

Guidance Note:

Measuring GBV Risk Mitigation Interventions in Humanitarian Settings

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HARVARD
HUMANITARIAN
INITIATIVE



Table of Contents

HHI, Unicef and Harvard Humanitarian Initiative	3
Introduction	4
Background	4
Purpose of this document	4
What is GBV risk mitigation?	5
What are GBV risks?	5
What are GBV risk mitigation interventions?	6
How to measure GBV risk mitigation interventions	7
Preparing to measure GBV risk mitigation	9
Determining what to measure	10
Demographics and Disaggregation	11
Other factors to consider when deciding how to measure GBV risk mitigation in your programme	12
Adapting the Menu to your context	13
Determining what approach to measurement is appropriate for your context	14
Decision Tree	15
Scenario 1: Locations where there are no GBV response services available	16
Scenario 1 summary of characteristics	16
How to incorporate Scenario 1 measurement into programmatic M&E	17
Scenario 2: Locations where GBV response services/referral pathways are available	17
Scenario 2 summary of characteristics	18
How to incorporate Scenario 2 measurement into programmatic M&E	19
Scenario 3: Locations with GBV response services/referral pathways and available resources for more intensive research	19
Scenario 3 Summary of characteristics	21
Additional guidance for Scenario 3 measurement	22
Applying the GBV guiding principles to GBV risk mitigation measurement	22
Annex 1. Overview of GBV (excerpted from the GBV Guidelines)	24
Annex 2. Collective responsibility and obligation to address GBV (excerpted from the GBV Guidelines)	33
Annex 3. Consultations with Women and Girls Tip Sheet	37

HHI

The **Harvard Humanitarian Initiative (HHI)** is a university-wide academic and research center in humanitarian crisis and leadership. Our mission is to create new knowledge and advance evidence-based leadership in disasters and humanitarian crisis. Within HHI, the Program on Gender, Rights and Resilience (GR2) seeks to investigate and address issues relating to gender, peace, and security in fragile states. For more information, please visit: <https://hhi.harvard.edu>

UNICEF

UNICEF works in over 190 countries and territories to save children's lives, to defend their rights, and to help them fulfil their potential, from early childhood through adolescence. As the lead of interagency implementation of the IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action (GBV Guidelines), UNICEF has supported efforts globally to ensure that all humanitarian programs identify and address risks of GBV and provide safe, equitable access to assistance for all people. In South Sudan, UNICEF has supported strong collaborations and innovative partnerships with the Nutrition Cluster, NGOs, and civil society to strengthen GBV risk mitigation approaches within nutrition programs. For more information, please visit: <https://www.unicef.org>

UNICEF & HARVARD HUMANITARIAN INITIATIVE

Measuring GBV risk mitigation interventions is an area of work that continues to evolve. The content in this document represents a compilation of learning that was available at the time of its release. Colleagues who use the Menu of Measures are encouraged to provide feedback to the authors to help inform future iterations. Feedback can be shared with Christine Heckman (heckman@unicef.org), Katie Robinette (krobinette@unicef.org), Jocelyn Kelly (jtdkelly@gmail.com), or Vandana Sharma (vsharma@hsph.harvard.edu)

Additional resources and information on GBV risk mitigation measurement can be found here: <https://gbvguidelines.org/en/im/effectiveness/>

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Introduction

Gender-Based Violence (GBV) constitutes “any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e., gender) differences between males and females.” It includes acts that inflict physical, sexual, mental and economic harm or suffering; threats of acts; coercion; and deprivations of liberty whether occurring in public or private life.

-IASC 2015 GBV Guidelines



BACKGROUND

UNICEF’s work on gender-based violence in emergencies (GBViE) focuses on three main pillars: (i) supporting survivors with access to a comprehensive set of services; (ii) mitigating the risks of GBV across humanitarian sectors; and (iii) preventing GBV by addressing its underlying conditions and drivers. Under all three pillars, UNICEF aims to deliver humanitarian services that are safe for – and responsive to the needs of – women and girls.¹

In 2015, the *Inter-Agency Standing Committee (IASC) Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* (‘GBV Guidelines’)² were launched as a resource to support all humanitarian sectors seeking to integrate GBV risk mitigation into their respective areas of work³. UNICEF co-led the revision of the GBV Guidelines and – in partnership with a 15-member reference group – leads the global interagency rollout of this resource.

Though significant progress has been achieved in institutionalizing GBV risk mitigation across all programmatic sectors of humanitarian response, there is still a gap in understanding how to measure the effectiveness of these actions. Despite this gap, there are promising practices and helpful lessons learned about how to better measure GBV risk mitigation efforts. The guidance captured here and in other publications may provide helpful insights. However, it is important to note that this continues to be an evolving area of work and these learnings should always be considered within the specific context where you work.

PURPOSE OF THIS DOCUMENT

This Guidance Note, along with the accompanying Menu of Measures, was developed to support colleagues working in other (non-GBV) sectors to integrate measurement of GBV risk mitigation into their monitoring and evaluation (M&E) processes⁴. As of early 2022, both resources have been field-tested in one context; in the future, they will be introduced in additional geographic locations and types of emergencies. At present, the Menu of Measures is tailored to a single sector (Nutrition). This specificity was a deliberate decision to a) help ensure the content is as relevant as possible to the day-to-day work of colleagues in the sector and b) allow for more focused conversations during the field testing. The Menu may be expanded to other sectors in the future as well.

¹ See UNICEF’s Gender-Based Violence Operational Guide for further information.

² Learn more about and download the GBV Guidelines at www.gbvguidelines.org.

³ Corresponding to Pillar 2 of UNICEF’s programme model for GBViE.

⁴ Additional resources developed during Phase 1 of the UNICEF-HHI collaboration include a desk review of published and grey literature on GBV risk mitigation measurement and a compendium of good practice.

What is GBV risk mitigation?

“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.”

(IASC GBV Guidelines) (www.gbvguidelines.org)

The objective of GBV risk mitigation is to make humanitarian systems and services safe, effective and responsive to the needs and rights of women and girls. Concretely, this means ensuring humanitarian service delivery:

- (1) **does not increase the likelihood of GBV occurring;**
- (2) **seeks to identify and mitigate GBV risks; and**
- (3) **conducts ongoing monitoring of access and barriers to services, particularly those faced by women and girls.**

GBV risk mitigation is everyone’s responsibility, cutting across all sectors of humanitarian response. It is distinct from – but complementary to – GBV-specialized programming, which focuses on response services for GBV survivors (such as clinical care and psychosocial support) and longer-term prevention interventions.

At various points, this guidance references “GBV specialists.” A GBV specialist is someone who has GBV-specific training and expertise. GBV specialists are often in the role of providing direct response services, overseeing specialized GBV prevention and response programming and/or coordinating GBV activities at the interagency level (e.g., the GBV sub-cluster or working group coordinator). If there is no GBV specialist in the location where you work, you can contact other GBV specialists (within your agency or in other agencies) at national, regional and global levels.

For more information about GBV in emergencies, see **Annex 1**. For more information about the responsibilities of all sectors and actions to address GBV, see **Annex 2**.

WHAT ARE GBV RISKS?

GBV risk mitigation is everyone’s responsibility, cutting across all sectors of humanitarian response. It is distinct from – but complementary to – GBV-specialized programming, which focuses on response services for GBV survivors (such as clinical care and psychosocial support) and longer-term prevention interventions.



Examples of GBV risks in humanitarian settings.

WHAT ARE GBV RISKS MITIGATION INTERVENTIONS?

GBV risk mitigation interventions are actions taken to reduce identified risks. Below are some examples related to Nutrition programming.

EXAMPLE 1:

GBV risk: The route to a nutrition center passes through an area occupied by armed groups/checkpoints.

Implications:

Women and children have difficulty accessing services, due to fear and/or experience of assault and harassment.

GBV risk mitigation intervention: In some settings, it may be possible to move the facility to a safer location. In others, nutrition actors can set up mobile outreach modalities that provide services closer to target communities and minimize the need for service users to travel on unsafe routes.

EXAMPLE 2:

GBV risk:

Movement of women and girls is controlled by their husbands or other male family members.

Implications:

Severely malnourished children cannot stay overnight in stabilization centres because their mothers are not allowed to be away from home to accompany them. Mothers who do stay over with their children may face increased violence in the home.

GBV risk mitigation intervention:

Consult with women and girls about potential options to help address the situation. For example, they can advise if and how Nutrition programme staff could help male relatives and/or community leaders better understand nutrition service delivery.



For more information on GBV risks and risk mitigation actions, visit the GBV Guidelines website (www.gbvguidelines.org). There you can download guidance tailored to individual humanitarian sectors (WASH, Food Security, etc.) and browse the Knowledge Hub, an online repository that is frequently updated with GBV risk mitigation tools, guidance, and learning. In addition, many sectors/clusters and agencies are developing their own resources for GBV risk mitigation. Reach out to your focal points or relevant Cluster Help Desk for more information.

How to measure GBV risk mitigation interventions



Though the aim of GBV risk mitigation is to reduce exposure to GBV-related risks, for a variety of reasons, it is not appropriate to use data on GBV prevalence or incidence to indicate “success” or “failure” of risk mitigation interventions. In addition to the safety and ethical complexities that surround this type of data, many factors that contribute to increases or decreases in prevalence and incidence of GBV are outside the ability of the programme to influence. As such, the methodology developed by UNICEF and HHI combines:

- (1) **Existing indicators from the targeted sector(s) where a potential link to GBV risk has been identified (sometimes referred to as “proxy indicators”);**
- (2) **Access/barriers to services;**
- (3) **Reported safety perceptions of women and girls; and**
- (4) **Other key considerations for GBV risk mitigation such as unintended consequences of accessing services, linkages to GBV services and feedback on risk mitigation programmatic adaptations that have been implemented.**

These components are meant to be integrated into existing programme M&E frameworks to help programme staff monitor changes over time and stay aware of new or emerging issues related to GBV risk that may arise⁵. There are quantitative and qualitative options for measurement, making them adaptable to various settings and interventions.

Sector “proxy” indicators

Some of the information that is already being collected through existing M&E for another programmatic sector can be useful to incorporate into GBV risk mitigation measurement. For example, within the Menu of Measures there is a section dedicated to coping strategies. Though coping strategies are not a direct measure of exposure to GBV, they do help give a sense of changes in an individual’s/family’s ability to meet their basic needs, which impacts their vulnerability more generally and, in many cases, the risk of exposure to GBV. On their own, such indicators may not be enough to draw conclusions about GBV risk but when combined with other data points, they can help inform the overall analysis.

Access/barriers to services

When people in need of humanitarian services cannot access them, programming is less effective overall. In addition, barriers that impede access to services – including those that may not be immediately apparent – can increase the risk of multiple forms of GBV. For example, in some cultures, it is expected that past a certain age, women should be kept physically separated from men outside their immediate family. This can result in women and girls experiencing restricted mobility in public spaces and facilities, which can make it harder for them to access basic services without putting their safety at risk. As with the sector “proxy” indicators described above, information about barriers to services can serve as a valuable component of GBV risk analysis and GBV risk mitigation measurement, particularly in combination with other sources of data.

⁵ This methodology can also be used for more intensive measurement exercises that go beyond programmatic M&E when adequate resources are available (see Scenario 3 below).

GBV risk mitigation programming questions

The Menu of Measures also has a set of questions related to GBV risk mitigation programming. These questions are intended to elicit feedback from those accessing nutrition services on whether GBV risk mitigation actions are contributing to improved access and/or safer programmatic delivery. Asking questions about GBV risk mitigation programming helps ensure that affected populations can provide feedback on how program adaptations affect them. This helps ensure that GBV risk mitigation is accountable, adaptable, and suited to the given context.

Reported safety perceptions of women and girls

Though it is neither ethical nor feasible to directly measure the scale of GBV through other sectors' programmatic M&E, tracking how safe women and girls feel when accessing a facility or service can help give an indication of the overall level of risk. Questions on safety perceptions can be broad and ask about overall feeling of safety when accessing a service, or more specific and ask for more detailed information about specific safety risks. Questions must be carefully crafted and adapted to your local context. See [Annex 3](#) for general tips for working with local women's groups to get a sense of what wording is most likely to resonate with people in the location where you work and consult the Menu of Measures for examples of questions.

The safety perceptions category is for use in locations with GBV response services in place (scenarios 2 and 3 outlined below) because asking questions related to GBV can result in survivors disclosing their personal experiences of violence. If this occurs in situations where enumerators are not trained on how to appropriately respond and/or where there are no options available for referring survivors to specialized GBV response services, it can create additional harm for survivors and communities.

Triangulation

It is important to note that all four components described above have their own limitations, which is why analyzing a combination of data points is so important. If possible, all GBV risk mitigation measurement should include some sector proxy indicators, some data points on access/barriers to services as well as questions to elicit feedback on GBV risk mitigation programming. In locations where GBV services are available – and, ideally, with the involvement of a GBV specialist to support on planning and analysis – safety perceptions questions, and questions that fall into the other categories can also be incorporated.



SOME IMPORTANT DON'Ts FOR GBV RISK MITIGATION MEASUREMENT:

- **DON'T** ask questions about individual experiences of GBV (e.g., "Have you been raped?" or "Have any of your friends/neighbors/school mates experienced physical violence?").
- **DON'T** attempt to collect GBV incident data/numbers of cases (e.g., "How many domestic violence cases were reported in this community in the last month?").
- **DON'T** attempt to seek out or convene a group of GBV survivors to take part in assessments or other consultations.

A core component of GBV risk mitigation measurement – and quality M&E more broadly – is consultations with affected communities, especially women and girls.

These consultations can take the form of focus group discussions, community mapping, or other participatory methods. However, there are several factors to consider when determining *how* to approach these consultations to make them as safe and effective as possible. For example, depending on the context and culture, there may be particular characteristics of enumerators and/or group participants (such as age, marital status etc.) that affect how comfortable and safe participants feel voicing their opinions and/or discussing certain topics. These kinds of dynamics can be subtle. For instance, conducting a focus group with male leaders and young women together would result in clear power asymmetries. However, it is also possible to encounter less obvious dynamics. For instance, unmarried young women may even be uncomfortable speaking frankly in front of married women; or there may be power dynamics among wives in polygamous families. Working with a GBV specialist and/or local women's organizations in your location can help structure consultations in a way that is appropriate for the context. [Annex 3](#) contains a tip sheet on this topic. Local women's groups can be among the most important experts you can consult with. These groups can provide guidance on

appropriate approaches to engaging the community, help design more inclusive and effective questions for research, support creation of appropriate proxy questions about safety, and help interpret research results once they are available. Regular consultations can be a valuable resource for ongoing monitoring and programme adaptation as well.

Women and girls are key stakeholders in community consultations. It is also helpful to take time and think about other groups who might be important to consult with, but who may struggle to provide input to humanitarian programmes. For instance, individuals living with disabilities are often more vulnerable in times of crisis. Yet the needs of these individuals might not be fully accounted for in humanitarian programming. When considering possible measurement approaches, it is vital to think about groups that can provide important feedback and how to seek input from these groups in an ethical way.

PREPARING TO MEASURE GBV RISK MITIGATION

Before measuring GBV risk mitigation, there are a few steps that should be completed as preparation.

- (1) **Find out if there are GBV response services/referral pathways in the location(s) where the measurement will take place. This can be done by contacting the GBV coordinator at the national or sub-national level.**
- (2) **Determine if you will have access to a GBV specialist who can provide technical support on planning data collection, analyzing results, etc. If the organization you work for does not have GBV specialists on staff, you can ask the GBV coordinator for relevant contacts who may be able to support you.**
- (3) **Compile relevant secondary data (see text box below).**
- (4) **Train enumerators on managing participant distress, and on the GBV referral pathway (in locations where one exists) or on the GBV Pocket Guide (see text box below).**



BEFORE COLLECTING NEW INFORMATION, FIND OUT WHAT IS ALREADY AVAILABLE.

GBV risk mitigation, including the measurement component, first requires understanding a) GBV risks related to your sector and b) the barriers women and girls face when attempting to access your services. Start with a review of existing data (often called “secondary data”). Relevant information can be collected from many GBV and non-GBV sources such as: agency/sector assessments, gender analyses, programme monitoring, post-distribution monitoring, situation reports, displacement tracking, service mapping, surveys (such as MICS), etc. Work with GBV specialists to understand what existing sources are available, and what data points are most useful for your analysis.

AAAQ Framework for GBV Risk Mitigation

A 2-page tool to help identify potential barriers for women and girls accessing humanitarian aid and services.

[www.gbvguidelines.org/
knowledgehub](http://www.gbvguidelines.org/knowledgehub)

Consultations Tip Sheet

A 2-page tip sheet on conducting consultations with women and girls from affected communities.

See **Annex 3**.

“GBV Pocket Guide”

A step-by-step guide for non-GBV specialists on how to support survivors of GBV when a GBV actor is not available. Also available as a mobile app.

[www.gbvguidelines.org/
pocketguide](http://www.gbvguidelines.org/pocketguide)

DETERMINING WHAT TO MEASURE

The following section – including the table below and decision tree – will help determine what measurement options are most appropriate for a given programme. The framework is organized into three scenarios. No scenario is inherently preferable to another. Rather, the “best” approach is the one that fits your current context. Scenarios 1 and 2 are targeted at programmatic M&E and Scenario 3 applies to settings where operational research and/or more robust evaluations are possible.

The priority should always be the safety of affected communities and using your findings to strengthen programming.

SUMMARY OF GBV RISK MITIGATION APPROACHES TO MEASUREMENT

	PROGRAMMATIC M&E		IMPACT EVALUATION OR RESEARCH STUDY
	SCENARIO 1	SCENARIO 2	SCENARIO 3
CHARACTERISTICS OF THE LOCATION	No GBV response services/referral pathway in area	GBV response services available and GBV referral pathway in place	GBV response services available and GBV referral pathway in place + access to technical/financial resources for more intensive research
ROLE OF WOMEN AND GIRLS, INCLUDING LOCAL WOMEN'S GROUPS	Regular consultations incorporated into M&E plan + feedback on results of data collection shared with participants		Same as Scenarios 1 and 2 + formative research and decision-making role in design of the research/evaluation
OTHER CONSIDERATIONS	GBV specialist support recommended	GBV specialist support required	GBV specialist support required + research expertise and additional budget needed
WHAT TO MEASURE	Select sector indicators + Barriers to accessing services + GBV risk mitigation programming	Scenario 1 components + Safety perceptions, linkages to GBV services, and indirect effects/unintended consequences	Scenario 2 components + Methods specific to the research and/or evaluation design

DEMOGRAPHICS AND DISAGGREGATION

In March 2019, colleagues from the Global Nutrition Cluster participated in a workshop on GBV risk mitigation where they jointly identified the potential added value of including demographics questions in nutrition data collection efforts to improve understanding of GBV risks and barriers to services. Their proposed approach to demographics along with the good practices for data disaggregation are presented below⁶.

DEMOGRAPHICS AND DISAGGREGATED DATA GUIDANCE

DEMOGRAPHICS

Nutrition-related GBV risks and barriers to services directly affect two demographic groups: (1) **caregivers** – such as parents, family members, community members (most often women and girls) who accompany infants, children or other family members to nutrition services and (2) **direct recipients of nutrition services**, such as girls and boys (often the under-5 age group is targeted), adolescent girls and adult women who are pregnant and/or have nutrition deficiencies.

When collecting and analyzing primary information, include a demographic question that allows disaggregation of data by caregiver and direct recipient of nutrition services.

When collecting and analyzing secondary information, to the extent possible, interpret information through the lens of caregiver needs and experiences and direct recipient needs and experiences.

SEX, AGE AND DISABILITY DISAGGREGATED DATA

Sex, age and disability disaggregated data collection and analysis is a good practice in humanitarian settings and service delivery more broadly. All relevant quantitative and qualitative measurement options below require this disaggregation. Other disaggregation factors, such as type of service, displacement status and so on can be added based on the scope of the measure.

THE POWER OF SEX- AND AGE-DISAGGREGATED DATA: EXAMPLE FROM THE IASC GBV GUIDELINES

Example of Conducting M&E and Data Analysis Using a 'GBV Lens'

The education sector has designed a learning space for boys and girls from displaced communities. The success of the programme is monitored by collecting data on a suggested indicator from the GBV Guidelines and OCHA Humanitarian Indicators Registry: Emergency affected boys and girls attending learning spaces/schools in affected areas. The indicator is defined as:

of females attending learning spaces/schools in affected areas

of males attending learning spaces/schools in affected areas

The results are disaggregated by age group (5–13 years and 14–18 years). Using a 'GBV lens' to report and act on the findings of this indicator would involve considering the underlying differences for boys and girls of different ages who are not attending learning spaces, and whether these differences might be related to GBV. For example, an early dropout rate of adolescent girls may result from early marriage, domestic responsibilities or unsafe routes that discourage parents from sending their girls to school. Discovering a disparity in attendance between girls and boys can lead to further investigation about some of the GBV-related causes of those disparities.

⁶ WHO. (2021). Integrating gender data in health information systems: Challenges, opportunities, and good practices. WHO. <https://apps.who.int/iris/bitstream/handle/10665/342570/WHO-EURO-2021-2318-42073-57916-eng.pdf?sequence=1&isAllowed=y>.

OTHER FACTORS TO CONSIDER WHEN DECIDING HOW TO MEASURE GBV RISK MITIGATION IN YOUR PROGRAMME

1. **What is your programme's M&E capacity? Often this is influenced by:**
 - a. The type of setting that you are in (e.g., acute or protracted emergency, armed conflict, natural disaster, public health emergency, etc.). Protracted emergencies, for example, may have more established structures and capacities in place. In an acute emergency, the options for M&E may be more limited. Because GBV risk mitigation measurement sits within an existing programmatic M&E, your team will have to keep in mind some of these practical considerations to help ensure the GBV risk mitigation measurement is set up in a manner that is fit-for-purpose, provides useful information and does not overburden affected communities or programme staff.
 - b. Capacity of staff to conduct M&E activities, such as log frame/indicator/tool development, data collection, data analysis and interpretation, in alignment with best practices and ethical standards.
2. **Are there access or security constraints that may impede your ability to carry out the risk mitigation measurement as planned? For example, is your programme conducting remote management and/or remote monitoring? If so, what information can be gathered in a manner that is accurate, high-quality and ethical?**

For many of the categories in the Menu (availability, accessibility, etc.) there are two options for collecting information: (1) observation and (2) gathering feedback directly from affected communities in the form of surveys, focus group discussions or other participatory methods. In many cases, it is strategic to use these methods in tandem. However, for locations where consultations with affected communities is not feasible or safe – for example, if there is limited M&E capacity – an observation-only option may be more appropriate.



CASE STUDY FROM SOUTH SUDAN

In 2019, the South Sudan Nutrition Cluster – with support from Action Against Hunger, CARE and UNICEF – endorsed a standardized safety audit tool to identify potential GBV-related safety risks at and around Nutrition sites. The tool is divided into three parts:

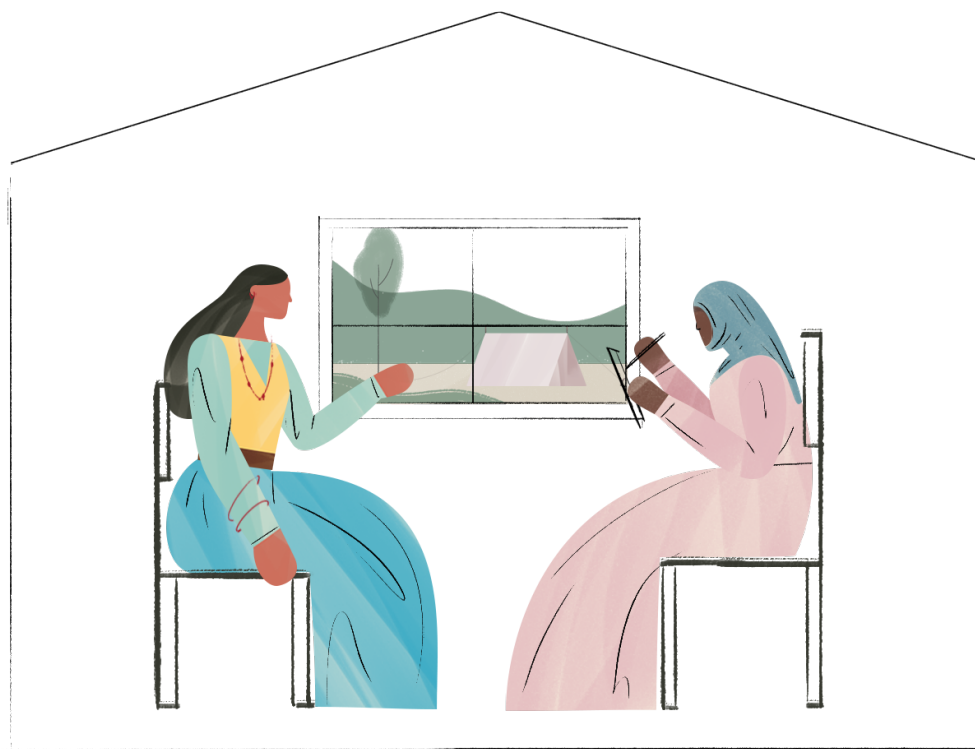
- 1) Observation Checklist
- 2) Community Consultation (through focus group discussions); and
- 3) Staff Consultation

The Cluster membership agreed to make the observation checklist a mandatory data collection exercise for all partners and identified a sub-group of partners – based on M&E capacity, presence in a minimum number of locations, etc. – to also conduct consultations with communities and nutrition staff. Nearly 600 sites across the country were covered with at least one component of the safety audit methodology and the findings were used to inform the subsequent Humanitarian Needs Overview (HNO) and Humanitarian Response Plan (HRP).

ADAPTING THE MENU TO YOUR CONTEXT⁷

The Menu of Measures includes questions on access, dignity and safety - words whose meanings can change across different languages and cultures. To identify terminology and question wording that will elicit meaningful information from women, girls and other groups, it is critical to first work with women, girls and local staff to strategize how to phrase the questions in a way that will make sense to people. Secondly, it is important to understand how to translate the questions. Having multiple people reach consensus on the best framing and translation is important. The process of “back-translation” may be helpful.

Similarly, the way some of the questions are worded may need to be adapted to fit a particular context. For example, in some places, people may not be used to describing their travel in terms of distance (i.e., kilometers), but rather by the time it takes to get there and the transport modality (e.g., walking, public transit etc.). Specific response options for survey questions may also require adaptation for different settings. For example, a survey question asking women about barriers to accessing services should provide response options that are relevant to the setting. Consultations with women, girls and local staff can also help to determine the appropriate response options for the selected questions. The Menu of Measures includes notes related to contextualization and adaptations for consideration.



Once the wording and translation are complete, make sure enough time is dedicated to help ensure that enumerators and/or interviewers understand what the questions and various answer options mean. This step is crucial, particularly for protection issues, as recent studies have shown that in some cases, enumerators understand only 10% of key terms from surveys they administer⁹. Overall, enumerator training is vital to the success of data collection. As noted in *Promising Practices for Monitoring and Evaluating GBV Risk Mitigation Interventions in Humanitarian Response*¹⁰, successful data collection requires enumerators trained in identifying and appropriately handling participant distress, as well as how to provide referral services. Employing same sex data collectors for data collection activities and

⁷ The UNICEF/Harvard Humanitarian collaboration included field testing of questions in one humanitarian context.

⁸ “Back translation” involves having one translator/set of translators translate the questions into the desired language and then having a different translator/set of translators translate from the desired language back to the first language to ensure that the meaning is captured accurately.

⁹ “The words between us” (Translators Without Borders, 2018)

https://translatorswithoutborders.org/wp-content/uploads/2018/12/TWB_Nigeria_EnumeratorComprehension_Nov2018-1.pdf.

¹⁰ Sharma, V., Ausubel, E., Heckman, C. et al. Promising practices for the monitoring and evaluation of gender-based violence risk mitigation interventions in humanitarian response: a multi-methods study. *Confl Health* 16, 11 (2022). <https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-022-00442-4>

considering other characteristics of the enumerators (including age, language/dialect spoken etc.) is also key. Training of enumerators is a process that consists of multiple steps. After training has been done, spot checks of data submitted by enumerators needs to be done to help identify whether collected data is of quality. Refresher trainings may also be needed.

The Menu of Measures includes information on measuring coping strategies as well. Coping strategies are ways of thinking or acting that people use to manage personal crisis, demands and difficult conditions. Individuals and families in humanitarian crisis may develop coping strategies to deal with deprivation and uncertainty. Coping strategies may have positive impacts on a person – for instance, women may come together to go to a nutrition facility in a group so they feel safer. However, other coping strategies can have harmful impacts, particularly in the long-term. For instance, women may skip meals for herself to ensure her children have enough to eat; or may sell food intended for a malnourished child at market to get money to support the entire family.

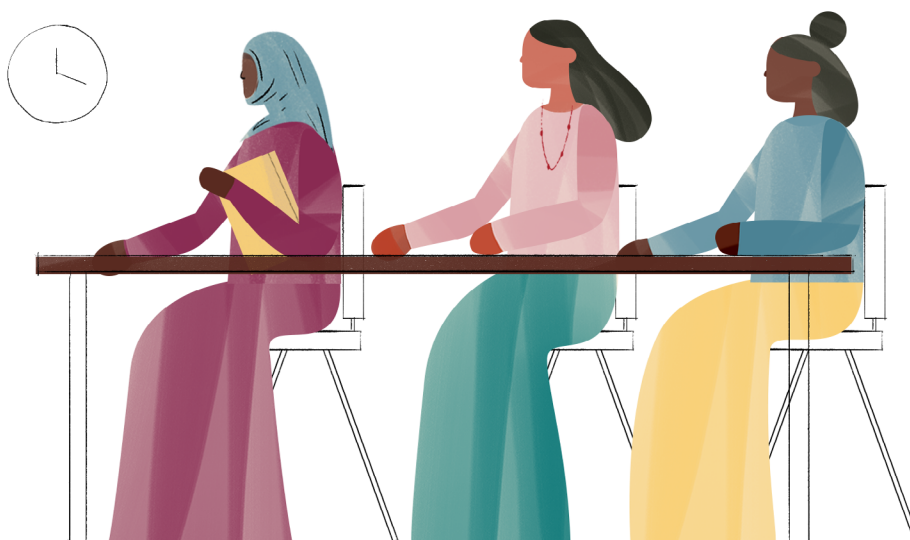
Coping strategies may also be a red flag for GBV risks. For example, women traveling together could be an indicator that a pathway or location is unsafe. Skipping meals could be linked to abuse or other controlling behaviours from someone else in the household (such as an intimate partner). While coping strategies are not always directly linked to GBV, gathering information on them can be useful for assessing potential GBV risks.

The Menu of Measures also includes other types of questions about both positive and negative indirect effects and unintended consequences of programming, such as changes to relationships at home or in the community as a result of accessing services. It is important that practitioners work with local partners to determine the appropriate questions to safely ask about coping strategies and unintended consequences of accessing services or programmes. Safeguards should also be put in place, in consultation with GBV specialists, to help ensure neither enumerators nor participants are placed in an uncomfortable situation and that any disclosures that do arise are handled appropriately.

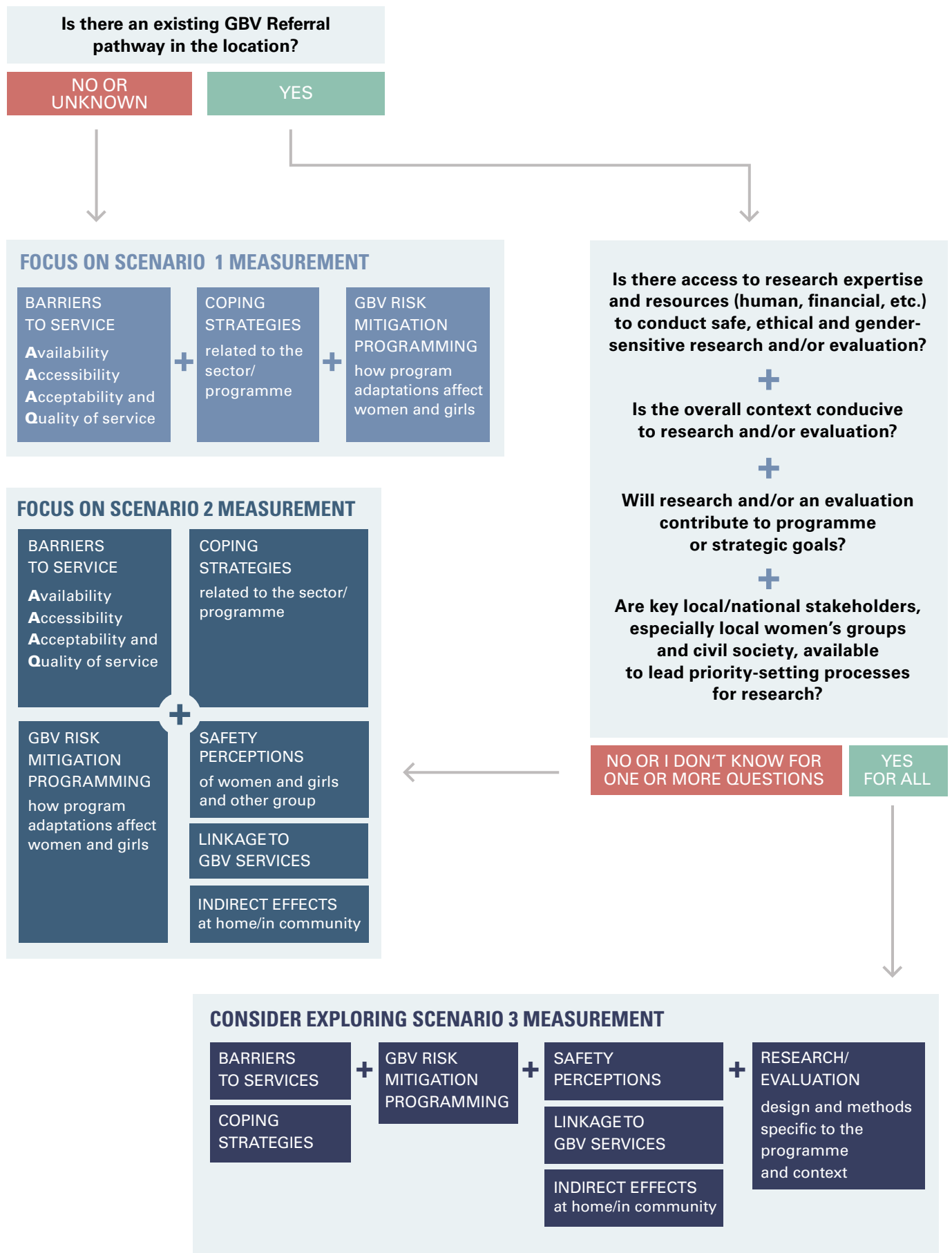
DETERMINING WHAT APPROACH TO MEASUREMENT IS APPROPRIATE FOR YOUR CONTEXT

Risk mitigation measurement should be tailored and adapted to the context you are in. Research that requires complex designs and long follow-up periods does not fit most situations. The measurement approach will be strongly influenced by the resources available to support you as a practitioner. For this reason, three different measurement approaches or “scenarios” have been described below. You can use the decision tree to help guide you to the most helpful approach for your current situation. Once you determine which scenario best aligns with your situation, you can read the guidance for that approach below.

It is also worth noting that humanitarian crises can unfold in different ways. A crisis may be sudden onset or protracted. There may also be a sudden onset emergency that presents within an ongoing crisis - for instance, if a flood occurs in a place of long-standing conflict. As explained above, GBV risk mitigation measurement must be adapted to each context. However, when deciding what these adaptations should be, the main considerations are: what is feasible, what information can be collected safely and ethically, and what resources are available to you as a practitioner.



DECISION TREE



SCENARIO 1: LOCATIONS WHERE THERE ARE NO GBV RESPONSE SERVICES AVAILABLE

To respect the principle of “Do no harm” for locations that do not have GBV services in place, it is recommended to focus GBV risk mitigation measurement on:

- Existing indicators from the targeted sector(s) where a potential link to GBV risk has been identified, which are sometimes referred to as “proxy indicators” (i.e., coping strategies),
- Access/barriers to services for women and girls; and
- GBV risk mitigation programming.

SCENARIO 1 SUMMARY OF CHARACTERISTICS

M&E APPROACH

Integrated into routine M&E within a programme.

MEASUREMENT

Focuses on understanding the barriers to accessing services that women and girls face. Sector indicators that can serve as “proxy” measures for potential shifts in overall vulnerability and/or GBV risk as well as GBV risk mitigation programming:

**Availability,
Accessibility,
Acceptability and
Quality of services**

+

Coping strategies
related to the sector/
programme

+

**GBV risk mitigation
programming
adaptations**

Indicators and questions can be quantitative, qualitative or a combination of both. Findings should be regularly analyzed and fed back into programme decision-making processes.

CONSULTATIONS WITH WOMEN AND GIRLS

Consultations should focus on use of and overall satisfaction with services, including barriers to access.

PRESENCE OF GBV SERVICES

Scenario 1 measurement is recommended for settings where GBV response services/referral pathways are not available.

TRAINING OF STAFF

All frontline workers should be trained on the “GBV Pocket Guide.”¹¹

All data collectors should be trained on basic research ethics, data collection techniques, including informed consent and handling participant distress.

GBV SPECIALIST SUPPORT (RECOMMENDED)

Technical support planning for data collection and conducting data analysis (including relevant information from secondary data reviews). Where no GBV specialist is available, the GBV Pocket Guide is the appropriate resource for mapping out other types of services that may be relevant.

¹¹ The GBV Pocket Guide outlines how to support GBV survivors in locations where there are no GBV services/GBV referral pathway in place.



HOW TO INCORPORATE SCENARIO 1 MEASUREMENT INTO PROGRAMMATIC M&E

STEP 1

Refer to the Menu of Measures and select which quantitative and/or qualitative elements are most relevant to your programme. Measurement categories:

- Availability
- Accessibility
- Acceptability
- Quality
- Coping Strategies
- GBV risk mitigation programming

STEP 2

Determine if the information selected in Step 1 is already being collected through existing M&E and, if not, whether it is feasible for your team to begin collecting it (See “Other factors to consider” on page 12).

STEP 3

Identify entry points for consulting with women and girls on their experiences with [barriers to accessing services](#), [coping strategies](#) and [feedback on any GBV risk mitigation actions undertaken](#). Refer to [Annex 3](#). Integrate these consultations throughout the programme cycle.

STEP 4

Adapt the questions, as needed, to the context and incorporate them into your M&E tools.

Sex- and age-disaggregated data collection/analysis applies throughout planning implementation and monitoring.

Consider disaggregating on other key characteristics, such as individuals living with disabilities.

SCENARIO 2: LOCATIONS WHERE GBV RESPONSE SERVICES/ REFERRAL PATHWAYS ARE AVAILABLE

This approach to measurement builds on Scenario 1 by adding the component of measuring perceptions of safety and GBV risk. As explained above, in order to respect the principle of “Do no harm”, prerequisites for Scenario 2 measurement are ensuring that GBV services are in place and including a GBV specialist in planning data collection and conducting the analysis.

The GBV specialist can help identify appropriate referral pathways and work with the Nutrition staff to incorporate this information appropriately into the measurement process. It is also possible that a situation exists where a referral pathway is in place, but there are question marks around its quality or functionality. In this case, it is a good idea to stay within Scenario 1 measurement.



SCENARIO 2 SUMMARY OF CHARACTERISTICS

M&E APPROACH

Integrated into routine M&E within a programme.

MEASUREMENT

Scenario 2 measurement focuses on understanding the barriers that communities, especially women and girls, face, coping strategies, GBV risk mitigation programming plus specific questions about perceptions of safety, linkages to GBV and indirect effects/unintended consequences

Availability, Accessibility, Acceptability and Quality of services	+	Coping strategies related to the sector/ programme + GBV risk mitigation programming adaptations	+	Safety perceptions, Linkages to GBV services + Indirect effects/ unintended consequences
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Measurement can be qualitative and/or quantitative. Findings should be regularly analyzed and fed back into programme decision-making processes.

CONSULTATIONS WITH WOMEN AND GIRLS

Consultations should focus on overall satisfaction with services, including barriers to accessing services, coping strategies, GBV risk mitigation programming and perceptions of safety/GBV risks, linkages to GBV services and unintended consequences.

PRESENCE OF GBV SERVICES

These locations have specialized GBV response services and a GBV referral pathway in place.

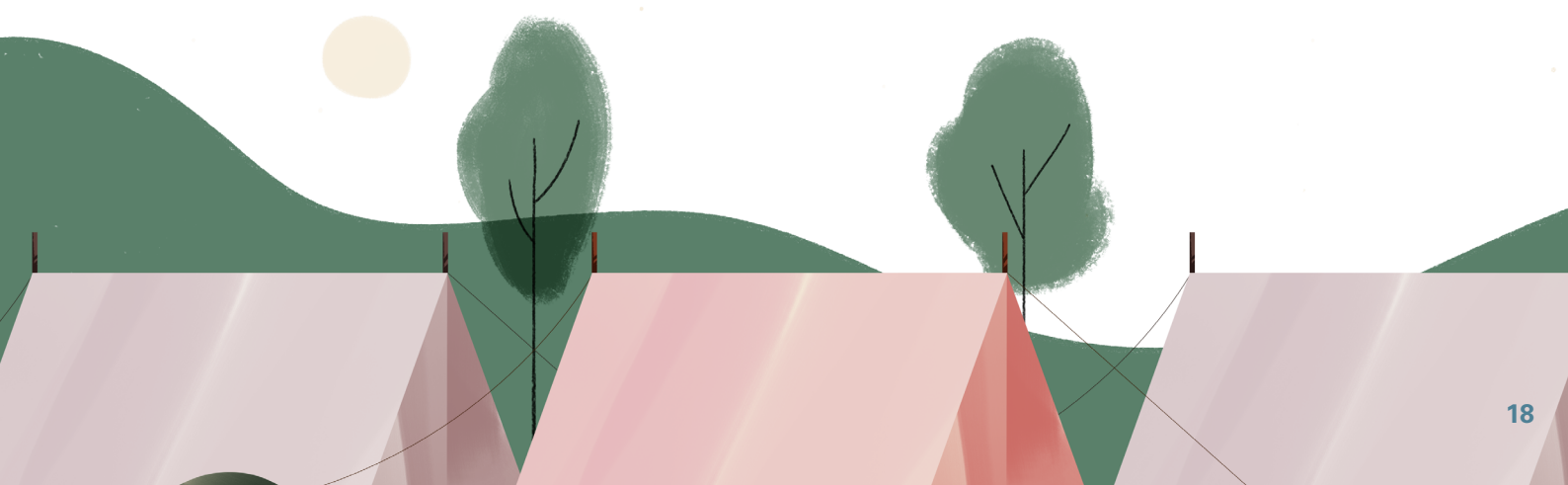
TRAINING OF STAFF

Scenario 2 measurement requires training of frontline workers on:

- How to support survivors of GBV and how to safely refer survivors to available GBV services using the GBV referral pathway for your setting
- Basic research ethics, data collection techniques, including informed consent and handling participant distress
- Facilitation of discussion groups and/or interviews on safety-related topics.

GBV SPECIALIST SUPPORT (REQUIRED)

GBV specialists provide technical support on planning for data collection, adapting safety questions to the context, conducting consultations in a safe and ethical way and analyzing data (including relevant information from secondary data reviews).



HOW TO INCORPORATE SCENARIO 2 MEASUREMENT INTO PROGRAMMATIC M&E

STEP 1

Refer to the Menu of Measures to select the quantitative and/or qualitative elements most relevant to your programme. All elements of the Menu can be considered for Scenario 2 measurement.

STEP 2

Determine if the information selected in Step 1 is already being collected through existing M&E and, if not, whether it is feasible for your team to begin collecting it (See “Other factors to consider” on page 12).

STEP 3

With support from a GBV specialist, assess how to consult with women and girls about their [barriers to accessing services](#), [coping strategies](#), [feedback on any GBV risk mitigation actions undertaken](#), [safety perceptions/GBV risk](#) and [assessment of any indirect effects/unintended consequences](#). Refer to [Annex 3](#). Integrate these consultations throughout the programme cycle.

STEP 4

Adapt the questions, as needed, to the context and incorporate them into your M&E tools.

Sex- and age-disaggregated data collection/analysis applies throughout.

Consider disaggregating on other key characteristics, such as individuals living with disabilities.

SCENARIO 3: LOCATIONS WITH GBV RESPONSE SERVICES/REFERRAL PATHWAYS AND AVAILABLE RESOURCES FOR MORE INTENSIVE RESEARCH

Scenario 3 measurement builds on the foundation of Scenario 2. Whereas the difference between Scenarios 1 and 2 is mainly about content (Scenario 2 includes perceptions of safety/GBV risk where Scenario 1 does not), the respective content for Scenarios 2 and 3 are the same. What distinguishes Scenario 3 from Scenario 2 is that it goes beyond programmatic M&E and introduces operational research and/or a more in-depth evaluation¹².

Scenario 3 requires a well-established GBV risk mitigation programme, access to support from a GBV specialist, and a research or evaluation partner with relevant expertise and additional budget over a longer period. Many impact evaluations require multi-year funding and engagement.

¹² To measure the effectiveness of GBV risk mitigation, programmes may decide to undertake an evaluation (e.g., outcome or impact). Various quantitative, qualitative and mixed method methodologies may be used depending on the context, needs and scope of the research.



At the time of this document's release, one pilot had been undertaken to generate learning to inform this Guidance Note and the associated Menu of Measures. While every project will be unique, some learning emerged from the Scenario 3 piloting process that may be applicable to future efforts. To undertake a Scenario 3 research project, it is important to have dedicated research expertise, in the form of a research firm, academic institution or consultant, to complement knowledge from nutrition practitioners. The research partner can support creation of the research questions, implementation of the research plan, data analysis and interpretation and can provide ongoing capacity building as needed. Research requires significant time and resources – it is smart to budget more time than you think you may need at every stage and recognize that unexpected events may require additional time and adaptation. It is vital to engage nutrition programming staff throughout the process. However, engaging existing programmatic staff in research means that they may have less time available for their ongoing programmatic responsibilities. In some cases, it may be necessary to hire additional staff on the programmatic side to ensure that there are enough staff available to support the research without negatively affecting the regular nutrition programming. Either way, it is important to be conscious of the additional time that this process may add to already-busy schedules.

Having a well-developed theory of change is helpful for guiding research processes and defining the expected changes as a result of programme implementation. Similarly, it is vital to create well-defined research questions at the start of the research process. This guides which information is gathered from whom and why. Additionally, a well-defined intervention package that is consistently implemented will help ensure that the research can make a logical link between any changes measured and the GBV risk mitigation interventions.

As mentioned elsewhere, for any formal research process, the team will need to seek ethical approval from an academic institution or other accredited Institutional Review Board (IRB), including through local structures such as health ministries. This can be a lengthy process, and often requires a detailed research protocol including data collection tools, so it is important to plan accordingly. Finally, as has been noted throughout this document, adapting the research process to the local context will be one of the most important considerations for creating a successful research project.

Even when the utmost care has been put into designing the methodology, questions and answer options, unanticipated challenges can arise. This may be in the form of questions/answer choices that are not interpreted in the way the research team intended, enumerators facing situations they do not feel equipped to handle (participant discomfort around certain topics, GBV disclosures, etc.) or other issues. As such, it is crucial that the team overseeing the data collection build in regular check-ins with the enumerators to get their feedback on the actual experience of collecting the data and where additional adaptations, capacity building and/or other forms of support are needed. The overall timeline and budget must also have enough flexibility to accommodate such modifications.



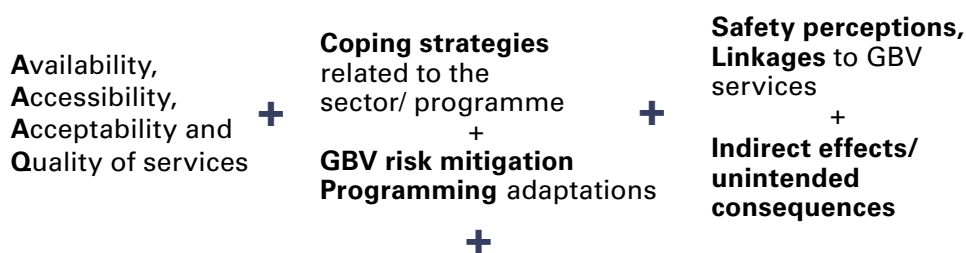
SCENARIO 3 SUMMARY OF CHARACTERISTICS

M&E AND RESEARCH APPROACH

Data collection/analysis will go beyond routine programmatic M&E but can also be used to strengthen other components of the programme's M&E. Ethical approval of the research should be obtained and special considerations for collecting data from individuals under 18 years of age are required.

MEASUREMENT

Scenario 3 measurement focuses on understanding the barriers that communities, especially women and girls, face, coping strategies, GBV risk mitigation programming plus specific questions about perceptions of safety, linkages to GBV and indirect effects/unintended consequences (same as Scenario 2) as well as a more robust research/evaluation design.



Research/evaluation design and methods specific to the programme and context

Research design and methods are determined based on research and programme objectives, context/operational constraints and other factors. Methods can be qualitative and/or quantitative.

Scenario 3 measurement findings have the capacity to more robustly measure effectiveness of GBV risk mitigation interventions (depending on design and methods utilized). However, it is important to note that Scenario 3 measurement is generally not as useful as Scenarios 1 and 2 for generating rapid/real-time information to guide day-to-day programmatic decisions. Scenario 2 measurement (see above) integrated into programme routine monitoring is a more appropriate option for flexible, real-time information to influence programme course corrections.

CONSULTATIONS WITH WOMEN AND GIRLS

Consultations should focus on overall satisfaction with services, including barriers to accessing services as well as perceptions of safety/GBV risks and the other measurement categories described above.

PRESENCE OF GBV SERVICES

These locations have specialized GBV response services and a GBV referral pathway is in place for all locations where data is being collected.

TRAINING OF FRONTLINE WORKERS

Scenario 3 measurement requires training and long-term capacity-building, supervision and coaching of frontline workers and all research personnel on:

- How to support survivors of GBV and how to safely refer survivors to available GBV services using the GBV referral pathway for your setting
- Basic research ethics, data collection techniques, including informed consent and handling participant distress
- Referral of research participants to services as needed
- Utilizing a survivor-centered approach.

GBV SPECIALIST SUPPORT (REQUIRED)

GBV specialist engagement is required. If possible, it is recommended that an agency/organization implementing GBV programming be a co-lead on the research.

RESEARCH PARTNER(S)

Scenario 3 measurement requires partnership with a research institution(s) that exhibit(s) the following capacities:

- GBV technical expertise including knowledge and track record of implementing research in alignment with global best practices on safety and ethics for research on gender-based violence.
- Sector-specific expertise relevant to the sector in question (nutrition, food security, cash, etc.).
- Experience conducting research in humanitarian settings.

Whenever feasible, involving a local/regional research institution is recommended.

COMMUNITY AND CIVIL SOCIETY ENGAGEMENT

Local stakeholders, especially women's groups/networks, women's movements and other relevant community and civil society structures must be involved in the research process to ensure methodologies are appropriate and to help align the research with broader priorities and goals. For example, it may be worth undertaking formative research. This can involve conducting focus groups or interviews with services providers, women's leaders and other experts in the community to, firstly, identify the most important issues to address with further research and, secondly, to understand the appropriate language to discuss these issues.

BUDGET

Additional budget is needed to engage in Scenario 3 measurement. The amount will depend on the scope and scale of research to be undertaken.

How to incorporate Scenario 3 measurement into programmatic M&E

Since the Scenario 3 measurement design and approach may require setting up a separate system of data collection, which can vary from project to project, it may or may not be necessary to adjust the existing programmatic M&E as recommended in Scenario 2. Practitioners and research teams can discuss the best approach for integrating the research work and programmatic M&E in this scenario.

APPLYING THE GBV GUIDING PRINCIPLES TO GBV RISK MITIGATION MEASUREMENT

Regardless of the approach to measurement selected, it is essential to uphold the guiding principles of GBV interventions: safety, confidentiality, respect and non-discrimination.

- **Safety:** The safety of affected communities and frontline workers is the number one priority. Any engagement with women, girls and other groups should ensure that they do not create additional risk or harm for participants. Practically, this means ensuring consultations are held in safe locations, scheduling these at a preferred time and location for participants, informing everyone involved about the potential risks/benefits of participating and training frontline workers on how to safely and appropriately respond to disclosures of GBV.
- **Confidentiality:** For GBV risk mitigation interventions, it is important to remember that no information on individual survivors, incidents or perpetrators should be collected¹³. Instead, confidentiality in this context refers to the ethical precautions and accountability standards that need to be upheld for any data collection exercise. For example, in most instances, enumerators should not collect or record identifying information about individual respondents. However, with Scenario 3 measurement, there may be certain circumstances where collecting identifying information may be necessary (such as when the research design requires follow up with the same individuals several times). In these cases, additional safeguards (such as assigning each person a numerical identifier) should be put in place in consultation with experts to ensure confidentiality. For the most part, information should be aggregated to see broader trends and themes instead of sharing individual responses.

¹³ If someone voluntarily chooses to disclose an experience of GBV during the data collection, it is important to maintain complete confidentiality of this disclosure and follow the guidance outlined in the GBV Pocket Guide.

- **Respect:** All actions taken are guided by respect for the choices, wishes, rights and dignity of women, girls and other groups engaged in measurement activities. Putting affected communities at the center of the process and listening to their wishes and opinions is central to this work. Women, girls and any other groups engaged in measurement activities must be treated with dignity and their opinions, experiences and input valued and validated. Design measurement activities to ensure that all participants understand they can stop taking part in measurement activities and/or decline to provide input on particular topics at any stage in the process.
- **Non-discrimination:** Measurement activities must proactively work to include the voices of those who are most marginalized and vulnerable and, therefore, less likely to participate in consultations. While preparing for data collection, programme staff should assess the factors that inhibit these groups from participating and find ways to work around these barriers. To the extent possible, activities should be appropriate and acceptable to people with different lived experiences (e.g., age, gender, marital status, race, religion, nationality, ethnicity, sexual orientation, etc.). In some cases, consulting with or engaging certain individuals or groups can place them at risk of harm. Measurement efforts should seek to reach the most marginalized while ensuring that people are able to safely and comfortably participate. As emphasized multiple times above, working with local women's groups can help ensure consultations are designed in a non-discriminatory way.



2. Overview of Gender-Based Violence

Defining GBV

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

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

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

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



ESSENTIAL TO KNOW

Informed Consent

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

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

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



ESSENTIAL TO KNOW

Women, Girls and GBV

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

Nature and Scope of GBV in Humanitarian Settings

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

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

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

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

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

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



ESSENTIAL TO KNOW

Women and Natural Disasters

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

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

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



ESSENTIAL TO KNOW

Protection from Sexual Exploitation and Abuse (PSEA)

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

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

Impact of GBV on Individuals and Communities

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

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

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

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

Contributing Factors to and Causes of GBV

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

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

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

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

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



ESSENTIAL TO KNOW

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

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

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

Key Considerations for At-Risk Groups

In any emergency, there are groups of individuals more vulnerable to harm than other members of the population. This is often because they hold less power in society, are more dependent on others for survival, are less visible to relief workers, or are otherwise marginalized. This TAG uses the term 'at-risk groups' to describe these individuals.

When sources of vulnerability—such as age, disability, sexual orientation, religion, ethnicity, etc.—intersect with gender-based discrimination, the likelihood of women's and girls' exposure to GBV can escalate. For example, adolescent girls who are forced into child marriage—a form of GBV itself—may be at greater risk of intimate partner violence than adult females. In the case of men and boys, gender-inequitable norms related to masculinity and femininity can increase their exposure to some forms of sexual violence. For example, men and boys in detention who are viewed by inmates as particularly weak (or 'feminine') may be subjected to sexual harassment, assault and rape. In some conflict-afflicted settings, some groups of males may not be protected from sexual violence because they are assumed to not be at risk by virtue of the privileges they enjoyed during peacetime.

Not all the at-risk groups listed below will always be at heightened risk of gender-based violence. Even so, they will very often be at heightened risk of harm in humanitarian settings. Whenever possible, efforts to address GBV should be alert to and promote the protection rights and needs of these groups. Targeted work with specific at-risk groups should be in collaboration with agencies that have expertise in addressing their needs. With due consideration for safety, ethics and feasibility, the particular experiences, perspectives and knowledge of at-risk groups should be solicited to inform work throughout all phases of the programme cycle. Specifically, education actors should:

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

Key Considerations for At-Risk Groups

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

Key Considerations for At-Risk Groups (continued)

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

! ESSENTIAL TO KNOW

What the Sphere Handbook Says:

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

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

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

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

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Tip Sheet: Consulting with women and girls

Effective GBV risk mitigation measurement a) integrates regular and routine consultations with women and girls; and b) measures, analyses and documents changes over time related to the GBV risk mitigation measure(s) in the project. This tip sheet provides supplementary guidance on how to engage women and girls to assess if your GBV risk mitigation measures are reducing barriers to services or helping women and girls feel safer.

Basic information:

In general, engaging women and girls during consultations happens at three critical moments:

1. Before a project begins: women and girls themselves can identify GBV risks in the environment and/or barriers to accessing services, along with their priorities for which risks and/or barriers are most critical to address;
2. During the project: women and girls provide feedback as to if/how your GBV risk mitigation efforts have affected their access to services and/or perceptions of safety. This feedback allows you to assess the effectiveness of your risk mitigation measure(s), identify any unanticipated or unintentional consequences; and, if necessary, make changes in your programming;
3. When the project is nearing completion or after it has ended: consultations help identify what worked and what did not work to generate lessons learned and next steps which risks and/or barriers are the most important to be addressed.

Remember! Consultations can take multiple modalities such as focus group discussions, key informant interviews, community mapping exercises, ranking methods or other participatory approaches.

For your programme, consultations can follow this model to assess perceptions of safety and if your GBV risk mitigation strategy is addressing the needs of women and girls.

Preparation:

- If there is a GBV sub-cluster/working group or an organization implementing GBV programming, connect with them to request support on planning and carrying out the consultations.
- Carefully consider the restrictions or cultural sensitivities that may prevent a woman or girl from participating in a consultation or lead to more harm for her. GBV specialists, even if in a different location or at national level can provide support in thinking through how to engage women and girls in the safest possible way.
- Find out what GBV services are in place in the location where the consultations will be conducted. Ensure staff who will be facilitating the consultations are equipped to respond if someone discloses that they have experienced GBV. Staff conducting safety consultations should be (a) familiar with the [“GBV Pocket Guide”](#)¹ on how to support GBV survivors and (b) familiar with how to appropriately refer survivors in a timely manner based on the GBV referral pathway in their area.
- Depending on the context, it may be necessary to speak with community leaders prior to the consultations. In some situations, guardians, husbands, male relatives, or mother-in-laws may need to be consulted and/or give their permission in order for women and girls to participate in your consultation.
- Related to the previous point, take care to carefully frame the purpose and scope of the consultation with communities and/or relevant stakeholders. Focus on the goal to improve programs and services for the community, especially with regards to making them safer and more accessible.
- Take into consideration what locations and times of day are safest and most appropriate for women and girls to participate in the study, based on school, chores, travel requirements, etc. Ensure

¹ <https://gbvguidelines.org/pocketguide/>

consultations take place in a secure setting where all individuals feel safe to contribute to discussions.

- Remember that participants may answer the same question differently depending on who is involved in the conversation (international vs. local staff), what they think the data collection team wants to hear, and what action or benefit they believe may result from responding in a certain way. Consider these factors when planning your consultations.
 - Be aware of the composition of a group during consultations and how to make sure everyone feels safe to express their voice and opinions without creating additional harm for them. For example, including unmarried girls with married girls or women can create different power dynamics. Similarly having young women and older women in the same group may prevent younger women from voicing their opinions or experiences. Groups that can be particularly difficult to access include:
 - Married girls
 - Unmarried women
 - People with disabilities
 - Female heads of household
 - Widows
 - Work with a GBV specialist to determine what questions are appropriate. Questions should be worded in a way that explicitly links perceptions of safety to a specific intervention, facility, etc. and should include a time-bound component. Refer to the **Menu of Methods** in the main **Guidance**
- Note.** Some examples specific to Level 2 and safety perceptions could be:
- “Do women and girls in your community feel safer moving around the camp at night since the lighting has been installed (as compared to before the lighting was installed)?”
 - “Do women and girls in your community feel safer going to the distribution point since the location was changed to align with the community’s preferences?”
 - “Do women and girls in your community feel their access to health services has improved with the increased number of female reception staff (as compared to when the reception staff were mostly male)?”

DO’s

- Have trained female staff facilitate the consultations with women and girls.
- Be conscious of the fact that the females who are most visible/accessible for consultations may not be representative of the female population as a whole (in terms of access to services, etc.). Consider if you need to make alternative arrangements to connect with other groups of women and girls in a safe, non-stigmatizing way.
- Explain the purpose of the consultation and how the information will be used. Obtain informed consent before beginning the consultation.
- Manage expectations about participating in the consultation and what participants can expect to receive. Be honest and upfront in explaining that there will be no compensation.
- Keep questions simple, relevant to programme objectives and straightforward.
- If relevant, consider options for consulting with women and girls who are using the service (i.e. visiting to a water point to speak to them).

Important DON’TS

- DON’T ask questions about individuals’/specific people’s experiences of GBV.
- DON’T collect or attempt to collect GBV incident data/numbers of cases.
- DON’T attempt to convene a consultation group comprised only of GBV survivors or to find GBV survivors to take part in the consultations.
- DON’T make questions too general. A question like “Do you feel safe?” can be interpreted in multiple ways and does not focus participants on the specific purpose of your consultation (whether there have been improvements in safety/access linked to particular risk mitigation measures).