Focal Point, and the Head of the concerned Agency).
If a survivor wishes to remain anonymous and does not give consent to follow-up, humanitarian personnel still have a duty to report the case, keeping details about the victim anonymous.

Survivor Assistance:
Given that SEA is a form of Gender-Based Violence (GBV), if the survivor requires and consents to assistance, the PSEA Coordinator immediately refers him/her to the GBV sub-sector for follow-up. This is to note that survivor assistance is not linked to the outcome of the investigation.

- **Informed consent**
  - **Informed Consent and Information Sharing**

- Information about GBV incidents is sensitive and confidential. Sharing any information about a GBV incident can have severe and potentially life-threatening consequences for the survivor and those helping them. Great care is needed when managing data, and GBV survivors have a right to control the management of their information.
- The survivor must also understand and consent to the sharing of non-identifying data about their case for data collection and security monitoring purposes.
- The WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies (2007) describe specific and concrete actions that must be taken when seeking a survivor's informed consent to share information about their situation. Anyone using these SOPs and working directly with, interviewing, and gathering information from survivors must be familiar with the WHO recommendations.
- In many cases, survivors do NOT wish to pursue security or police action and do not want to inform the relevant UN agency with a mandate for protection, despite ongoing protection and security risks. These are very challenging situations for humanitarian actors who are concerned with protection issues for the individual as well as the wider community.
- Children must be consulted and given all the information needed to make an informed decision using child-friendly techniques that encourage them to express themselves.

Their ability to provide consent on the use of the information and the credibility of the information will depend on their age, maturity and ability to express themselves freely.

- **Relevant Mandatory Reporting Laws and Policies**
  - **Mandatory reporting**

***Essential issues to consider**:*

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

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

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

A common strategy for addressing issues relating to mandatory reporting that could arise in the setting and/or the requirement for each individual actor to develop their own mandatory reporting strategy.

The requirement for service providers to inform survivors about mandatory reporting policies. This must be included as part of the consent process at the beginning of services, as described in section 3.3.2.

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

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

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

Inter-agency GBV minimum standards, p. 28.

In Bangladesh, mandatory reporting laws exist that require service providers to report cases of actual or suspected violence to a central agency, limiting confidentiality between agencies and their clients. These laws are implemented inconsistently and, in some instances, pertain only to certain actors (e.g., government institutions).

In addition to this, certain types of GBV are to be reported through relevant reporting mechanisms, as in the case of sexual exploitation and abuse (refer to 2.1.2 for SEA specific guidance) or to other services providers and authorities as, in cases where the survivor presents harm to herself or others.

In such cases, mandatory reporting should be explained in full to the survivor and, where relevant caregiver/guardian, during the informed consent process. Service providers should then consider the survivor's safety and organizational obligations under Bangladesh laws. Where mandatory reporting applies, decisions regarding compliance with relevant laws should be taken by the technical lead, and when appropriate, in coordination with senior management of an organization.

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

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

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

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

In some countries there are mandatory reporting requirements for cases of trafficking in persons. Service providers who believe that a GBV survivor has been subjected to trafficking in person should, with the survivor's consent, consult with experts and/or refer the case to specialized anti-trafficking protection actors to determine whether the case falls under the anti-trafficking mandatory reporting laws.[93]

Before taking the steps for mandatory reporting:

Always inform the survivor of your obligation to report a specific type of GBV, which includes PSEA, self-harm, or harm to others- before the person shares their story, to the extent possible.

- If the survivor shares information that you must report, explain what information you must share, whom you will share it with, and what is likely to happen next.
- In cases of SEA, inform the survivor of the investigation process. Inform them that a focal point is assigned who will be able to tell them of steps taken at a higher level, she will participate in the investigation. Discuss safety considerations related to this with her.
- Discuss and plan for any safety needs associated with mandatory reporting, such as re-traumatization or revenge violence, stigma, and isolation in case of compromised confidentiality.

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

- Discuss the situation with your supervisor/technical lead first before reporting to the required authorities.

- **Referral Pathway**

Essential issues to consider

How to establish and update referral pathways

- *Draw on coordinated mapping and/or assessment of available services and capacity in each location to establish the referral pathway. This includes understanding the capacity of each actor that may be included in the referral system.*
- *Consult with women, girls and other community members about where and with what organization(s) the "entry point(s)" for GBV response services should be located and what might make these entry points safer and more accessible.*
- *Establish a clear referral system in each setting so that survivors of an incident know to whom they should disclose and what sort of assistance survivors can expect to receive from the health, psychosocial, case management and other sectors.*
- *Include easy-to-understand terms explaining what to do and where to go for immediate service delivery. The people who are most likely to refer survivors to services need to understand the referral pathway.*
- *Document the quality of services and monitor this over time to ensure they are functional and meet minimum standards of care in line with GBV guiding principles.*[94]
- *Update referral pathways when service providers change. Agree amongst service providers how to share the referral pathway so that it reaches key community members.*

Key information and accessibility considerations

- *In settings where it is safe to include more detailed information about entry points, the referral pathway should include both (1) the name of the organization and (2) its GBV focal point, with the contact phone number and/or address.*

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

- *Involve representatives and members of groups who face barriers to access in the development of the GBV SOPS and referral pathway to ensure appropriate adaptations and increase marginalized groups' safe access to services.*
- *Implement specific access adaptations to the referral pathway for groups of persons who face additional barriers to access, including survivors with disabilities and older women.*

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

A referral system is a flexible mechanism that safely links survivors to services such as health, psychosocial support, case management, safety/security and justice and legal aid. A functional referral system adapts a survivor centered approach to connect a survivor to multisectoral service providers that support survivors' health, healing and empowerment.

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

The existence of an up to date referral pathway with focal points and clear contact details is a prerequisite for case management services. This is maintained through periodic service mapping that help identify service gaps as well as continued services. Service audits that identify risks, strategies for mitigation and areas for improvement in response services precede the service providers' inclusion in formal referral pathways. Up to date referral pathways should be disseminated amongst service providers and the community where appropriate. Inter-agency referral for GBV survivors must follow the GBV guiding principles. Specialized GBV actors should seek to inform non-GBV actors on how to refer to GBV survivors who present outside of formal entry points. They should:

- Refrain from investigating and obtaining further information. They should immediately call the GBV camp focal point and refer the survivor to the GBV CFP, who can link him/ her to the appropriate GBV services.
- Use a referral form that does not mention GBV. A coding system should be developed with referral facilities. Always ask the survivor whether they feel comfortable to access the referral agency in question. If they express they are not, then call the receiving agency directly.

- **Immediate Response Actions and Referrals**
  - In general, the person who receives the initial disclosure (report) of a GBV incident from a survivor will act according to the existing referral mechanism which includes opportunities at each stage to move forward or stop.
    - The survivor has the freedom to choose whether to seek assistance, what type(s) of aid and from which organizations.
  - Service providers will inform the survivor of what assistance they can offer and any limitations to services, to avoid creating false expectations.
  - For cases of sexual and physical violence, urgent health care is the number one priority for survivors due to the life-threatening nature of incidents and timebound treatment for certain conditions that can result from GBV.
    - In cases of rape, encourage the survivor to seek health care, ideally within 72 hours of a GBV incident. Assistance must be per the WHO/*Clinical Management of Rape* guidelines, which may include emergency contraception and post-exposure prophylaxis for HIV.
    - If a survivor discloses violence, provide them with supportive, healing messages is essential for healing, building trust and empowering the survivor.
    - Thank the survivor for sharing and ask the survivor if they would like to have a one to one discussion afterward.
  - All GBV service providers should know the GBV referral pathways and the forms of assistance that are available in their setting.
  - Provide direct interventions, including psychosocial interventions, if appropriate.
  - When referring a survivor for services, always ask for their consent.
    - With the consent of the survivor, refer them to the appropriate services for follow-up support and advocate (if required) to access the assistance needed.
  - Contact the primary focal point on the GBV referral pathway for your location (CFP, in case of Cox's Bazar) and facilitate the contact between the service provider and survivor to arrange for follow-up care.
    - Information about referrals should be kept to a minimum; do not discuss sensitive information with anyone except the GBV focal point.
    - Ask the survivor if they would like to be accompanied to the agency to which they are being referred.

- Referrals should be done using the coded GBV Referral Form, which does not include the name, address, or any other information that might identify the survivor. Always prioritize the confidentiality and security of survivors.
    - The referral form is sent by email and is password protected. Only focal points know the passwords for the referral forms.
- If the survivor does not want to access services, provide them with details of service providers in your area in case they want to use them in the future.
    - The wishes of the survivor must always be respected; they have the right to decide. A survivor should not be urged or forced to take a particular course of actions.

Disseminating referral pathways

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

See also section 3.7 on raising awareness.

3.4. Specialized GBV service providers

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

3.4.1 Health care for GBV survivors

Access to quality, confidential, age-appropriate and compassionate health care services is a critical component of a multisectoral response to GBV in emergencies. Adequate health services

are not only vital to ensuring life-saving care for women, girls and other at-risk groups, they are also essential for a society to overcome the devastation of a humanitarian emergency. Health service delivery systems should be equipped to ensure clinical management of rape, intimate partner violence and the consequences of other forms of GBV.[95]

Health services play a crucial role in ensuring the delivery of immediate and lifesaving care to GBV survivors. Health workers provide treatment related to rape, sexual assault, and other forms of GBV preventing further harm and health consequences.

Trained on GBV core concepts and GBV guiding principles, health providers will follow a survivor-centered approach and adhere to standards, protocols and practices, in accordance with the minimum prevention and response interventions detailed in the GBV Guidelines (IASC, 2015) and the SOP guiding health responses to GBV for the Rohingya population (See Annex 22.). They will also follow protocols relevant to the care of GBV survivors set out in the WHO Clinical Management of Rape (CMR) Guidelines.

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

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

Similar to other actors, health workers will always take informed consent from a survivor and will explain the timeline for clinical care for rape to prevent HIV, STI and pregnancy. Health workers will be trained in and will follow the guidelines on when to refer a case to a GBV worker or another

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

specialized service such as a MHPSS focal point and how to coordinate with different service providers.

- **Regulations and key approaches to care relating to health service delivery**

All medical staff play an important role in reducing the harmful effects of GBV, by adhering to the GBV guiding principles while caring for survivors of GBV. Survivors of GBV have experienced an abuse of power. It is therefore essential that in the path to recovery, service providers give back the control to the survivor and focus on her/his wishes. They should only ask questions that are relevant only for the care of the survivors and prior to making further referrals, should take the full and informed consent of the survivor.

The role of the health care service provider is to provide immediate health services and information on other services (MHPSS, legal, protection, GBV case management etc.) and make referrals as appropriate. Health care workers should know who the GBV actors are and the procedures of accessing services. After being informed of all options available for support and referral, the survivor has the right to make the choices s/he/they want.

- **Regulations and laws related to forensic examination and menstrual regulation**
  - In addition to being acquainted with the basics of survivor centered approaches in line with the GBV guiding principles and referral pathways, it is important for the health worker to know the laws pertaining to GBV response.
  - For example as per the existing laws of Bangladesh
  - Menstrual regulation should be offered within 12 weeks of the missed period according to the existing law.
  - Medico-legal services including forensic examination can only be provided by government sub-district or district hospitals.

*Health service providers should never display or publicize data on Clinical Management of Rape.

- **Core elements of an essential package of services**
  - Health care for GBV survivors will be provided as per the health sector minimum essential service package, based on various levels of capacities by the facilities. During emergencies the Minimum Initial Service Package (MISP) shall be upheld.
  - Health service providers must ensure confidential, accessible, compassionate, and appropriate medical care for survivors of GBV.

- SRH service providers within the health facility will be trained to provide Comprehensive Clinical Management of Rape/Intimate partner violence services.
- All other medical and non-medical staff at the facility will also be trained on how to provide first line support[96] where they suspect violence may have occurred but not disclosed; or when they receive self-disclosures of violence- they may refer for appropriate clinical care within the facility or another facility if specific service is not available at the facility.
- Health service providers will provide information on case management services[97] provided by GBV actors and connect them with the service providers as relevant.
- The health facility must have updated information about referral pathways from the GBV focal point.
- Health service providers must ask for informed consent while before and during any health procedures/physical examination or as needed.
- Health care for sexual violence includes:
    - Examination and history taking
    - Treatment of injuries
    - Prevention of disease, including STIs/HIV
    - Prevention of unwanted pregnancy
    - Collection of minimum forensic evidence
    - Psychological/emotional support
    - Medical documentation
    - Follow up care
- Health care providers must follow the urgent medical treatment timeline chart below, while treating a rape/sexual violence survivor.

[96] First-line support provides practical care and responds to a woman's emotional, physical, safety and support needs, without intruding on her privacy.
[97] GBV case management involves a trained psychosocial support or social services actor.

Prevention of HIV	The risk of HIV can be reduced if a survivor is referred for medical care to receive HIV post-exposure prophylaxis within **3 days (72 hours)**
Prevention of Pregnancy	The risk of unwanted pregnancy can be reduced if a survivor is referred for medical care to receive emergency contraception within **5 days (120 hours)**
Evidence Collection	If the survivor requests evidence collection for legal purposes, it is important that the medical examination be arranged and recorded **as soon as possible (48 hours).**

- Health service providers should prioritize referring survivors to the GBV focal point if the case is identified as a GBV case and refer to MHPSS only when there is a specialized MHPSS need.
- Ensure a safe and trusting environment while engaging with the GBV survivors.
- Have female practitioners for female genital examinations and male practitioners for male survivors.
- It is important to acknowledge each population as having separate needs because they face different risks. So, the services should be adapted for specific populations such as LGBTQIAs, sex workers, persons with disabilities, male survivors, children and other age, gender and disabilities (AGD) groups.

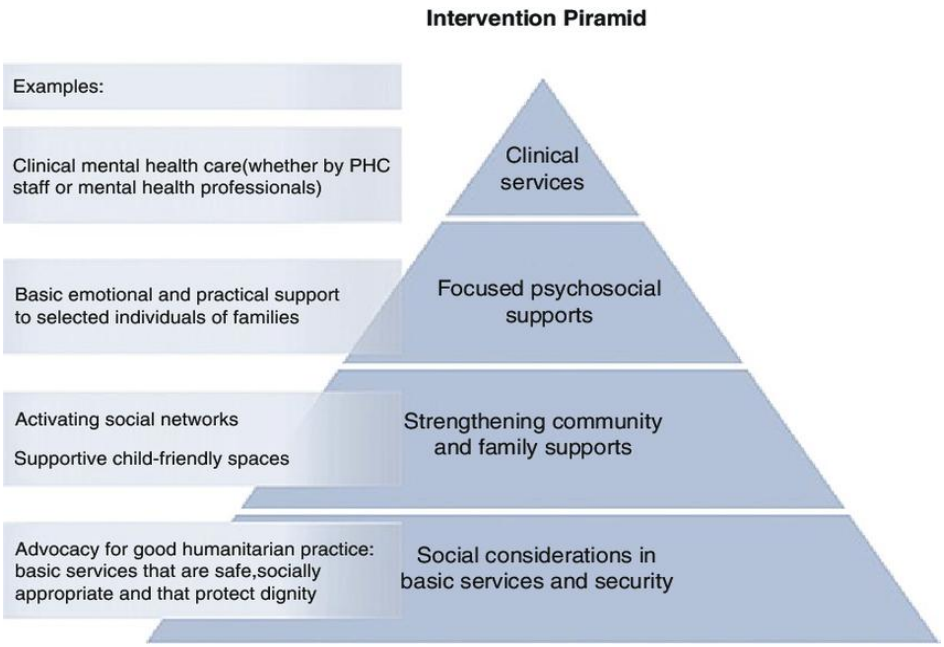
3.4.2 Mental Health and Psychosocial Response (MHPSS)

MHPSS is any type of local or outside support that aims to protect and promote psychosocial well-being and/or prevent or treat mental illness.[98] Psychosocial services (PSS) for GBV survivors include the following interrelated types of activities:1) emotional support to assist with psychological and spiritual recovery and healing from trauma; 2) case management, support, and advocacy to assist survivors in assessing needed services; and 3) support and assistance with

[98] IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2008)

social reintegration. The intervention pyramid for mental health and psychosocial support in emergencies offers a useful guide for demonstrating priority MHPSS services in an emergency response. GBV case management qualifies for the minimum MHPSS package if the staff are well trained in offering psychosocial support to survivors.

Intervention Pyramid for Mental Health and Psychosocial Support



Layer 1 - Basic services and security: The majority of people are represented in the bottom level of the pyramid. Most of them recover their psychosocial well-being when basic physical security is established and they obtain the social material (e.g., food and NFIs), communal and health services they need. The humanitarian actors and the governments can further help by:

1. Ensuring that basic services and goods consider social and cultural factors and individual dignity while providing food, NFIs, health, education and livelihood opportunities
    a. Furthermore, consulting women and girls when planning response can add to their sense of security, well being and value.-e.g., contents of NFI kits, accessibility of the proposed location of health services for women and girls and ensuring lighting and locks on latrines and showers to reduce risks for women and girls.

2. Security and state actors ensuring that people are residing far from active conflict and front lines;
3. Protection partners advocating for basic services to be met and documentation provided to access services like PDS.

Layer 2 - **Community and family support**: A smaller but still substantial number of people require extra support from their community and families to recover their psychosocial well-being, as shown in the second level of the pyramid. Humanitarian actors can support by encouraging relevant traditional supports and social networks.

A wide range of Interventions can contribute to such support and assistance for example:

- Support to social re-integration including vocational training and women's empowerment
- Literacy training, school reintegration,
- Women and child-friendly spaces,
- Family tracing and reunification, parenting/family support.
- Women's groups, youth clubs
- Structured recreational and creative activities (like in women's centers).
- Sharing information on available services and assistance within the community.
- Community and religious leaders facilitating conditions for indigenous traditional, spiritual or religious support including communal healing practices.
- Actors provide communal spaces/meetings to discuss, problem-solve and organize community members to respond to the emergency.

Layer 3 - **Focused, non-specialized support**: A smaller number of people may need more focused services to regain their psychosocial well-being and protect their mental health, as shown in the third level. Such interventions include:

- Basic emotional and practical support, such as GBV case management, provided by community-based workers or organizations.
- GBV, CP and MHPSS actors providing psychosocial first aid or case management services.
- Use of psychological first aid (PFA), as well as basic counseling for individuals, groups and families;
- Psychoeducation about trauma, stress and emotional responses to conflict and displacement and messages on positive coping and relaxation techniques.

Layer 4 - Specialized services: For a very small percentage of people, the supports outlined above are not enough, and their mental health and ability to function productively depends on more specialized care. For these individuals, professional support is required from trained professionals, such as clinical psychologists (masters-level), psychotherapists and psychiatrists, who can provide more advanced mental health interventions (in-patient and out-patient).

The coordination between the protection sector and the MHPSS working group for the implementation of key activities helps to improve impact, avoid duplication of actions, optimize human resources in the field and clarify common actions and specific domains for each programme. From the MHPSS perspective:

- Without attention to protection issues, MHPSS can become focused on consequences while ignoring underlying and ongoing causes.
- Promoting a protective environment is an integral part of psychosocial support.
- Psychosocial and mental health issues can also contribute to protection threats. For example, children who have lost their families and who are extremely distressed face increased risks of being exploited or, in some emergencies, joining armed groups.
- In addition, people with severe mental disabilities may wander, exposing themselves to hazards that most other people can avoid. Protection requires both legal and social mechanisms. Legal protection entails applying international human rights instruments and international and national laws
- Social protection occurs largely through activating and strengthening social networks and community mechanisms that reduce risks and meet immediate needs.

The SoP is based on the multilayer IASC MHPSS response, according to the goals and activities that the MHPSS working group in Cox's Bazar has established for each level of response, informed by the MHPSS needs assessment. Specifically, the purpose of the SoP document is to highlight the key actions recommended as minimum MHPSS response in the protection sector, according to IASC guidelines and the standards to be upheld while implementing those.

- Implement mental health and psychosocial support in a way that promotes and protects human rights.

- Establish mechanisms for the monitoring and reporting of abuse and exploitation by humanitarian agencies within the context of humanitarian and pre-existing services.
- Advocate for the alignment of relevant national legislation, policies, programmes and practices with international law and standards.
- Activate or establish social protection mechanisms, building local protection capacities where needed.
- Respond to protection threats by taking appropriate, community-guided action.
- Continuously monitor and share ongoing protection threats in venues such as schools and marketplaces.
- Share information with relevant agencies and protection stakeholders to the extent that it is absolutely critical for referrals;
- Increase affected people's awareness of their legal rights and their ability to assert these rights in the safest possible way, using culturally appropriate communication methods.

3.4.3 Case Management

A case management approach is essential for survivors with complex and multiple needs who seek access to services from a range of service providers, organizations and groups. Case management serves as a means for achieving survivor wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The goal of case management is to empower the survivor by giving them increased awareness of choices they have in dealing with the problem and assisting them to make informed decisions about what to do about the problem. Case management ensures that the survivor is involved in all aspects of the planning and service delivery.

The basic principles that underpin a survivor centered case management approach include:

- Ensuring the survivor is the primary actor in case management; empowering the survivor and ensuring that he/she is involved in all aspects of the planning and service delivery
- Respecting the wishes, the rights, dignity needs and capacity of the survivor
- Providing emotional support by demonstrating a caring attitude towards the survivor
- Providing information to the survivor to allow them to make informed choices about services requested
- Listening and establishing rapport and a trusting relationship, which creates a supportive environment in which the survivor can begin to heal.

- Ensuring confidentiality which is critical to protecting the survivor's safety and security and to prevent misuse of information, explain clearly to survivors the exceptions as to when confidentiality may be breached.
- Ensuring non-discrimination by treating every survivor in a dignified manner irrespective of their sex, (dis)ability, gender identity and sexual orientation, age, religious, ethnic and racial background, or circumstances of the incident(s);
- Obtaining informed consent from the survivor prior to sharing any information

- **Responsibilities of Caseworkers and Organizations**

Caseworkers, social workers, case managers and supervisors must have the skills to manage cases in line with the above principles, an understanding of their roles and responsibilities, and an ability to handle difficult situations professionally and with cultural sensitivity.

The case management agencies are responsible for staffing, supervising and monitoring GBV case management service provision to ensure guiding principles and a survivor-centered approach are used, best practices are met, all available referral services are mapped, gaps are identified, barriers to accessing services are addressed and advocated for, services are coordinated with other actors, and full case management services are provided, including follow-up. Appropriately staffing case management services is essential for quality of care. As per the global guidelines, it is recommended that:

- A GBV case management agency has enough GBV caseworkers to allow for a case-to-survivor ratio of 1:15 active cases, or at the most 1:20. This should be monitored very closely by supervisors with the understanding that some cases require greater involvement depending on the needs and circumstances of the survivor and the stage of the case in the management process.
- Caseworkers speak the language(s) spoken by survivors enabling them to communicate in their first language.
- The gender of caseworkers should be considered. For example, for programs addressing GBV against women and girls and where the entry point for case management services is a women's center, female caseworkers must be hired in order to keep the women's centers 'women-only', to protect the emotional and physical safety of the survivors. In all inclusive centers, it may be beneficial to have a mix of female and male caseworkers. These decisions should be based on the context, type of GBV and your organization's or program's focus.

- The ethnic, religious and cultural background of caseworkers should also be considered, and caseworkers should be hired to create a staff mix that is proportional to the makeup of the population being served. Conduct, ongoing training, learning, support and other capacity building opportunities for caseworkers to further develop core qualities and skills and for supervisors to advance their technical and management abilities.
- Ongoing training, learning, support and other capacity building opportunities for caseworkers to further develop core qualities and skills and for supervisors to advance their technical and management abilities. Additionally regular supervision should be done where A supervisor to caseworker ratio of 1:5 and no larger than 1:8.

- **Steps of Case Management**

Case management services include basic counseling and psychosocial support, assessment of needs and resources, developing safety and action plan, implementing the plan, appropriate follow-up and referrals, case closure (if and when appropriate)

Step 1: Introduction and engagement

The first step of the case management process – Welcome and Introductions- begins when the caseworker first meets the survivor. This is the case worker's first chance to develop a rapport with a survivor and build a foundation for a healing relationship. The guidance below can help caseworkers do this with a survivor from the very beginning.

Step 2: Assessment

Providing good case management services rests on conducting a good assessment. In social work, assessment is defined as the act of gathering information or data from a client and evaluating it for the purpose of making a decision about the client care.

In GBV case management the goal of the assessment is to safely and slowly assess the survivor's situation and their experience of violence so that you can determine their immediate and eventually, longer-term needs. The focus of the assessment is listening, NOT asking.

- o Assessing psychosocial needs:
- o The key assessments areas for psychosocial needs and support are: *(for more details on how to do the assessment and when to refer to MHPSS specialists refer to the Annexes on assessing the psychosocial needs of survivors in this document)*:
    - Get a basic sense of how the person is feeling

1. Assess any changes in behaviour, emotions and thoughts after the GBV incident
2. Assess opportunities for livelihood/educational activities

3. Identify protective factors and strengths
4. Assess self-harm or suicide risk.

Step 3: Case action planning and implementation

In this step, case workers develop a case action plan with the survivor based on the needs that emerge during the assessment. Case action plans are developed collaboratively with the survivor by having a discussion with them about how to best meet their needs identified during the assessment. Case workers will need to be familiar with the typical interventions and services available in the community and will need to discuss positive and negative aspects of making such a referral.

Step 4: Implement the Case Action Plan

This step involves the case worker implementing the case action plan that includes making referrals, developed in consultation between her and the survivor and in line with the survivor's wishes. Throughout the case action plan implementation, the case worker should continue to ensure the survivor's informed consent is obtained before each step in the process. For critical cases, the case worker will seek advice and approval from their supervisor.

Step 5: Case follow up

Case follow up is a very important part of a survivor-centered case management process. It allows you to assess the status of the survivor's situation and case action plan. Through case follow- up we seek to:

- find out the current status of the survivor's safety
- revise the action plan based on the survivor's changing needs
- update the referral pathway

Step 6: Case closure

How to close a case:

1. Determine if the case meets criteria for closure. With the approval of their supervisor, case workers can close a case by following procedure below:
2. When the survivor's needs are met and/or their (normal or new) support system are functioning
3. Follow up with the survivor and discuss their safety situation and related concerns and needs
4. Review together the final action plan made with the survivor and the status of each goal

5. Explain that it is time to close the case but reassure the survivor that they can always return if she encounters new issues or experiences abuse again.
6. Only close the case at the survivor's request or
7. When the survivor leaves the area or is relocated to another place
8. Where the survivor "disappears" and is not contactable for a minimum of 30 days, the case will be considered as an inactive case. After 90 days the case will be closed
9. Document when a case is closed and the specific reasons for doing soSafely store the close case filed. Moved the file to a "closed case" cabinet. Do not include the consent form in the closed file. Leave it in the original cabinet for consent forms or move it to a locked "closed case consent form" cabinet.
10. Closed case documentation
11. Supervision tools

- **Case Conferencing**

Caseworkers act as a liaison between the survivor and service providers, advocate for timely and quality care for the survivor, and work with service providers to reduce obstacles to accessing services. This requires regular communication and follow-up with other actors working with a survivor. One aspect of case coordination is case conferencing.

Case conferencing is a planned, structured meeting convened by the caseworker to discuss a particular case with other service providers involved in the survivor's care and treatment. Case conferences allow the caseworker to:

- ✓ Review activities, including progress, challenges and barriers towards goals;
- ✓ Map roles and responsibilities;
- ✓ Resolve conflicts and strategize solutions;
- ✓ Adjust current action plans;

Case conferences can be effective venues for addressing any problems with services not being provided in a timely way, or to get clarity on who is doing what to avoid duplication of efforts in complex cases involving many actors. Case conferencing is done on an ad hoc basis and is distinct from ongoing service coordination and other coordination forums.

Getting the survivor's consent is a crucial prerequisite for any case conference. The survivor must consent to information sharing with each participant service provider in the case conference. If

consent has not been given, then the individual case must not be discussed. Service providers may participate in case conferences by invitation only and should only include actors who are providing care to the survivor (or potential service providers) and who receive consent from the survivor to receive/share information. The information shared at this conference is strictly confidential and will focus on actions taken and actions needed. Information-sharing must only include relevant information and should not include irrelevant personal or other details about the survivor or the incident. A survivor has the choice to be present in the case conference and has the right to limit what information is shared.

Detailed notes and action points from the case conference should be taken by the caseworker and stored in the case file using a survivor code, not name or other identifying information. Note that case review meetings are separate from case conferencing. Case review meetings are internal meetings as part of case supervision between the caseworker and her supervisor, and do not involve other agencies.

All members of this meeting are responsible for ensuring that the dignity and confidentiality of survivors are maintained and that information discussed is only that which is needed to resolve problems and coordinate actions. It is the responsibility of the designated case managers for each case discussed to ensure that information sharing has been duly pre-authorized by the survivor. The case manager also keeps the survivor informed of decisions and progress made. See Chapter 3 of the *Interagency GBV Case Management Guidelines* (2017), which outlines the minimum qualities, skills and knowledge of GBV caseworkers.

Case Management Procedures for Specific at Risk Groups

- **Child Survivors**

Children have the right to participate in decisions affecting them, appropriate to their level of maturity. Children's ability to form and express their opinions develops with age, and adults should give the views of adolescents greater weight than those of a younger child. A child's best interests are central to good care. Best interest considerations for children are focused on securing their physical and emotional safety and well-being throughout their care and treatment. Service providers must evaluate the positive and negative consequences of actions with the participation of the child and her caregivers as appropriate. The least harmful course of action is

always preferred. All actions should ensure that children's rights to safety and ongoing development are never compromised.

Older adolescents, aged 15 years and above, are generally considered mature enough to make decisions. They are often allowed to make decisions about their own care and treatment, especially for sexual and reproductive health-care services. They can give their informed consent or assent in accordance with local laws and with the best interests of the child.

The informed consent/assent process requires that caseworkers explain to the child and non-offending caregiver what the services entail, including possible benefits and risks:

- give the child and non-offending caregivers all possible information and options available so they can make choices, using different formats and exploring different means to give consent.
- inform the child and caregiver that their information may need to be shared with others and for what purposes.
- explain how their information will be safely and securely stored.
- explain what will likely happen to the child when engaging in services.
- explain the benefits and risks of services.
- explain to the child and non-offending caregivers that they have the right to decline or refuse any part of services.
- explain the limits of confidentiality.
    - Coordination with child protection actor(s)

Essential issues to consider

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

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

Engaging in joint coordination and mapping of response services, joint referral pathways and clear criteria for offering specialized support to children are key actions for child protection and GBV response actors. See the Guidance Note on Working with Child Survivor Cases (2025) to support work to address service provision gaps and promote complementarity in humanitarian settings.

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

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

Overview of informed consent/assent for different age groups

Age group	Child	Caregiver	If no caregiver or not in child's best interests	Means
0–5 years	Not applicable	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent
6–11 years	Informed assent	Informed consent	Other trusted adult's or caseworker's informed consent	Oral assent Written consent
12–14 years	Informed assent	Informed consent	Other trusted adult's informed consent or child's informed assent. Child's view should take due weight according to maturity level.	Written assent Written consent
15–17 years	Informed consent/ Informed assent	Obtain informed consent with child's permission	Child's view should take due weight according to maturity level.	Written consent

Caseworkers should always assume that all children with a disability (including those with intellectual disabilities) have the capacity to provide informed consent or informed assent in line with the age group recommendations. It is the caseworker's responsibility to:

- ask the non-offending caregiver or another trusted adult or family member for guidance on communicating with the child.
- adjust communication using a range of styles.
- ask the child if there is someone, they would like to support them with communication;
- make decisions based on the best interpretation of the child's will and preferences as appropriate to their age, development and understanding.

Just because a child survivor has a communication-related disability (such as a hearing impairment or verbal impairment) does not mean that they cannot communicate or comprehend what is being explained to them.

When informed consent becomes challenging

Seeking informed assent and informed consent may be further impacted by dynamics with caregivers. For example, a non-offending caregiver may not want to give consent for services for reasons such as stigma, fear, and/or shame. Additionally, the only caregiver culturally permitted to give consent may also be the perpetrator of the sexual abuse, or the child survivor may be unaccompanied, without a legal guardian. Examples of other common challenges are:

- the non-offending female caregiver cannot or does not believe she can give informed consent as she is not the head of the household.
- there is no official legal guardian, non-offending caregiver, other trusted adult or specific agency that can act as the decision maker for a child.
- a non-offending caregiver is present in the child's life but disclosure of sexual abuse to the caregiver would almost certainly result in additional violence or death (that is, honor killing) of the child.

- adolescent girl and boy survivors are mature enough to make their own decisions and provide informed consent, but either do not want to tell/involve their non-offending caregiver(s) in the process or their non-offending
- caregivers have legal authority and do not consent to services.
- adolescent survivors are accompanied by a young adult friend/neighbour/family member who does not have the legal authority to provide informed consent on behalf of the survivor who is under the legal age to consent or under the age of a set policy.

In situations such as these or others in which gaining informed consent presents challenges, caseworkers should consider:

How urgent is the decision regarding care? When the child survivor of sexual abuse is at imminent risk of danger and/or has urgent health needs and the non-offending caregiver refuses to give informed consent for health services, caseworkers should immediately involve a supervisor. Ideally, supervisors will have already developed a protocol for such situations. It may be beneficial for the caseworker (along with their supervisor) to carry out case consultations with other gender-based violence or child protection actors, including relevant national protection actors, in order to seek input on the course action that will ultimately uphold the child's best interests.

If the caregiver is refusing consent, what are the driving factors for doing so? If a non-offending caregiver is reluctant or refuses to consent to services for their child initially or throughout, it is important to understand their underlying concerns. A caregiver may not want to consent because of shame, stigma, security/retaliation and/or fear. They may feel the child needs to be disciplined or they may be in denial about the abuse. They may not believe the incident is abuse. They may be seeking to protect the offender who is a relative or friend or has powerful influence in the community. They may also face practical barriers to engaging in services, like insufficient funds to travel to the centre or conflicting priorities (for example, collecting water or searching for food). In the absence of an urgent health or safety need, the caseworker should: engage with the non-offending caregiver to better understand their refusal or hesitancy. Identify critical barriers to giving informed consent. Assess if those barriers can be addressed, removed or the risk associated with them reduced. Create a plan to address barriers with the non-offending caregiver before seeking informed consent again.

What is the age of the survivor and their capacity for consent? In situations in which children are old enough or determined to have the capacity for decision-making, they can give their own consent without the consent of the caregiver. To assess a child's comprehension and capacity to make the decision at hand, caseworkers should consider the child's ability to:

- Comprehend and reflect key pieces of information in relation to the decision.
- Think and make choices with some degree of independence.
- Evaluate the possible benefits and risks that accompany the decision.
    - Survivors living with disabilities
    - Male survivors
    - Survivors of transactional sex

Staff Care

Organizations, particularly those providing GBV services in humanitarian settings, have the responsibility to provide a level of care for their staff. An organizational culture that prioritizes the safety and well-being of its staff is critical when the staff is exposed to highly stressful situations and the risk of vicarious (also known as secondary) trauma is very high. "Self-care" —or what an individual can do to prevent stress from becoming overwhelming, is critical for effective service delivery. Inability to practice self-care can lead to physical, emotional, mental and spiritual harm and disrupt overall well-being, quality of life and personal relationships of the service provider, which is highly likely to spill over her work. While the emphasis of self-care is usually on the individual, it is important for individuals and organizations as productivity often declines when self-care is not encouraged by supervisors and individuals alike.

Caseworkers are often the people working closest with survivors, hearing their experiences of GBV, and responding with care, compassion, and concern. Over time, without appropriate support and supervision, caseworkers may begin to feel overwhelmed and tired, and may even begin to feel hopeless and helpless. In order to prevent caseworker burn-out and to facilitate caseworkers' capacity to provide the best care and services to survivors, supervisors and organizations need to make an explicit commitment to staff well-being and implement specific strategies to promote it. While every organization will need to develop its own strategies and approaches for staff care based on resources and structure, below are the basic tips for how supervisors can promote the care of GBV casework staff.

Facilitating everyday staff care:

- Case supervision is one way that front line workers can be supported in their daily challenges/ dilemmas while executing their duties. This relationship enhances the caseworker's technical competence and practice, promotes well-being and enables effective and supportive monitoring of casework.
- Create a supportive climate – regularly check on the well-being of staff, create an environment where staff feel comfortable sharing information and concerns with you.
- Establish routines – including for supervision and team meetings.
- Regularly demonstrate appreciation for staff. This can be as simple as communicating gratitude or praise for something they did or arranging to have refreshments at meetings to something more elaborate such as a "staff of the month" award.
- Manage information – Routinely share information and create an environment of transparency.
- Monitor the health and well-being of staff. For example, be mindful of how staff are taking care of themselves and encourage them to take lunch breaks, etc., and take note of changes in appearance or health.
- Monitor stress levels – support staff to identify and monitor stressors in their lives and to develop self-care plans.
- Provide opportunities for exercise and access to the outdoors.
- Organize "staff care" days that allow staff to come together to do something fun or relaxing.
- Encourage staff to identify a "self-care buddy" – another staff person with whom they connect on a regular basis to discuss how they are and what support they need from each other.
- Accommodate staff – be flexible with the response of different individuals to personal or work crises (e.g. allow flexible schedules, if possible, give time off where needed, provide additional supervision, etc.)

Providing support for staff in crisis

When staff are in crisis either because of a professional or personal experience that may be impacting their work, the following may be important:

- Create opportunities for staff to share experiences and stressors (e.g. through supervision) Watch for caseworkers who may be suffering in silence and actively reach out to them.
- Ensure MHPSS is part of organizational commitment to staff wellbeing
- GBV-SS will ensure that the Senior Management of every organization delivering case management services to survivors is oriented on this SOP.
- Connect staff to psychological support – if available in the context, connect staff to mental health professionals on a regular basis.

3.4.4 *Women's and Girls' Safe Spaces*

Women's and girls' safe spaces[99] (WGSS) are a critical part of GBV programming.[100] WGSS serves as an entry point for women and girls to report protection concerns, express their needs, receive services, engage in empowerment activities and connect with the community.

A WGSS is "a structured place where women and girls' physical and emotional safety is respected and where women and girls are supported through processes of empowerment to seek, share and obtain information, access services, express themselves, enhance psychosocial wellbeing and more fully realize their rights."[101] Safe spaces may also be a venue for sexual and reproductive health information and materials (e.g. as part of menstrual health and hygiene management), laundering of menstrual materials and access to justice services. See Advancing Women's and Girls' Empowerment in Humanitarian Settings: A Global Toolkit for Women's and Girls' Safe Spaces[102] and Guidelines for delegations visiting Women Friendly Spaces for additional information on WGSS, including the five standard objectives.

3.4.5 *Safety and Security*

The safety and security of survivors should always be prioritized and based on an up to date safety assessment. The responsibility of maintaining safety and security in the camps rests with the government security forces deployed in the camps. Caseworkers may, upon receiving a case:

[99] The terms women-friendly space and adolescent girls' safe spaces also refer to WGSS.
[100] A "safe space" is a women-and-girls-only space; this is important because public spaces in most cultures are inhabited largely by men. Safe spaces provide a critical space where women and girls can be free from harm and harassment and can access opportunities to exercise their rights and promote their own safety and decision-making.
[101] IRC and International Medical Corps (2019). Advancing women's and girls' empowerment in humanitarian settings: a global toolkit for women's and girls' safe spaces
[102] Ibid.

- Work with survivors to explore options and strategies to stay with or leave their family, when appropriate and according to their choices, always prioritizing safety;
- Provide the hotline number to be used in case of emergency;
- As a last resort, provide interim alternative accommodation such as safe shelters and community based shelters, pending long-term options, providing referral costs and transport to the safe location whenever possible. Always assess the security risks related to this option and ensure ongoing monitoring of protection risks.

Security/safety actors

Security/safety concerns may be addressed by security personnel, neighborhood watch teams, police, APBn and/or the military responsible for security. These actors need to be identified and have clearly delineated responsibilities. In addition, communities must understand how to contact security personnel for help with safety, security, and protection.

Security/safety actors should:

- Encourage the community to report threats and help women coordinate solutions. The community needs to know that security personnel are there to help in cases of GBV.
- Pay adequate attention to safety plans and introduce the community-based protection mechanism where the survivors can seek urgent support while facing a life-threatening situation
- Provide hotline numbers (protection focal or other security personnel)
- The roles of the APBns and community-based protection mechanisms should be made clear so that survivors know where to report and security personnel know their role to support ensuring barriers are addressed.
- Safe shelter should be introduced as a last resort and Case workers should inform the CiC of any shelter referrals and ask for permission.
- Service providers should coordinate with CiC and the protection focal to address any urgent risk related to herself and the survivors.
- Explain to the community the reason for the presence of armed personnel in certain situations, such as patrols.
- Have female personnel receive reports of GBV and risks for women and girls and intervene to support survivors in police stations and during the transportation of the survivor. Provide a secure and private environment for speaking with the survivor/family. Be readily available to

listen to the concerns of the GBV survivor and receive the survivor with compassion and accept the survivor's story without passing judgment.

3.4.6 *Justice and Legal Aid*

The constitution of Bangladesh (in light of article 25, 31, 32, 33, 34 and 35) offers protection to the refugees in accordance with international tools like UDHR, CAT, ICCPR and CRC. In case a survivor wishes to pursue legal action for a GBV-related incident, comprehensive considerations should be taken into account. The survivor will receive clear and exhaustive information about procedures, limitations, pros and cons about legal options by a lawyer/ or legal actors. All actions are to be taken with the fully informed consent of the survivor.

The information will include:

- Physical and safety from further harm by the alleged perpetrator.
- Possible retaliation from the community and family members of the perpetrators and how support can be provided to protect the survivor
- Information related to the lodging of the complaint at the police station through the CIC in including the need for collection and preservation of forensic evidence in view of the hearing
- The restrictions in relation to medical examinations to be made only by the government authorized OCC.
- Challenges related to lengthy court procedures (up to 3 years) and hearing in open court to prepare the survivor mentally. This should not be told in such a way as to discourage the survivor.
- Available legal representation services in case of criminal or civil proceedings to be initiated at the request of the survivor; which partner or government entity will provide which support
- The continuation of all other case management services alongside the legal services or as the survivor desires.
- Available support if remedies through *alternative justice systems* are initiated.

Procedure for legal referral out of the camp for GBV incidents:

a) The case manager should refer the survivor to the lawyer who will provide counselling on the procedures of legal actions. The lawyer will make sure the Consent Form has been signed so that the survivor can be referred to the CIC to request immediate legal action.
b) The lawyer will provide support to fill out the complaint addressing the CIC, which will serve as a base for First Information Report (FIR). The FIR should state the basic details of the GBV incident: facts, time, place and name of the perpetrator(s) (if possible).
c) The CIC should immediately prepare the forwarding letter to the police requesting to register the complaint and authorize the movement of the survivor to the OCC.
d) The organization supporting the legal support should immediately organize the transportation of the survivor to Sadar Hospital/OCC, for forensic evidence and other urgent actions, if need be.
e) If the survivor wants, a family member may accompany her/him to the hospital. In case of children, an adult caregiver should always accompany them.
f) Arrangements of family members remaining in the camp should be discussed and finalized with the survivors
g) Based on the complaint forwarded by CIC, the Officer in Charge of the local police station will take the necessary legal action.
h) If at the police station the officer in charge refuses to register the case for any reason, the case will be filed directly at the Court.
i) In the case of CIC is not present in camp when referral needs to be done, for such a situation, the acting CIC will provide referral/forwarding with the consent and coordination of CIC.
j) Where possible especially in emergencies the CIC should give telephone authorization to ensure that justice prevails
k) The lawyer will follow up on the progress of the case and will keep the survivor / direct case manager updated on the case and will provide required support.

Mediation: GBV caseworkers do not conduct or take part in the mediation process. If a survivor wishes for mediation, the risks and potential consequences should be explained to her by the caseworker and she should be referred to a legal advocate to facilitate the mediation process. Upon the request of the survivor, a caseworker can accompany the survivor, stay on the margins

as an observer and intervene if the best interests of the survivor are at stake. The disengagement from the mediation process is to ensure the security of the caseworker and avoid further harm to the survivor.

Mandatory reporting of cases of sexual violence:

Non compoundable offenses: Under the Code of Criminal Procedure, 1898 (CrPC)[103], the police must investigate any cognizable offense, including rape, upon receiving a complaint, as per Section 157, without needing a warrant. The Women and Children Repression Prevention Act, 2000[104] further mandates the reporting and investigation of violence against women, including rape. Rape is a non-compoundable offense, meaning it cannot be settled between the survivor and the perpetrator, and the state must prosecute the accused, ensuring justice for the survivor.

Consent of age and rape: sexual relationship with girls below 16 is considered rape, consent is irrelevant/not considered by law. However, an exception in case of a married couple, sexual intercourse by a man with the wife not being under thirteen years of age, is not rape.[105]

1. Emergency preparedness and response for GBV case management services
2. Self-care and staff safety
3. Delayed reporting of rape case: Under Limitation Act 1908 , there is no statute of limitations for filing a rape case. This means survivors can report the crime at any time, even if there is a significant delay in filing the case. According to Section 157 of the CrPC, the police are required to investigate a cognizable offense such as rape, even if the report is made days, weeks, or months after the incident. However, justifications for delay may be important in certain circumstances to help establish the credibility of the survivor's complaint. Delayed reporting may affect the strength of the case due to the degradation of evidence, but it does not prevent a survivor from pursuing justice.

Police procedures for reports of GBV related crimes in the host community

Referrals will be made to the national justice systems by the police ONLY if the survivor has given their consent. If a referral is to be made and if the survivor wishes, a legal counselor or other support person will accompany them to the relevant authorities. If a survivor chooses to report their case to the police, the procedures are:

[103] The Code of Criminal Procedure, 1898
[104] Women and Children Repression Prevention Act 2000
[105] Section 375 of the Penal Code of 1860

- Survivor and their accompaniment report at the main police desk that there is a confidential matter to discuss
- The police officer will show the survivor and their accompaniment to the private interview room
- A police officer will take the survivor's statement and obtain information relevant to investigation of the alleged crime(s)
- Interviews with GBV survivors, and any witnesses, will only be conducted by police who have received training in interviewing survivors of GBV crimes. If there are female police officers available, they will conduct the interviews
- When the statement is complete, the police will issue the P-3 medical form to the survivor to be completed
- Survivor takes the P-3 form to health post for completion; as soon as possible after it is completed, the form is returned to the police
- Police conduct investigation immediately, even if the P-3 has not yet been returned
- When warranted, police arrest the alleged assailant, and file charges with the court.

3.4.7 *Dignity Kits*

Essential issues to consider

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

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

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

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

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

Humanitarian actors often distribute dignity kits that typically contain menstrual hygiene materials, soap, underwear and information on available GBV services, including where and how to access those services. Dignity kits may also include items that may help mitigate GBV risks such as radios, whistles and lights.[106]

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

It is important to conduct post-distribution monitoring to assess the distribution results, whether the right beneficiaries received the kits or any risks resulting from the distribution.[107] For further information see section 6.1 on menstrual hygiene management.

3.4.8 *Cash and Voucher Assistance (CVA)*

Essential issues to consider

Cash and voucher assistance (CVA) refers to all programmes where cash transfers or vouchers for goods or services are provided directly to recipients. In the context of humanitarian assistance, the term is used to refer to the provision of cash transfers or vouchers to individuals

[106] Dignity Kits Guidance Note

[107] Post-distribution monitoring is done through focus group discussions (FGDs) with women and girls 1-3 months after distribution to assess whether the kits achieved the intended result. It is important to ensure women and girls who receive kits are involved in post-distribution FGDs.

and household or community recipients only (not to governments or other State actors). The terms "cash" or "cash assistance" refer specifically to cash transfers (and do not include vouchers).

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

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

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

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

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

3.5 Economic Empowerment and Livelihood

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

for GBV survivors to receive information and access services and may also provide an outlet for emotional support and healing activities.

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

3.5.3 Additional Support Services

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

Life-skills, Education, Vocational and Business Restoration Support: This support can enhance the healing and recovery process of survivors including increasing confidence and their access to social support networks. Caseworkers will further conduct safety planning with survivors to understand risks and identify risk mitigation to increase their safety and reduce the risk of harm.

Caregiver Support during Hospitalization: If the survivor stays in a hospital, she may require a caregiver to provide support that the hospital will not provide and traditionally expects family members to provide. During a survivor's stay in the hospital, if no family caregivers exist, she needs to hire a caregiver to support her needs.

Other special considerations: Survivors may require changing their location due to safety concerns, they need support such as safe accommodation, school charges and other basic support for their children.

Material support for GBV survivors: GBV survivors will be provided dignity kits, risk-reduction supplies according to assessed needs.

3.5.4 Safe houses/emergency shelter

Safe houses/shelters are places that provide immediate security, temporary refuge and support to survivors who are escaping violent or abusive situations. This service is made available to women and girl survivors of GBV who are in imminent danger. Ideally, a safe shelter or house is

accredited and staffed by professionals. Admission is contingent on specific criteria and strict standard operating procedures. It is rarely possible for safe houses and shelters to be operated safely within a camp setting due to the need for their location to be confidential.[108]

In cases where safe houses/shelters are not available, emergency accommodation may be provided in the form of rented private houses or apartments, hotels or commercial venues, rooms in specialized facilities (e.g. hospitals or medical centres), places of worship (e.g. churches, mosques, temples, etc.) or a community-based system.[109]

Challenges to accessing additional services

Sometimes, GBV organizations lack livelihood programs and food/non-food items distribution are not their primary focus. Furthermore, they may be operational in areas with limited or no access to livelihood and relief/distribution services. As a result, survivors cannot be referred to these essential services. In conflict and crisis contexts, access to such services is further limited.

3.6 Refugee Case Processing

3.6.3 Registration

3.6.4 Refugee Status Determination

3.6.5 Durable Solutions

3.7 Community Outreach for Awareness Raising

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

Safety is an essential element to consider when designing community outreach information and methods. It is important to assess how certain information may be viewed by different members of the community. The means of sharing information with communities must also be considered. All GBV outreach should be led by or coordinated with GBV specialized actors.

Key attributes of effective community outreach messages on GBV include:

- Clarity: Keep the wording and meaning of the message simple.

[108] Inter-Agency Minimum Standards for GBV in Emergencies (2019), p. 64.

[109] For examples of alternative safe shelter, see ''Safe haven: sheltering displaced persons from sexual and gender-based violence''

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

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

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

In the context of the Rohingya refugee camps and host communities in Cox's Bazar and Bhasan Char, community outreach activities are mainly delivered by local partners, community-based organizations or community workers/volunteers. With the deepening in-fights in most locations, it is not safe to organize a group of people for awareness raising or mass campaigns and distribution of service information with contact details in printed materials of late. There are many locations where people cannot access telecommunication which further limits people's access to awareness or service information especially if there are limited humanitarian actors on the ground. Furthermore, there are many locations where there are limited or no GBV actors present on the ground, and it creates additional challenges for GBV survivors to access the available service information.

The humanitarian actors have been using below community outreach or awareness raising methods as a safe and context specific approach including but not limited to-

- Small group discussions
- Door to door visit
- Awareness raising in safe spaces/women & girls' friendly spaces/Adolescents and youths centers/ health facilities/ community spaces/religious buildings

In addition to the above outreach methods, the following community outreach methods have been used by humanitarian actors depending on the context.

- Structured social mobilization approach and male engagement activities
- Dissemination of IEC materials – posters, pamphlets, radio, Billboards
- Trainings / workshops (15-30 people)
- Meetings (15-50 people), Door to door visit (one-on-one discussions, 1-3 people)

Considerations in community outreach

Safety (of women and girls and of staff):

- Consult with women and girls to find out what is safe.
- People lose trust during crises, and families may not appreciate a woman talking to a stranger. Just talking to a stranger can sometimes lead to confinement or physical violence.
- Cultural attitudes towards different types of GBV.
- Respect people's time - women and girls (especially single female headed households) may be too busy to meet and go to find information or join information meetings.
- Be very careful with the kind of messaging that is used. Avoid messages that place the blame – even in an understated way - on women and girls for the violence they experience.

3.7.1 Gender Based Violence Prevention

Gender-based violence (GBV) prevention is a crucial aspect of any humanitarian response. It involves identifying and addressing factors that contribute to making some members of the

community more vulnerable to violence. Effective prevention strategies require a thorough understanding of the causes and contributing factors of GBV in a given context. Such strategies should be tailored to the specific needs of the community and should aim to protect and empower women, girls, and other at-risk groups. This includes addressing underlying causes of GBV, such as gender inequality. GBV prevention should be integrated into emergency response programs from the outset to facilitate early recovery.

Prevention and response are interrelated activities, and many GBV response measures are also preventive in nature. Prevention efforts must target the affected community, humanitarian aid staff, host country nationals, and government authorities. Strategies should aim to reach potential perpetrators, survivors, and those who may assist survivors. To be effective, prevention should include awareness-raising initiatives such as campaigns and mass media messaging, and other community-based and behavioral change approaches.

Preventing Gender-Based Violence (GBV): Principles and Approaches

To design and implement an effective prevention strategy for GBV, several key elements must be considered:

- All activities must target both the refugee/FDMN and host community, even if they are not done in the same activity or at the same time.
- A combination of short- and long-term approaches should be used to prevent GBV and promote positive behavior change.
- Short-term measures can include gender-sensitive design of services and assistance programs to reduce GBV risks (e.g., advocating for sex-segregated latrines or lighting systems, increasing the capacities of community outreach volunteers and frontline workers to safely identify and refer cases, monitoring protection concerns).
- Long-term prevention strategies aim to create a permanent change in social, cultural, and traditional norms, ultimately leading to behavioral and policy change (e.g., high-level advocacy for the revision of the legal framework, community-based dialogue, work on masculinity).
- Effective community participation in the program's design, implementation, and evaluation should be integral to prevention activities. Community participation helps to minimize the risk of exclusion of certain groups during the design and delivery of services, recognize and understand power relations within communities, promote greater respect

for the rights of women and gender equality, and encourage the participation of children, particularly adolescents, as well as elderly persons and persons with specific needs.

- All staff working on the program's implementation should be trained in GBV prevention and response, PSEA, communication skills, GBV guiding principles, human rights, and women's rights. It is important to acknowledge that each staff member has their own attitudes and beliefs that also need to be addressed through internal behavioral-change interventions, as well as stressing the importance of separating personal beliefs from professional conduct.
- Prevention strategies and mechanisms should be adapted to each target group, taking into account gender and age-sensitive approaches and targeting children, adolescents, adults, women, girls, men, and boys.
- All key messages, sensitization tools, and other IEC materials produced should be pre-tested with communities (separate consultations held with women, girls, men, and boys), and their feedback should be included in the final design.
- Programs and activities should target all levels - individual, relationship, community, and society levels. Examples of prevention activities include behavioral change, which are often conducted simultaneously and are interrelated.

Social behavioral change to transform social norms

This can be achieved through various means such as the development of Information, Education and Communication materials with key messages for prevention, and using these materials to facilitate discussions on gender-based violence (GBV) and gender roles. Other strategies include mobilizing religious and community leaders to promote the protection of women and girls and speak out against GBV; establishing peer-to-peer support groups for women, girls, men, and boys; and engaging men and boys in prevention and response efforts through the establishment of men's groups, youth activities and centers, peer-to-peer support, and role models to promote non-violent behavior.

Adolescent-targeted programming, such as Girl Shine, can also be implemented to help prevent and respond to violence against adolescent girls in humanitarian settings by providing them with skills and knowledge to identify types of GBV and seek support services if they experience or are at risk of GBV.

A comprehensive and systematic community mobilization approach, such as SASA!, can also be used to mobilize the community. This involves conducting dialogue sessions that unpack both positive and negative powers and the impacts of both on women and girls, using local activism, community leadership, and institutional strengthening strategies

3.7.2 GBV Service Providers

To prevent GBV effectively, all parties/GBV service providers to these SOPs should:

- Provide or participate in training about GBV, the IASC GBV Guidelines, these SOPs, and other relevant materials adapted to the sector of intervention.
- Strengthen community-based prevention efforts, including promoting positive gender norms and engaging men and boys in GBV prevention.
- Establish safe spaces for women and girls where they can access services and support and participate in activities to build their resilience and promote their empowerment.
- Provide comprehensive SRH education and information to adolescents and young people to prevent GBV and promote healthy relationships.
- Strengthen the capacity of local organizations and community leaders to prevent and respond to GBV.
- Adopt codes of conduct for all staff that focus on preventing sexual exploitation and abuse. This includes providing training to all staff, requiring all staff to sign the code of conduct, establishing safe and confidential reporting mechanisms, and following up on reports.
- Ensure services are inclusive and accessible for persons with special needs.
- Carefully coordinate, develop, and implement GBV awareness-raising activities within the community and advocacy among other humanitarian actors and government authorities in collaboration with the GBV sub-working group.
- Organize economic empowerment activities to reduce vulnerabilities.
- Assess security and safety and address protection issues to strengthen the protective environment. When designing projects and implementing interventions,

3.7.3 Security and Legal Sector

Maintain adequate security presence.

- Through formal and informal networks, maintain awareness of protection and security issues related to GBV;

- Provide information to the GBV Sub-Sector and working group about protection and security issues;
- Develop and strengthen specific prevention strategies to address evolving security issues;
- For legal justice actors, raise awareness among the refugee/FDMN on national laws and available legal aid services;

3.7.4 Community Leaders including religious leaders

- Maintain awareness of GBV risks and issues in the setting, communicate those to security actors and the GBV working group;
- Engage in problem-solving discussions to continuously strengthen prevention strategies;
- Actively promote respect for human rights and women's rights, including equal participation of women;
- Ensure peace among and between the communities;
- Facilitate reconciliation within their jurisdictions as a means of peace building and conflict mitigation;
- Create awareness on GBV prevention;

3.7.5 Social services and civil society organizations

- Provide GBV prevention, protection, care and management services.
- Advocate and lobby for enforcement and implementation of GBV related laws, policies, and programs.
- Raise awareness on GBV prevention, protection and response;
- Encourage participation and inclusion of marginalized persons;
- Ensure non –discrimination if any action of discrimination is observed report to service providers
- Influence changes in socio-cultural norms; promote respect for human rights and women rights;
- Ensure survivors have access to information about where to seek assistance and how to report; with consent of the survivor;

3.7.6 Health and medical sector

- Ensure health services are accessible to women and children
- Integrate GBV awareness-raising and behavior change activities into community health activities

Prevention of GBV, means identifying, understanding and addressing its causes and contributing factors. All actors recognize that anyone can experience GBV and that risks exist at individual, relationship, community, society level and these risks increase during crisis or emergency.

Safe and Appropriate Community Outreach Methods

Safe and Appropriate Community Outreach Methods	***Description***
Community Meetings and Group Discussions	*Organize small-group discussions and community meetings in safe locations.* *Use trained local community volunteers/incentive workers to conduct sessions, ensuring cultural appropriateness and sensitivity.*
House to House Visits	*Use local incentive workers/ outreach workers to conduct sharing sessions on GBV, SRHR, organization's available services, and Community Feedback Mechanisms (CFM), and hotline numbers.*
Information, Education, and Communication (IEC) Materials	*Distribute posters, pamphlets, and flyers with clear, culturally appropriate messaging.* *Utilize visual aids and simple language to ensure inclusiveness by all community members.*
Mobile Outreach	*Implement mobile teams to reach remote and hard to reach areas.* *Provide information and services through mobile units equipped with necessary resources.*
Distribution Points	*Share information during distributions of dignity kits, non-food items, or other aid, ensuring messages reach a broad audience.*

	Coordinate with distribution teams to include GBV awareness materials and service information in distribution packages.
Schools and Educational Institutions	*Conduct special sessions for students, teachers and parents on GBV prevention and response.*

By employing these methods, outreach activities can effectively increase timely and safe access to GBV services while mitigating risks, enhancing a supportive and informed community.

4 SECTION 4: DOCUMENTATION CONSIDERATIONS FOR CASE MANAGEMENT PROVIDERS

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

Case documentation[110] refers to the documentation of information (either on paper or digitally) relating to an individual survivor's case management service provision by a case management organization. Generally, case documentation information includes dates of services and summaries of discussions, a brief description of the incident and the survivor's situation, relevant action plans and follow-up appointment information. Case documentation also includes the date and reason for closing the survivor's case.

Although documentation supports the quality of service provision to survivors and promotes accountability, it is not required to provide quality case management services and might be inappropriate under certain conditions. Setting up a system to document individual case

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

information is appropriate only if a service is offered and paper or digital records can be securely stored. Any type of survivor information should only be collected in line with the GBV guiding principles, on a need-to-know basis and as part of direct service provision. It is not appropriate, for example, to seek out or record identifiable information about survivors solely for the purpose of protection or human rights monitoring.

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

Documentation is an important part of all stages of case management practice. It helps keep track of what has been discussed between the caseworker and the survivor, of what has been identified to support the survivor, and what steps are to be taken to help address the survivor's needs. Maintaining case files depends on the specific context and the ability to ensure safe, confidential storage of all information. All program data containing information about survivors should be collected and stored in adherence to international standards that prioritize survivors' confidentiality, safety and security.

Since 2018, the GBV SS has endorsed and recommended for all actors providing GBV services to adopt a case management approach which includes using the GBV Information Management System (GBVIMS) for collecting GBV incidents data. As lead agency of the GBV SS, the United Nations Population Fund (UNFPA) is responsible for ensuring regular compilation and consolidation of GBVIMS data and reporting of non-identifying GBV incidents data. Led by UNFPA and co-led by the United Nations High Commissioner for Refugees (UNHCR) a GBVIMS Task Force ensures that GBVIMS statistics reports are discussed and analysed at the level of the GBV-SS. See Annex 10 for the Terms of Reference. To support analysis the task force will use any qualitative data submitted by GBV-SS members concerning unreported incidents following a unique format and using focus group discussions (FDGs). Adhering to the GBVIMS Information Sharing Protocol (ISP), recommendations and gaps highlighted from that analysis are

disseminated to key actors and sectors to take joint actions to improve GBV services, mitigate GBV risks and influence policies. Such actors include the refugees and host communities as well as the government counterparts (CiCs, RRRC, security and justice actors). Communication with local government and CiCs is the responsibility of GBV focal points.
In developing and sharing any GBV incidents data report, all potentially identifying information of the survivors/victims, their families, and the perpetrators must be removed following the agreed guidance of the GBVIMS ISP. See Annex11 for the Terms of Reference.

The data collected through GBVIMS is only representative of the reported GBV incidents which is only a fraction of the actual GBV incidents situation in the camps and host communities. Every GBV partners under the leadership of the GBV Sub Sector coordination should engage in regular monitoring of GBV risks and vulnerabilities in their respective location to ensure appropriate measures are taken to mitigate GBV risks, prevent and adapt their response accordingly. Specific indicators about relevant aspect to monitor under each sector can be found under Annex 12 and 13

4.1 Documentation of reported GBV incidents (New Guiding document lists this as Case Management Forms and Case Files.)

The GBV-SS has endorsed the GBVIMS tools for any GBV incidents data collection in the context of service provision to GBV survivors in the Rohingya humanitarian response in Cox's Bazar. The GBVIMS tools include an intake and consent forms that are used to document GBV incidents in a safe and ethical way (see Annex 14 and 15).

These tools are meant to be used ONLY by the direct service providers using GBV case management as an approach in assessing survivors' needs and link them with other services to ensure a multi sector response to their needs. These forms should not be shared externally except for the purpose of referrals where incident details are necessary and only with the informed consent of survivors. As per the GBVIMS standards, each survivor should have a **separate** case file that includes all relevant completed case management forms. Consent forms signed by the survivor need to be stored separately. A code should be assigned and marked on the front of each case file. **Names should never be recorded on the front of or inside case files and photos should never be affixed to case files**. Organizations collecting GBV data must have a

contingency plan to deal with GBV case files (forms) as well as their electronic data in case of any natural disaster and based on an updated security analysis in the camps and host communities. The GBV-SS should coordinate with the ISCG to advocate on the confidentiality of data sharing with the RRRC and other government stakeholders.

To implement the GBVIMS+/Primero tool, organizations should be endorsed by the GBV-SS Task Team (TT) once they have met the requirements as per the GBVIMS assessment (See Annex 16). All staff involved in filling the GBVIMS forms must be trained in GBV case management and on the use of GBVIMS before they start using the forms. As per 2022 and the GBVIMS Terms of Reference (ToR), the GBVIMS tools will be used by trained staff. While filling the intake form, the purpose of the case workers should not be collecting necessarily all the data but rather they should actively listen to the survivors with compassion, maintaining confidentiality and respecting their wishes. Due to the sensitive nature of the data collected in the intake form, case workers must always explain to survivors the measures they take to keep survivors information safe and confidential (e.g.: intake forms must be kept in a locked cabinet; prior to any information sharing survivors will be consulted for their informed consent. In cases of SEA, survivors must be informed of the limits around SEA before they share information. After that, if they choose to proceed, the case worker should offer the different options available for reporting an SEA incident and the survivor can choose the option most suitable to them. The GBV case worker needs to remain survivor-centered and offer survivors every opportunity to make choices throughout any mandatory reporting process, including the choice to report anonymously. Informed consent is mandatory irrespective of the reporting option that the survivor sought.

As lead of the GBV Sub Sector UNFPA will coordinate and facilitate training on GBVIMS for agencies once they have submitted their training request for the purpose of using the GBVIMS tools.

To document GBV incidents, the GBV SS has endorsed the definition of GBV types under the GBVIMS. These include rape, sexual assault, physical assault, forced marriage, denial of resources and psychological and emotional abuse (see section definition of terms). Under these SOPs, the definitions of GBV types are for the purpose of GBV programming for humanitarian assistance to survivors and are not necessarily legal definitions in relation to the GBVIMS classification tool.

4.1.1 Data management about reported GBV incidents

As described above, each organization providing GBV case management must use the GBVIMS intake form to document GBV incidents reported by survivors themselves or by their guardians (accompanied by the child survivor) in a consistent and timely manner. In line with the existing GBVIMS ISP (See Annex 11) applicable to these SOPs, non-identifying monthly aggregated data about these incident reports will be collected and shared with UNFPA. Obtaining survivors' informed consent is a condition for any data sharing except for PSEA cases or where someone's life is in danger in connection with the reported GBV incident.

The GBVIMS Coordinator under the GBV-SS is responsible for compilation of monthly, and quarterly factsheets and annual reports that contain non-identifying data about reported incidents, service provision and gaps. These consolidated reports will be submitted to the GBVIMS Task Force members who will compare monthly reports over time, discuss and analyse summary information about GBV incidents being reported, general outcomes, security issues, referral and coordination issues, and key programmatic recommendations and advocacy across sectors. As per the data sharing guidance prescribed by the GBVIMS ISP, GBVIMS report findings and recommendations will be shared to the GBV-SS for further comments and endorsement. This information will guide the continuous development of multi sectoral prevention and response actions involving actors from Child Protection, Protection, Health, SRH, and other humanitarian sectors as well as the existing government counterparts Security actors, CICs and RRRC. It is important to always remind the users that these statistics are only information about self-reported GBV incidents, which represents only a small proportion of the actual GBV incidents happening in the Rohingya refugee and host communities.

The data elements included in these reports are:

- Context, methodology, limitations of the GBVIMS data
- Statistics in percentages about GBV types, incident location, incident time of day, case context, Survivor age and sex, displacement status during reporting and stage of displacement during incident, perpetrator's age and occupation
- Services received, services declined, referrals made, services gaps,
- Key Programmatic recommendations and responsibilities

4.1.2 Qualitative Data About GBV Risks and Unreported Incidents

Because the statistics on reported incidents represent only a small proportion of the actual GBV incidents occurring in the Rohingya refugees and host communities, each GBV organization should find, compile, and monitor *qualitative* information. This information includes findings from focus group discussions, anecdotal information on GBV incidents, community perceptions of risky areas or suspicious activities, and any issues that may be recognized or suspected. These must be presented and discussed at the camp level coordination, GBVIMS task team and where necessary the GBV-SS meetings. See Annex 17 for Tools and indicators that can support qualitative data collection.

4.1.3 GBV monitoring report

The GBV-SS monitors and compiles key prevention and response achievements which are provided to the ISCG on a monthly basis. Additionally, and within the limits of the GBVIMS ISP, the GBV-SS produces quarterly and annual GBVIMS factsheets and reports that are shared with members of the GBV, Child Protection and Protection sub-sectors, as well as relevant government counterparts such as the CiCs, RRRC, MOCHA, . Any other actor interested in these reports can submit a request to the GBV-SS (see Annex 18).

4.2 Refugee Case Processing Documentation and Information Sharing.

5 SECTION 5: PROTECTION FROM SEXUAL EXPLOITATION AND ABUSE

Essential issues to consider

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

- Ensuring that GBV services and referral pathways reflect the needs of SEA survivors and that the support is streamlined (i.e. that no parallel referral pathway is created).
- Sharing information on referral pathways with the PSEA coordinator and focal points.

- Supporting training for PSEA focal points and network members on GBV SOPs and referral pathways.
- Promoting PSEA training and codes of conduct for GBV actors.
- Supporting the development of PSEA SOPs to ensure the integration of GBV guiding principles and survivor-centered approach.
- Promoting the establishment or support of community accountability and feedback mechanisms.

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

As outlined in the UN Secretary-General's bulletin for protection from sexual exploitation and abuse,[111] sexual exploitation and abuse violates universally recognized international legal norms and standards and is prohibited conduct for humanitarian aid personnel. It harms those whom humanitarian actors are mandated to protect.

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

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

[111] United Nations Secretary-General, 2003. Secretary-General's Bulletin: special measures for protection from sexual exploitation and sexual abuse, ST/ SGB/2003/13.

Limits to confidentiality

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

Harmonized service provision

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

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

Inter-agency GBV minimum standards, p. 23.

5.1 Prevention

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

5.2 Reporting and response

The GBV response system is the appropriate referral system for women and girls to access support if they experience sexual exploitation and abuse perpetrated by humanitarian actors or other duty bearers.[112]

Each organization is responsible for ensuring that their staff understand their individual responsibilities to report any suspected incidents and know the mechanisms in place for

[112] See also UNFPA, Tip sheet: defining linkages to better assist survivors of sexual exploitation and abuse (2022)

mandatory reporting (see section 3.3.3). They must also establish reporting mechanisms if these are not already in place.

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

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

Please refer to Section 3.3 on PSEA reporting and referral processes.

6 SECTION 6: RISK MITIGATION

Essential issues to consider

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

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

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

All humanitarian sectors and actors are responsible for promoting women's and girls' safety and reducing their risk of GBV. The IASC GBV Guidelines state clearly and prominently: "All humanitarian actors must be aware of the risks of GBV and – acting collectively to ensure a

comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation." (p. 14). Protecting women and girls from GBV stems from all national and international actors' essential duty to protect those affected by crises.

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

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

GBV specialized actors must be aware of risks to women and girls to inform advocacy with the sectors responsible for mitigating these risks. GBV specialized actors' role is to facilitate support to non-GBV sectors and actors to analyze the GBV risks safely and ethically in their environment, using available information and data from an age, gender and diversity perspective; and to provide technical inputs to other sectors' coordination and programming actions on GBV risk mitigation. This encompasses how to consult safely with affected communities, especially women and girls, on barriers to accessing services as well as safety concerns they may have, including sexual exploitation and abuse perpetrated by humanitarian actors.[113]

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

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

GBV Risk Mitigation

Risk mitigation refers to a process and set of specific interventions in all phases of humanitarian programming. It includes actions that are taken in each humanitarian sector and area of work to reduce risks and exposure to GBV and improve safety as part of an agency-wide mainstreaming approach. Cross-sectoral coordination is essential to ensure a comprehensive approach. Risk mitigation measures also contribute to reducing the risk of Sexual exploitation & abuse (SEA). Sectors must anticipate and identify GBV risks and take prompt action to mitigate them, including through intervention/advocacy with national authorities and service providers. In order to reduce GBV risks, sectors will integrate risk mitigation interventions into all planning documents, work plans and strategies.

GBV risk mitigation means taking actions to:

• Avoid causing or increasing the risk of GBV associated with humanitarian programming

• Facilitate and monitor vulnerable populations' safe access to and use of humanitarian services

• Identify and actively reduce the risks of GBV in the environment and programming/service delivery.

OBJECTIVES:

Integrating GBV risk mitigation actions into the sector/cluster's programs, across all elements of the program cycle:

- To contribute to safer programming in order to avoid increasing the GBV occurring by creating or exacerbating GBV risks.
- Seek to identify and actively mitigate GBV risks
- Contribute to ongoing monitoring of access and barriers to services, particularly for women and girls,
- Staff are equipped to refer survivors of GBV using available GBV referral mechanisms safely and confidentially.

IMPLEMENTATION/ METHODOLOGY:

To mainstream effective GBV risk mitigation measures in all programming and service delivery, members of the workforce need to understand who is at risk, the source of that risk, and the (un)

intended impact of acting or not acting to mitigate the risk of GBV within their respective functions.

The proactive and ongoing process of mainstreaming is a shared responsibility whereby all colleagues, and multi-functional teams (MFTs), must consider GBV and take measures to reduce exposure to identified risks at all stages and the displacement continuum. Mainstreaming responsibilities require specific actions to be undertaken in preparedness, needs assessment, strategic planning, resource mobilization, implementing and reporting. Applying the four elements of protection mainstreaming (i.e., safety and dignity, non-discrimination/meaningful access, accountability and participation, and empowerment) in all sectors and areas of work will contribute to mitigating the risk of GBV. In the context of Bangladesh UN agencies working on GBV under the leadership of GBV SS will advocate for and support the integration of appropriate mainstreaming measures. Mainstreaming also requires that all workforce, and partners be appropriately trained to safely handle disclosures of GBV incidents and to make referrals. This includes incidents reported directly or indirectly. All members of the workforce, within the context of their role and function, must apply the GBV Guiding Principles, and ensure that survivors are referred to services as requested. The limits of role and function means that case management service provision should only be undertaken by specialized GBV and/or personnel trained in GBV Case Management.

The following are actions to be included in humanitarian programming to mitigate GBV:

Assessment & Design:

- Ensure meaningful and safe consultation with all ages including at-risk groups to identify safety risks in all thematic areas of programmes and measure to address and mitigate these risks, for example, using safety audits.
- Assess gender and community norms and practices related to the thematic area that may increase the risk of GBV.
- Facilitate participatory planning and design with at-risk groups, including women and girls, older people, people with disabilities and others with specific protection concerns.
- Collaborate with all ages of community people including women, men, girls, boys and those people with disabilities to determine the design of the program in order to avoid risk of GBV.

Implementation Response:

- Identify, analyze and mitigate social, physical and psychological barriers that prevent safe access to humanitarian services.
- Identify and address GBV risks associated with accessing services.
- Use checklists to ensure that all considerations for GBV risk mitigations have been made. The IASC criteria for checklists can be followed.
- Implement specific measures to make programming safer and more responsive to the diverse needs of community people.
- In case of distribution of any items ensure an appropriate distribution system that enables access to services and mitigates increased risk of GBV.

Monitoring and Evaluation

- Conduct ongoing safety audits with at-risk groups as part of regular programmatic monitoring and evaluation for activities.
- Collect and analyze sex, age and disability disaggregated data to understand who is being reached and who is missing out and address gaps and improve targeting.
- Establish confidential, accessible and safe community feedback, complaint and accountability mechanisms.

Resource Mobilization:

- Ensure that appropriate and adequate resources are mobilized within the sectors and allocated for GBV risk mitigation interventions.
- Document and report on GBV risk mitigation interventions, and lessons learnt within the area-based sector for continuous learning and programming.

GBV Safety Audits

GBV safety audits can be an inclusive, simple, and safe way of rapidly assessing GBV risk and response gaps in humanitarian settings. Safety audits have four main objectives:

- Assess and monitor the overall safety and GBV prevention, mitigation and response programming within a given setting in the camps.
- Identify promptly GBV risks and gaps in new programming or identify programming that requires adjustment to advocate for actions that reduce GBV risks and improve response across humanitarian sectors.

- Enhance evidence-informed programming, advocacy, coordination, and partnership, including informing GBV response, risk reduction and prevention specialized programs.
- Act as GBV accountability to affected communities' tool as community members are consulted on risk and then GBV actors follow up on action points in a coordinated way and eventually give feedback to communities on actions for ongoing engagement. Note that the community itself can lead on certain follow up actions from safety audits, in a safe way, as the community has a key role in GBV risk reduction.

Safety audits can be adapted in the development context, where specific actors work on GBV prevention and response programming and services to identify gaps, minimize risks, enhance performance, and ensure accountability to the people they serve. Similarly, self- audit can also be adapted to review, for instance, compliance with standards, system functionality, quality of services, the type of risks a program or service poses, incidents or events, and records in a specific sector or context. The tools for safety or self-audits should either be newly developed or contextualized.

Key resources/toolkit:

The key global tool for supporting the integration of GBV risk mitigation actions in humanitarian programming is the **2015 Inter Guidelines for Integrating Gender-- agency Standing Committee (IASC) based Violence Interventions (the "GBV Guidelines") in Humanitarian Action.** The purpose of the GBV Guidelines is to assist humanitarian actors and communities affected by armed conflict, natural disasters and other humanitarian emergencies to coordinate, plan, implement, monitor and evaluate essential actions for the prevention and mitigation of gender in all sectors of humanitarian response.

The Guidelines provide sector-- based violence (GBV) across specific recommendations for integrating GBV risk mitigation across each element of the program cycle. Please see www.gbvguidelines.org for additional tools and information.

GBV specialized actors' commitments[114] to other humanitarian sectors to reduce risk of GBV in the setting include but are not limited to:	**Non-GBV actors'** commitments to mitigate risk of GBV, including but not limited to the following:
- Providing accurate and accessible information on available GBV services and referral processes. - Supporting non-GBV actors to analyse the GBV risks safely and ethically in their environment. - Providing technical inputs to other sectors' coordination and programming actions on GBV risk mitigation, including how to consult safely with affected communities, especially women and girls, on barriers to accessing services as well as safety concerns they may have, including sexual exploitation and abuse perpetrated by humanitarian actors; 1. Supporting or providing training about gender-based violence, the Inter-agency GBV minimum standards, IASC GBV Guidelines, these	- Require code of conduct commitments by all staff and create accountability mechanisms for staff about sexual exploitation and abuse. - Identify an active GBV focal point per sector. - Include GBV risk mitigation interventions in all humanitarian response plans and refugee response plans. - Conduct and track safety audits.[115] - Set up functional community-based feedback and complaint mechanisms that can respond to sexual exploitation and abuse, including complaint referral forms. - Ensure that all staff: 1. Have at least a basic understanding of gender-based violence, the GBV minimum standards and the IASC GBV Guidelines. 2. Are trained on safe response to disclosure and know how and where to refer a survivor for support and assistance (using a psychological

[114] GBV staff are not expected to have specialized knowledge of each humanitarian sector. Efforts to integrate GBV risk reduction strategies into different sectoral responses are led by sector actors to ensure that any recommendations from GBV specialized actors are relevant and feasible within the sectoral response.
[115] UNHCR, Safety audit toolkit. Safety Audit Toolkit (2021).

GBV SOPs and other relevant materials. *UNFPA and GBV actors coordinate with other sectors (Non-GBV actors) for the consideration of GBV risk mitigation in their program/project locations. UNFPA and GBV actors provide training on guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action to the non- GBV actors (Wash, Food and Education, etc.).* *UNFPA provides safety audit orientation sessions to both GBV and non-GBV actors in terms of GBV risks mitigation. Mostly, GBV actors conduct the safety audit 1 -2 times a year to identify GBV risks in the environment and share the key finding with GBV SS members as well as protection actors/Wash actors.* *Moreover, the findings are shared and advocated with GBV and other clusters to address identified GBV risks. Some GBV specialized actors conduct regular listening sessions with women and girls to identify risks of GBV. In terms of risk mitigation in advance, code of conduct and PSEAH training for staff including community volunteers/incentive workers are regularly conducted by both GBV and non-GBV specialized actors in Rakhine. In addition, Community Feedback and Response Mechanisms (CFRM) are established to safely*	first aid approach, in line with the GBV pocket guide). *Non-GBV actors join monthly GBV SS meetings to know GBV updates as well to integrate GBV risk mitigation in their existing project implementation activities.* *Health care service providers provide essential health services, including treatment for injuries resulting from GBV, sexual and reproductive health care, and mental health and psychological support. Most non-GBV actors regularly organize basic GBV concepts, GBV awareness including community awareness sessions, organize public events such as 16 Days of Activism events, and referral pathways in place. In addition to that, non-GBV actors provide life skills training, vocational trainings, on-farm and off-farm livelihood supports for women and girls including GBV survivors in terms of women empowerment for GBV risk mitigation.*

monitor GBV and SEAH risks through various channels including hotline numbers, emails, suggestions boxes, and surveys. In addition to GBV awareness sessions, PSEAH, CFRM awareness and available services information sharing sessions are regularly conducted in WGCs and communities by some GBV specialized actors to increase community members' knowledge of GBV and SEAH risks and how to seek services/support.	

6.1 Menstrual hygiene management

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

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

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

Access to menstrual products can also be provided through CVA. Key considerations include availability of a variety of quality items and barriers to access, including specific barriers for adolescent girls.[116]

Women's and girls' safe spaces (WGSS) (see section 3.4.4) and dignity kit distribution – particularly when complemented by information/awareness sessions – can be important entry

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

points for women and girls to access information about menstruation and receive MHM materials.

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

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

6.2 Cash and voucher assistance[117]

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

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

[117] IASC GBV Guidelines, Cash & voucher assistance and GBV compendium: Practical guidance for humanitarian practitioners (2019)

7 SECTION 7: GBV PREVENTION

Essential issues to consider

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

GBV prevention programming aims to address the root causes of GBV and promote the safety and equality of women and girls. GBV prevention programming requires working along a spectrum ranging from immediate risk mitigation in an acute emergency (see section 6) to longer term social norms and systemic change. GBV prevention approaches can be divided into four categories:[118]

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

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

addressing trauma and the long-term medical and psychosocial needs a survivor may have.

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

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

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

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

Creating spaces for dialogue and sharing with communities – i.e. adopting inclusive and intersectional approaches rather than defensive positions when facing opposition or questions on the prevention work – is a pathway to reaching agreement on an ultimate goal (e.g. ending VAWG).[119]

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

1. Prioritize the safety of women and girls.
2. Use an intersectional gender-power analysis.
3. Start with ourselves.
4. Centre the voices, power and agency of women and girls.

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

5. Recognize, engage and be accountable to women and girls experiencing multiple forms of discrimination.
6. Reflect the specific context.
7. Work in solidarity with women's rights organizations, activists and leaders.
8. Engage communities in ways that are meaningful, creative and dynamic, asking questions rather than giving messages.[120]

Prevention programming may encourage women and girls to speak out on violence and seek assistance. **As such, it is critical to remember that it is unethical for prevention programmes to stimulate attention on GBV in communities without first ensuring there are services in place for survivors**.[121]

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

Prevention and response are two sides of the GBV continuum and are intricately linked and built on each other. Prevention efforts must target the affected community, humanitarian aid staff, host country nationals, and government authorities. Strategies should aim to reach potential perpetrators, survivors, and those who may assist survivors. To be effective, prevention should include awareness-raising initiatives such as campaigns, mass media messaging, and other community-based and behavioral change approaches - to the extent possible, based on evidence.

7.1 Preventing Gender-Based Violence (GBV): Principles and Approaches

To design and implement an effective prevention strategy for GBV, several key elements must be considered:

- All activities must target both the refugee and host communities, even though there may be contextual variations in the activities and the period of their implementation.
- A combination of short- and long-term approaches should be used to prevent GBV and promote positive behavior change.

[120] See International Rescue, EMPOWER: Preventing violence against women and girls in acute emergencies (2021)
[121] These and other potential risks and concerns are identified in the prevention programming risk analysis checklist in Annex 6. See also Inter-Agency Minimum Standards for GBV in Emergencies (2019), standard 13: Transforming systems and social norms.

- Short-term measures can include gender-sensitive design of services and assistance programs to reduce GBV risks (e.g., advocating for sex-segregated latrines or lighting systems, increasing the capacities of community outreach volunteers and frontline workers to safely identify and refer cases, monitoring protection concerns).
- Long-term prevention strategies aim to create a permanent change in social, cultural, and traditional norms, ultimately leading to behavioral and policy change (e.g., high-level advocacy for the revision of the legal framework, community-based dialogue, work on masculinity).
- Effective community participation in the program's design, implementation, and evaluation should inform prevention activities. Community participation helps to minimize the risk of exclusion of certain groups during the design and delivery of services, recognize and understand power relations within communities, promote greater respect for the rights of women and gender equality, and encourage the participation of children, particularly adolescents, as well as elderly persons and persons with specific needs.
- All staff working on the program's implementation should be trained in GBV prevention and response, PSEA, communication skills, GBV guiding principles, human rights, and women's rights. It is important to acknowledge that each staff member has their own attitudes and beliefs that also need to be addressed through internal behavioral-change interventions, as well as stressing the importance of separating personal beliefs from professional conduct.
- Prevention strategies and mechanisms should be adapted to each target group, taking into account gender and age-sensitive approaches and targeting children, adolescents, adults, women, girls, men, and boys.
- All key messages, sensitization tools, and other IEC materials produced should be pre-tested with communities (separate consultations held with women, girls, men, and boys), and their feedback should be included in the final design.
- Programs and activities should target all levels - individual, relationship, community, and society levels. Examples of prevention activities include behavioral change, which are often conducted simultaneously and are interrelated.

Social behavioral change to transform social norms

This can be achieved through various means such as the development of Information, Education and Communication materials with key messages for prevention, and the use of these materials to facilitate discussions on gender-based violence (GBV) and gender roles. Other strategies include mobilizing religious and community leaders to promote the protection of women and girls and speak out against GBV; establishing peer-to-peer support groups for women, girls, men, and boys; and engaging men and boys in prevention and response efforts through the establishment of men's groups, youth activities and centers, peer-to-peer support, and role models to promote non-violent behavior.

Adolescent-targeted programming, such as Girl Shine, can also be implemented to help prevent and respond to violence against adolescent girls in humanitarian settings by providing them with skills and knowledge to identify types of GBV and seek support services if they experience or are at risk of GBV.

A comprehensive and systematic community mobilization approach, such as SASA!, can also be used to mobilize the community. This involves conducting dialogue sessions that unpack both positive and negative powers and the impacts of both on women and girls, using local activism, community leadership, and institutional strengthening strategies

7.2 GBV Service Providers

To prevent GBV effectively, GBV service providers/Parties to these SOPs should:

- Provide or participate in training about GBV, the IASC GBV Guidelines, these SOPs, and other relevant materials adapted to the sector of intervention.
- Strengthen community-based prevention efforts, including promoting positive gender norms and engaging men and boys in GBV prevention.
- Establish safe spaces for women and girls where they can access services and support and participate in activities to build their resilience and promote their empowerment.
- Provide comprehensive SRH education and information to adolescents and young people to prevent GBV and promote healthy relationships.
- Strengthen the capacity of local organizations and community leaders to prevent and respond to GBV.
- Adopt codes of conduct for all staff that focus on preventing sexual exploitation and abuse. This includes providing training to all staff, requiring all staff to sign the code of

conduct, establishing safe and confidential reporting mechanisms, and following up on reports.

- Ensure services are inclusive and accessible for persons with special needs.
- Carefully coordinate, develop, and implement GBV awareness-raising activities within the community and advocacy among other humanitarian actors and government authorities in collaboration with the GBV sub-working group.
- Organize economic empowerment activities to reduce vulnerabilities.
- Assess security and safety and address protection issues to strengthen the protective environment, when designing projects and implementing interventions.

7.3 Security and Legal Sector

Maintain adequate security presence.

- Through formal and informal networks, maintain awareness of protection and security issues related to GBV;
- Provide information to the GBV Sub-Sector and working group about protection and security issues;
- Develop and strengthen specific prevention strategies to address evolving security issues.
- For legal justice actors, raise awareness among the refugee/FDMN on national laws and available legal aid services;

7.4 Community Leaders including religious leaders

- Maintain awareness of GBV risks and issues in the setting, communicate those to security actors and the GBV working group;
- Engage in problem-solving discussions to continuously strengthen prevention strategies;
- Actively promote respect for human rights and women's rights, including equal participation of women;
- Ensure peace among and between the communities;
- Facilitate reconciliation within their jurisdictions as a means of peace building and conflict mitigation;
- Create awareness on GBV prevention;

7.5 Social Services and Civil Society Organizations

- Provide GBV prevention, protection, care and management services.
- Advocate and lobby for enforcement and implementation of GBV related laws, policies, and programs.

- Raise awareness on GBV prevention, protection and response;
- Encourage participation and inclusion of marginalized persons;
- Ensure non –discrimination if any action of discrimination is observed report to service providers
- Influence changes in socio-cultural norms; promote respect for human rights and women rights;
- Ensure survivors have access to information about where to seek assistance and how to report; with consent of the survivor;

7.6 Health/medical sector

- Ensure health services are accessible to women and children
- Integrate GBV awareness-raising and behavior change activities into community health activities

Prevention of GBV, means identifying, understanding and addressing its causes and contributing factors. All actors recognize that anyone can experience GBV and that risks exist at individual, relationship, community, society level and these risks increase during crisis or emergency.

8 SECTION 8: PREPAREDNESS

Essential issues to consider

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

GBV sub- sector play a significant role in ensuring that appropriate arrangements are in place for immediate provision of GBV services and that risk mitigation measures are in place across other sectors of humanitarian response. Contingency planning is also an opportunity for GBV coordination bodies to draft templates or pre-proposals for their response. When undertaking

preparedness and contingency planning for disasters, it is important to assess the variety of risk factors within the setting.

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

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

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

Cox's Bazar, Bangladesh, faces frequent emergencies, including internal conflicts, fires, landslides, cyclones, and epidemics. These events often disrupt or close essential services, reducing safe opportunities for survivors to disclose cases of GBV and limiting protection mechanisms. Women and adolescent girls, already at risk, face heightened vulnerabilities during emergencies, such as increased risks of sexual violence, domestic violence, intimate partner violence, exploitation, and child marriage.

Key Priority Actions in Emergency Response:

1. **Outreach Teams and First Responders:**
   GBV actors, including volunteers, serve as first responders by providing Psychological First Aid (PFA), sharing information and raising awareness about GBV, disseminating messages from the Emergency Preparedness and Response Working Group (EPRWG) and other protection sectors, counseling survivors, making referrals, and monitoring GBV risks.
2. **Static GBV Service Facilities:**
   Provide psychosocial support (PSS), information dissemination, referrals, and case management services for GBV survivors.

3. **Remote Case Management**[122]**:** In cases of restricted mobility, GBV service providers with prior case management experience offer remote services to ensure continued access for survivors unable to attend in-person sessions.
4. **Intersectoral Business Continuity Plan (ISBCP):**
   Essential GBV actors are identified under ISCG guidance to ensure the provision of life-saving GBV services across camps during emergencies or restricted mobility.
5. **Dignity Kit Distributions:** GBVSS coordinates monthly with partners to assess stockpiles, prevent duplication, and prioritize vulnerable groups, especially women and girls of reproductive age. Regular surveys track stock availability, identify gaps, and advocate for increased allocations during emergencies.
6. **GBV Camp Focal Points (CFPs) and Alternates**[123]**:** Positioned across camps to lead emergency preparedness and response activities, including:
   - Participating in emergency meetings.
   - Assessing service availability and needs in affected areas.
   - Facilitating safe and ethical referrals.
   - Engaging with community-based mechanisms.
   - Coordinating with PERU GBV Officers.
7. **PERU**[124] **and RPA:** GBV officers within the Protection Emergency Response Unit (PERU) and Rapid Protection Assessment (RPA) team work under the guidance of GBVSS and Protection Sector to:
   - Provide PFA and ensure safe, ethical referrals to GBV case management services.
   - Reinforce GBV guiding principles, data protection, and referral pathways.
   - Assess disaster impacts on service access, prioritize dignity kit distribution, and coordinate with GBV focal points and emergency teams.

   PERU is activated by the Protection Sector Coordinator in specific emergency scenarios.
8. **Risk Education:** Deliver multi-hazard risk education in line with EPR WG guidance.
9. **GBV Risk Monitoring:** GBV actors to identify GBV risks and urgent needs to inform response strategies and advocacy efforts.

[122] Training package on Remote GBV Services Focusing on Phone-based Case Management and Hotlines
[123] GBV CFP and ACFP list
[124] PERU ToR

10. **Capacity Building:** Train PERU GBV officers and GBV focal points on GBV core concepts, data protection, referral pathways, PFA, and emergency coordination. Regular training strengthens preparedness and enhances response effectiveness.
11. **Temporary Shelters:** During emergencies, GBV service facilities will remain accessible as temporary shelters to women, girls, men, and boys of all diversities, based on the modalities of the facilities. Women and Girls Safe Spaces (WGSS) are exclusively available to women and girls, providing privacy, security, and gender-specific support. Multipurpose centers and other facilities are open to all genders and age groups, ensuring inclusivity and equitable access to services.

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

- Up to date mapping of GBV response structures and capacities (including mobile and static) either on a regular basis as part of general preparedness or as part of contingency planning for an identified crisis.
- Prepositioning of dignity kits, post-rape kits, IEC materials,
- Emergency stock tracking information for dignity kits and other non-food items (NFIs), when relevant, has been collected through the GBV sub-sector on a quarterly basis.
- Plans for safeguarding documentation relating to case management or other service provision in case of evacuation.
- Training of first responders (focusing on those most likely to respond in the first 48 hours to two weeks of a crisis).
- Identification of first responder personnel with appropriate training, through a “roster” or other form of rapid response mechanism.
- Operational guidance/procedures for key areas of GBV prevention or risk mitigation or commitments to develop such documents (e.g. one-pagers on actions to implement in the first 72 hours of a crisis to mitigate GBV risk for internally displaced persons and refugees during food distribution or in transit areas).

9 SECTION 9: COORDINATION

9.1 Coordination among GBV specialized actors and other service providers

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

Essential issues to consider

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

In Cox Bazar, UNFPA is the lead agency for GBV Sub-Sector. A GBV coordination mechanism has been established under the Protection Sector.

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

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

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

The core functions listed below can be applied to GBV coordination mechanisms in refugee settings. Examples of activities relating to each of the core functions can be found in the GBV coordination handbook[125] and standard 14 in the GBV minimum standards.

Coordination systems help plan interventions and strategies, manage information, mobilize resources, uphold accountability, fill gaps and avoid duplication. Coordination is also important in ensuring capacity gaps are addressed, including by supporting governments on preparedness and contingency planning.

The primary goals of GBV coordination are to:

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

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

1. **To support service delivery by:**
    - Providing a platform that ensures service delivery is driven by the humanitarian/refugee response plan and strategic priorities.
    - Developing mechanisms to eliminate duplication of service delivery.
2. **To inform the humanitarian coordinator/humanitarian country team/refugee coordinator's strategic decision-making by:**
    - Preparing needs assessments and analysis of gaps to inform priority-setting.
    - Identifying and finding solutions for (emerging) gaps, obstacles, duplication and cross-cutting issues.
    - Formulating priorities based on analysis.
3. **To plan and implement the sub-cluster/sector strategy by:**

[125] See GBV AOR coordination handbook (2019)

- Developing a GBV sectoral plan, objectives and indicators that directly support realization of the overall response's strategic objectives.
- Applying and adhering to common standards and guidelines.
- Clarifying funding requirements, helping to set priorities and agreeing on sub-cluster/sector contributions to the humanitarian coordinator/humanitarian country team/refugee coordinator's overall humanitarian funding proposals.

4. **To monitor and evaluate performance by:**
    - Monitoring and reporting on activities and needs.
    - Measuring progress against the sub-cluster/sector strategy and agreed results.
    - Recommending corrective action where necessary.
5. **To build national capacity in preparedness and contingency planning**
6. **To support robust advocacy by:**
    - Identifying concerns and contributing key information and messages to the humanitarian coordinator and humanitarian country team messaging and action.
    - Undertaking advocacy on behalf of the sector, sector members and affected people.

This section outlines the GBV coordination group's ways of working for *Cox Bazar:*

- Monthly meetings - Hybrid
- Attended by GBV and Non- GBV actors from different agencies
- The GBV Sub-sector coordinator leads the meetings
- GBV Sub-Sector has sub-groups and taskforces within the coordination e.g. strategic advisory group, case management task force or GBVIMS task force
- GBV Sub-sector/ GBV Coordinator develops, revises and updates relevant coordination documents including service mapping, referral pathways, GBV strategy and GBV SOPs; and
- Priorities and/or strategies for advocacy.]

Effective GBV coordination requires the active participation of cross-sectoral partners and lead agencies to ensure an effective prevention and response to GBV. It is not limited to GBV actors. Multi- sectoral coordination requires action among, at a minimum, health and social services actors, legal, human rights, and security sectors and the community. The IASC GBV Guidelines stress the multi-sectoral approach and provide important directives for GBV coordination in any humanitarian context. (http://gbvaor.net/). An effective GBV coordination process does not only serve the actors engaged in prevention and response interventions, it should also lead to positive outcomes for the affected populations.

The GBV-SS is the coordinating body with the objective to strengthen GBV prevention and response in emergency settings, with a focus on women, girls and other people at risk of GBV in the refugee camps and the host communities. In Cox's Bazar, UNFPA coordinates the GBV-SS under the GBV Area of Responsibility (AOR) model, the GBV SS TOR/2019 and the JRP/2022 with the objective to strengthen GBV prevention and response in the refugee camps and affected host communities (JRP 2019). The GBV-SS works to facilitate multi-sectoral, inter-agency actions aimed to prevent GBV, and to ensure the provision of accessible, timely and survivor-cantered GBV response services under the goal of reducing risks and mitigating consequences of GBV experienced by women, girls, boys and men in the refugee camps and host communities. The GBV-SS also leads the camp GBV Focal Points Network, who are trained in GBV risk mitigation and case referrals, 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.

Members of the Cox's Bazar GBV SS include the Government of Bangladesh through its various Ministries and departments, civil society organizations, international and national NGOs and international UN organizations, with each sector and sub sector designating a focal point that will represent the organization and/or sector in taking action for prevention and response to GBV ("GBV focal points"). Coordinating agencies are responsible for encouraging participation in the GBV working groups and representing the GBV working groups at relevant cluster/sector meetings and/or with government authorities to inform and advocate for GBV issues and concerns.

General and specific responsibilities of a multi sectoral GBV coordination mechanism include gathering data and managing information, mobilizing resources and ensuring accountability, monitoring effectiveness; identifying and resolving challenges, providing leadership, sharing information about resources, guidelines, and other materials, sharing non-identifying data about GBV incidents, discussion and problem-solving about prevention and response activities, including planning these activities and engaging with other relevant coordinating and leadership bodies, collaborative monitoring and evaluation, identifying programme planning and advocacy needs, and sharing those among other actors, coordinating bodies, and leadership structures.

GBV Service Facilities

It is mandatory for all GBV-SS partners to provide information to the GBV-SS detailing the GBV facilities and services they provide as well as the GBV prevention and risk mitigation activities they are implementing. This applies to both JRP partners as well as those who are not part of the Joint Response Plan (JRP). This enables the GBV-SS to provide GBV partners with activity and partner mapping for the purposes of coordinating, rationalizing and streamlining activities.

9.1.1 Information management for coordination purposes

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

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

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

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

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

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

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

Inter-agency GBV information-sharing protocols must take into account (1) what information is being shared, (2) how it will be used, (3) at what levels (within an organization, among signatories to the information-sharing protocol, external to protocol signatories and geographic levels of sharing).[126]

In order to develop such agreements, organizations collecting survivor data through service provision should agree on using the same information management system, such as one based

[126][157] For more information on information-sharing protocols, including format, contents and development, and acute emergency toolkit see www.gbvims.com

on the GBVIMS to allow for standardized data. Signatories to these protocols are limited to organizations providing direct service provision for GBV survivors (usually GBV case management services) and collecting data as part of that service provision and those agencies supporting the implementation of the information management system.

In the first weeks and months of a rapid onset emergency or in contexts where a limited amount of documentation and data sharing is possible, a simplified version of standardized tools and information-sharing protocols is available.[127] This can be used to assist response coordination and mitigate the risk of any unsafe data collection and information sharing. The simplified system should only be used as an interim solution until a more comprehensive system (such as the GBVIMS) are able to be established. This is only a solution if all of the minimum criteria for data protection and security and other established best practices around GBV data collection can be met.

- Management of other GBV-related information

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

9.2 Coordination with other sectors

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

Signature page for participating actors

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

- Abide by the procedures and guidelines contained in this document.
- Fulfil our roles and responsibilities to respond to, mitigate and prevent GBV.

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- Provide copies of this document to all incoming staff in our organizations with responsibilities for action to address GBV so that these procedures will continue beyond the contract term of any individual staff member.

Organization / Agency Name	Date	Signature

