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Intersectionality in Gender-Based Violence Programming

A Toolkit for Humanitarian
and Development Practitioners

Handicap International
Humanity & Inclusion

Handicap International — Humanity & Inclusion network

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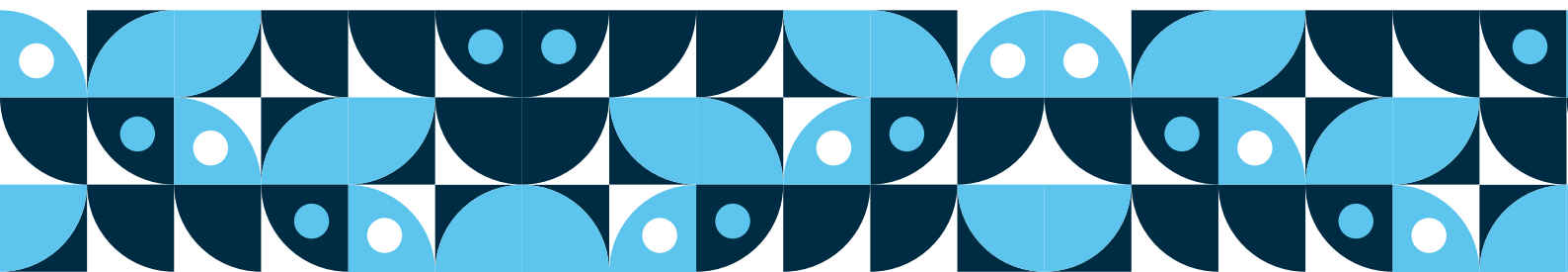
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(to be found in attached document ready-to be printed in Appendix section)

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Referral pathway template	?
CONFIDENTIAL Consent for Release of Information [Written]	?
CONFIDENTIAL Consent for Release of Information [Verbal]	?
Intake and Assessment Form	?



Acknowledgements

I am delighted to present this toolkit to you as an output of Humanity and Inclusion's (HI) "Intersectionality in GBV Programming" project. The toolkit was developed by Rooted Impact Consultants in cooperation with HI through a year of consultations, participatory co-development and field testing, as a basis for building it.

Making use of Kimberlé Crenshaw's concept of intersectionality, HI intends to contribute this resource to facilitate more inclusive practices across diverse practitioners. This resource aims to start moving the discussion from intersectionality at the policy level to 'unpacking' it and finding the best possible ways to make it concrete in daily work in both humanitarian and development contexts. By doing so, at HI we aim to leave no one behind, and hope it can benefit the global community. This resource builds on HI's experience with the 'Making it Work How-To Guide: Intersectionality in Practice' project and is meant to be complementary to existing resources such as the recently launched 'Intersectionality Resource Guide and

Toolkit' and the Gender-Based Violence Information Management System.

First of all, I would like to express my gratitude to the Bureau of Humanitarian Assistance for their interest in this project and for supporting and funding this important work.

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Flavia Stea Antonini
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Acronyms

CS	Case Management
CP	Child Protection
DRC	Danish Refugee Council
FGM	Female genital mutilation
GBV	Gender-based violence
GBV AoR	Gender-based violence Area of Responsibility
GBVIMS	Gender-based violence Information Management System
HI	Humanity and Inclusion
IASC	Inter-Agency Standing Committee
IMC	International Medical Corps
IOM	International Organization for Migration
IRC	International Rescue Committee
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, and asexual
MIW	Making It Work
NGO	Non-governmental organization
OPD	Organization of persons with disabilities
RI	Rooted Impact
SOGIESC	Sexual orientation, gender identity, gender expression and sex characteristics
SOP	Standard Operating Procedure
UN	United Nations
UNFPA	United Nations Population Fund
VAW	Violence against Women
WGSQ	Washington Group Short Questions

I. Introduction

This toolkit was envisioned to help humanitarian and development actors better understand the inequalities and barriers affecting diverse communities so that gender-based violence (GBV) interventions can be increasingly designed and adapted to ensure that diverse survivors have improved access to equitable and inclusive services without discrimination.

Power is at the heart of how societies are organized and how people relate to and interact with each other. Systems of oppression provide greater power and privilege to some people, while leaving others at greater risk of discrimination, exclusion, and violence. Sexism, ageism, ableism, classism, racism etc., are all systems of oppression that perpetuate systemic inequalities.

Patriarchy is a system of power based on gender, where men are provided with greater power and privilege than women, girls, and people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC).

As a result, gender inequality is widespread in patriarchal societies. Systemic inequality and discrimination based on patriarchal norms are at the root of GBV. Women and girls and people with diverse SOGIESC are the most at risk of GBV under this system because society gives men power over their bodies, sexuality, reproductive capacity, and labor.

Gender, however, is not binary and people of the same gender are not homogenous. People's lived realities are multifaceted and involve intersecting experiences. Characteristics such as age, disability, class, ethnic affiliation, geographic location and migration status, among others, interplay with gender and result in a power dynamic that increases or decreases their risk of discrimination and violence. A woman of higher socio-economic status who holds citizenship will not have the same lived experiences as an adolescent girl

who is a refugee affiliated with a non-dominant religious group and so power affects their lives differently.

Intersectionality helps us better understand why this woman could hold more privilege and face less discrimination than the adolescent girl. It is a lens and analytic framework to recognize and understand how the intersection of different identities, power relations and lived experience can lead to discrimination or privilege in a specific context. It refers to the way in which systems of power are interconnected and uphold each other.

To ensure that no one is left behind, humanitarian and development practitioners need to identify where inequalities exist in contexts where they work, and then take action

to understand the root causes driving these inequalities.

If practitioners do not analyze these dynamics, how can they ensure that no one is at risk of exclusion from their interventions?

It is not one characteristic of a person's identity that leads to their discrimination or resilience but the interactions of multiple characteristics with systems of oppression.

To understand why and how some people are at higher risk of GBV in a context, practitioners need to understand power relations, discrimination and inequalities across societal norms and systems. To understand why and how GBV survivors with different backgrounds and lived experience may face greater barriers to safety, support, and services, practitioners need to understand similar dynamics across societal norms and institutions. If practitioners want to design more inclusive and transformative interventions, an intersectional approach is critical to address the inequalities and discrimination that perpetuate exclusion and violence.

FURTHER RESOURCES ON INTERSECTIONALITY:

VIDEO - KIMBERLÉ CRENSHAW AND THE CONCEPT OF INTERSECTIONALITY

[HTTPS://WWW.TED.COM/TALKS/KIMBERLE_CRENSHAW_THE_URGENCY_OF_INTERSECTIONALITY?LANGUAGE=EN](https://www.ted.com/talks/kimberle_crenshaw_the_urgency_of_intersectionality?language=en)



PURPOSE

What is the aim of Intersectionality in the GBV Toolkit?

This toolkit aims to help GBV actors, as well as non-specialized actors, embrace intersectionality in their work to ensure GBV survivors - in all their diversities - are not at risk of 'being left behind'. The toolkit is designed in line with the 'GBV Guiding Principles' and the survivor-centered approach and is complementary to the GBVIMS (as outlined under 'Structure: How to use this toolkit'). In line with the Interagency Gender-based Violence Case Management Guidelines, the toolkit distinguishes between a GBV response as the responsibility of GBV actors versus actors that are not specialized in GBV. However, non-specialized actors, such as OPDs, women's organizations, and human rights organizations, often encounter GBV survivors and link them to services providers. Therefore,

this toolkit aims to provide helpful guidance to GBV actors as well as non-specialized actors¹ when working with diverse GBV survivors².

The toolkit and accompanying e-learning helps diverse practitioners - from organizations of persons with disabilities (OPD) to GBV actors - to understand why and how different lived realities and inequalities impact people's risk of GBV and work together, so that the specific needs of GBV survivors in all their diversities can be identified and, ultimately, better addressed.

The toolkit is tailored to meet the specific needs identified during an initial assessment conducted in late 2021-early 2022. This process included extensive consultation with a diverse range of actors such as GBV specialists, inclusion specialists, OPDs, human rights organizations, women's networks, and community-based organizations (CBOs) interacting with survivors of GBV at global as well as at regional and country level in Ethiopia and in Myanmar. These consultations indicated that intersectionality remains a fairly vague, intangible concept.

1 — Such as when there is no GBV actor available.

2 — Please note differing terminology is used throughout the toolkit, for instance 'diverse GBV survivors' or 'diverse survivors'.

Intersectionality practice continues to be limited to gender, age, and in some cases disability inclusion for many practitioners and organizations. The tools in this toolkit are based on a variety of needs expressed both at global level and in local contexts such as Ethiopia and Myanmar.

Overall, while a significant amount of technical guidance has been developed by the GBV community, simple and practical approaches are still needed according to international, regional and national stakeholders consulted. For many of the actors who encounter diverse GBV survivors, the array of information and guidance can be quite overwhelming and limited in its concrete guidance on how to approach their diverse needs.

The overarching aim of this toolkit is to address several of the needs addressed during the consultation process, by:

- 1. Simplifying and bridging the concept and practice** of intersectionality for humanitarian and development practitioners, as well as representative groups, through participatory activities
- 2. Providing a selection of the practical and intersectional tools in this toolkit** to support all actors working with GBV survivors when there is no GBV actor available
- 3. Providing simple, practical intersectional tools to GBV actors who do not make use of the GBVIMS**
- 4. Providing complementary resources and guidance for GBVIMS users,** bringing an intersectional lens to contribute to their inclusion efforts

AUDIENCE:

Who is this Toolkit for and in what settings can it be?

The toolkit is intended for humanitarian and development practitioners who encounter diverse groups of GBV survivors in their work

and need tools to support them through, for example, linking survivors to service referrals, or through direct service delivery by GBV actors. Moreover, the toolkit brings together a diverse group of actors – including representative groups – to facilitate a deeper understanding of power, inequality and discrimination and to reflect on capacities to work with survivors in all their diversity, and encourage collaboration.

The main group of users of this toolkit could be:

- 1. Actors which already provide GBV responses and wish to include an intersectional lens in their intervention.** Through the adaptation of widely used tools such as the GBVIMS intake form and/or gap analysis, this toolkit provides practical tips and adaptive options. It will help to adapt to a greater diversity of needs in line with the GBV AoR Minimum Standards, in particular the GBV Guiding Principle on Non-Discrimination.
- 2. Actors not providing GBV responses, but which may encounter GBV survivors where there are no GBV actors available.** In particular, those that work with groups affected by inequality and discrimination in their context. It will help to improve the understanding of risk factors, how to interact in a supportive way, and improve capacities to rely on key GBV principles such as non-discrimination, dignity, and safety.

CONTEXTUALIZATION:

How this toolkit can be used in different contexts.

As a global toolkit, it needs to be contextualized to your specific context for optimal use. **Intersectionality must be contextualized for it to be applied in practice.** A key enabler to an intersectional approach is understanding the context and the interplay of political and socio-economic factors; for example, particular power relations and the resulting inequalities, discrimination, and violence are more

prevalent in certain contexts than in others.³

A **Do No Harm approach** should be consistently applied when using any of the tools or approaches in this toolkit. For example, acknowledging the legal frameworks in a context and the use of certain terminology needs to be considered to ensure safety of survivors, practitioners, and partners. An illustrative example is during the toolkit testing in Ethiopia, where the tools were contextualized by referring to SOGIESC survivors instead of LGBTQIA+. In each specific context, it is always important to prioritize the safety of diverse survivors, as practitioners work to ensure no one is left behind in GBV prevention and in how diverse survivors access and receive services.

Language is also of critical importance in contextualization. Intersectionality is a term that is often not translatable in different contexts and time and space is needed to understand the nuances across different national and local languages. This toolkit has been translated and made available in English, French, Spanish, and local languages in Ethiopia and Myanmar.

POSITION:

Where this Toolkit fits among existing tools and guidelines.

This toolkit was conceptualized after close examination of the wide array of GBV and inclusion tools. A need was identified for a convergence of tools that focus on mindset and behavior, as well as providing tangible information that can be used in day-to-day work with survivors.

The selection of tools was intentional to prevent duplication of existing toolkits and guidelines. This toolkit is not intended to replace existing guidance and resources on GBV case management, in particular the GBV AoR Minimum Standards and the GBVIMS. Users of the **programming tools** need the competencies and skills from a GBV actor. Ideally, all users of the toolkit work

together with a GBV actor and/or a trained GBV specialist when contextualizing the tools. Additional relevant resources from the humanitarian and development communities are indicated throughout the toolkit for complementary references and learning.

The positioning of the tools builds on and complements existing intersectional resources, particularly intersectional/power analysis tools. It complements the work of Humanity and Inclusion (HI)'s 'Making It Work How-to Guide' on intersectionality.⁴

PROCESS:

How we developed this Toolkit.

The process itself is an important outcome of this toolkit. The development of this toolkit was a participatory, iterative, and people-centered process that aimed to build understanding of intersectionality in practical ways.

Starting in late 2021, an in-depth literature review and extensive consultations with global, regional, and national (Ethiopia and Myanmar) stakeholders were conducted. Researchers asked about key informants' experiences with practicing intersectionality in humanitarian and development contexts and GBV programming, enablers/barriers to the inclusion of groups most affected by inequality and discrimination in GBV prevention, referral, and response, inclusive practices taking place within their organizations, and the tools they use to bring an intersectional lens to their work.

GBV and social inclusion-focused resources across various contexts were reviewed (e.g. emergencies, protracted situations, camps, urban, natural disasters, conflict, etc.). The initial literature review was expanded to include resources recommended during consultations with humanitarian and development practitioners. Researchers experienced a scarcity of literature relating to intersectionality within the humanitarian and development contexts with more focus on single identity marginalization (e.g. persons with disabilities, women and girls, etc.) and less focus on systemic inequalities.

ADDITIONAL RESOURCE: MIW PROJECT - HOW-TO GUIDE, IN THE ANNEXES SECTION ON PAGE 150

3 — The toolkit outlines systems of oppression in the cards on page 49 and makes use of contextualized scenarios.

4 — <https://www.makingitwork-crpd.org/sites/default/files/2022-03/MIW%20How-To-Guide-Intersectionality%2008March2022.pdf>

Participatory co-design with end users at country level was a critical aspect of this process. Both Myanmar and Ethiopia were engaged remotely, and in-person sessions were held in Ethiopia. Humanitarian and development practitioners from UNFPA, IMC, DRC, IRC, IOM, civil society, government, one-stop centers, the private sector, and OPDs participated in the co-design process.

An effective co-design process required a shared baseline of knowledge and sensitization on intersectionality before moving fully into the design phase. To meet these needs, **the process was adapted to start with training on core concepts of intersectionality.**

Participants had space to engage in deeper self-reflection and awareness on power and privilege and on how power operates in a society – shaping the narrative of individuals, groups, communities, and institutions. Together, participants analyzed how inequality (and intersecting inequalities) and violence affect people from different backgrounds

and lived realities. This inspired the need for process tools to complement the more practical programming tools (forms, guidance documents). The process tools help to unpack concepts and connect people. The process tools entail activities that can ideally be conducted with a diverse group of actors to deepen each other's understanding of lived experience of inequality, discrimination, and violence.

To ensure optimal uptake of the practical programming tools, practitioners should pair them with the process tools. The process tools were co-developed and put into practice in Jijiga and Gambella in Ethiopia with GBV and non-GBV actors, which helped stakeholders to prepare for the testing of the programming tools.

After the tools were drafted, training on intersectionality and on the tools was delivered to organizations' key representatives in Ethiopia in Jijiga and Gambella (in-person), and in Myanmar (remotely), in order to prepare them for testing the tools at field level. This toolkit is the result of these tested tools.

The Process



LIMITATIONS:

The limits throughout the Process and within the Toolkit.

The toolkit was developed within an 18-months project, 12 months of which were dedicated to the participatory development of the toolkit and its complementary resources. This automatically shed light on the project duration as the main limitation which mainly impacted outreach. Interagency coordination was therefore not possible as it would have needed a longer timeframe for cooperation.

The project is grounded in global and particularly local engagement in Ethiopia and Myanmar. Individual actors have been approached, for example, through the GBV Area of Responsibility at global, national, and local level, although the IASC GBV Guidelines Reference Group as well as the GBV Case Management team under the GBVIMS Steering Committee have not been involved.

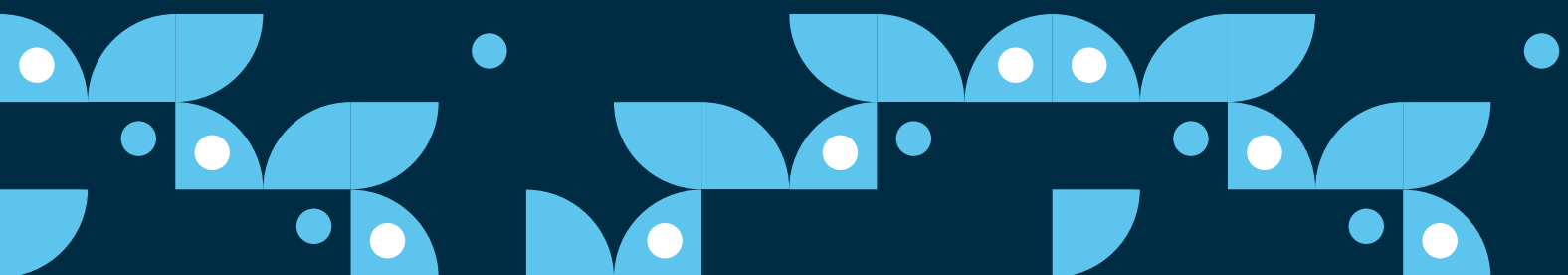
Throughout the toolkit, engagement with diverse groups, actors and networks is encouraged. This engagement needs time for which, within the project period, HI and RI mainly focused on building on already established contacts and partnerships at global as well as at pilot country level. The resulting main outreach and engagement often had a focus on disability inclusion and was largely with GBV response representatives as well as with representatives from OPDs and disability networks. Ideally, the engagement

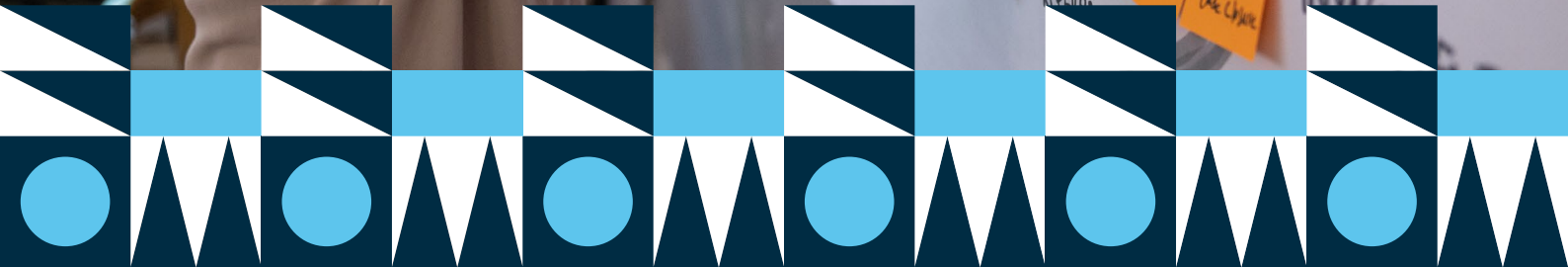
with representative groups would have also included such actors as youth groups, older people's associations, women's groups, regional and national feminist organizations, religious affiliated institutions, etc. The restriction to two pilot countries impacted the possibility of looking at a third country with different power dynamics around inequality, discrimination, and violence and intersecting oppressions.

Covid-19 hugely restricted the project in several ways. In Myanmar, all project work including the training had to be done remotely. The main impact observed was on building trust and collaboration as this is more difficult remotely compared with in person. Moreover, considering the highly sensitive topics, the remote work impacted significantly the 'rapport' and the willingness to share. On top of Covid-19 restrictions, the political situation in Ethiopia and Myanmar and its humanitarian effects also had an impact.

The translation of this toolkit into other languages is limited and only made available at the time of publishing in English, French, Spanish, and local languages in Ethiopia and Myanmar.

Lastly, language is impactful and evolving. None of the language or terminology used within this toolkit is meant to cause harm and will likely need to be updated as the intersectionality conversation expands across the humanitarian and development sectors. The time to investigate preferred terminology from representative groups was limited.





Applying the Tools in Ethiopia and Myanmar

From June until August 2022 interested organizations had the opportunity to test a selection of the tools. In Ethiopia, the tools have been tested in Gambella and its surrounding area (Gambella Region), as well as in Jijiga and its surrounding area, and also in Dolo Ado by Humanity and Inclusion (Somali Region). In Myanmar, the tools have been tested in Kachin State, Rakhine State as well as in Yangon.

Overall, the training provided ahead of the testing was much appreciated, which

shows a great interest and eagerness in intersectionality as a topic and in efforts to become more inclusive from many participants and particularly from GBV actors. Also, representative groups were extremely interested in being part of the preparatory co-development process and taking part in testing the process tools. Through one of the in-person sessions in which the process tools were tested, there was a realization that a similar collaboration, similar to that with women's organizations when conducting case management, could be envisioned with the OPDs in the room, which validated the expected partnership results through meaningful contact using the process tools. Of the process tools, the Intersectionality Yarn Tool is validated by all actors as a great sensitization tool. Testers expressed that it is good to learn by doing, that

inclusion of all matters in order to have more informed perspectives which impact referral and response. One user expressed it by saying “I now understand that it’s not about addressing multisectoral needs but about addressing the needs from diverse groups of population.”

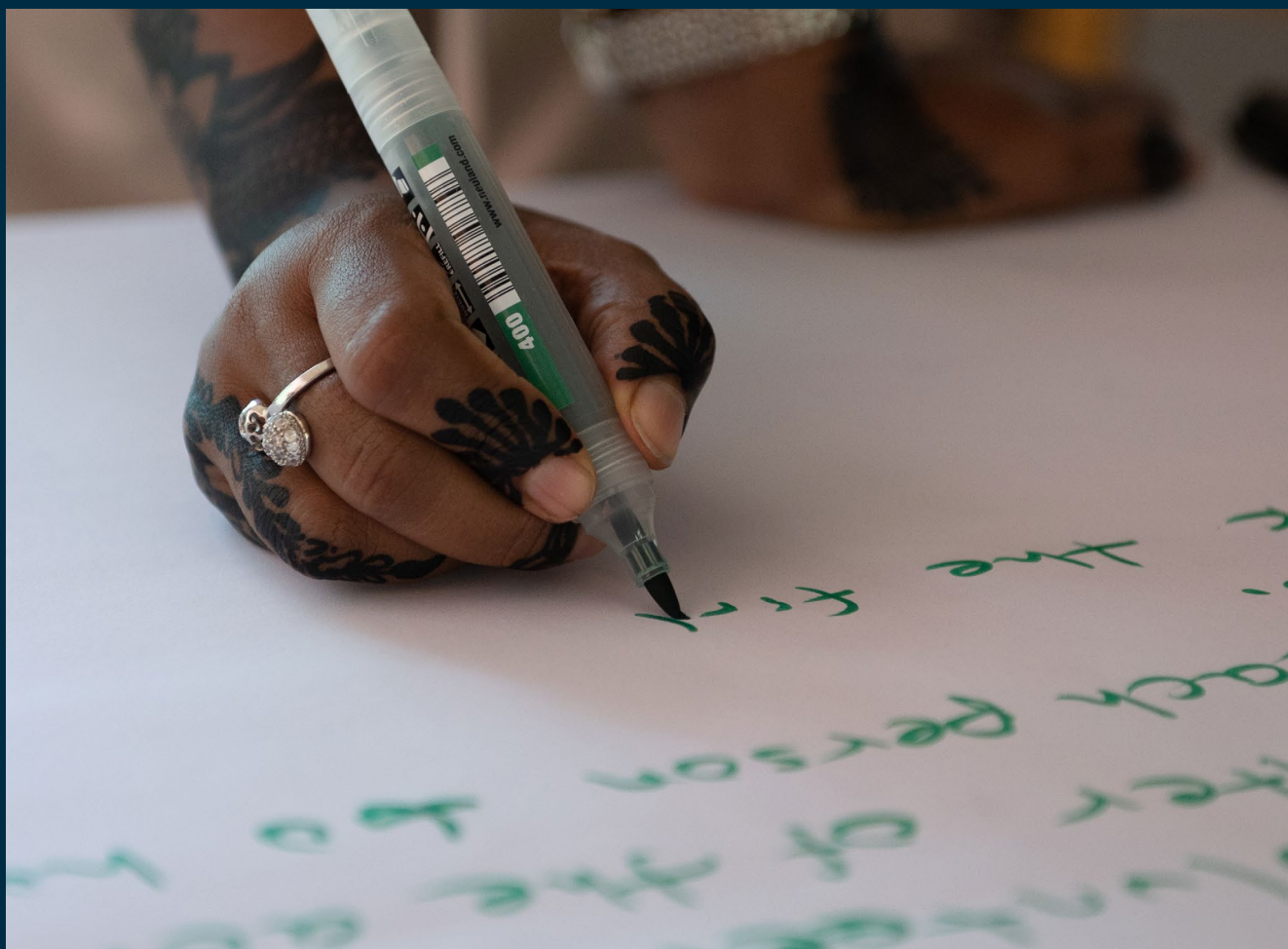
Using accessible terminology, as well as having clear explanations on intersectionality, is partly addressed through the creation of videos with further explanation, as well as through the e-learning that explains/recaps GBV basics – intersectionality and the facilitation of toolkit navigation.

The main testing result was on the need to contextualize: for instance, by referring to all SOGIESC in Ethiopia; by clarifying what security services entail in Myanmar; and by focusing on the contextualization of access to services so that no one is left behind. The need for good quality translation, therefore, is of paramount importance to facilitate (adequate) uptake.

A selection of the reactions showed that

GBV actors, especially in Myanmar, that do not currently have tools in place, expressed the usefulness of the easily understandable consent/assent form for both the GBV actor as well as for the survivor. OPDs expressed the usefulness of the toolkit as reference material, as it often happens that GBV survivors with disabilities get referred to an OPD instead of the GBV service provider. The bias tools were appreciated by many for the awareness of bias, i.e. to get more insight into their own attitudes and how this facilitates or hinders GBV referral and response to make sure it does not get in the way of supporting survivors in the future. Identifying services and making use of a referral pathway was also appreciated, particularly by actors that normally do not work with mapping.

Throughout the toolkit, small to more major revisions were made – from time indications to additions in the intake form on displacement status during the incident – as well as having forms that were easy to fill in.



II. Framework

FOUNDATION:

How power relates to Intersectionality and GBV

Power isn't 'out there', it reveals itself in our day-to-day interactions and choices. It is present in our intimate relationships, cultures, social circles, jobs, etc. and shapes us psychologically, socially, and economically. Power manifests as capacity (power to, power within, power with) and control (power over, power under) in our societies.

The way power is distributed mirrors how opportunities, rights, and privileges are distributed across a society. Power hierarchies perpetuate power imbalances, where some people are advantaged, and others disadvantaged and, in many cases, oppressed.

Understanding the root causes of why and how power is imbalanced across structures and relationships is critical to understanding why and how inequalities exist in communities and why the risk of exclusion and violence increases for some people.

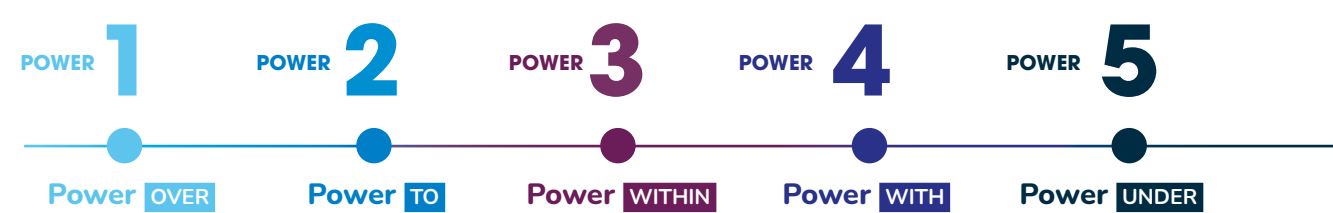
Understanding the root causes of why and how power is imbalanced across structures and relationships is critical to understanding why and how inequalities exist in communities and why the risk of exclusion and violence increases for some people.

Some people are at greater risk of GBV because of the systemic inequalities that they face.

Since all oppression is linked⁵, intersectionality is an important lens for humanitarian and development practitioners to use to design programs that address root causes of power hierarchies, inequalities, and discrimination, thereby removing barriers and preventing the exclusion of, and violence towards, some people based on their lived experience.

Transformative programming happens when the root causes of intersecting inequalities are disrupted and addressed. Without analyzing and addressing the root causes of intersecting inequalities, the humanitarian and development system continues only to address the symptoms of exclusion and falls short of attaining equality, social justice, well-being, and positive social change, and preventing violence such as GBV.

5 Expressions of Power



5 — Taylor, B. (2019) 'Intersectionality 101: What is it and Why is it Important?' Womankind Worldwide (www.womankind.org.uk/intersectionality-101-what-is-it-and-why-is-it-important/).

STRUCTURE:

How to use this toolkit

This toolkit includes two different types of tools: **process tools** and **GBV programming tools**. The tools can be used in a flexible 'pick and choose' way, although the toolkit design as well as the accompanying e-learning takes the user from the 'Awareness' via the 'Analysis' to the 'Action' theme.

The toolkit offers the user the opportunity to pair the process tool within each theme with the programming tools within the same theme. The process tools are interlinked to one another and provide a basis for understanding and creating connections around intersectionality. The **process tools** can either be used independently of the programming tools or they can be paired with them. Pairing is recommended and means that before using one of the programming tools, the process tool within that theme should be used.

The **programming tools** are hybrid tools – some are adapted from the GBVIMS and others are newly created to bring an intersectional lens.

In addition to the sensitization through the process tools and the tip sheet, the programming **'awareness'** tools also increase sensitization and can be used by any actor. Awareness tools are used to raise awareness on intersectionality and supporting concepts such as power and unconscious bias.

The programming **'analysis'** tools are recommended for GBV actors to pair with the tip sheet and are focused on mapping as well as on quality improvement. Analysis tools are used to self-assess and/or to assess the landscape around practitioners that encounter or work with GBV survivors.

Lastly, the programming **'action'** tools are supporting the GBV response by GBV actors through GBVIMS modified forms and guidance, which can be used independently or as a supplement to the GBVIMS. The action tools can be used to plan within organizations and networks as well as in day-to-day work with survivors.

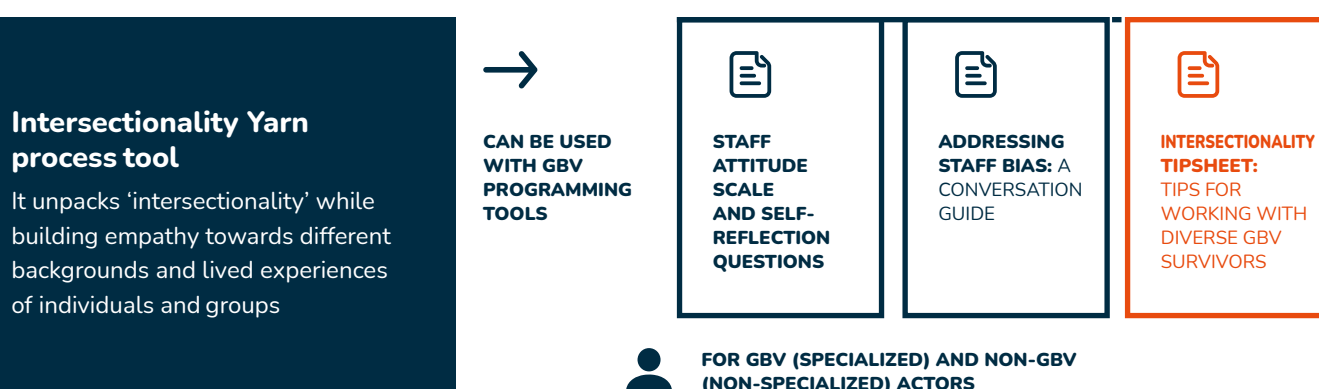


A toolkit for humanitarian and development practitioners

The infographic below lays out the structure of the tools in the toolkit indicating the relationships between the tools. The toolkit is not meant to be linear, therefore users should reference the guiding questions and notes within the infographic for further details on how to help users decide where to start and where to progress.

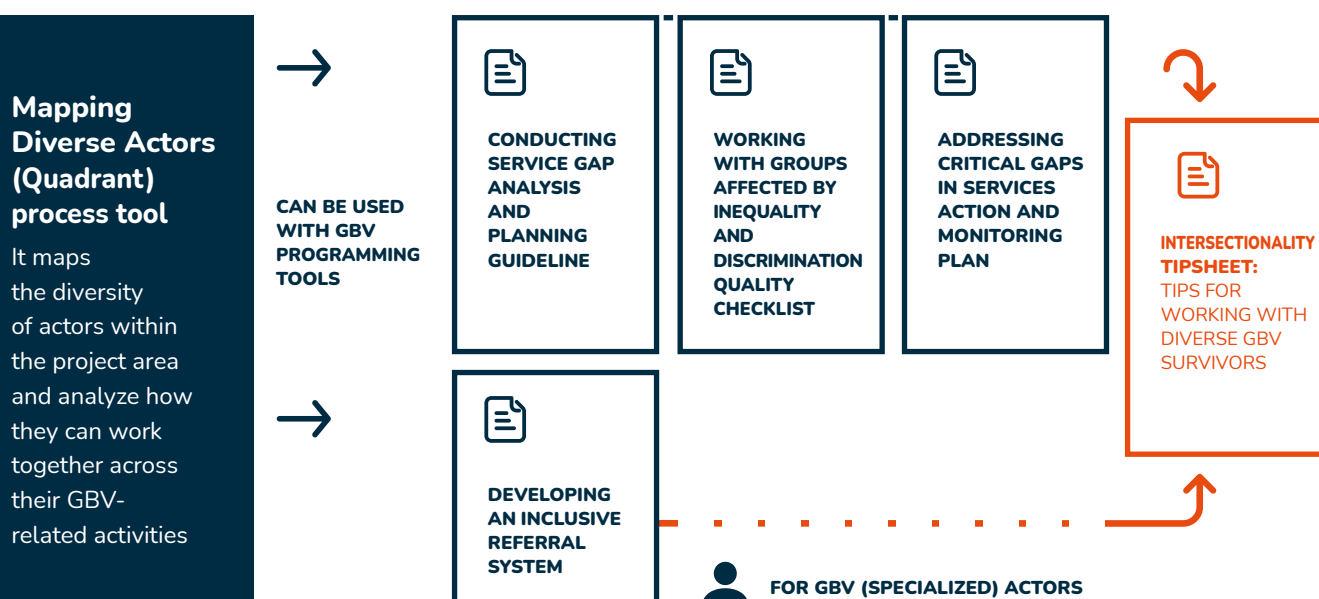
DO YOU WANT TO INCREASE YOUR KNOWLEDGE ON INTERSECTIONALITY?

Awareness tools are used to raise individual and organizational awareness on intersectionality and supporting concepts such as power and unconscious bias.



DO YOU WANT TO DIVERSIFY WHO YOU WORK WITH ON GBV?

Analysis tools are used to assess the landscape around practitioners work with GBV survivors.



DO YOU WANT TO BRING DIVERSE ACTORS TOGETHER TO DESIGN AN “ECOSYSTEM” OF SAFETY AND CARE FOR GBV SURVIVORS?

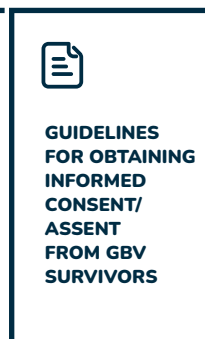
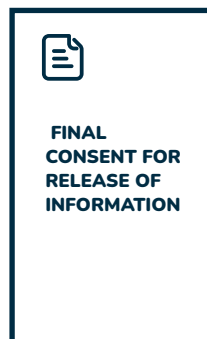
Action tools are used to plan within organizations and networks as well as in day-to-day work with survivors.

Creating Ecosystems of Safety and Care process tool

It brings together actors to co-design an inclusive safety and care-centered “ecosystem” for GBV survivors across prevention, response, and referral programming by identifying critical connections and collaborations between diverse actors



CAN BE USED WITH GBV PROGRAMMING TOOLS



INTERSECTIONALITY TIPSHEET:
TIPS FOR WORKING WITH DIVERSE GBV SURVIVORS



FOR GBV (SPECIALIZED) ACTORS



Guidance Note

- A dotted line means no direct hierarchy between and among the boxes.
- A straight line with an arrow means that the previous box/es is/are a pre-requisite to move forward.

Tools: Overview

This section provides an overview of process tools and GBV programming tools, including GBV response tools for GBV actors. Process tools can be used to build awareness, map stakeholders, analyze needs around intersectionality, and take action to create safer spaces by working together with a diverse set of GBV and non-GBV actors across humanitarian and development contexts.

The programming tools included here have been adapted to help ensure intersectional issues are better addressed and that agencies with no or

many tools are supported outside the formal GBVIMS. The analysis and action programming tools should be used by GBV actors, while the awareness tools can be used by both GBV and non-GBV actors. Additionally, GBVIMS users can supplement their own tools with an intersectional lens by referring to the GBV response tools in this toolkit.

The table below includes all tools by their designated themes of awareness, analysis, and action.

CATEGORY	TOOL(S)	PURPOSE	AUDIENCE	HOW TO USE	TIME NEEDED
Awareness	Intersectionality Yarn	This aims to connect people to the concept of intersectionality, build empathy, and link people to each other to build trust and relationships and, ultimately, stronger networks to prevent and respond to GBV.	GBV and non-specialized actors	Use with a variety of actors to get a strong visual or feeling of what intersectionality is about, to start/increase sensitization around this topic.	1-1.5 hours
Awareness	Staff Attitude Scale and Self-Reflection Questions (Staff Bias Tool 1)	This aims to evaluate and address the attitudes and biases of staff members who encounter GBV survivors through their daily work, or staff members who provide direct support to GBV survivors so that those biases do not lead to the exclusion (in referral or service provision) of survivors based on their diverse backgrounds and lived experience.	GBV and non-specialized actors	Use as an organizational reflection tool with staff members in your organization supplemented by GBVIMS Survivor Centered Attitude Scale. Also, can be adapted to be used more widely with other actors (e.g. partners, community members).	45 mins-1 hour
Awareness	Addressing Staff Bias: A Conversation Guide (Staff Bias Tool 2)	This helps staff members take an introspective look at where their attitudes and beliefs originate, and how they may affect their attitude when confronted with GBV survivors and/or the eventual impact this has on working with survivors.	GBV and non-specialized actors	This can be facilitated by a staff member or supervisor, or by a GBV specialist facilitator from another organization.	1-3 hours, based on chosen modality

CATEGORY	TOOL(S)	PURPOSE	AUDIENCE	HOW TO USE	TIME NEEDED
Analysis	Service Gap Analysis – Quality Checklist for Working with Groups Affected by Inequality and Discrimination (Part B)	This can be used to identify capacities, gaps, availability, and willingness to adapt GBV services to target diverse groups. Actors using this tool should take into consideration their capacities as well as their limitations, their strategic stand within the GBV response of the context where they work, and the needs and wishes of their beneficiaries.	Primarily for use by GBV actors	This tool can be facilitated by a GBV-Inclusion specialist in coordination and collaboration with a GBV specialized actor and/or GBV cluster leads with implementing partners, or with referral partner staff, or internally by organizations who are engaging in self-assessment of capacities.	2 hours
Analysis	Service Gap Analysis – Action Plan and Monitoring for Addressing Critical Gaps in GBV Programs when Working with Groups Affected by Inequality and Discrimination (Part C)	This can be used to identify and plan ways to address gaps in services.	Primarily for use by GBV actors	This tool can be facilitated by a GBV-Inclusion specialist in coordination and collaboration with a GBV specialized actor and/or GBV cluster leads with implementing partners, or with referral partner staff, or internally by organizations who are engaging in self-assessment of capacities.	2 hours
Analysis	Developing an Inclusive Referral System for GBV Survivors'	This shows the referral pathways for GBV survivors which includes reporting, immediate response, follow-up, and other services.	Primarily for design and use by GBV actors and for usage by non-specialized actors	Project Manager to map with existing service providers in the area.	2 hours
Action	Creating Ecosystems of Safety and Care for GBV Survivors	This tool aims to bring together diverse actors to co-design an inclusive safety and care-centered 'ecosystem' for GBV survivors across prevention, response, and referral programming by identifying critical connections and collaborations between diverse actors.	GBV and non-specialized actors	Use as a collaborative planning tool with GBV and non-GBV actors in your context. Also, can be used as an internal planning tool only.	1-1.5 hours

CATEGORY	TOOL(S)	PURPOSE	AUDIENCE	HOW TO USE	TIME NEEDED
Action	Information Sharing - Final consent form for release of information	This tool emphasizes intersectionality through the identification of data collection, analysis and sharing of intersectional data to meet the needs and rights of diverse survivors.	GBV actors	Project Manager to facilitate for implementing partners or referral partner staff, or for organizations who are involved in partnerships.	30 mins
Action	Guidelines for obtaining informed consent/ assent from GBV survivors	This emphasizes the importance of obtaining informed consent and assent from survivors to share their information when they access services or are referred to other service providers during initial intake interviews.	Primarily for use by GBV actors	Apply this guidance to intake and consent process.	1-1.5 hours
Action	Intake and Consent – Intake and initial assessment form	This shows the content of the intake and assessment form.	GBV actors that do not have these tools in place OR have existing tools and want to supplement them with intersectional guidance (e.g. GBVIMS users).	Complete this form during consultation with the survivor.	Depends on time with survivor.
Action	Intake and Consent – Intake and initial assessment form guidance	This emphasizes intersectionality through the collection of data on characteristics on who has (or does not have) access to services when conducting initial intake interviews.	GBV actors that do not have these tools in place OR have existing tools and want to supplement them with intersectional guidance (e.g. GBVIMS users).	Ensure Do No Harm approach when using this tool (prioritize safety of survivor). Apply this guidance to intake and consent process.	1-1.5 hours

It is important to create opportunities for humanitarian and development staff to reflect on and explore their own backgrounds, power and privilege, and internalized discrimination as a first step in putting intersectionality into practice. The process tools provide opportunities for deeper understanding and connection among diverse actors working with diverse survivors. These are facilitative tools to work, ideally, with other actors in the GBV/humanitarian/development landscape, but they can also be used by individual agencies to reflect on and improve understanding of intersectionality.

Included in this section are the following tools:

CATEGORY	TOOL(S)
Awareness	Intersectionality Yarn
Analysis	Mapping Diverse Actors — Quadrant
Action	Creating Ecosystems of Safety and Care for GBV Survivors

ADDITIONAL RESOURCES TO SUPPORT THESE TOOLS:

- UN WOMEN, INTERSECTIONALITY RESOURCES GUIDE AND TOOLKIT
- SAVE THE CHILDREN, GENDER AND POWER ANALYSIS (GAP) TOOLKIT
- IRC AND WRC, BUILDING CAPACITY FOR DISABILITY INCLUSION IN GENDER-

BASED VIOLENCE PROGRAMMING IN HUMANITARIAN SETTINGS:

- A TOOLKIT FOR GBV PRACTITIONERS
- WE RISE — TOOLKIT, CREATING SAFE SPACES
- RAISING VOICES, SASA! TIPS
- CARE, RAPID GENDER ANALYSIS TOOLKIT

• CBM INTERNATIONAL, DISABILITY AND GENDER ANALYSIS TOOLKIT

- HUMANITY 7 INCLUSION, MAKING IT WORK HOW-TO GUIDE
- INTERSECTIONALITY IN PRACTICE
- ROSA, SKILL BUILDING APPLICATION
- TRANSLATORS WITHOUT BORDERS, TIP SHEET: 6 TIPS FOR HUMANITARIAN

PROCESS TOOL 1:

Intersectionality Yarn

Theme: Awareness

REFERENCE MATERIALS:

- **Figure 1 - Power Graphic from the Reference Materials section**
- **Scenario specific to your context**
(See example provided at the end of the Reference Materials section)
- **Systems of Oppression and Characteristics cards found in the Reference Materials section**
- **Video: Intersectionality Yarn**
<https://youtu.be/bfHR4fpI2yA>

Time



1-1.5 HOURS

Materials Needed



LARGE COLOR
INDEX CARDS



MARKERS



A LARGE BALL
OF COLORFUL
YARN OR THICK
STRING

Introduction

The following exercise aims to unpack the concept of ‘intersectionality’, while building empathy towards the different backgrounds and lived experiences of individuals and groups.

The **What**, **Who** and **When** will help you understand the purpose of the tool. The **step-by-step** and **guidance notes** in the following sections will lead you through the process.

WHAT

A participatory exercise to reflect on power, privilege, systems of oppression and inequalities affecting diverse GBV survivors.

WHO

This tool can be used with a wide and diverse set of stakeholders working in proximity to GBV survivors, including both specialized and non-specialized actors. Such actors could include INGO staff, regional and national NGO partners, community leaders, civil society actors, government, and representative groups, i.e. organizations of persons with disabilities (OPDs), women-led and feminist organizations,

older people’s associations, youth associations, religious/ethnic affiliations, healthcare actors, etc. Try to create as diverse a group as possible to engage in this participatory activity (e.g. ensuring gender balance). Invite a maximum 12 participants.

WHEN

This tool can be used at any point in the humanitarian and gender-based violence (GBV) program cycle. Ideally, it will be used to increase knowledge among stakeholders before the design of a program to bring greater awareness across the program cycle.

ACCESSIBILITY TIPS

Invite and anticipate attendance of persons with different types of disability. **Ask participants in advance to submit any requests for reasonable accommodation. If you have persons with disabilities participating in the session, please use the following guidance and think about further adaptations that will ensure their meaningful participation.**

Good Practice Tips

TYPE	GOOD PRACTICE TIPS
General	<ul style="list-style-type: none"> • Plan for breaks every 45 minutes to provide a mental and physical break and to re-energize the group. • Provide option to receive in advance activity materials that will be shared or presented during the session. • Provide information and details on the venue such as ways to get there. • Provide a point person that they contact for any concerns, questions, or support needed.
Language	Evaluate beforehand if any of your colleagues need alternative formats, such as plain language format, and/or translations for better access to the information provided in this tool.
Mobility impairment	<ul style="list-style-type: none"> • Select a venue that is physically accessible to people who use wheelchairs and other assistive devices, and is conducive for various activity methods. • If someone with a mobility impairment volunteers to be the survivor – adjust directions to ensure appropriate accessibility, comfort and safety for the participant. Let people with assistive devices choose their position (to stand up or to sit down).
Visual impairment	<ul style="list-style-type: none"> • Select a venue that is physically accessible to people who use wheelchairs and other assistive devices. • If someone with a mobility impairment volunteers to be the survivor – adjust directions to ensure appropriate accessibility, comfort and safety for the participant. Let people with assistive devices choose their position (to stand up or to sit down).
Hearing impairment	<ul style="list-style-type: none"> • Arrange sign language interpretation in advance. Ensure that the interpreters are fluent in national/local languages based on the needs of the participants. • Ensure that there are options for communication other than sign language available, such as use of note pads, availability of induction loop, lip-reading, etc. • If the group is composed only of women, ensure that the interpreter is a woman. • Ensure that the interpreter is familiar with the subject matter of intersectionality and GBV, including specific terminology (adapted to context). • Organize a briefing pre-workshop if possible.
Neurodiversity	<ul style="list-style-type: none"> • Read and repeat instructions at each separate step to ensure clarity. • Have simple directions for each step written down on flip charts for participants to refer to. • Incorporate energizers to create breaks and re-initiate focus on activities.

Using the Tool

PREWORK

- Assign or hire a dynamic facilitator who is empathetic and culturally sensitive, understands intersectionality and power, and can engage a group in a participatory way.
- **Invite participants** (maximum 12 people).
- **Create scenario** — ask participants for a scenario of a diverse survivor in their context. Alternatively, the facilitator can sit down with 1-2 people and create a scenario of a GBV survivor inspired by this specific context. Ensure that it is an imaginary scenario and only inspired by the context (not based on a real survivor's situation). An example case scenario is provided under Reference Materials - Additional Resources
- Prepare 'Systems of Oppression' cards and 'Characteristic' cards by referencing the intersectionality matrix (Figure 1), found in the Reference Materials section. e.g. characteristic – sex correlates to the 'system of oppression' – sexism.
- Set up the room with a circle of chairs.

STEP 1

- Introduce the activity and frame it based on the purpose outlined above. This is meant to be an icebreaker to this topic and should be limited to 10 minutes.
- Share that this exercise is about a survivor – their diverse identities and how they interact with structures of power and oppression.
- Highlight the importance of holding self-awareness, empathy, and critical analysis, while considering the agency and capacities of the survivor as well as the discriminations, inequalities, barriers, and violence they experience based on the interactions of their diverse backgrounds and lived experiences and systems of power.
- Present group agreements and ask for contributions to those suggested (example below). Encourage participants to be self-aware during this process and to recognize and manage their own judgements/bias.

- Play the Conceptual Mapping of Intersectionality in GBV video for participants.
- Present the 'Power Graphic' (Figure 1 in Process Tools: Reference Materials) – **using guidance notes for Step 1** – as a short introduction to the interrelationship between power and GBV.
- **Refer to 'facilitators notes' on page 43** and the introductory sections of this toolkit to familiarize yourself with important concepts.

STEP 2

- Facilitator: please reference the **Intersectionality Tip Sheet (on page 66)**.
- Hand out the 'characteristic' cards among the participants and place the 'system of oppression' cards on the floor in the middle of the circle. Refer to cards in annexes.
- Begin the session by asking participants to reflect on the power vortex and explain what they think each different 'system of oppression' means. Then ask the group to match each of their 'characteristic cards with a 'system of oppression'.
- Move through the exercise until all 'characteristic' cards have been grouped together with their matching 'system of oppression' – understanding that some characteristics may overlap with different systems of oppression.
- Ask the group questions about how that 'system of oppression' looks in their context and programming. Ask for specific examples. Hand out the groupings of cards among all participants – everyone should have at least one group of matching cards.
- Facilitate questions from Step 2.

STEP 3

- Ask for a volunteer from the group to stand in the middle of the group and represent the survivor in the scenario.

- Ask one of the participants to tell the story of the survivor in their scenario (or read the scenario provided). Ask if any clarification is needed about the scenario before proceeding with the next part of the exercise.
- Ask everyone to stand in a circle around the 'acting survivor'.
- The facilitator starts with the ball of yarn/string, wrapping it once around the survivor and then asking for participants to describe what the scenario demonstrates about the different system of oppression that may be impacting this survivor – ask them to be as specific as possible.
- When the first volunteer explains what system of oppression(s) are impacting the survivor – the facilitator will keep hold of their string and throws it to the person who stated the acts of discrimination and oppression.
- This person then wraps it around the 'survivor' and the process continues until the person is wrapped in different layers of oppression.
- The facilitator asks probing questions to encourage discussion and examples. See guidance notes. For example, if it is a scenario where the person in the middle is a mother and/or head of household – ask her to try to act out 'taking care of her kids' or 'going to work' wrapped up in all the yarn (to show the physical struggle – this represents the psychological struggle).

STEP 4

- Ask for another volunteer from the group to play the role of a privileged person.
- Tell a short story describing this person and facilitate the same sub-steps in Step 3. The purpose of this exercise is to provide a point of comparison for power and privilege.

STEP 5

- To liberate the survivor and amplify their agency – the facilitator directly engages with the 'survivor' asking questions about their

agency, capacities, support systems, etc. as well as additional support that is needed from their community and service providers. With each answer, the 'survivor' sheds different layers of the yarn until they are free, demonstrating their empowerment and resilience.

- Facilitate a debrief among the group to reflect on this experience both as themselves and as a representative of their organization. See guidance notes.

WHERE TO GO NEXT

Pair this Awareness Tool with the Staff Bias Tools which can be used to promote self-reflection and collective dialogue on implicit bias that affects people's diverse backgrounds and lived experience.



Guidance Note

When using this tool, use the guidance notes for each step. Start with the wisdom of the participants by asking open questions to identify existing knowledge, practices, and expertise in the room – and to identify what is missing. Then use the Facilitator Questions in the next box to spark further discussions on the subject matter. There are questions to reflect on per each step.

Guiding questions

Step 1	<ul style="list-style-type: none">• What did you notice most about this video?• Who holds the most power in your society?• How have you witnessed inequalities leading to gender-based violence? Probe: ask for specific examples• How do you think analyzing where power sits can help our programming?• What are 3 ways you hold power and privilege?
Step 2	<ul style="list-style-type: none">• How would you describe some of the systems of oppression that you hold in your hands?• Do you recognize any power hierarchies in the communities you work with? If so, which ones?• What specific forms of discrimination are perpetuated by these systems in your context?
Step 3	<ul style="list-style-type: none">• Based on the scenario included:• What is your understanding of the experiences of this adolescent girl? Probe: household, community, access to services, education, etc.• How does discrimination affect her daily life?• Is she making her own decisions? Who is making decisions on her behalf?• Does she have the same rights as others? Probe.• What are some of the barriers and discrimination this girl could face specifically in this context? Probe: cultural norms, policies, practices• What are the main causes of inequalities between girls of different backgrounds?
Step 4	Do you think this person has more privilege or less privilege than the survivor? Why?
Step 5	<ul style="list-style-type: none">• What resources does this person have access to that can promote their resilience?• What are some practices your organization is doing (should be doing) to ensure intersectional inclusion?• What are the barriers to inclusive GBV prevention/response approaches when you consider an intersectional view?• What thoughts and reflections are arising for you after this exercise? Your initial reactions?• Is there something from this experience you can use/apply in your current work?• How have you considered your own position, perspective, and privilege in your work with GBV survivors?

PROCESS TOOL 2:

Mapping Diverse Actors, 'The Quadrant'

Theme: Analysis

REFERENCE MATERIALS:

- **Figure 1 - Power Graphic**
- **Figure 2 - Intersectionality Matrix**
- **Figure 3 - Quadrant Graphic**
- **Figure 4 - Intersectionality and Survivor Graphic**
- **Case scenario specific to your context** (or see example provided at the end of the Reference Materials section)
- **Characteristics Cards**
- **Video: Conceptual Mapping of Intersectionality in GBV**
<https://www.youtube.com/watch?v=wqFO6qsY4wc&t=5s>

Time



1-1.5 HOURS

Materials Needed



BANNER
PAPER



COLOR
MARKERS



FLIP CHART



MASKING
TAPE



COLOR
POST-IT
NOTES



GUIDING
QUESTIONS
(BELOW)

Introduction

This tool will help you map the diverse actors in your context working on GBV or in proximity to GBV programming and to consider how to begin collaborating with these actors. Some of these actors could be organizations of persons with disabilities (OPD), women-led OPDs, women's and feminist organizations, older people's associations, human rights actors, SOGIESC organizations, religious affiliation groups, and activist groups.

The What, Who and When will help you understand the purpose of the tool. The step-by-step and guidance notes in the following sections will lead you through the process.

WHAT

This mapping activity is about expansion of partners, coalitions, and alliances to meet the needs and rights of GBV survivors.

WHO

Invite humanitarian and development colleagues with diverse perspectives and roles – aim to have GBV specialists, inclusion specialists, and general humanitarian and development practitioners participating in

this exercise (ensuring gender balance). Additionally, invite staff from representative groups, i.e. OPDs, women-led and feminist organizations, older people's associations, youth associations, religious/ethnic affiliations, healthcare actors, etc. Invite a maximum 12 participants.

WHEN

This tool can be used at any point in the humanitarian and gender-based violence (GBV) program cycle. It should be used by humanitarian and development partners to map the diversity of actors within their project area and analyze how they can work with these diverse actors across their GBV related activities.

ACCESSIBILITY TIPS

Invite and anticipate attendance of people with different types of disabilities. Ask participants in advance to submit any requests for reasonable accommodation. If you have persons with disabilities participating in the session, please use the following guidance and think about further adaptations that will ensure their meaningful participation.

Good Practice Tips

TYPE	GUIDING QUESTIONS (BELOW)
General	<ul style="list-style-type: none"> • Plan for breaks every 45 minutes to provide a mental and physical break and to re-energize the group. • Provide option to receive in advance activity materials that will be shared or presented during the session. • Provide information and details on the venue such as ways to get there. • Provide a point person that they contact for any concerns, questions, or support needed.
Language	Evaluate beforehand if any of your colleagues need alternative formats, such as plain language format, and/or translations for better access to the information provided in this tool.
Mobility impairment	<ul style="list-style-type: none"> • Select a venue that is physically accessible to people who use wheelchairs and other assistive devices, and is conducive for various activity methods. • If someone with a mobility impairment volunteers to be the survivor – adjust directions to ensure appropriate accessibility, comfort and safety for the participant. Let people with assistive devices choose their position (to stand up or to sit down).
Visual impairment	<ul style="list-style-type: none"> • If there is anyone in the group with a visual impairment, read aloud the different sections when introducing activities. • Invite people with visual impairments to touch the layers of yarn during the exercise.
Hearing impairment	<ul style="list-style-type: none"> • Arrange sign language interpretation in advance. Ensure that the interpreters are fluent in national/local languages based on the needs of the participants. • Ensure that there are options for communication other than sign language available, such as use of note pads, availability of induction loop, lip-reading, etc. • If the group is composed only of women, ensure that the interpreter is a woman. • Ensure that the interpreter is familiar with the subject matter of intersectionality and GBV, including • Specific terminology (adapted to context). Organize a briefing pre-workshop if possible.
Neurodiversity	<ul style="list-style-type: none"> • Read and repeat instructions at each separate step to ensure clarity. • Have simple directions for each step written down on flip charts for participants to refer to. • Incorporate energizers to create breaks and re-initiate focus on activities.

Using the Tool

PREWORK

- Invite participants (maximum 12 people).
- Draw Figure 3 from Reference Materials at the end of the section (the quadrant graphic) on large banner paper. Tape it to a wall or set it up on a shared space so everyone in the group has access.
- Draw Figure 4 from Reference Materials at the end of the section (The Intersectionality and Survivor graphic) on a flip chart. Using Figure 2 from Reference Materials (the Intersectionality Matrix), add different characteristics around the 'survivor' such as age, gender, disability, class, displacement status, etc. with color circles next to each characteristic.
- Have the **Conceptual Mapping of Intersectionality in GBV video** ready to support Step 2 if participants have not experienced Process Tool 1 – Intersectionality Yarn or are unfamiliar with the concepts of intersectionality, inequalities, and power relations.

STEP 1

- Introduce the activity. This activity is about expansion of partners, coalitions, and alliances.
- Introduce the quadrant or ask participants to draw their own version of the quadrant representing their GBV cycle.
- Ask participants to take Post-it notes and list activities they currently do at different parts of the quadrant.
- Ask them to list one activity per Post-it note.

STEP 2

- Optional Step: Show the Conceptual Mapping of Intersectionality in GBV video
- Next move to the flip chart with the intersectionality and survivor picture (figure 2). Refer to the different 'identity characteristics' listed – race, ethnicity, disability, gender, displacement/immigration status, age, etc.

- Ask participants for a story/scenario of a survivor who has diverse background and lived experience in your specific context. You can use the scenario from the 'Intersectionality Yarn' if conducting this exercise as a follow-on to that activity.
- Ask participants to call out the intersecting characteristics held by the survivor that could lead to discrimination or barriers – based on the context presented. Put a Post-it note on top of each identity characteristic listed.

STEP 3

- Break participants into smaller groups (maximum 4 people per group) – ideally 2-4 groups depending on the number of participants in the workshop
- Hand out Post-it notes to each small group and ask them to list individual actors representing/working with people from different backgrounds (e.g. persons with disabilities) and cross-movement (e.g. women-led OPDs) their context and cluster them around the survivor graphic.
- Ask them to list one actor per Post-it note.

STEP 4

- Re-introduce the quadrant graphic (Figure 3). Assign each small group 1-2 quadrant areas.
- Introduce the **Guiding Questions** provided below (under Step 4). Ask each group to discuss the guiding questions and write down their group's answers on the flip chart.
- After answering these questions, groups should refer to the survivor graphic and compare the actors clustered on the Post-it notes that they identified during Step 3 with their responses on the flip chart. Ask participants to add any additional actors not mentioned to new Post-it notes.
- Ask each group to map these Post-it notes to relevant quadrants representing the GBV program cycle. When this step is finished, the group should have identified diverse



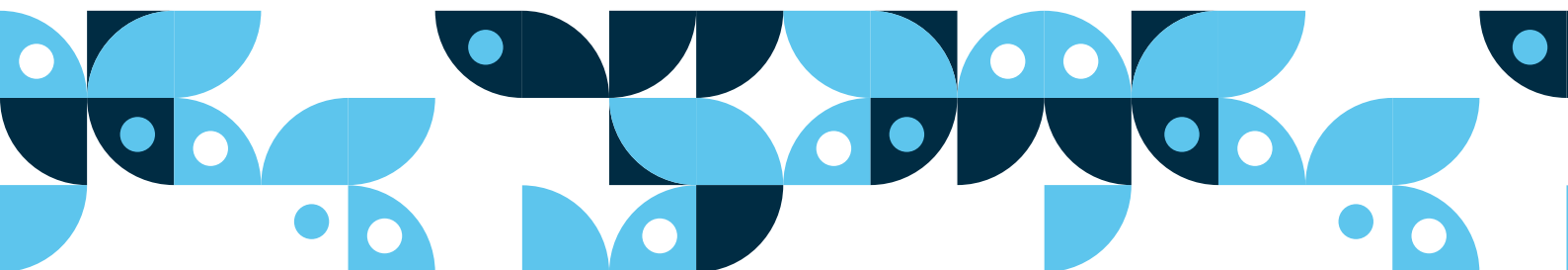
actors that operate or could operate in that quadrant of the program cycle.

STEP 5

- Come back together as a large group for a plenary discussion.
- Facilitate general plenary discussions on what each group noticed from the exercise, main takeaways etc.
- Facilitate Step 5 of the Guiding Questions.

WHERE TO GO NEXT

It is recommended that you move forward from this tool to the next process tool – ‘Ecosystems for Safety and Care of GBV Survivors’ to continue to the planning stage.





Guidance Note

When using this tool, use the guidance notes for each step. Start with the wisdom of the participants by asking open questions to identify existing knowledge, practices, and expertise in the room – and to identify what is missing. Then use the questions to spark further discussions on the subject matter.

Guiding questions

TYPE	GUIDING QUESTIONS	
Step 1	Who are you currently working with on GBV?	
Step 2	Which characteristics describe the survivor in the scenario?	
Step 3	<ul style="list-style-type: none">• Who in your context is working with people with this background and lived experience (list out the identity characteristics highlighted during Step 2)?• Who is working on cross-movement?	
Step 4	<ul style="list-style-type: none">• Who are the actors with relationships with, and representing, groups most affected by inequality and discrimination in this context?• Who are considered representative groups within your operational context?• Who do these actors have relationships with/ influence over, and/or provide services to?• Who has/is creating spaces of psychological and physical safety for groups most affected by inequality and discrimination in this context? Which groups?	<ul style="list-style-type: none">• Who are the actors involved in specialized and non-specialized GBV work in this context and who are they working with?• Who are the actors involved with GBV prevention? Who are the actors involved with GBV response activities?• Who are the allies? Who are the service providers? Who are the interlocutors?• Are there barriers that diverse actors face in engaging in GBV work? If so, which barriers?
Step 5	<ul style="list-style-type: none">• Are there are diverse actors listed that you do not currently work with? If so, will you involve them in your GBV activities? Which ones?• How will you begin to involve these actors in your GBV programming? At what phases of the program cycle? To discuss in more detail in the next (ecosystems) tool (do not need to go into deeply if continuing with the next tool).• Who is your organization not positioned to work with and why? What resources would you need to work with them effectively?	

PROCESS TOOL 3:

Creating Ecosystems of Safety and Care for GBV Survivors

Theme: Action

REFERENCE MATERIALS:

- **Figure 4 - Intersectionality and Survivor Graphic (from Quadrant exercise)**
- **Quadrant mapping completed by the same participants during previous exercise in Process Tool 2**

Time



1-1.5 HOURS

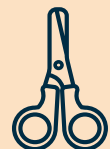
Materials Needed



BANNER
PAPER



COLOR
MARKERS



SCISSORS



MASKING TAPE

Introduction

This tool aims to bring together diverse actors to co-design an inclusive safety and care-centered 'ecosystem' for GBV survivors across prevention, response, and referral programming by identifying critical connections and collaborations between diverse actors. An important aspect of this process is acknowledging informal and formal GBV systems and how these systems converge in a specific context.

The What, Who and When will help you understand the purpose of the tool. The step-by-step and guidance notes in the following sections will lead you through the process.

WHEN

This tool builds on 'Process Tool 2: Mapping Diverse Actors – Quadrant' and should be used during the design phase of new programs and/or adaptation of existing GBV programming.

WHAT

A planning tool to connect diverse actors and outline activities and ways of working together to support the safety and care of GBV survivors.

WHO

Ideally, participants who have experienced the Intersectionality Yarn Tool and at a minimum, those who have recently used the Mapping Diverse Actors – Quadrant Tool should be included in this exercise as a continuation of the foundations built (maximum 12 participants). Participants should be people who work in specialized GBV programming, or non-specialized who encounter GBV survivors in their work.

ACCESSIBILITY TIPS

Invite and anticipate attendance of people with different types of disabilities. Ask participants in advance to submit any requests for reasonable accommodation. If you have persons with disabilities participating in the session, please use the following guidance and think about further adaptations that will ensure their meaningful participation.

Good Practice Tips

TYPE	GUIDING QUESTIONS (BELOW)
General	<ul style="list-style-type: none"> • Plan for breaks every 45 minutes to provide a mental and physical break and to re-energize the group. • Provide option to receive in advance activity materials that will be shared or presented during the session. • Provide information and details on the venue such as ways to get there. • Provide a point person that they contact for any concerns, questions, or support needed.
Language	Evaluate beforehand if any of your colleagues need alternative formats, such as plain language format, and/or translations for better access to the information provided in this tool.
Mobility impairment	<ul style="list-style-type: none"> • Select a venue that is physically accessible to people who use wheelchairs and other assistive devices, and is conducive for various activity methods. • If someone with a mobility impairment volunteers to be the survivor – adjust directions to ensure appropriate accessibility, comfort and safety for the participant. Let people with assistive devices choose their position (to stand up or to sit down).
Visual impairment	<ul style="list-style-type: none"> • If there is anyone in the group with a visual impairment, read aloud the different sections when introducing activities. • Invite people with visual impairments to touch the layers of yarn during the exercise.
Hearing impairment	<ul style="list-style-type: none"> • Arrange sign language interpretation in advance. Ensure that the interpreters are fluent in national/ local languages based on the needs of the participants. • Ensure that there are options for communication other than sign language available, such as use of note pads, availability of induction loop, lip-reading, etc. • If the group is composed only of women, ensure that the interpreter is a woman. • Ensure that the interpreter is familiar with the subject matter of intersectionality and GBV, including specific terminology (adapted to context). • Organize a briefing pre-workshop if possible.
Neurodiversity	<ul style="list-style-type: none"> • Read and repeat instructions at each separate step to ensure clarity. • Have simple directions for each step written down on flip charts for participants to refer to. • Incorporate energizers to create breaks and re-initiate focus on activities.

Using the Tool

PREWORK

- This is a continuation of the Quadrant exercise, so the same participants should be invited to attend (maximum 12 people)
- Display the Mapping Diverse Actors Quadrant Tool created by the participants (with Post-it notes still positioned on the quadrant) in the previous exercise for them to refer to during this session.
- Remake the Intersectionality and Survivor picture (Figure 4 from the reference materials section) on a flip chart if needed. Or, if continuing from the 'Quadrant' exercise, reuse the same survivor picture from that exercise.
- Create 4 large templates on banner paper.
- Set up the room with a circle of chairs and a separate area for breakout groups (4 small tables or wall/floor space).

STEP 1

- Introduce the activity and frame it based on the purpose outlined above. Share that this activity is about planning (action) more diverse networks and inclusive strategies to support GBV survivors.
- Begin the session by referring to the analysis tool – mapping diverse actors, the Quadrant – and how participants will now take that analysis of actors and activities and develop a plan. Ask participants for some of their reflections that emerged during the debrief.

STEP 2

While everyone is in circle – introduce the template for the activity and the following directions:

- The larger group will be divided into 4 smaller groups of 3 people.
- Each small group will be asked to tell the story of a survivor. They can also use the survivor scenario from the 'mapping diverse actors' tool. In section 1 – write a short description of the survivor's story.
- At this point, re-introduce the 'intersectionality and survivor' picture because it will be referenced during the exercise to map quickly the different characteristics.
- In section 2 of the Ecosystem Plan template consider how these identities may intersect and result in unique forms of discrimination map out, with the template provided, by drawing lines (and cross lines) to the survivor in the center of the graphic.
- Explain that for sections 3–6 of the template, there are 4 parts.
- Each of these 4 parts relates to that number of the next section.
- For example, section 3, line 1 relates to section 4, line 1, then section 5, line 1 and finally section 6, line 1. **See visual below.**
- Ask participants to think about formal and informal prevention and response to GBV in their context – ask them how they can consider both types of activities and actors in this exercise.
- In section 3 of the template – participants should write 4 'problems/challenges' that the survivor faces, thinking about the inequities and discrimination this survivor would experience in this context based on the interaction between their diverse identities and systems of oppression, power, and risks of violence.
- In section 4 of the template – participants should write 4 'solutions' that address the problems listed in section 3 and promote safety and care of survivors.
- In section 5 of the template – participants will list WHO they can work with to co-design and co-create these solutions – the ecosystem.
- Have the participants refer to the quadrant they mapped in this previous exercise for inspiration. Instruct participants to be specific by naming different actors – for example rather than saying 'civil society actors', a specific example could be 'the regional network for women-led OPDs.'

- In section 6 – participants will outline HOW they will work with these actors – the strategies. Instruct participants to be as specific as possible when it comes to strategies and avoid generalizations. For example, rather than saying ‘conduct awareness campaigns together’, a specific example would be ‘work with OPD to ensure accessibility of media campaigns’.

STEP 3

- Hand out the templates on banner paper among all 4 groups and provide color markers.
- State that there are 35 minutes available to complete their template.

STEP 4

- Each group will have 5 minutes to present their ‘plan’ to the larger group (20 minutes in total).
- Ask participants to be specific if generalities are presented, especially in sections 5 (who) and 6 (how).

- Invite the larger group to ask clarification questions and offer ideas/reflections.

STEP 5

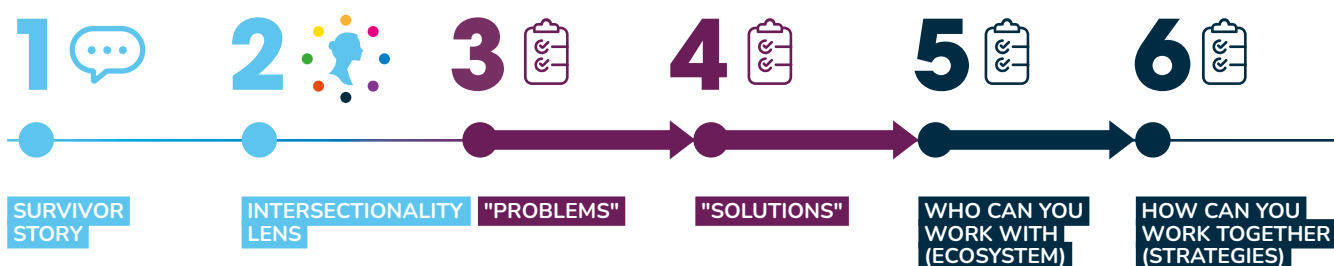
- Debrief for 10 minutes with the larger group on key themes that emerged from their planning for ‘ecosystems of safety and care’.
- End the exercise by introducing a flip chart named ‘I commit to...’ and ask participants to write one commitment they can tangibly make based on their plan – whether it is a new process, partnership and/or a specific strategy.

WHERE TO GO NEXT

Use this Action Tool with the following tools:

1. Developing an Inclusive Referral System for GBV Survivors
2. Information Sharing Minimum Standards Checklist.

Ecosystem plan





Guidance Note

When using this tool, use the guidance notes for each step. Start with the wisdom of the participants by asking open questions to identify existing knowledge, practices, and expertise in the room – and to identify what is missing. Then use the questions to spark further discussions on the subject matter

Guiding questions

Step 1	What are some of the key takeaways from the Quadrant tool that you can bring into a co-design and planning activity?
Step 2	Follow the instructions above.
Step 3	<ul style="list-style-type: none">• What are the inequities and discrimination this survivor could experience in your context based on the interaction between their diverse identities and systems of oppression, power, and risks of violence?• What are the ways your organization could address these challenges and remove barriers?• How can your organization work with other actors to address these challenges and remove barriers?• How can you be as specific as possible in your recommended actions?• How will you begin to involve new actors in your GBV programming? At what phases of the program cycle?• How do you see your relationship in the long term with these diverse actors? What long term activities can you be involved in together?
Step 4	Ask clarification questions based on their plan. Invite reflections from others.
Step 5	Repeat the commitments presented and ask for clarification.



PROCESS TOOL:

Facilitators Notes

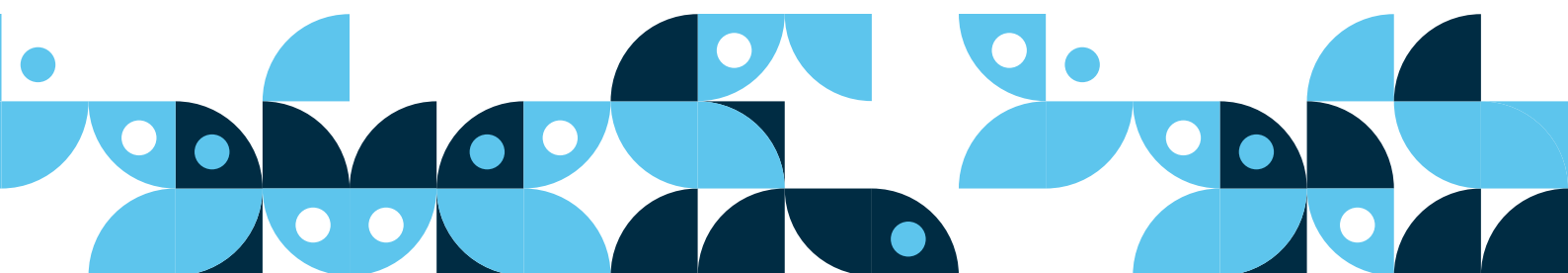
- Power can be privilege, control, capacity, disadvantage, or influence. It exists between people and groups of people. Power is not always visible. Often, power is hidden or invisible.
- **[Show Power Graphic from Reference Materials]** This image will help us ground power in a socio-ecological model to understand how power is structured at different levels of society (center image) and how power can manifest in GBV at different levels of society (left side) when power is systematized through systems of oppression (right side). In the center, you have the different levels of society - Individual, Interpersonal, Community, and bigger Society. On the left, the blue squares represent different forms of GBV and a two-sided arrow to show that GBV runs across all of these levels. For example, femicide, sexual violence, child marriage, intimate partner violence, etc. On the right, pink squares represent different systems of oppression and a two-sided arrow to show that systems of oppression run across all of these levels. For example, ableism, sexism, classism, ageism, etc.
- When systems of oppression become embedded at different levels of society, such as in personal relationships and cultural norms, where greater power and privilege reside with dominant groups [give a specific

example from your context], these power imbalances can lead to forms of GBV [go on to explain different examples, such as how intimate partner violence (IPV), is rooted in power imbalances between couples which can lead to emotional, physical and economic violence or how child marriage is a result of ageism and deeming that children lack human rights and decision making power over their own bodies and situations]

- Power relations and systems of oppression that are present in our societies influence beliefs, narratives and behaviors around violence, including GBV.
- Gender-based violence or GBV is defined as different types of violence perpetrated against someone based on their biological sex or gender identity and can be violence that is physical, psychological, sexual or economical in nature.
- Within patriarchal systems, men and boys are bestowed more power than women, girls, and gender non-conforming people. These power inequalities result in higher risks of GBV for these groups. However, gender is only one characteristic and isn't the only dimension that needs to be explored to understand the inequalities that happen under patriarchy.
- Sexism and genderism and the inequalities they create are often compounded by other systems of oppression including ageism, homophobia, xenophobia, ableism, classism, etc.
- Violence against women and girls, which is a form of GBV, is rooted in social and cultural

beliefs that men should be in charge of making decisions within families and control the finances. GBV can materialize as men forcibly making decisions over women's bodies and their personal freedom.

- By applying an intersectional lens to GBV, we begin to better understand how inequalities exacerbate each other, which intensifies the risk of GBV. For example, an adolescent girl with an intellectual disability will lack more power and privileges than her non-disabled male peer in a society that perpetuates ableism, sexism, and ageism. These intersecting forms of discrimination put her at higher risk of GBV when her rights, needs and social protections are not prioritized by her community.
- Men and boys are also negatively impact by society, especially when their experiences overlap with other areas of their lives where they have less power. For example, a white man from the Global North who speaks fluent English will not experience the same unique forms of discrimination that a Black man from the Global South who does not speak any English will experience in the same society. The latter being impacted by intersecting oppressions of racism, colonialism, classism, and xenophobia, etc.
- To prevent and respond to GBV, we must address all forms of inequality, and look at how different people experience discrimination in diverse ways, so that our strategies are intersectional and equitable.





PROCESS TOOL:

Reference Materials

FIGURE 1

How Power is Structured

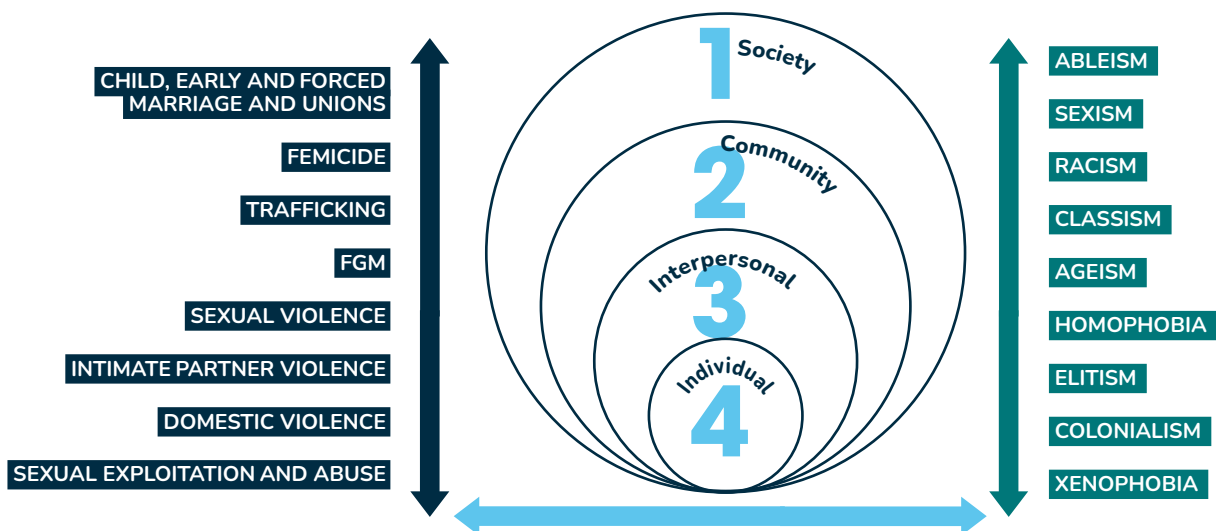
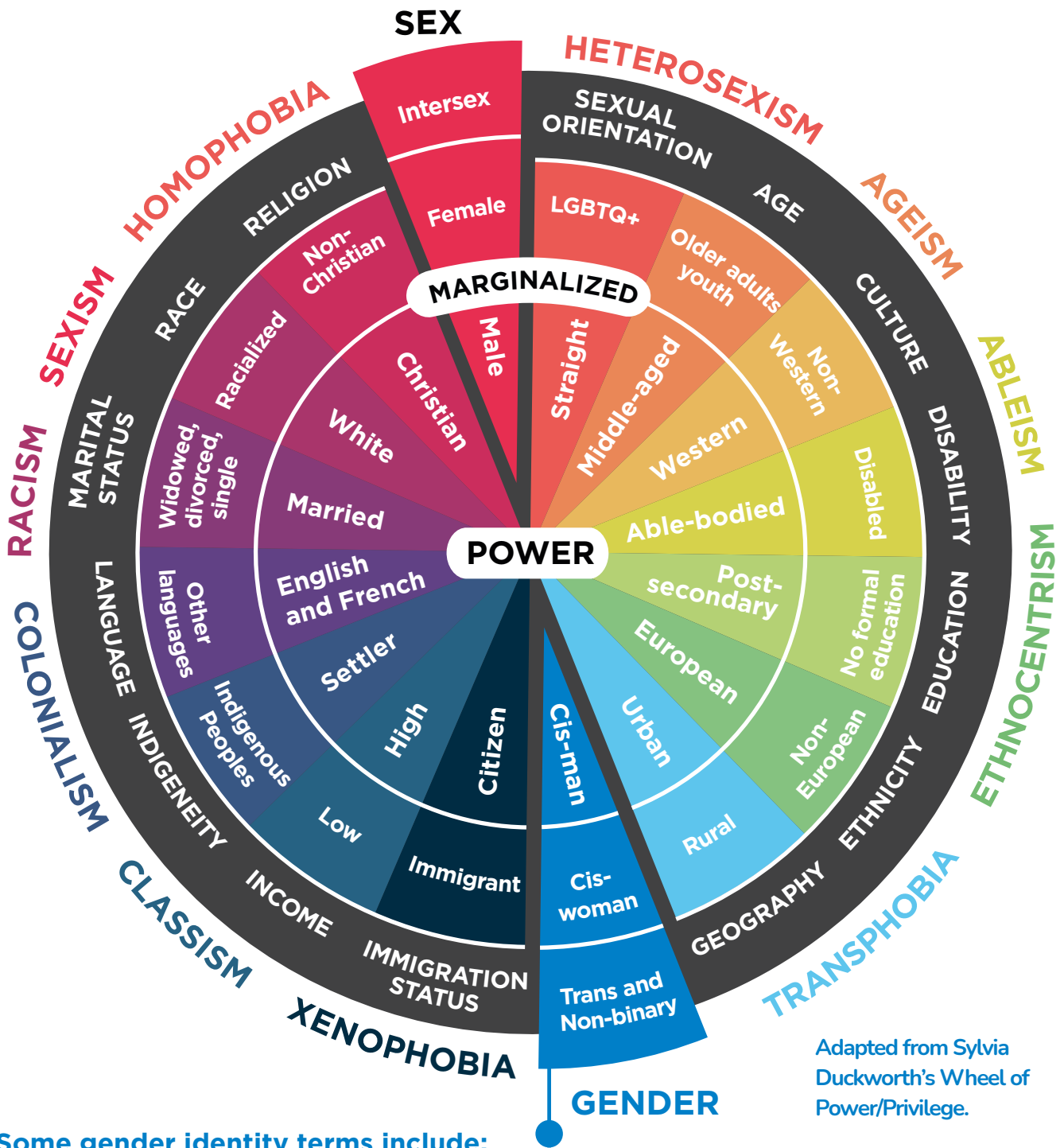


FIGURE 2

Intersectionality Matrix



Some gender identity terms include:

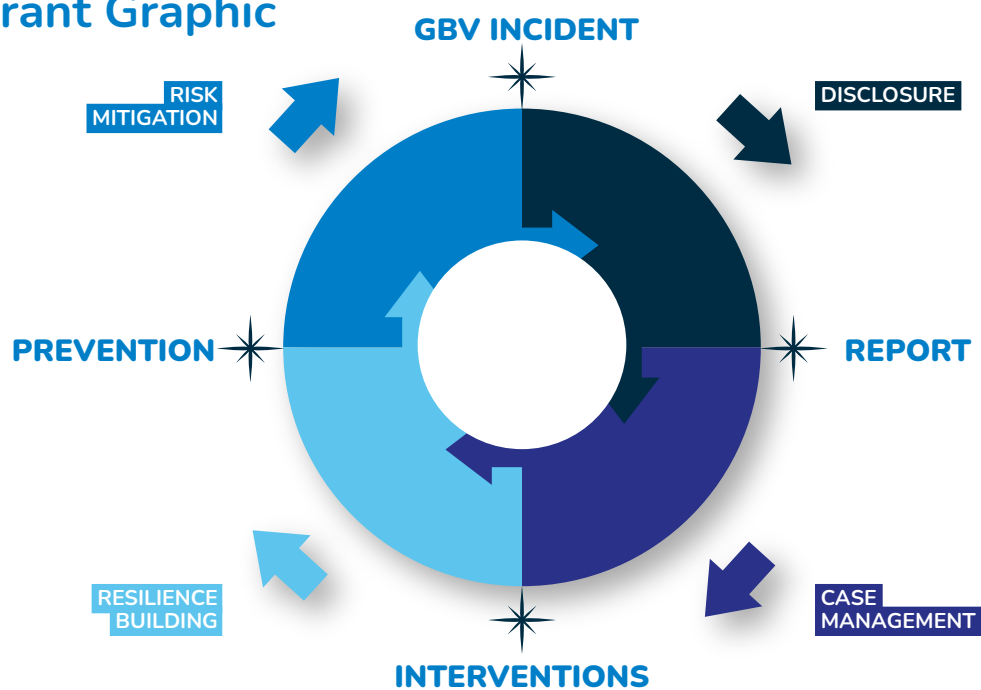
Agender	Genderfluid	Gender neutral	Transgender man
Bigender	Genderqueer	Non-binary	Transgender woman



FIGURE 3

Quadrant Graphic

CI-DESSUS
EXAMPLE OF
ETHIOPIA
PARTICIPANT
COMPLETING
QUADRANT
DURING ACTIVITY



* Note — This is one way to portray the GBV cycle. The facilitator may wish to adjust this with colleagues/staff from the host organization to present it in a different way based on the local context

FIGURE 4

Intersectionality and Survivor Graphic

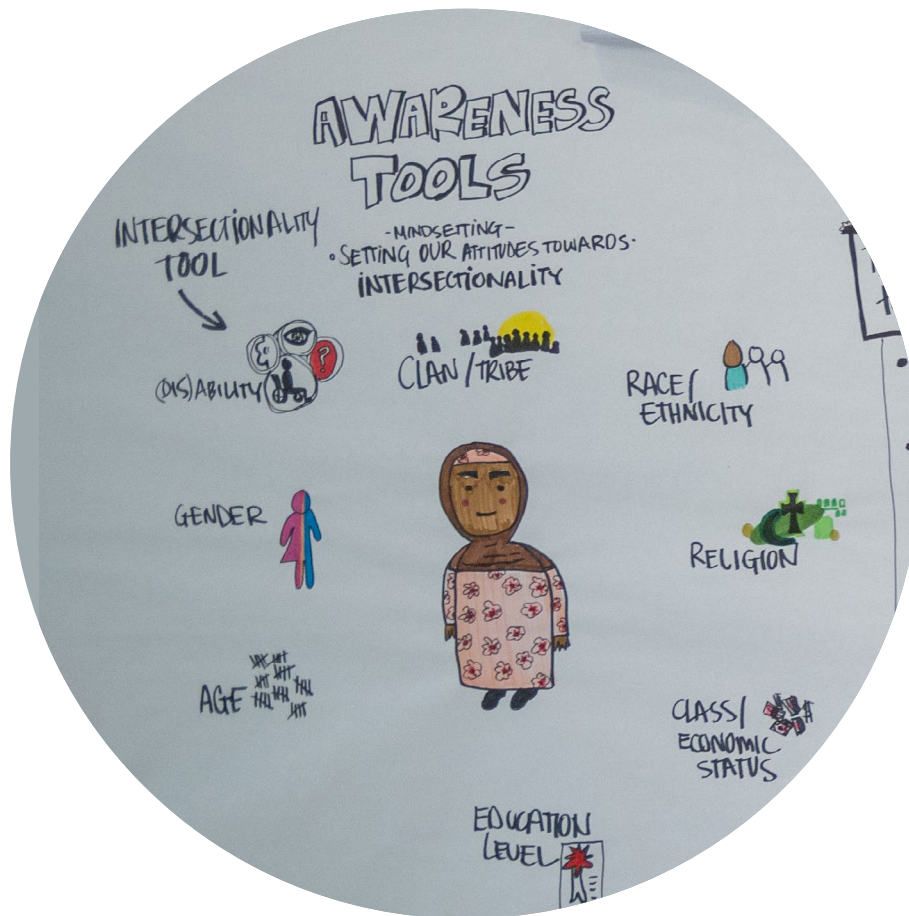
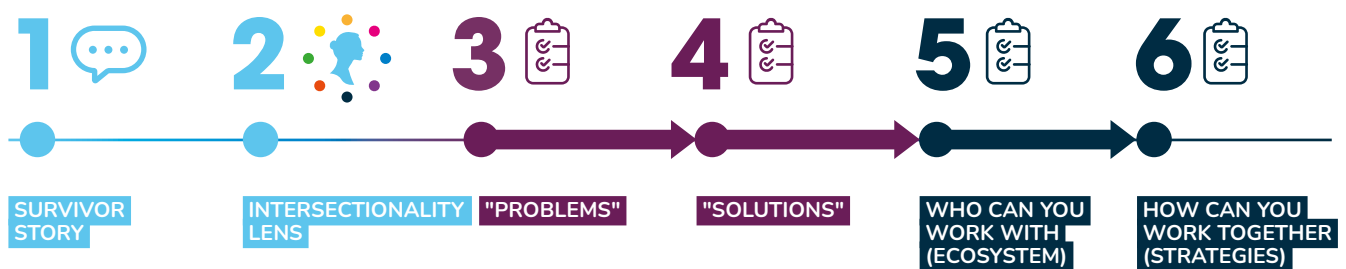
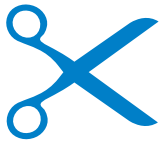


FIGURE 5

Ecosystems Template





Systems of oppression and characteristic cards

Ableism

Disability

Sexism

Sex

**Heterosexism /
Homophobia**

**Sexual
Orientation**

Tribalism

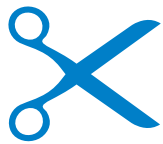
Tribe / Clan

Racism

Skin Color

Classism

**Social Status /
Class**



Systems of oppression and characteristic cards

Colonialism

Indigeneity

Ageism

Ageism

**Religious
Intolerance**

Religion

Ethnocentrism

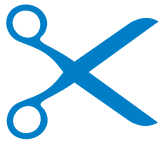
Ethnicity

Gender

Transphobia

Xenophobia

**Immigration
Status**



Systems of oppression and characteristic cards

Case Scenario

Seemara is an adolescent girl with a hearing impairment living in Baratu refugee camp. She was recently forced to leave her home country of East Sahara due to ongoing conflict between two ethnic groups in her region. During a recent violent clash in the early hours of the morning, her family was separated, leaving Seemara, her infant sister and her mother to cross the border into West Sahara. After arriving at the Baratu camp, Seemara's mother realized that they had left their identity cards behind. Without support from her extended family, Seemara was sent by her mother to find work and find supplies while her mother cared for her infant sister.

ADDITIONAL RESOURCES: SYSTEMS OF OPPRESSION IN TIP SHEET

2

Part two |

Gender-Based Violence Programming Tools

In many contexts, formal and informal pathways exist to prevent and respond to GBV. Informal pathways can often be tribal and familial and not linked to the formal GBV system and specialized actors. There are humanitarian and development actors that are not specialized in GBV who work with survivors from different backgrounds through a range of programming. Diverse survivors need access to quality survivor-centered sensitization, case management and referral services that consider one's different identities and lived experiences and are responsive to meet their specific needs, rights, and capabilities.

Building on interagency efforts, these GBV programming tools – sensitization and GBV response – are based on the GBVIMS. They are simplified and adapted versions of existing, tested tools that integrate an intersectional lens, including new guidance to consider, new data points to collect, and additional considerations for inclusion and accessibility where gaps previously existed.

Included in this section are the following tools:

CATEGORY	TOOL(S)
Awareness	Staff Bias Tools <ul style="list-style-type: none"> • Staff Attitude Scale and Self-Reflection Questions • Addressing Staff Bias: a Conversation Guide Intersectionality Tip Sheet – Tips for Working with Diverse GBV Survivors
Analysis	Service Gap Analysis Tools <ul style="list-style-type: none"> • Part A: Guidelines for Conducting Service Gap Analysis and Planning • Part B: Quality Checklist for Working with Groups Affected by Inequality and Discrimination • Part C: Action Plan and Monitoring for Addressing Critical Gaps in GBV Programs when Working with Groups Affected by Inequality and Discrimination Developing an Inclusive Referral System for GBV Survivors
Action	Information Sharing Tools Final Consent for Release of Information Intake and Consent Tools <ul style="list-style-type: none"> • Guidelines for Obtaining Informed Consent/Assent from GBV Survivors • Intake and Initial Assessment Form Guidance • Intake and Assessment Form

ADDITIONAL RESOURCES TO SUPPORT THESE TOOLS:

- GBV INFORMATION MANAGEMENT SYSTEM
- IASC GUIDELINES FOR INTEGRATING GENDER-BASED VIOLENCE INTERVENTIONS IN HUMANITARIAN ACTION
- HANDBOOK FOR GBV IN EMERGENCIES
- POCKET GUIDE FOR NON-GBV ACTORS
- IRC, WOMEN RISE, GBV PSS FRAMEWORK AND TOOLKIT
- IRC, GIRL SHINE
- WASHINGTON GROUP QUESTIONS





PROGRAMMING TOOL 1:

STAFF BIAS – Staff attitude scale and self-reflection questions

Theme: Awareness

Phase of GBV programme cycle: Prevention

WHO

This tool can be used by any organisation that provides direct support, for instance through referral or through service provision, to GBV survivors and can be facilitated by a staff member or supervisor, or by a facilitator from another organisation. The Staff Attitude Scale and Self-Reflection Questions will be completed individually by staff members. Facilitators should use the Conversation Guide: Addressing Staff Bias as a guide to have conversations about bias with staff after they have completed this exercise.

PURPOSE

This exercise aims to evaluate and address attitudes and biases of staff that are in direct contact with GBV survivors so that those biases do not lead to the exclusion of diverse survivors. It also allows for an introspective look at where those attitudes and beliefs originate, and how they may impact work with survivors. In addition, it can be used to highlight specific areas in which the staff member may require further education and training.

Note — The attitude statements below can be adapted to a specific location and cultural context. Statements can also be added. Remember that if you add or change a statement, it will change the scoring system and you will then need to revise that accordingly.



Attitude Scale Instructions

How to administer:

STEP 1

Arrange a private, comfortable setting and give at least 30 minutes to complete the assessment.

STEP 2

Explain the purpose. Facilitators should clearly explain to staff that this is an assessment to understand better their personal beliefs and feelings about GBV and those who experience it. It is important to emphasise to staff that all answers should be honest, accurate, and self-reflective, and that the Attitude Scale is a tool to identify areas where individuals can benefit from further training and staff development. Assure them that their responses will not be

shared with other staff members, and that how they respond will not affect their employment or contract with the organisation.

STEP 3

Explain how to complete the Attitude Scale and Self-Reflection Questions. Individuals will place a mark in the box corresponding to their response for each question.

STEP 4

Ask the individual to complete the Attitude Scale and Self-Reflection Questions.

STEP 5

Score the Attitude Scale.

Scoring

Each question was devised so that answers could range from a positive high (4) to a negative low (1). Some questions are inversely scored. Add all the numbers together to calculate the total score. Guidelines for interpreting the scores are below.

60-80 POINTS

Scores in this range indicate that the individual has a survivor-friendly and inclusive attitude towards working with diverse survivors – they have positive beliefs and values for working with survivors.

40-59 POINTS

Scores in this range indicate some troubling attitudes that may be harmful to survivors.

Managers and supervisors should use their discretion when allowing staff to work on cases and may want to consider ‘coaching’ the staff member before they work independently with survivors.

39 POINTS AND BELOW

Scores in this range indicate that an individual is not ready to work with survivors. Managers and supervisors should work independently with a staff member who scores less than 39 to address negative beliefs and attitudes and identify immediate actions to address them.

Staff Attitude Scale

Note: the template with the scores below is only for facilitators. **Provide the blank form to staff to complete so that the scoring is hidden (blank form can be found below and in the annex section)**

CATEGORY	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	NEUTRAL
All survivors of GBV have the right to receive help, regardless of their gender, age, disability status, race, ethnicity, religion, sexual orientation, and other identity factors.	4	3	2	1	N/A
If LGBTQIA+ individuals who behave inappropriately are raped, it is their fault.	1	2	3	4	N/A
If a survivor with disabilities can't answer questions about the incident, they must not be telling the truth.	1	2	3	4	N/A
If a caregiver forces a woman with a disability to be sterilised, it is for her own good and not a form of GBV.	1	2	3	4	N/A
Poor women often lie about having been raped or abused so that they can get attention, money or resources.	1	2	3	4	N/A
Women from certain religions cause their husband's violence because of their behaviour.	1	2	3	4	N/A
If a young girl does not have citizenship, her father has the right to force her to marry.	1	2	3	4	N/A
A husband can take away his disabled wife's assistive device as punishment for her not obeying him.	1	2	3	4	N/A
Violence between spouses or dating partners that occurs within certain ethnic or religious groups should be handled within that community as they have their own culture or practices.	1	2	3	4	N/A
A survivor with disabilities should have the right to make decisions about what actions are best for them.	4	3	2	1	N/A
Men who assault LGBTQIA+ individuals are justified because that individual makes them uncomfortable.	1	2	3	4	N/A
Refugee women are uneducated and can only do household jobs.	1	2	3	4	N/A
All women have the same vulnerability to GBV, regardless of their other identity factors.	1	2	3	4	N/A
It's not possible to provide GBV services that are able to meet the needs of all survivors, especially those with diverse identities.	1	2	3	4	N/A
GBV programs should <i>only</i> focus on addressing the vulnerabilities of survivors instead of also addressing the unequal power structures that support and enable GBV.	1	2	3	4	N/A

CATEGORY	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	NEUTRAL
In order to provide GBV services that meet the needs of all survivors, it is important to understand different forms of discrimination, such as sexism, racism, homophobia, ageism, and ableism.	4	3	2	1	N/A
My identity — such as my gender, race, socioeconomic status, education, disability, ethnicity, religion and sexual orientation — could cause me to act in a biased way, either positively or negatively, toward someone else.	4	3	2	1	N/A
Identity factors, such as gender, race, socioeconomic status, education, disability, ethnicity, religion and sexual orientation, can have a huge impact on the opportunities we have throughout our lives.	4	3	2	1	N/A
Bias is a natural part of being human and is something everyone experiences.	4	3	2	1	N/A
If a topic, such as gender identity, race, disability, ethnicity, religion and sexual orientation, makes me uncomfortable, I'll try to avoid it.	1	2	3	4	N/A
TOTAL SCORE (add up the scores in each column and then add these together for the total score)					

Attitudes and Self-Reflection Questions

(After completing the Attitude Scale, staff should answer the following questions individually)

1. Is this really what I think, or is this what my society, my family, my friends, or the media are telling me?
2. Is it possible that my biases, and the biases of the people and organisations around me (such as my workplace, my church/mosque), influence me in how I work on a daily basis?
3. Is it possible that my assumptions may cause me to forget to ask survivors certain questions? Is it possible that I do not always understand the answers because I have a totally different experience compared with the survivors I work with?
4. Why is learning about unconscious bias important in the work we do with survivors who don't look like me, sound like me, or have the same identities as me?
5. What do I need to learn more about when it comes to bias when working with diverse GBV survivors? What do I need to learn more about when it comes to the concept of intersectionality?

This tool is a supplement to the GBVIMS Survivor-Centered Attitude Scale, which can be found at: <https://www.gbvims.com/wp/wp-content/uploads/Survivor-Centered-Attitude-Scale-3.docx>. The GBVIMS tool focuses on staff attitudes towards survivors in general, while this focuses specifically on attitudes towards diverse survivors.

This tool is paired with the **Conversation Guide: Addressing Staff Bias guide**, which should be used by facilitators to have discussions with staff on addressing bias after they have completed this exercise.

Before administering this exercise, facilitators can conduct the **Intersectionality Yarn exercise** to allow staff to reflect on power, privilege, systems of oppression and inequalities affecting diverse GBV survivors.

EXPECTATION



- Tools that is developed from previous section

I fell more thing learning like explain C, BV and other thing

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information sharing protect S/Kills

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Staff Attitude Scale

Note: give the blank form to staff to complete so that the scoring is hidden.

CATEGORY	STRONGLY AGREE		STRONGLY DISAGREE		
	AGREE	AGREE	DISAGREE	DISAGREE	NEUTRAL
All survivors of GBV have the right to receive help, regardless of their gender, age, disability status, race, ethnicity, religion, sexual orientation, and other identity factors.					
If LGBTQIA+ individuals who behave inappropriately are raped, it is their fault.					
If a survivor with disabilities can't answer questions about the incident, they must not be telling the truth.					
If a caregiver forces a woman with a disability to be sterilised, it is for her own good and not a form of GBV.					
Poor women often lie about having been raped or abused so that they can get attention, money or resources.					
Women from certain religions cause their husband's violence because of their behaviour.					
If a young girl does not have citizenship, her father has the right to force her to marry.					
A husband can take away his disabled wife's assistive device as punishment for her not obeying him.					
Violence between spouses or dating partners that occurs within certain ethnic or religious groups should be handled within that community as they have their own culture or practices.					
A survivor with disabilities should have the right to make decisions about what actions are best for them.					
Men who assault LGBTQIA+ individuals are justified because that individual makes them uncomfortable.					
Refugee women are uneducated and can only do household jobs.					
All women have the same vulnerability to GBV, regardless of their other identity factors.					
It's not possible to provide GBV services that are able to meet the needs of all survivors, especially those with diverse identities.					
GBV programs should <i>only</i> focus on addressing the vulnerabilities of survivors instead of also addressing the unequal power structures that support and enable GBV.					

CATEGORY	STRONGLY AGREE		STRONGLY DISAGREE		
	AGREE	AGREE	DISAGREE	DISAGREE	NEUTRAL
In order to provide GBV services that meet the needs of all survivors, it is important to understand different forms of discrimination, such as sexism, racism, homophobia, ageism, and ableism.					
My identity — such as my gender, race, socioeconomic status, education, disability, ethnicity, religion and sexual orientation — could cause me to act in a biased way, either positively or negatively, toward someone else.					
Identity factors, such as gender, race, socioeconomic status, education, disability, ethnicity, religion and sexual orientation, can have a huge impact on the opportunities we have throughout our lives.					
Bias is a natural part of being human and is something everyone experiences.					
If a topic, such as gender identity, race, disability, ethnicity, religion and sexual orientation, makes me uncomfortable, I'll try to avoid it.					
TOTAL SCORE (add up the scores in each column and then add these together for the total score)					

Attitudes and Self-Reflection Questions

(After completing the Attitude Scale, please answer the following questions individually)

1. Is this really what I think, or is this what my society, my family, my friends, or the media are telling me?
2. Is it possible that my biases, and the biases of the people and organisations around me (such as my workplace, my church/mosque), influence me in how I work on a daily basis?
3. Is it possible that my assumptions may cause me to forget to ask certain questions? Is it possible that I do not always understand the answers because I have a totally different experience compared with the survivors I work with?
4. Why is learning about unconscious bias important in the work we do with survivors who don't look like me, sound like me, or have the same identities as me?
5. What do I need to learn more about when it comes to bias when working with diverse GBV survivors? What do I need to learn more about when it comes to the concept of intersectionality?

PROGRAMMING TOOL 2:

STAFF BIAS – Addressing staff bias: a conversation guide

Theme: Awareness

Phase of GBV program cycle: Prevention

WHO

This tool can be used by any organization that provides direct support, for instance through referral or through service provision, to GBV survivors and can be facilitated by a staff member or supervisor, or by a facilitator from another organization. Facilitators should use the Conversation Guide: Addressing Staff Bias as a guide to have conversations about bias with staff after they have completed the Staff Bias Questionnaire.

PURPOSE

This exercise aims to evaluate and address attitudes and biases of staff that are in direct contact with GBV survivors so that those biases do not lead to the exclusion of diverse survivors. It also allows for an introspective look at where those attitudes and beliefs originate, and how they may impact work with survivors. In addition, it can be used to highlight specific areas in which the staff member may require further education and training.

Instructions

HOW THIS GUIDE SHOULD BE USED

Staff have had the opportunity to complete the Staff Attitude Scale and Self-Reflection Questions. In that activity, staff began to identify their own beliefs and potential biases and think about how these may influence the work they do with diverse survivors. This guide will help the facilitation of a conversation that will now allow staff to self-reflect on the potential biases they identified. In addition, staff will be better positioned to consider the possible harmful consequences of these biases when working with survivors, and understand that while we all have unconscious biases, we can work to reduce the negative impact they can have.

FACILITATORS WILL USE THESE QUESTIONS AND TALKING POINTS WITH STAFF TO DISCUSS:

- How unconscious bias affects ways of working with survivors, especially diverse survivors
- How these biases can be addressed so that staff are better suited to respond to the needs of all survivors.

BEFORE YOU BEGIN:

Facilitators should watch the explainer video: "Unconscious or Implicit Bias" to deepen their understanding of unconscious bias before facilitating this conversation. Facilitator can also use the video during the discussion to help staff better understand the concept of unconscious bias.

A TIP FOR CREATING SAFE SPACES FOR DIFFICULT CONVERSATIONS:

Conversations about attitudes and bias, especially those that require us to be vulnerable, can make people feel uncomfortable. It is important to provide a safe space which allows for both compassionate and critical dialogue.

HERE ARE SOME SUGGESTED COMMUNICATION AGREEMENTS THE FACILITATOR CAN OUTLINE BEFORE THE DISCUSSIONS BEGIN:

- Each person will speak for themselves and allow others to speak for themselves, with no pressure to represent or explain an entire group. We will listen to others, even when something is hard to hear.
- We will not make assumptions about what others may say. Instead, we will consider asking a question to understand better.
- We will not interrupt, except to indicate that we cannot or did not hear a speaker.
- We will keep in mind that understanding and agreeing are not the same thing.
- The information that is shared here will not leave this group.

Facilitator Talking Points

Start the discussion by getting people on the same page around 'why' you are all gathered for the discussion, so that people feel invested in learning, and comfortable sharing. Set ground rules for safe communications, including the tips listed above.

Explain that unconscious bias refers to the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious way. These biases, which can include both positive and negative stereotypes, are activated involuntarily and without an individual's awareness or intentional control. These biases cause us to have feelings and attitudes about other people based on characteristics such as gender, disability, race, ethnicity, religion, age, sexual orientation, socioeconomic status, appearance, etc. These biases may also affect the way we understand and unconsciously interpret other's realities and lived experiences.

The facilitator should remind staff that biases are present in everybody, consciously or unconsciously, and these biases can influence behaviour. It is therefore important to work to uncover and deconstruct these biases in everyone who is involved in working with GBV survivors, including staff members themselves. This is not a one-time activity. It is essential that we consistently and critically check our own attitudes, beliefs and assumptions, and explore how they affect our work with diverse survivors.

FACILITATOR TALKING POINTS UNDER EACH QUESTION ARE INDICATED IN THE COLORFUL BOXES BELOW. THESE ARE POINTS THAT THE FACILITATOR CAN USE TO RESPOND TO QUESTIONS, PROVIDE INFORMATION AND DEEPEN THE DISCUSSION.



Questions

The facilitator will ask the group the following questions, and may use the talking points as required:

1. WHY IS LEARNING ABOUT UNCONSCIOUS BIAS IMPORTANT FOR THE WORK WE DO WITH SURVIVORS, ESPECIALLY DIVERSE SURVIVORS?

Facilitator talking point: We all have unconscious biases that affect our judgement and our decision-making. This can negatively influence our work with diverse survivors because we may not be able to understand their lived realities and experiences or provide appropriate support. Learning about unconscious bias can help us develop strategies to be sure we are being inclusive and responding to the needs of all survivors.

2. WHY SHOULD WE FOCUS ON IDENTIFYING OUR OWN BIAS(ES)?

A. WHAT WOULD HAPPEN IF WE DON'T?

B. WHAT BENEFITS MAY WE GAIN FROM UNDERSTANDING OUR OWN BIAS? DISCUSS THE UNDERSTANDING OF UNCONSCIOUS BIAS.

Facilitator talking point: When our biases are unidentified, it can lead to discrimination, even if we don't intend to discriminate. For example, offering appointments at the time women pick children up from school, or assuming that a survivor is heterosexual can lead to discrimination. In fact, suppressing or denying biased thoughts can actually increase prejudice instead of eliminating it. When we understand our biases, we can learn about how they impact our behaviors and then we can actively work to change our responses.

3. FROM YOUR UNDERSTANDING, HOW ARE UNCONSCIOUS BIASES DEVELOPED?

Facilitator talking point: Unconscious biases are developed through the cultural stereotypes that we have been exposed to throughout our lives, including through the messages we received while growing up, from our families, our friends, the movies and TV shows we watch, the books and news stories we read, the jokes we hear, and the music we listen to, etc.

4. IN WHAT WAYS CAN A PERSON GENUINELY BELIEVE THAT DIFFERENT FORMS OF DISCRIMINATION (E.G. RACISM, SEXISM, HOMOPHOBIA, CIS-SEXISM, ABLEISM, XENOPHOBIA, AGEISM, ETC.) ARE WRONG BUT STILL HOLD UNCONSCIOUS BIAS?

Facilitator talking point: Unconscious bias is often in direct conflict with our conscious values and beliefs.

5. HOW CAN UNCONSCIOUS BIAS AFFECT OUR WORK WITH DIVERSE SURVIVORS?

Facilitator talking point: For instance, unconscious bias may impact:

- Who reports GBV cases. For example, if a staff member believes that women should not be out of the house unaccompanied, they may respond to a survivor by asking why she was out alone or what her parents think about her being out by herself. These insensitive questions may lead the survivor to feel she is at fault for the incident and, therefore, not report the case.
- Who receives appropriate care, services, and referral.
- How we perceive levels of risk for different groups.
- How we interact with survivors and how we're able to listen to what a survivor is saying.

6. CAN YOU GIVE EXAMPLES OF HOW UNCONSCIOUS BIAS MAY SHOW UP IN OUR WORK WITH SURVIVORS? HOW CAN THESE BIASES INFLUENCE THE INTERACTION WITH, OR SERVICES PROVIDED TO A SURVIVOR?

Facilitator talking point: How we think about a person or who/how we assume they may be can affect if we help them, and how. For example, unconscious bias may cause us to refer a survivor to inappropriate services, or not make a needed referral. We may not understand, or

may misinterpret their experience, and therefore ask insensitive questions and cause harm. We may also dismiss abuse that a survivor has experienced because of a limited consideration of their characteristics, such as gender, age, ethnicity and disability.

7. CAN WE CHANGE OUR UNCONSCIOUS BIAS?

Facilitator talking point: Unconscious biases can change. Our brains are incredibly complex, and the assumptions and beliefs that we have formed can gradually be unlearned through identifying our biases and engaging in inclusive dialogue to seek out diverse experiences and perspectives of survivors with diverse identities.

8. HOW DO YOU SEE YOURSELF ADDRESSING YOUR OWN UNCONSCIOUS BIAS SO AS TO DELIVER SERVICES TO SURVIVORS WITH DIVERSE IDENTITIES BETTER? WHAT STEPS CAN YOU TAKE?

Facilitator talking point: Examples of steps to take may include:

Learning more about the cultural norms and values of the survivors we are working with (i.e. those from particular ethnic or religious backgrounds) to help remove existing stereotypes we may have; learning correct terminology and appropriate ways of communicating with survivors from groups affected by inequality and discrimination; actively seeking the feedback of people who experience intersecting discrimination; attending training courses on raising awareness of and changing attitudes towards groups affected by inequality and discrimination.

Closing:

It is important that people leave the discussion committing to an action based on the knowledge participants have just gained. Dedicate time at the end of the discussion to brainstorm action items as individuals, teams, or as an organization. Make sure that you take notes and follow up with the group afterwards, with reminders or progress updates.

Intersectionality Tip Sheet – Tips for Working with GBV survivors from an intersectional lens

Theme: Awareness

WHO

This tool can be used by any organization wishing to provide support to GBV survivors in all their diversity. Though the primary focus of the Tip sheet is on supporting those who interact with, and provide services to GBV survivors, much of the content is relevant for all individuals who interact with diverse groups, whether or not they are known to have experienced violence.

PURPOSE

This tip sheet aims to:

- present how diverse groups may be at increased risk of GBV. Mainstream and create greater cohesion of knowledge, attitudes and practices relating to intersectionality across GBV actors, representative groups and others
- help organizations adapt quality care and support for survivors in all their diversity. Provide tips on how to ensure security and dignity when working with diverse GBV survivors. It includes recommendations for collecting data and providing direct support
- increase understanding of different systems of oppression

THIS TIP SHEET IS ORGANIZED INTO THE FOLLOWING SECTIONS:

- General recommendations when working with diverse survivors
- Facts and figures relating to diverse groups and tailored tips for GBV actors working with diverse at-risk groups, including:
 - adolescent girls and young women
 - children
 - older people
 - men and adolescent boys living in development/conflict contexts
 - people with diverse sexual orientations, gender identities, gender expression and sex characteristics (SOCIESC)
 - persons with disabilities
 - diverse religious and ethnic affiliations
 - migration status/survivor on the move
 - women and child heads of household
 - women, girls, men and boys living with HIV
- Definition of systems of oppression & discrimination



General recommendations when working with diverse survivors

Intersectionality and the survivor-centered approach

The survivor-centered approach demands a supportive attitude that embodies the respect, kindness, and empathy that survivors need. This is particularly true in cases of diverse GBV survivors, where prejudicial attitudes can drive harmful behaviors, increase risks, and present important barriers to quality and supportive care, with these conditions ultimately limiting recovery and healing. A survivor with intersecting identity factors may face a multiplicity of discrimination and stigmatization.

Each survivor's experience of violence is unique. A survivor-centered approach with an intersectional lens involves understanding and accepting each individual survivor's physical, psychological, emotional, social, cultural and spiritual aspects, and building on these to support and facilitate recovery. It also considers different systems of oppression which may lead to re-victimization or unique discrimination or stigmatization.

Approaching violence through an intersectional analysis helps us better understand the multiple identities and experiences of people, including inequality and discrimination between men and women, and within subsets of men and women, which may uniquely shape the way they experience violence.

All people have the right to the best possible assistance regardless of gender, age, disability, race, color, language, religious or political beliefs, sexual orientation, social class, nationality and migratory status. In the case of adolescent girl GBV survivors on the move, for example, this means that survivors should receive care and support based on their needs – due to their circumstances and experiences – not based on who they are.

Stereotypes about different aspects of their particular identity may negatively impact GBV survivors. That is why it is important to address the negative attitudes and assumptions that GBV actors may have.

When collecting and recording data on diverse identities, be mindful of the context/country you are working in as some information may be very sensitive and/or contentious.

Key Steps when working with diverse survivors

UNDERSTAND

- Combining identity factors may increase the risk of violence, especially of GBV.
- Diverse survivors face many different and unique barriers to accessing GBV services.
- Many services are not tailored to the needs of diverse survivors, leaving them without quality support, e.g. a transwoman can be excluded from a shelter based on her gender identity, unmarried adolescent girls may not access awareness activities about SRH etc.
- Assess your own attitudes and biases. Do not let them get in the way of respecting GBV guiding principles. (You can refer to the Staff Bias tool in this toolkit and Process Tool 1: Intersectionality Yarn)
- Remember that survivors with diverse identities may be more isolated and have more limited support networks, strategies and safety plans.
- DO ask survivors if they want to talk to a person of the same gender.
- DO NOT make assumptions about someone or their experiences, and do not discriminate for any reason including age, marital status, disability, religion, ethnicity, class, sexual orientation, gender identity, identity of the perpetrator(s), etc.

IDENTIFY

- Find out what services are available in your area, and how supportive they are of different profiles of survivors. (You can refer to the following tools within this toolkit: Mapping of Diverse Actors Quadrant, Creating Ecosystems of Care, and Gap Analysis)
- Work with different groups (e.g. adolescent girls, women with disabilities, male survivors, LGBTQIA+ people, etc.) to understand the specific barriers they face in your context, and how they can best access services.
- Assess the risks involved in direct focus group discussions (especially in contexts where there is stigma and discrimination around some identity factors such as sexual orientation, religious beliefs, etc.).
- Consider how you can partner up with community associations and organizations that work on other matters with specific groups of people, such as indigenous associations, lesbian/bisexual organizations or disability support groups.

SUPPORT

- Work to reduce barriers relating to attitudes, lack of documentation, cost of services, accessibility of services, access to information, as relevant.
- Establish, promote, or follow referral mechanisms and standard operating procedures that support survivors with diverse profiles to access services. (You can refer to the Referral Pathway tools within this toolkit)
- Ensure safety and confidentiality of services by following information-sharing protocols, and survivor codes. Ensure that the collection of individual identity factors is done in an appropriate way. (For an example of an intake and assessment form please refer to the tools within this toolkit)
- Ensure that all staff have the right training, attitudes and skills to support GBV survivors in all their diversity. (You can refer to the Staff Bias tool in this toolkit and Process Tool 1: Intersectionality Yarn, as well the accompanying e-module)
- Avoid describing a person based simply on their identity (e.g., lesbian woman, disabled woman).
- DO NOT identify diverse participants by pointing out or identifying their age, disability, sexual orientation, gender identity, religion, ethnicity, or other characteristic, as this can be harmful and stigmatizing. Remember to let the person tell you how they identify themselves.

ADAPT

- Consider and address the needs of survivors of different profiles and abilities.
- Develop and distribute IEC materials tailored to each group.
- DO listen more than you speak.
- DO ensure female staff members are present to provide support.
- DO ask the survivor if they feel comfortable talking to you in your current location. If a survivor is accompanied by someone, do not assume it is safe to talk to the survivor about their experience in front of that person.

Diverse at-risk groups

In this tool the term ‘at-risk group’ refers to groups of people who are at increased risk of experiencing GBV because of the interaction between their gender and other personal factors such as age, sexual orientation, religion, social class, migration status etc. This may lead to specific forms of discrimination and therefore less power. They can also be more dependent on others and less visible to GBV service providers.

1. Intersectionality and the survivor-centered approach

Adolescent girls and young women around the world too often face unique risks of gender discrimination and gender-based violence (GBV), including sexual violence, human trafficking, forced marriage, and sexual exploitation and abuse. This is particularly the case in humanitarian settings, where girls’ already-limited access to vital services and family and peer support networks are disrupted by crises and displacement. Adolescent girls face intersecting risks of violence due to their relative lack of power because of both their gender and their status as children or young people in a world dominated by men and adults. Adolescent girls experience harmful social norms and practices (like child, early, and forced marriage) at higher rates than their male counterparts. Harmful social norms can also compound girls’ experience of violence, as some girls are considered ‘defiled’ or ‘ruined’ after rape. Caught between childhood and adulthood, these girls are often not able or willing to access services designed for adult women or young girls.

Young women can also face specific forms of violence, including sexual harassment and sexual assault in the workplace and/or at school.

TIPS FOR GBV ACTORS:

- DO adapt content of GBV awareness sessions to adolescent girls’ and young women’s specific needs. Develop adolescent-friendly communication materials.
- DO screen your staff on supportive attitudes and behaviors. Challenge negative attitudes/assumptions about adolescent girls that staff members from your organization may have, such as: “Adolescent girls’ problems are not as serious as women’s problems”, “Giving adolescent girls information about sex and sexual reproductive health encourages irresponsible sexual behavior”, “Adolescent girls are promiscuous and difficult to manage” etc.
- DO give girls the option to speak on their own, in peer groups, or in groups with caregivers. Don’t assume that girls will share the same information in each of these settings. For example, younger adolescents may not feel as comfortable speaking in front of older adolescents or mature women – if holding group discussions, break them down by age group (10 to 14 and 15 to 19) and try to have young women facilitate group discussion.

2. Children

Children seek help in different ways compared with adults, and rarely make direct disclosures. Children may find it difficult to trust or talk to adults,

especially adults they do not know well; they experience fear, embarrassment or shame, or they are afraid of expressing their emotions.

When working with child survivors you should always put into practice the Guiding Principles for Working with Child Survivors

1. Promote the child's best interest
2. Ensure the safety of the child
3. Comfort the child
4. Ensure appropriate confidentiality
5. Involve the child in decision-making: speak to a child survivor in a way that they understand and with respect for their dignity and opinions
6. Treat every child fairly and equally: all children should be offered the same unbiased support regardless of their sex, age, family situation, status of their caregiver or any other part of their identity.
7. Strengthen a child's resilience: do not treat a child that has experienced GBV as helpless. Each child has unique capacities and strengths and possesses the capacity to heal.

For more practical guidance and training you may refer to the CCS Guidelines from IRC (Caring for Child Survivors of Sexual Abuse): <https://childprotectionpractitioners.org/child-protection-areas-of-intervention/child-level-interventions/caring-for-child-survivors/>

3. Older persons

Violence against older persons is often addressed through the lens of elder abuse. Elder abuse is usually any single or repeated act – physical, psychological, sexual, emotional or financial – including neglect and abandonment.

Culturally specific types of elder abuse can include demeaning widows, hyper-exploitation of household labor by adult children, extreme isolation due to limited literacy proficiency and/or immigration status, rejection of now-elderly women who were raped in conflict zones or refugee camps, and severely ostracizing elderly gay/lesbian couples.

Violence against older women can also be seen from a GBV perspective. Older women are at greater risk of physical and psychological abuse due to discriminatory societal attitudes. Older women encounter negative views of ageing, that is, ageism, worsened by sexist social norms, and have lower standards of living in older age due to decreasing opportunities for economic security and education throughout their life because of their gender. Some harmful traditional and customary practices result in abuse and violence directed at older women, often exacerbated by poverty and lack of access to legal protection. Be mindful of intersecting forms of inequality and oppression for older women as they can be at a greater or unique risk of violence throughout their lifespan and in older age: women of diverse migrant and ethnic minorities, women in emergencies, indigenous women, sex workers, sexual and gender-minority women.

Elder abuse, and especially violence against old women, may be overlooked by service providers who assume that respect for and deference to elders is culturally normative, and may not screen for it.

TIPS FOR GBV ACTORS⁵:

- DO not hesitate to ask potential older victims about possible sexual assault or abuse. Do not assume that because a person is older, sexual abuse could not have occurred.
- DO follow-up on coded disclosures. Some victims may wear many layers of clothing, talk about not wanting someone near them, say things like “he’s my boyfriend” (referring to a young staff member) or wonder if they could be pregnant. They may not talk directly about sexual abuse.
- DO avoid the assumption that an older person with communication barriers or cognitive functional limitation cannot provide meaningful information about an assault they have experienced.
- DO recognize that older adults may have difficulty talking about sexuality and sexual abuse. Some may be uncomfortable using sexual language or words for body parts.
- DO create a welcoming and inclusive environment for older victims. Include images of older adults from various backgrounds in physical spaces, online and in outreach materials. Offer books, movies and social activities of interest to individuals of all ages and generations.
- DO consider hiring older staff members and volunteers to be available to work with these survivors, as some older survivors may have difficulty talking to younger professionals who are similar in age to their grandchildren.
- DO ensure that barriers that limit access for individuals with mobility and communication issues are addressed.
- DO learn about available options for older victims.
- DO know your legal context and mandatory reporting laws. In some countries, professionals are legally required to report all alleged abuse of older adults to the state authorities.

4. Men and adolescent boys living in development/conflict contexts

If women and girls are disproportionately subjected to sexual violence and intimate partner violence (IPV), men and boys can also be subjected to sexual and gender-based violence (SGBV). They have specific health, psychosocial, legal and safety needs but often find it hard to discuss their experience and access the support they need.

- Worldwide it is estimated that **1 in 5 men have been sexually abused** (mostly during childhood).
- **Men and boys with disabilities are at higher risk of suffering GBV, especially sexual violence.** Other groups particularly vulnerable to sexual victimization include young boys, adolescent boys, people selling sex, and people with diverse sexual orientation, gender identity, gender expression or sex characteristics (SOGIESC).

5 — Adapted from: Sexual Abuse and Later Life, <http://s3-us-east-2.amazonaws.com/ncall/wp-content/uploads/2018/12/05160021/SexualAbuseLaterLife.pdf>; and Domestic Abuse in Later Life: Tips on Working with Victims. Barbara Blue Scenario, https://wss.ccdet.uwosh.edu/stc/CAREGIVER/_WebRedesign/Documents/Blue/Handouts/barbtips.pdf

- Men are also **highly affected in armed conflict (torture, sexual violence) and in detention**. In Liberia, according to a study, 32.6% male former combatants had experienced sexual violence, mostly at the hands of soldiers or rebels⁶. Surveys of male torture survivors, both from conflict zones and from repressive states, have consistently shown high levels of sexual violence in detention (above 50%).

SEXUAL ABUSE AGAINST BOYS

According to a study conducted by UNICEF among children aged 6 to 12 years old in South Asia⁷, boys are generally considered to be more vulnerable than girls outside the home because **social customs protect and monitor girls more, while boys have relatively more freedom. Social customs contribute to boys' vulnerability, as they are generally considered capable of protecting themselves and because society in general tends to deny the sexual abuse of boys and consensual sexual relationships between males**. This may explain why the sexual abuse of boys is less frequently reported than the abuse of girls, whether due to lower frequency or greater denial of the problem, and statistics may not give an accurate picture of the problem.

However, boys may be relatively **more at risk of sexual abuse in cultures that have barriers against having sex with females outside marriage, that strongly protect the virginity of unmarried women**.

SEXUAL VIOLENCE AGAINST MEN AND BOYS WITH DISABILITIES

Men and boys with disabilities are at increased risk of experiencing such kinds of violence. According to UNFPA, between **16% and 30% of young men with disabilities will experience sexual violence before the age of 18**⁸. The Women's Refugee Commission also highlights sexual violence against men and boys with disabilities in humanitarian settings. In Burundi, some participants in the research suggested that this group may be targeted by perpetrators who believe the myths that they will be cured of illness or amass wealth by having sex with boys. *"There is a traditional belief that they practice sodomy to cure illness, like HIV, or to become rich. So, men will rape boys. Boys with mental disabilities are more at risk than non-disabled boys because they believe everything people tell them."* (Caregiver of male survivor in Burundi).

BARRIERS FOR MEN AND BOY SURVIVORS OF SGBV TO ACCESS SERVICES

The Practice of Bacha Bazi in Afghanistan

In Afghanistan, the practice of 'Bacha Bazi' refers to the sexual exploitation of young boys forced to sell their bodies and their dancing skills to meet their families' financial needs. Powerful adult men exploit these young boys, make them dress up as females, wear makeup, and dance at men-only parties. Some of these boys are taken from their families in the promise of work, education or a better life. Mostly, their families are not aware of the fact that they are being exploited as sex slaves.

6 — JOHNSON, KIRSTEN & ASHER, JANA & KAYDEN, STEPHANIE & RAJA, AMISHA & PANJABI, RAJESH & BEADLING, CHARLES & LAWRY, LYNN (2008), " Association of combatant status and sexual violence with health and mental health outcomes in post conflict Liberia". Journal of the American Medical Association, 300(6), 676-690. JAMA : the journal of the American Medical Association. 300. 676-90. 10.1001/jama.300.6.676.

7 — UNICEF, JOHN FREDERICK, (2010) "Innocenti Working Paper. Sexual Violence and Exploitation of Boys in South Asia. A Review of Research Findings, Legislation, Policy and Programmes Responses." https://www.unicef-irc.org/publications/pdf/iwp_2010_02.pdf

8 — UNFPA, WE DECIDE INITIATIVE, (2018) "Global Study on Ending Gender-based Violence and Realizing Sexual and Reproductive Health and Rights" <https://www.unfpa.org/publications/young-persons-disabilities>

Men and boy survivors of sexual violence and/or IPV often suffer silently because widely held social norms and perceptions of gender, social stigma and cultural taboos with regard to the discussion of sex and sexuality make it difficult for them to come forward. Rape by another male can be aimed at stripping a man or boy of his heterosexual status — a particularly powerful attack in cultures where homosexuality is socially or religiously taboo. Where same-sex relations are criminalized, male survivors are at risk of being interrogated about their sexual orientation and prosecuted for having engaged in same-sex activity. Intrusive questioning by medical staff (or fear of it) inhibits survivors from seeking assistance.

Moreover, when they do speak, service providers frequently fail to listen to or believe them. Often, they do not recognize the gravity of their experiences or the impact on their subsequent well-being and capacity for self-reliance. These failures are often based on insensitivity or lack of training on the extent to which men and boys suffer from SGBV, and its impact, or how the needs of survivors can be addressed. Legal definitions of rape are often specific to women and children, making it impossible for adult men to lay a charge of rape.

TIPS FOR GBV ACTORS:

- Train your staff on SGBV against males, its impact and their specific needs.
- When working with men or adolescent boys be mindful that they too can be survivors of GBV, including sexual violence.
- Explicitly acknowledge the experience of men and boy survivors, respect their right to confidentiality, and include them in programs that meet their distinct needs.
- Pay attention to signs of abuse against men and boys.
- Don't assume that a male survivor will prefer to receive care from another male. Always ask what their preference is.
- Check in your area if urgent medical services for male rape survivors is available.
- Know the legal context, if same-sex relations are criminalized in your country, collecting/sharing data about male perpetrators may put survivors and perpetrators at further risk. Your organization may have SOPs to handle such situations.
- Provide information about urgent medical services, if appropriate, and all other available services, confidentially and sensitively.
- Convey the message that sensitive issues can be addressed confidentially when the survivor feels ready to talk about them.
- Implement GBV awareness activities about SGBV against men and boys.

5. People with Diverse Sexual Orientations, Gender Identities, Gender Expression and Sex Characteristics (SOGIESC)

While there is still a lack of research and global data on violence against SOGIESC people, the United Nations and many human rights organizations have documented widespread physical and psychological violence against SOGIESC people in all regions – including murder, assault, kidnapping, rape, sexual violence, as well as torture and ill-treatment in institutional and

other settings. Homosexual young men, lesbian, bisexual and transgender women are at particular risk of physical, psychological and sexual violence in family and community settings. SOGIESC people often face violence and discrimination when seeking medical care in instances of sexual violence. In 76 countries, laws still criminalize consensual same-sex relationships between adults, exposing individuals to the risk of arbitrary arrest, prosecution, imprisonment – even the death penalty in at least five countries.⁹

There is very little practical guidance on how to carry out programming on GBV that is inclusive of people with diverse SOGIESC. The following table, however, outlines a norms-based approach drawing from gender models.¹⁰

PLACE ON THE DIVERSE SOGIESC SPECTRUM	RESULTS/IMPACT
Diverse SOGIESC	Aggravates underlying norms that exclude people with diverse SOGIESC and marginalisation associated with those norms.
Harmful	Lack of analysis and awareness may reinforce underlying norms that exclude people with diverse SOGIESC and marginalisation associated with those norms.
Diverse SOGIESC	Analysis and awareness has not yet led to substantive effort to challenge norms that exclude people with diverse SOGIESC and the marginalisation associated with those norms.
Unaware	Analysis and awareness has led to targeted initiatives that address marginalisation of people with diverse SOGIESC, but not necessarily in ways that challenge underlying norms.
Diverse SOGIESC	Analysis and awareness has led to targeted and mainstreamed initiatives that address marginalisation of people with diverse SOGIESC, and challenge underlying norms that lead to that marginalisation.

9 — OHCHR (2015), “Ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex people” https://www.ohchr.org/Documents/Issues/Discrimination/Joint_LGBTI_Statement_ENG.PDF

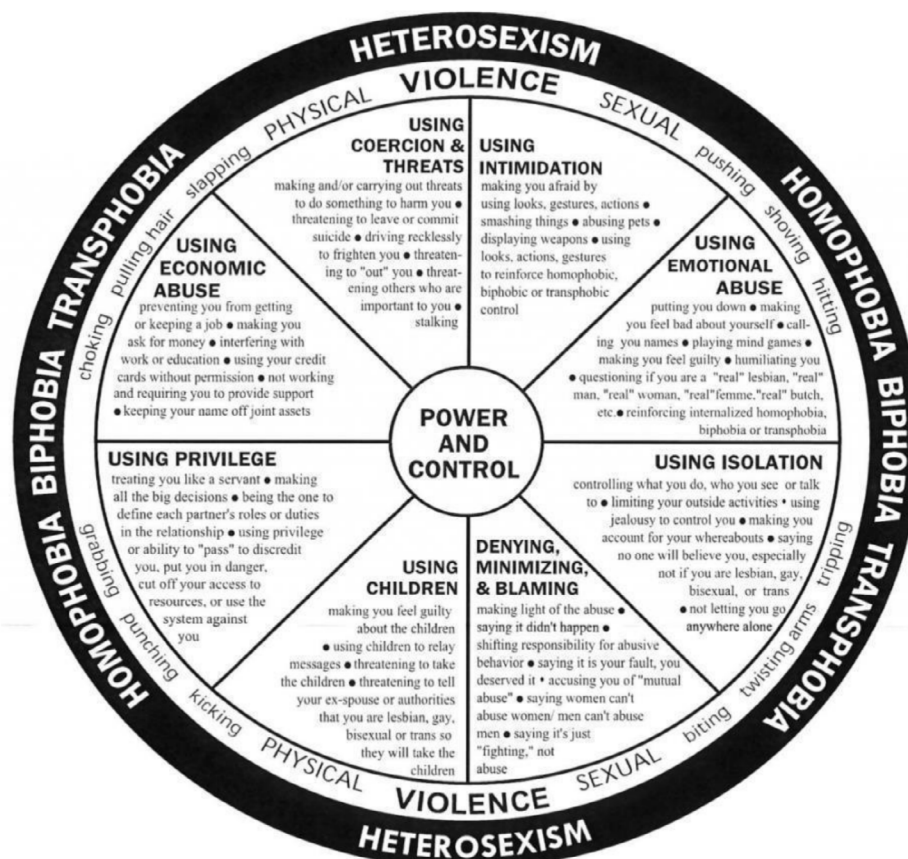
10 — EDGE EFFECT (2001), “The Only Way Is Up: Monitoring and Encouraging Diverse SOGIESC Inclusion in the Humanitarian and DRR Sectors.” www.edgeeffect.org/wp-content/uploads/2021/03/TheOnlyWayIsUp_Web.pdf

Violence in same-sex relationships

Violence in same-sex relationships can be distinct from violence in heterosexual relationships:

- Gay or lesbian perpetrators may threaten 'outing' the survivors to family, friends or colleagues. This threat increases the sense of extreme isolation among survivors.
- Survivors are also less likely to report abuse to legal authorities and may not want to contact law-enforcement agencies as this may force them to reveal their sexual orientation or gender identity.
- Survivors are reluctant to seek help out of fear of showing a lack of solidarity with the LGBTQIA+ community.
- Survivors are more likely than heterosexual women to fight back, and incorrectly lead service providers to assume that the fighting was mutual, ignoring the history of violence, power and contro.

THE POWER AND CONTROL WHEEL FOR LGBTQIA+ RELATIONSHIPS IS ALSO A USEFUL WAY OF LOOKING AT HOW VIOLENCE PLAYS OUT IN THE RELATIONSHIP:



Practicing the Know and Tell Why

The Know and Tell Why factsheet explains the importance of service providers knowing why they are asking specific questions and explaining to survivors what information the agency is trying to find out with the questions.

This is particularly important when questions may be perceived as insensitive or inappropriate when working with transgender survivors.

Example: if you find yourself wanting to know a transgender survivor's genital status, for instance, asking yourself how you intend to use the answer may be revealing. You may have a false belief that you should know the answer, have a right to know the answer, or that you simply want to know.

On the other hand, you may think you need to know the answer because the client will be sharing sex-segregated facilities where the client might be 'outed' as transgender if they 1) hadn't had surgery to alter the look of their primary and/or secondary sex characteristics; and 2) someone else saw their unclothed body. In this case, an appropriate question might be, "This service won't be able to guarantee your body privacy. Would you like to talk about the possible implications for you?"

The practice of telling a client why you need sensitive information prior to asking it is extremely helpful in many situations. By telling a transgender client why you are asking a question, you reassure them that you have not singled them out (as they may have experienced with other providers), to ask questions purely out of curiosity, or to find a reason to deny them services. Telling why is a simple style that promotes trust. An added bonus to this Know and Tell Why practice is that it gives (all) survivors a better sense of control over what is happening to them and conveys a healing sense that you respect them and their choices

The Know and Tell Why Factsheet

The importance of using the preferred pronouns

A pronoun is a word that refers to either the person talking or involved in the conversation (I or you), or someone or something being talked about (she, he, it, them, they or this/that). Transgender people face difficulties when the pronoun they identify with does not match the sex they were assigned at birth or others' perception of their gender identity.

For example, a transgender woman may be called 'he' by people who are unaware she identifies as female and prefers the pronoun 'she', by people who are confused by her gender identity, or by people who are deliberately trying to hurt her.

TIPS FOR GBV ACTORS:

- DO ask questions in a way that avoids assumptions around sexual orientation or gender identity. Use gender-neutral terminology when referring to partners (e.g. asking a survivor if they are dating someone, rather than asking a female survivor if she has a boyfriend)
- DO train your staff members and your partners on violence against diverse SOGIESC
- DO practice the simple technique of 'Know and Tell Why'
- DO recognize that individuals with diverse SOGIESC may not identify or disclose as such
- DO prepare for what to do when a survivor discloses their sexual or gender identity (e.g. offer support, engage in conversation if they wish, maintain privacy, and locate appropriate services and support)
- DO ensure use of the words gay, lesbian, bisexual and transgender is appropriate when talking with survivors, other staff members and volunteers
- DO acknowledge that intimate partner violence, including sexual violence (e.g. rape) also occurs between same-sex partners
- DO consider that there may be a high risk of mental health challenges and/or suicide
- DO treat LGBTQIA+ survivors with respect and ensure their safety when using your services
- DO be mindful and sensitive when collecting data about survivors within a same-sex couple and/or with diverse SOGIESC, especially where it's considered illegal and where it is criminalized
- DO know about LGBTQIA+ services and resources
- DO provide referral ONLY towards services that are inclusive of people with diverse SOGIESC (e.g. counselling services, legal services, accommodation support, other community support groups etc.)
- DO NOT use anti-gay slurs or jokes and intervene appropriately if others do
- DO NOT make assumptions when speaking to SOGIESC people. Remember to refer to the person by the name and pronoun they share with you. When you are unsure about what term to use when talking about or to an individual with diverse sexual orientations or gender identities, it is important to ask the individual about the language and terms they prefer, including their preferred pronouns. Avoid referring to people using acronyms, as these can label and 'other' individuals which undermines their dignity. Respecting a person's pronoun(s) is a simple act of inclusion.

6. Persons with disabilities

Women, men, girls and boys with disabilities are subjected to multiple layers of violence and discrimination linked to their age, disability, gender and socio-economic status.

Evidence shows that the main factors behind the incidence of violence against persons with disabilities include:

- Stigma associated with disability whereby they are considered by society to be

‘not completely human and of less value’.

- Dependence from caregivers: Men, women, boys and girls with disabilities in need of regular care/assistance may be in situations of dependence towards their caregivers and may be stuck in an abusive relationship. Particular forms of abuse and neglect may arise: a caregiver engaging in sexual touching during bathing or toilet routines, a caregiver confiscating assisted devices, a caregiver stealing their income etc.
- Capacity to consent: The respect of consent of persons with disabilities is key and should always be analyzed in light of these specific situations above. Firstly, in some contexts, people and even legal frameworks do not recognize the capacity of persons with disabilities to consent and/or take decisions, even if their disabilities do not impede them in making choices or in expressing consent. Before providing services and referral it will be key to ensure that ALL the information has been shared with the survivor in an appropriate way and that the capacity of consent and the choices of the person with disabilities have been correctly assessed. On the other hand, consent should also be taken into consideration when engaging in a sexual relationship with someone with mental or intellectual disabilities. Those with disabilities that prevent their full comprehension of the sexual nature of an act, that impede choice or make them unable to express consent, cannot give informed consent to this act, so although they may be of the age of majority and not physically resisting, the imposition of such an act by another individual would still constitute sexual abuse.
- Social isolation and limited access to protection-related information: A lack of community support and friendships can mean that they do not acquire the information and skills they need or have people that they trust to go to when they experience violence. It also limits the capacity of service providers to detect violence and to protect persons with disabilities who may need protection. Some persons with disabilities, particularly those with intellectual and mental disabilities, may be hidden by family members.
- Difficulty of complying with gender norms: Persons with disabilities are at a heightened risk of violence due to their incapacity to comply with their assigned gender roles, for instance men to be the ‘breadwinners’ and women to assume the house chores. This dynamic may be particularly evident in households and communities where people have acquired new disabilities: for instance, if a man acquires a new disability (as a result of a conflict or a traffic accident) and loses his income, he can be exposed to psychological violence as he cannot fulfil his social obligations anymore. On the other hand, a woman with a new disability may suffer from the full range of intimate partner violence (IPV), and be abandoned by her husband.
- Forced confinement: In some countries, forced confinement and/or chaining is commonly used to keep persons with disabilities inside the home and/or institution. Even if the reason given by caregivers is to protect persons with disabilities, it is in fact a human rights violation and may have exposed them to extra violence (e.g. sexual violence against women or children with disabilities who are left alone at home).
- Myths and beliefs around disability
In humanitarian settings, additional contributing factors include:
 - Family stress: The extreme stress experienced by families during conflict and

displacement can create family environments where violence is more likely to be perpetrated against persons with disabilities who are often seen as an extra burden.

- Loss of community support and protection mechanisms: The separation of families and neighbors, and the weakening or rupture of traditional community support structures and protection mechanisms increase the risk of violence for persons with disabilities.
- Scarcity of resources: When financial resources are reduced, caregivers may use negative coping mechanisms which jeopardizes safety and health outcomes for persons with disabilities, such as reducing food portions for persons with disabilities, placing persons with disabilities in institutions or with other family members, or arranging a forced marriage.

Violence against women and girls with disabilities

Violence against women and girls with disabilities is not just a subset of gender-based violence: it is an **intersectional category dealing with gender-based violence, age-based violence and disability-based violence**.

In childhood, discrimination against girls with disabilities occurs almost immediately after birth. Female infants born with disabilities may never be legally registered, **due to social stigma and shame**, which prevents them from accessing public health care, education and social services, making them more likely to experience violence and abuse.¹¹ **Widespread stigma** surrounding disability often results in parents hiding their children with disabilities to avoid being shamed or shunned. Research has shown that girls **with hearing or intellectual impairments** may be particularly sought out because of their impairment. Girls with intellectual or psychosocial disabilities can be forced into early marriage because it is believed that marriage helps to remove the stigma of disability or 'cure/improve' their disability,¹² or reduce the financial burden on the family.

Adolescence

As young girls with disabilities enter adolescence, their risk of experiencing sexual violence increases. **Harmful myths** make them an easy target. In East Africa, for example, some believe that having sex with a virgin girl or a girl with albinism may cure HIV/AIDS and other sexually transmitted infections, or that it brings luck and wealth. As **persons with disabilities are often perceived as asexual**, girls and young women with disabilities are presumed to be virgins and easy to target because of their disabilities, which may make it less likely that the violence will be

11 — UN POPULATION FUND (2018), "Young Persons with disabilities: Global Study on Ending Gender-Based Violence and Realising Sexual and Reproductive Health and Rights". https://www.unfpa.org/sites/default/files/pub-pdf/Final_Global_Study_English_3_Oct.pdf

12 — ISLAMIC RELIEF (2018), "Don't Force Me! A Policy Brief on Early and Forced Marriage".

13 — DEVANDAS AGUILAR, C. (2017), "Sexual and Reproductive Health and Rights of Girls and Young Women with Disabilities. UN Special Rapporteur on the rights of persons with disabilities". Presented at the 72nd session of the UN General Assembly.

reported or prosecuted.¹³ Adolescent girls with disabilities may be **excluded from peer networks and education, as well as asset-based programming activities**. Other harmful practices against girls and young women with disabilities are perceived as **legitimate medical care condoned by legislation**: forced sterilization to prevent unwanted pregnancies, coerced and invasive contraception to reduce the burden on families, and carers administering oral contraceptives, menstruation and sexual expression suppression, including through hysterectomies, to avoid having to manage menstruation, especially among adolescent girls with severe, multiple, or intellectual disabilities.¹⁴ The intersection of gender and disability bias makes it less likely that girls with disabilities in many developing countries **will receive school education beyond their early primary years, if at all**.¹⁵ This can be due to negative attitudes and a lack of inclusive education systems and accessible transportation. Without going to school, it **is less likely that they will receive sexual and reproductive health information to manage their menstruation, prevent sexually transmitted infections and unwanted pregnancies**, or make informed choices regarding their sexual and reproductive rights.¹⁶

Reproductive adulthood

Sexual reproductive and health rights violations continue for women with disabilities as they grow older. While all women are exposed to various forms of violence, those with disabilities are at further risk of violence that is unique and less detectable. It includes **refusal by caregivers to assist with daily living**, such as: bathing, dressing, eating; verbal abuse and ridiculing the disability; threats of harm to the person, or their pets/support animals; and forced administration or withholding of drugs and medication.¹⁷ Women with disabilities are often expected to tolerate non-consensual sex and sexually abusive behavior because of **misconceptions about their sexuality and their right not to be harmed**. Women with disabilities are often discouraged or **denied the opportunity to bear or raise children**. Parents with disabilities, especially mothers, are 10 times more likely to have their children removed from their care based on their disability rather than on the evidence of child neglect.¹⁸

Older Age

Disability tends to be an added risk factor for violence against older women, whether it is an acquired, age-related disability, or a lifelong disability. The **cumulative experience of violence throughout the life cycle** can have a negative effect on the physical and psychological health and well-being of women in old age.¹⁹

14 — FROHMADER, C. AND S. ORTOLEVA (2013), "The Sexual and Reproductive Rights of Women and Girls with Disabilities". Issues Paper. https://wwda.org.au/wp-content/uploads/2013/12/issues_paper_srr_women_and_girls_with_disabilities_final.pdf

15 — MALE, C. AND WODON, Q. (2017), GLOBAL PARTNERSHIP FOR EDUCATION AND THE WORLD BANK, "The Price of Exclusion: Disability and Education. Disability Gaps in Educational Attainment and Literacy." Global Partnership for Education and the World Bank.

16 — ANDRAE, K., ACTION ON DISABILITY AND DEVELOPMENT INTERNATIONAL (2017), "Disability and Gender-Based Violence – Peer Research in Kibaha and Mkuranga, Tanzania. https://add.org.uk/sites/default/files/Tanzania_GBV.pdf

17 — UN POPULATION FUND (2018), "Young Persons with disabilities: Global Study on Ending Gender-Based Violence and Realising Sexual and Reproductive Health and Rights". https://www.unfpa.org/sites/default/files/pub-pdf/Final_Global_Study_English_3_Oct.pdf

18 — FROHMADER, C. AND S. ORTOLEVA (2013) "The Sexual and Reproductive Rights of Women and Girls with Disabilities". Issues Paper. https://wwda.org.au/wp-content/uploads/2013/12/issues_paper_srr_women_and_girls_with_disabilities_final.pdf

19 — WORLD BANK GROUP, THE GLOBAL WOMEN'S INSTITUTE, INTER-AMERICAN DEVELOPMENT BANK, INTERNATIONAL CENTRE FOR RESEARCH ON WOMEN (2016), "Violence Against Women and Girls (VAWG) – Brief on Violence Against Older Women".

TIPS FOR GBV ACTORS:

- DO ensure that each case management entry point must be accessible; physical barriers to access can include lack of suitable transportation and accommodation options. This may mean providing additional services such as transport for those with disabilities and/or their caregivers.
- DO provide the opportunity for persons with disabilities to communicate with you without the presence of their caregiver if wished, and if this does not endanger or create tension in that relationship.
- DO, to the best of your ability, ask the survivor to choose someone they feel comfortable with to translate for and/or support them if needed.
- DO check communication requirements (interpreter/Braille/easy to read) and if a communication aid is needed.
- DO always talk directly to the survivor even when a caregiver is present.
- DO treat adults with disabilities as you would other adults, paying particular attention to gender issues.
- DO pay attention to the way in which the individual wishes to communicate. This could be through words, gestures, emotions, or in writing. It is okay, however, to say "I don't understand".
- DO plan extra time and adapt your communication style with survivors with communication or cognitive functional limitations
- DO watch for signs of agitation, anger or distress that may indicate that an individual is not happy to proceed at this time, and respect this, even when talking with the caregiver. Try to plan another session to see if they are more comfortable and want to continue.
- DO be sensitive to any negative language being used by family members or caregivers towards a person with a disability and rephrase statements in a positive language, as appropriate.
- DO NOT assume that the survivor has or does not have the capacity to provide informed consent; evaluate the best interests of the survivor as needed.
- Be aware: Women and girls with intellectual disabilities are particularly vulnerable to sexual violence. Those with intellectual, psychosocial or physical disabilities who are isolated in their homes all too often report rape and intimate partner violence. In addition, women and adolescent girls who disproportionately assume caregiving roles in households with persons with disabilities may be exposed to harassment and exploitation when seeking assistance or accessing income. Attitudes of families, GBV service providers and community members can be the biggest barriers or the greatest facilitators for persons with disabilities to access safe and effective services and assistance.

See GBV Disability Inclusion Toolkit for guidance to help identify potential communication methods and strategies that promote participation of the individual with disabilities: <https://www.womensrefugeecommission.org/wp-content/uploads/2020/04/GBV-Disability-Toolkit-English.pdf>

7. Diverse Religious and Ethnic Affiliations

Indigenous women, girls, men and boys, and ethnic and religious minorities, can be particularly vulnerable to social discrimination, exclusion and oppression. Some ethnicities are excluded from economic opportunities and

are at increased risk of trafficking, including sexual exploitation. This risk multiplies in a situation of displacement, especially for women and girls with diverse ethnic and religious affiliations.

Some individuals from certain religious or ethnic communities may be more socially isolated and may lack community protection compared with more dominant social groups, and may also lose their support networks when separated during or after displacement, which can be particularly harmful to those who have experienced GBV.

Women and girls may not be able to speak openly if interpreters are from a different community in the country of origin or country of refugee or asylum.

TIPS FOR GBV ACTORS:

- DO ensure that conditions are sufficiently secure for the survivor to feel comfortable about identifying themselves as members of an ethnic or religious group.
- DO acknowledge that women and girls may not be able to speak openly if interpreters are from a different community in the country of origin or country of refugee or asylum

8. Diverse Religious and Ethnic Affiliations

The phenomenon of violence against migrants and displaced populations has significantly increased over recent years, manifesting itself in forms such as physical violence, labor exploitation, trafficking, sexual harassment and abuse, discrimination and hate speech. Violence against migrants and a displaced population is also further exacerbated along gender, age and disability lines. Numerous studies²⁰ have highlighted the vulnerability of women and children in displacement settings, often based upon the premise that camps are spaces where political and power structures reinforce and strengthen the patriarchal tendencies of displaced communities. Persons with disabilities also represent a substantial subgroup among displaced populations. Young men travelling alone are also vulnerable to sexual violence.

Women and girls are likely to experience a continuum of gender-based violence **at all stages of migration**, from bullying and verbal, physical and psychological abuse, to sexual violence. In addition, those who are using irregular channels, face increased risk of becoming victims of people trafficking, especially for the purpose of sexual exploitation, as well as labor exploitation and domestic servitude.

Gender-based violence is committed by a variety of actors, including smugglers, human traffickers, the authorities (i.e. police and border guards), intimate partners or other migrants.

Migrant women are less likely to report cases of gender-based violence for fear of losing their job, partner or residency status. Migrant women whose residency status is dependent on their partners are at high risk of intimate partner violence and domestic violence, and do not report such incidents for fear of deportation.

20 — FIDDIAN-QASMIYEH, ELENA (2014)), "Gender and Forced Migration". https://www.researchgate.net/publication/281062228_Gender_and_Forced_Migration ; MIXED MIGRATION REVIEW (2018), "Women on the Move – Drivers, Choices and Risks".

The COVID-19 pandemic has exacerbated women's risk of gender-based violence at all stages of migration, particularly those with irregular migration status or those who are sexual and gender minorities, who are least likely to report violence due to discrimination or fear of arrest or deportation.

TIPS FOR GBV ACTORS:

- DO ensure that language interpreters (trained on GBV survivor guiding principles) are available to support survivors speaking different languages/IEC material available in different languages
- DO ensure that your service is available regardless of migration status and/or presence of civil documentation
- DO offer services on a variety of days, at different times and in various locations, including virtually via helplines and apps, to make it easier for survivors on the move to take up the service delivery
- DO prioritize safety and security, and information. Information about service provision should never be passed on to immigration enforcement actors

9. Diverse Religious and Ethnic Affiliations

Women and child heads of household can be particularly vulnerable to sexual assault, sexual exploitation and survival sex, child and forced marriage, and denial of rights to housing and property. Increased domestic responsibilities that keep them isolated in the home, dependence on exploitative or unhealthy relationships for basic needs, engagement in unsafe livelihood activities can be key risk factors.

10. Diverse Religious and Ethnic Affiliations

Women and child heads of household can be particularly vulnerable to sexual assault, sexual exploitation and survival sex, child and forced marriage, and denial of rights to housing and property. Increased domestic responsibilities that keep them isolated in the home, dependence on exploitative or unhealthy relationships for basic needs, engagement in unsafe livelihood activities can be key risk factors.

TIPS FOR GBV ACTORS:

- Educate your team about HIV: what it is, how it is, and is not, transmitted, how it is treated, and how people can stay healthy with HIV. But also about the intersection between GBV and STIs.
- Know your country's specific laws regarding partner notification. If it is learnt that a partner may be experiencing GBV, this information is crucial for protecting the partner from the risk of violence related to HIV-partner notification. Partner notification can be deferred if there is a risk of behavior toward the HIV-infected individual which may affect their physical health and safety, their children, or someone who is close to them or to a partner/contact.
- If a GBV survivor has a positive test result, discuss strategies to promote safety around partner HIV notification.
- Don't ask a survivor about their HIV status. If someone has disclosed their HIV status to you, thank them for trusting you with their private health information. If appropriate, ask if there's anything that you can do to help them. One reason they may have chosen to disclose their status to you is that they need an ally

or advocate, or they may need help with a particular issue or challenge. Some people are public with this information, other people keep it very private. Ask whether other people know this information, and how private they are about their HIV status.

- Let the person know, through your words or actions, that their HIV status does not change your relationship and that you will keep this information private if they want you to. When supporting referral, don't share information about the HIV status of a survivor without their informed consent.
- Ensure that GBV services, such as shelters, accept survivors living with HIV .
- Before implementing an intervention targeting a survivor living with HIV, ask yourself how it can increase/decrease their safety.

Systems of oppression and discrimination

SYSTEM OF OPPRESSION	MEANING
Ableism	Refers to prejudice or discrimination towards people who have physical, mental, or cognitive disabilities, i.e. persons with disabilities, older people, etc.
Ageism	Refers to prejudice or discrimination against a particular age group. i.e. young people, older people, etc.
Classism	Refers to prejudiced beliefs and or behaviors towards groups of people sharing similar social positions and certain economic, political and cultural characteristics, i.e. upper and upper-middle class.
Colorism	Refers to the prejudicial practice of giving unfair preferential treatment to those who are light, pale.
Colonialism	Refers to the prejudicial practice of domination of people or area.
Elitism	Refers to the belief that society or systems should be controlled by the elite.
Ethnocentrism	Refers to the belief where people judge other groups as inferior to one's own.
Heterosexism	Heterosexism is a system of attitudes, bias, and discrimination in favor of female–male sexuality and relationships. It can include the presumption that female–male attractions and relationships are the only norm and therefore superior.
Favoritism	Refers to the practice of giving unfair preferential treatment to one person or group at the expense of another.
Genderism	Refers to the practice of giving unfair preferential treatment to males and masculine people over females and feminine people.
Homophobia	Negative attitudes and beliefs about, aversion to, or prejudice towards homosexual individuals that may be expressed at the individual, cultural and institutional level.
Racism	Refers to the belief that races have distinctive cultural characteristics determined by hereditary factors that gives certain races an intrinsic superiority over others.
Religious discrimination	Refers to discrimination towards people based on their religious beliefs and practices.
Sexism	Refers to the oppression of women where there is an enforced belief in male dominance and control.
Tribalism	Discriminatory behavior or attitudes towards out-groups, based on in-group loyalty.

Where to go next in the toolkit:

This tip sheet can be paired with the following tools/materials:

- Staff Bias tools
- Analysis Tools
- Action Tools
- Intersectionality in GBV Video
- Unconscious or Implicit Bias Video

PROGRAMMING TOOL 4:

SERVICE GAP ANALYSIS

Part A: Guidelines for Conducting Service Gap Analysis and Planning

Theme: Analysis

Phase of GBV program cycle: Referral

This tool provides an intersectional lens in identifying organizational capacity gaps when working with diverse groups. This tool is supplementary to the **GBVIMS Service Gap Analysis and Planning Tool**. For further information see the GBVIMS tools:

<https://www.gbvims.com>

This tool should be accompanied by the document '**Intersectionality Tipsheet - Tips for Working with GBV Survivors from an Intersectional Lens**', which can be found in this toolkit.

WHO

This tool is designed to be used amongst actors providing GBV services to identify capacities, availability, and willingness to adapt their service to target diverse groups with specific needs. Actors using this tool should take into consideration their capacities as well as their limitations, their strategic stand within the GBV response of the context where they work, and the needs and wishes of their beneficiaries.

This tool can be facilitated by a GBV/Inclusion specialist in coordination and collaboration with a GBV specialized actor and/or GBV cluster leads with implementing partners or with referral partner staff, or internally by organizations who are engaging in the self-assessment of capacities.

PURPOSE

This tool can be used to identify capacity gaps in GBV service providers preventing GBV survivors with diverse identities from receiving quality care, and to develop an action plan to address these gaps, and to ensure that services are inclusive and leave no one behind. The tool can also be used for organizational self-assessment.

THIS TOOL HAS THREE PARTS:

Part A provides instructions on how to identify critical capacity gaps of actors delivering GBV services to survivors with diversity identities and to develop an action plan to address them.

Part B is a checklist of minimum standards which allows gaps to be identified in the service provided to groups affected by inequality and discrimination. It can also be used to measure progress in addressing gaps once an action plan has been implemented. It can also be used as a quality monitoring tool to ensure that services are implemented according to good-practice standards when serving diverse survivors.

Part C is a template to document the action plan, detailing how the gaps will be addressed and by whom.



How to Administer

Part A: Steps in Addressing Gaps in Service Provision to Diverse Groups

STEP 1

After identifying relevant organizations using the Quadrant – Mapping Diverse Actors Tool found in this toolkit, it is now time to work with these organizations to identify capacity gaps in the service and to develop an action plan to address them.

- Organize a workshop with organizations and services providing services to GBV survivors. This exercise should be led by GBV coordination systems and/or GBV specialized services in collaboration with the implementing actors providing services to GBV survivors and referral actors. In the context where non-specialized GBV actors encounter GBV survivors through their work, it would be ideal to include them in this exercise.
- Invite diverse organizations and actors providing services to GBV survivors, but also include rights groups, women-led organizations, organizations of persons with disabilities (DPOs), community-based organizations (CBOs), and other actors that may be involved in referral, to identify and address critical capacity gaps in services being provided to survivors with intersecting identities.
- Alternatively, if this tool is to be used

by an organization for self-assessment purposes, organize an internal working group to carry out the assessment and action-plan development.

- Section 1 allows organizations to identify their capacity for safe programming when working with vulnerable population and at-risk groups. Section 2 allows organizations to identify strengths and gaps in service provision to groups affected by inequality and discrimination who might be at a greater risk of GBV. It is not necessary that all organizations meet all the standards.

STEP 2

Using the Quality Checklist from Part B, identify where each service provider is at in relation to each standard

- During the workshop, form working groups.
- Have each group review the list of standards as set out in Part B: Quality Checklist for Working with Groups Affected by Inequality and Discrimination and discuss where each organization is at in relation to which standard.
- Fill in the table following the sub-heading of each column. Not all the organizations need to have the goal of meeting all the minimum standards. It is possible that an organization is not meeting certain standards because some organizations are better placed at providing some specific

services, or simply because strategically, their programmatic priorities are elsewhere. This does not mean that the organization is not qualified to provide services to those groups for which the standards are being met. At the same time, some survivors may prefer services targeting specific groups instead of services that serve general groups.

- When this exercise has been completed for all service providers, write the recommendations in Part C: Action Plan & Monitoring. You now have a list of the critical capacity gaps to be addressed to ensure diverse survivors of GBV receive a minimum standard of care and support in service delivery.

STEP 3

Develop a plan for addressing each gap within each service provider, and together as a collective.

- Have each working group review and discuss every standard on the list and identify strategies for addressing gaps in services.
- Ask the group to document which gaps and actions are high priority, what the solutions are, who is responsible for them, and the timeframe.
- You may not be able to identify all the solutions for all the gaps in one workshop. You may need to consult with others before finalising the action plan.

STEP 4

Document, implement and review the action plan for addressing capacity gaps.

- Using Part C: Action Plan & Monitoring for Addressing Critical Gaps in GBV Programs When Working with Groups Affected by Inequality and Discrimination, document the action plan and distribute it to all relevant stakeholders.
- Start implementing the action plan.
- Organize a review meeting to follow up on progress in implementing the plan and make adjustments as needed. You can use Part B: Quality Checklist again to review and monitor progress towards addressing gaps.

Where to go next in the toolkit

- This tool can also be used with **Quadrant - Mapping Diverse Actors Tool** to identify implementing or referral partners.
- This tool is paired with **Part B – Quality Checklist & Part C - Action Plan & Monitoring tools**, which should be used by facilitators to have discussions with implementing partners or referral partners, or internally within organizations, on identifying strengths and gaps in services that prevent diverse survivors of GBV from receiving minimum standard care, and to develop a plan to address these gaps.
- The Gap Analysis Tools can be used to identify which organizations may appear in the referral systems, as in current capacity to provide quality care for specific groups. Refer to the **Developing an Inclusive Referral System for GBV Survivors**, within this Toolkit



Risk Mitig2
- Policy
- structuraly
- police
- women affe

Awareness
creation

Conducting
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- Safety audit
- Assessments

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OSG
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- Medically R
- Referral

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& report it
back

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- CME, Nutrition
livelihood

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provided by the
GORDS to
help the victim
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- Referral
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GBV services
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REFERRAL

PROGRAMMING TOOL 4:

SERVICE GAP ANALYSIS

Part B: Quality Checklist for Working with Groups Affected by Inequality and Discrimination

Theme: Analysis

Phase of GBV program cycle: Referral

This tool provides an intersectional lens in identifying organizational capacity gaps when working with diverse groups. This tool is supplementary to the **GBVIMS Service Gap Analysis and Planning Tool**. For further information see the GBVIMS tools: <https://www.gbvims.com>

This tool should be accompanied by the document 'Intersectionality Tipsheet -Tips for Working with GBV Survivors from an Intersectional Lens', which can be found in this toolkit.

WHO

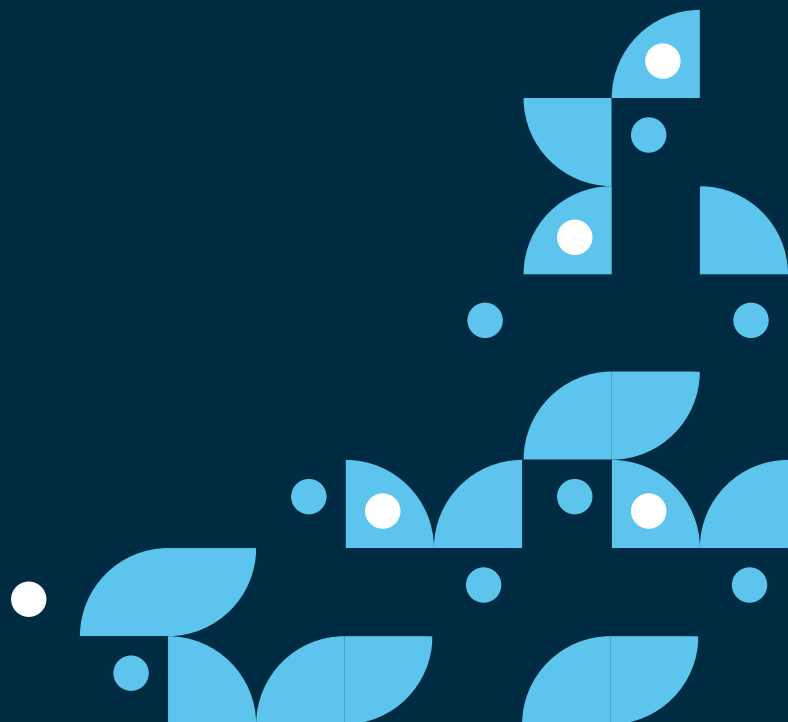
This tool is designed to be used amongst actors providing GBV services to identify capacities, availability and willingness to adapt their service to target diverse groups with specific needs. Actors using this tool should take into consideration their capacities as well as their limitations, their strategic stand within the GBV response of the context where they work, and the needs and wishes of their beneficiaries.

This tool can be facilitated by a GBV/Inclusion specialist in coordination and collaboration with a GBV specialized actor and/or GBV cluster leads with implementing partners or with referral partner staff, or internally by organizations who are engaging in the self-assessment of capacities.

PURPOSE

This tool can be used to identify capacity gaps in GBV service providers preventing GBV survivors with diverse identities from receiving quality care, and to develop an action plan to address these gaps, and to ensure that services are inclusive and leave no one behind.

This tool is not meant to evaluate GBV programs or to encourage actors to work with groups they are not prepared to work with; instead, it is meant to identify programmatic strengths and/or gaps in service providers providing GBV services to diverse groups at greater risk of GBV. This tool could also be used to identify areas of expertise that need to improve within organizations wishing to serve additional groups of persons with diverse intersecting identities.



1. General safe programming

minimum standards for working with vulnerable groups

	YES	NO	WORKING TOWARDS IT	EXPLAIN WHY NOT
Service provider has protection policies in place that ensure that the rights of individuals are respected				
Service provider has guidelines/protocols/SOPs in place that operationalize the protection policies of the organization				
All staff and volunteers are trained, they understand and can discuss the organization's protection policies				
Staff and volunteers put into practice and mainstream, throughout their work, their organization's protection policies				
The service provider has a Code of Conduct that defines the grounds for misconduct				
Service provider has gender equality policies that look after the rights of women to equal opportunities				
Service provider has a child safeguarding policy and policies that look after the rights of children				
Service provider has a policy on protection against sexual exploitation and abuse and has reporting mechanisms in place				
Service provider has whistleblowing – or internal reporting – mechanisms in place that protects both the victim and the reporting person				
Service provider has data protection policies/protocols/SOPs that ensure sensitive data are protected when collected, stored, and shared				

1. General safe programming

minimum standards for working with vulnerable groups (Continued)

	YES	NO	WORKING TOWARDS IT	EXPLAIN WHY NOT
All staff and volunteers are trained, can understand and can discuss the organization's safeguarding policies				
All staff and volunteers are trained on informed consent and confidentiality				
Service provider can discuss with clients the bounds of confidentiality and which information collected is for internal use only and what can be shared, and with whom.				
Field staff/volunteers are trained on the basics of psychological first aid				
Field staff/volunteers are trained on the survivor-centered approach				
Staff/volunteers are trained on intersectionality, including working with groups affected by inequality and discrimination				
Trained field staff/volunteers know how to provide information and make referrals for protection, safety, health services and psychosocial support within the bounds of client confidentiality				
Trained staff/volunteers are able to provide basic crisis support to individuals and families (e.g. emergency food support or access to crisis accommodation where appropriate).				
Staff/volunteers dealing with child survivors are trained in and put into practice the Guiding Principles for Working with Child Survivors				

1. General safe programming

minimum standards for working with vulnerable groups (Continued)

	YES	NO	WORKING TOWARDS IT	EXPLAIN WHY NOT
Survivors, regardless of gender, age, sexual orientation, religious beliefs, or other identity factors are treated with respect and dignity and receive the same level of service quality				
Services can be accessed without payment or specific documentation that survivors may not have				

RECOMMENDATIONS:

If any of the above statements was answered as <No>, please provide practical recommendation on how the organization will meet ALL the standards.

Answering <YES> to all the questions in this section should be the basis of ensuring safe programming when working with people affected by inequality and discrimination.

COMMENTS & RECOMMENDATIONS (TO BE ADDRESSED IN PART C: ACTION PLAN):

2. GBV safe programming

Minimum Standards for working with groups affected by inequality and discrimination and persons at greater risk of GBV

2.1 WOMEN, MEN, ADOLESCENTS, BOYS AND GIRLS	YES	NO	PLANNING, BUT DOES NOT YET MEET THE STANDARD	DOES NOT APPLY	EXPLAIN WHY NOT / ADDITIONAL COMMENTS
Trained female staff are available so that the survivor can choose to meet with a female care provider					
Women and girls with disabilities have full access to GBV services with or without the presence of a caregiver					
Staff attitudes and biases towards adolescent girls and young women are assessed prior to engaging with survivors, are discussed with staff, and are monitored regularly					
Service providers work under and promote the best interests of the child					
Adolescents can consent to receiving GBV services without the presence of their legal guardian					
Staff are trained on providing services to men and adolescent boy survivors of GBV including survivors of sexual violence					
Staff dealing with child survivors are trained in and put into practice the Guiding Principles for Working with Child Survivors					

RECOMMENDATIONS:

If any of the above statements was answered as <No>, please provide practical recommendation on how the organization will meet ALL the standards.

Answering <YES> to all the questions in sections 1 and 2.1, can help you ensure your program takes into consideration the needs of women and girl survivors of GBV

COMMENTS & RECOMMENDATIONS (TO BE ADDRESSED IN PART C: ACTION PLAN):

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2.2 LGBTQIA+ PERSONS			PLANNING, BUT DOES NOT YET MEET THE STANDARD	DOES NOT APPLY	EXPLAIN WHY NOT / ADDITIONAL COMMENTS
	YES	NO			
Survivors can choose to meet with trained male or female care providers					
Service provider has policies/ protocols that specifically protect the rights of LGBTQIA+ survivors					
Child protection policies in place should specifically protect the rights of LGBTQIA+ children					
LGBTQIA+ persons with disabilities, survivors of GBV, can access information and services that prioritize providing them with a timely GBV response over assumed barriers due to their disability					
LGBTQIA+ persons with disabilities have safe access to support services, both prevention and response, for GBV					
Service provider discusses with clients protection policies that may be in disagreement with national obligations of mandatory reporting, as well as risks associated with referrals, wherever the survivor may be subject to arrest or detention based on their gender identity and sexual orientation					
[Especially in contexts where there are national obligations of mandatory reporting, the organization must do its best to protect the best interest of the client and explain the policy before engaging with the survivor, and before they disclose the event, their sexual orientation and/or gender identity]					

2.2 LGBTQIA+ PERSONS (CONTINUED)			PLANNING, BUT DOES NOT YET MEET THE STANDARD	DOES NOT APPLY	EXPLAIN WHY NOT / ADDITIONAL COMMENTS
	YES	NO			
Any services provided are available to people of diverse gender identities (including gender neutral, gender fluid, binary and non-binary)					
Any services provided are available to survivors of all sexual orientations					
Staff attitudes and unconscious biases towards LGBTQIA+ survivors are assessed prior to engaging with survivors, are discussed with the staff, and are monitored regularly					
Service provider links up with rights activists, diversity networks, LGBTQIA+ rights advocates and allies, to inform their program to ensure GBV response is well informed and comprehensive and to connect survivors					

RECOMMENDATIONS:

If any of the above statements was answered as <No>, please provide practical recommendation on how the organization will meet ALL the standards.

Answering <YES> to all the questions in section 1, 2.1, and 2.2 should be a priority for organizations wishing to work with or those who are already engaging with LGBTQIA+ persons

COMMENTS & RECOMMENDATIONS (TO BE ADDRESSED IN PART C: ACTION PLAN):

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**2.3 PERSONS WITH
FUNCTIONAL LIMITATIONS,
PERSONS WITH DISABILITIES,
AND OLDER PERSONS**

	YES	NO	PLANNING, BUT DOES NOT YET MEET THE STANDARD	DOES NOT APPLY	EXPLAIN WHY NOT / ADDITIONAL COMMENTS
Physical location of GBV services for survivors is accessible and appropriate					
Barriers that limit access to GBV services for individuals with physical functional limitations and mobility impairments are identified and addressed through reasonable accommodations					
Barriers that limit access to GBV services for individuals with sensory impairments (vision impairments, hearing impairments, speech, and language impairments, etc.) are identified and addressed through reasonable accommodations					
Information on GBV services is available in alternative formats, as much as possible and as long as it is safe to survivors without exposing them to further harm, to account for diverse abilities (e.g. written and audio material, use of appropriate font size and font color, simple messaging, use of pictograms, use of sign language interpretation in main and local languages when needed, etc.).					
GBV Staff have been trained on disability-inclusion and working with persons with disabilities and functional limitations (you can refer to <Additional Resources> at the bottom of this tool for training resources)					
Children with disabilities have access to support services with trained personnel aware of working under the best interest of the child, regardless of their disability					

**2.3 PERSONS WITH
FUNCTIONAL LIMITATIONS,
PERSONS WITH DISABILITIES,
AND OLDER PERSONS
(CONTINUED)**

	YES	NO	PLANNING, BUT DOES NOT YET MEET THE STANDARD	DOES NOT APPLY	EXPLAIN WHY NOT / ADDITIONAL COMMENTS
Staff attitudes and biases towards persons with disabilities and older persons are assessed prior to engaging with survivors, are discussed with the staff, and are monitored regularly, avoiding making assumptions on the sexual and reproductive health of persons with disabilities or older people					
Women and girls with disabilities, survivors of GBV, are consulted (when possible, without their caregiver) and participate in the decisions affecting their sexual and reproductive health					
Services provide reasonable accommodation to survivors with sensory impairment					
Services provide reasonable accommodation to survivors with psychosocial impairment					
Services provide reasonable accommodation to survivors with intellectual impairment					

RECOMMENDATIONS:

If any of the above statements was answered as <No>, please provide practical recommendation on how the organization will meet ALL the standards.

Answering <YES> to all the questions in section 1, 2.1, and 2.2 should be a priority for organizations wishing to work with or those who are already engaging with LGBTQIA+ persons

COMMENTS & RECOMMENDATIONS (TO BE ADDRESSED IN PART C: ACTION PLAN):

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2.4 PERSONS WITH OTHER IDENTITY FACTORS			PLANNING, BUT DOES NOT YET MEET THE STANDARD	DOES NOT APPLY	EXPLAIN WHY NOT / ADDITIONAL COMMENTS
	YES	NO			
GBV services can reasonably accommodate the specific needs of survivors based on their ethnic, cultural or religious backgrounds					
The GBV service provider discusses with clients' protection policies that may be in disagreement with national obligations of mandatory reporting, as well as risks associated with referrals, wherever the survivor may be subject to arrest or detention based on their legal status [Especially in contexts where there are national obligations of mandatory reporting, the organization must do its best to protect the best interest of the client, and explain the policy before engaging with the survivor or collecting any information]					
Service provider discusses with clients' protection policies that may be in disagreement with national obligations of mandatory reporting, as well as risks associated with referrals, wherever the survivor may be subject to arrest or detention based on any other identity factor, prior to engaging with the survivor and collecting information.					
Interpreters and translators in local languages are trained on GBV, GBV guiding principles, and the area available to GBV survivors who do not speak the same language as staff/ volunteers					

2.4 PERSONS WITH OTHER IDENTITY FACTORS (CONTINUED)

YES NO PLANNING, BUT
DOES NOT YET MEET
THE STANDARD

DOES NOT APPLY

EXPLAIN WHY
NOT / ADDITIONAL
COMMENTS

Traditional and cultural healing practices that survivors perceive as helpful are promoted and not disregarded as negative, on condition that they promote the human rights of survivors and the best interest of the survivors					
Community outreach and education on stigma and discrimination is delivered as part of the programme					
Any provided services are available to survivors with other diverse identity factors (if applicable, please explain in the Comments box)					

RECOMMENDATIONS:

If any of the above statements was answered as <No>, please provide practical recommendation on how the organization will meet ALL the standards.

Answering <YES> to all the questions in this section will ensure services take into consideration other intersecting identity factors.

GENERAL RECOMMENDATIONS FOR SERVICE PROVIDERS:

Answering <YES> to all the questions in sections 1 and 2 ensures GBV response programs take into consideration the needs of persons with intersecting identities survivors of GBV, to ensure that no one is left behind.

COMMENTS & RECOMMENDATIONS (TO BE ADDRESSED IN PART C: ACTION PLAN):

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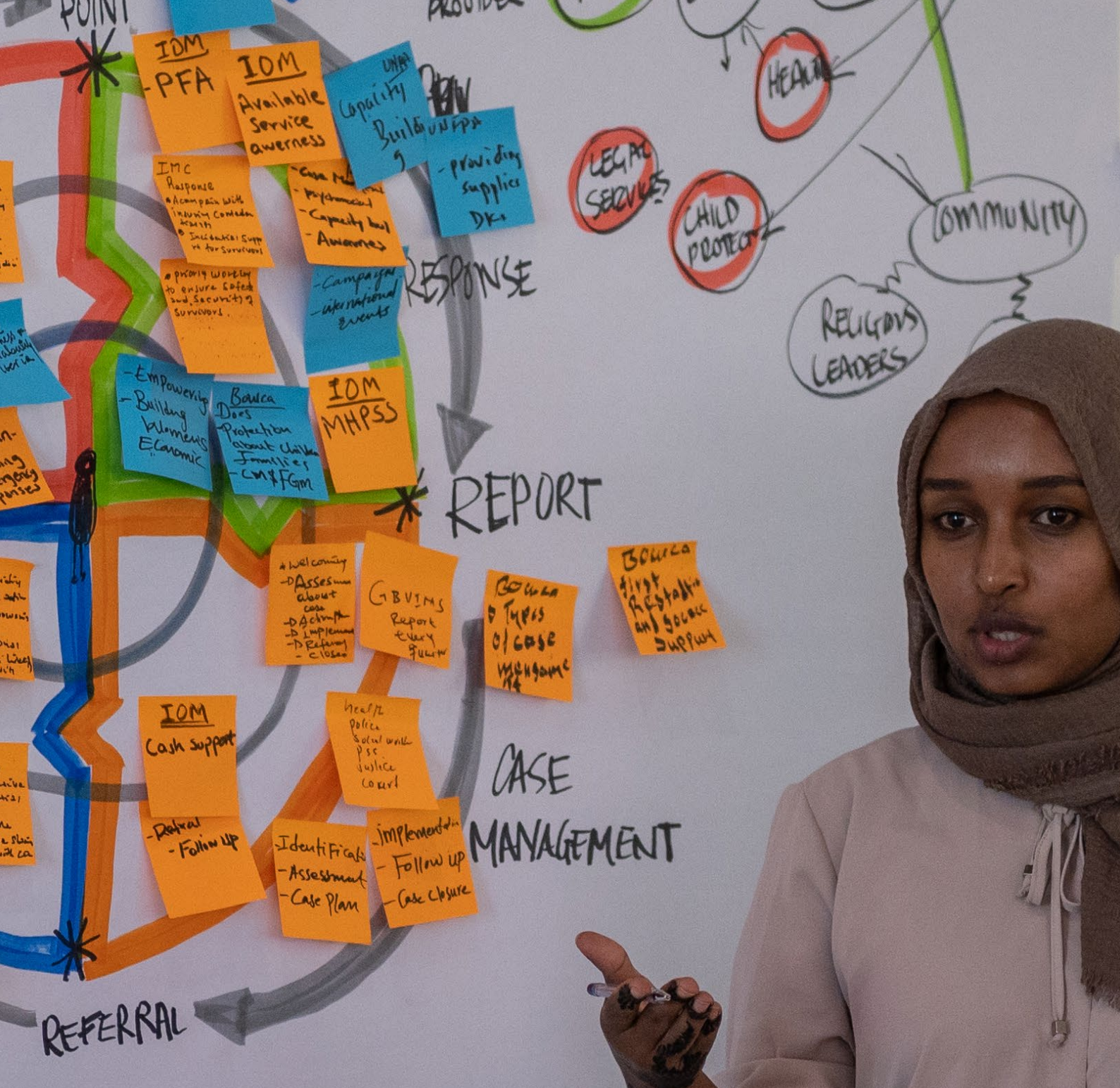
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External resources to support this tool

Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings: Tool 6: Guidance on communicating with persons with disabilities.
<https://www.womensrefugeecommission.org/wp-content/uploads/2020/04/Disability-Inclusion-in-GBV-Tools-Overview.pdf>

Where to go next in the toolkit

This tool is paired with Part A - Guidelines for Conducting Service Gap Analysis and Planning and Part C – Action Plan & Monitoring, especially the steps listed in Part A on how to complete Part B. Please use Part B after Part A is completed. Part B can also be used after Part C to review and monitor progress towards addressing gaps.

PROGRAMMING TOOL 4:

SERVICE GAP ANALYSIS

Part C: Action Plan & Monitoring for Addressing Critical Gaps in GBV Programs When Working with Groups Affected by Inequality and Discrimination

Theme: Analysis

Phase of GBV program cycle: Referral

This tool provides an intersectional lens in identifying organizational capacity gaps when working with diverse groups. This tool is supplementary to the **GBVIMS Service Gap Analysis and Planning Tool**. For further information see the GBVIMS tools: <https://www.gbvims.com>

This tool should be accompanied by the document 'Intersectionality Tipsheet - Tips for Working with GBV Survivors from an Intersectional Lens', which can be found in this toolkit.

WHO

This tool is designed to be used amongst actors providing GBV services who have completed Part B: Quality Checklist for Working with Groups Affected by Inequality and Discrimination (found in this Toolkit). Actors using this tool should take into consideration their capacities as well as their limitations, their

strategic stand within the GBV response of the context where they work, and the needs and wishes of their beneficiaries.

This tool can be facilitated by a GBV/Inclusion specialist in coordination and collaboration with a GBV specialized actor and/or GBV cluster leads with implementing partners or with referral partner staff or internally by organizations who are engaging in self-assessment of capacities.

PURPOSE

This tool can be used to develop an action plan to address capacity gaps in GBV service providers preventing GBV survivors with diverse identities from receiving quality care and to monitor progress to ensure that services are inclusive and leave no one behind. Please refer to Part B: Quality Checklist for Working with Groups Affected by Inequality and Discrimination (found in this Toolkit).

How to Administer

After you have reviewed the checklist in Part B: Quality Checklist for Working with Groups Affected by Inequality and Discrimination, you can work with stakeholders to identify gaps, and plan ways to address them to ensure GBV programs are inclusive of people affected by inequality and discrimination who are at greater risk of GBV. It will not likely be possible to address all the gaps and fix all the problems immediately, but this tool will help you to work with stakeholders to prioritize and develop a plan:

- Refer to the table below; one table per organization. Utilize as many tables as there are organizations.
- Refer to Part B, recommendations sections, and list the Gaps Identified from each criteria per organization
- Discuss as a group which actions and actions are high, medium or low priority, what the solutions are, who is responsible for them, the timeframe and progress review date.
- Strategies for addressing gaps might include:
 - capacity building for service providers, such as training on intersectionality or disability-inclusion
 - developing solutions to adapt existing resources and,
 - identify level of current and future risks the survivor of GBV may be exposed
- Fix a Review date where progress will be reviewed.
- The orange section of the table is to be completed during the Review meeting. 'Not achieved' action points should then be transposed to a new table as 'High' priority.

It will not likely be possible to address all the gaps and fix all the problems immediately, but this tool will help you to work with stakeholders to prioritize and develop a plan.



Part C: Action Plan and Monitoring Tool

 RESPONSIBLE (ORGANIZATION'S NAME, PERSON (TITLE AND CONTACT INFORMATION)):				DATE:	
PRIORITY [HIGH, MEDIUM, LOW]	GAP IDENTIFIED	STRATEGY/ ACTION FOR ADDRESSING THE GAP	TIMEFRAME	PROGRESS REVIEW DATE*	
PROGRESS REVIEW MEETING			DATE*:		
ACHIEVED:					
Not achieved: (after review meeting, please enter here points of action that need to be carried over next quarter)					

 RESPONSIBLE (ORGANIZATION'S NAME, PERSON (TITLE AND CONTACT INFORMATION)):				DATE:	
PRIORITY [HIGH, MEDIUM, LOW]	GAP IDENTIFIED	STRATEGY/ ACTION FOR ADDRESSING THE GAP	TIMEFRAME	PROGRESS REVIEW DATE*	
PROGRESS REVIEW MEETING			DATE*:		
ACHIEVED:					
Not achieved: (after review meeting, please enter here points of action that need to be carried over next quarter)					

Part C: Action Plan and Monitoring Tool

		RESPONSIBLE (ORGANIZATION'S NAME, PERSON (TITLE AND CONTACT INFORMATION):		DATE:
PRIORITY [HIGH, MEDIUM, LOW]	GAP IDENTIFIED	STRATEGY/ ACTION FOR ADDRESSING THE GAP	TIMEFRAME	PROGRESS REVIEW DATE*
PROGRESS REVIEW MEETING			DATE*:	
ACHIEVED:				
Not achieved: (after review meeting, please enter here points of action that need to be carried over next quarter)				

Where to go next in the toolkit

This tool is paired with **Part A - Guidelines for Conducting Service Gap Analysis and Planning** and **Part B - Quality Checklist for Working with Groups Affected by Inequality and Discrimination**, especially the steps listed under Part A on how to complete Part C. Please use Part C after Part A and Part B are completed.

The Gap Analysis Tools can be used to identify which organizations may appear in the referral systems, as in current capacity to provide quality care for specific groups. Refer to the **Developing an Inclusive Referral System for GBV Survivors**, found in this Toolkit.

Developing an Inclusive Referral System for GBV Survivors

Theme: Analysis

WHO

This tool is primarily targeting GBV actors/ coordination systems in charge of developing a GBV Interagency SOP and referral system.

PURPOSE

Currently, most referral systems do not take survivors in all their diversity into consideration. With this tool we will provide practical tips on how to take intersectionality into account when developing/using a referral system. It will support actors to establish, promote, or follow referral mechanisms and standard operating procedures that support survivors with diverse profiles in their access to services.

What could be an inclusive referral system?

The success of providing services to survivors will largely depend on the **information, resources and referrals** you can provide for people. This requires continuous coordination at local, national, and transnational level – including national authorities and civil society organizations – to update service mapping and protocols dictating how survivors can be referred across service providers.

A referral system is a flexible mechanism that safely links survivors to supportive and competent systems of care, such as medical care, mental health and psychosocial services, police assistance, and legal and justice support. When we provide services, we often notice that some groups are not accessing our services even if we know that they are disproportionately affected by GBV, such as women and girls with

disabilities or transwomen. In order that no survivor is left behind there is a need for more inclusive referral systems taking into account the specific needs of the survivor.

This inclusive referral system should rely on the following guiding principles:

Non-discrimination Principles

Adhering to the non-discrimination principle means **ensuring that survivors in all their diversity are not discriminated against** (treated poorly or denied services) because of their individual characteristics or a group they belong to (e.g. gender, age, socio-economic background, race, religion, ethnicity, disability, sexual orientation or gender identity).

Survivors in need of protective services should receive assistance from agencies and caseworkers who are trained and skilled to form respectful, non-discriminatory relationships with them, treating them with compassion, empathy and care. **Case-management staff must actively work to be non-judgmental and avoid negative/judgmental language in their work.** Whether engaged in awareness raising, prevention or response activities, agencies and caseworkers should challenge discrimination, including policies and practices that reinforce discrimination.

- **DO** use the ATTITUDE BIAS exercise with caseworkers, organize awareness-raising activities, provide training on topics such as: persons with disabilities, people with diverse SOGIESC, male survivors, people living with HIV etc.
- **DO** develop internal policies and practices that protect the rights of groups affected by inequality and discrimination

Confidentiality

Confidentiality is linked to sharing information on a need-to-know basis. The term ‘need to-know’ describes the limiting of information that is considered sensitive and sharing it only with those individuals who require the information in order to protect the survivor. **Any sensitive and identifying information collected on survivors, and especially information such as sexual orientation, HIV status and legal status, should only be shared on a need-to-know basis with as few individuals as possible.**

Respecting confidentiality requires service providers to protect information gathered about clients and to ensure it is accessible only with a client’s explicit permission. **In some situations, even collecting data through an intake form is not appropriate, as it can put the survivor and/or the agency at risk if there is a breach.** For extra-sensitive data, such as ethnic minority and/or sexual orientation, information should be coded. For agencies and caseworkers involved in case management, it means collecting, keeping, sharing and storing information on individual cases in a safe way and according to agreed-upon data protection policies. Workers should not reveal the survivor’s name or any identifying information to anyone not directly involved in the care of the survivor. This means taking special care in securing case files and documents and avoiding informal conversations with colleagues who may be naturally curious and interested in the work.

- **DO** use codes when collecting extra-sensitive data

Observe Mandatory Reporting Laws and Policies

Many countries have mandatory reporting requirements, which oblige certain actors (such as child protection agencies and staff, teachers, nurses and doctors) **to report cases of child abuse, intimate partner violence (IPV), same-sex relationships and sexual violence to the relevant government authorities.** However, these requirements can be challenging for caseworkers when the information is of such a sensitive nature that it cannot be shared with other actors without placing the survivor at risk of further harm.

This is of particular concern when data-protection protocols are not in place or are not strictly followed. In humanitarian settings, where there is concern about the safety and security of those involved, it is good practice to deal with reporting decisions on a case-by-case basis, informed by the local standards and practices applicable in the country of operation, and always guided by the best interests of the survivor.

- DO train caseworkers on mandatory reporting laws through case studies
- DO develop Internal Guidelines for Specific Cases
- DO exchange with other NGOs, human rights activists on how to deal with mandatory reporting laws in order ALWAYS to ensure the best interests of the survivor.

Main component of an inclusive referral system

A functional GBV referral system that is accessible and safe for ALL survivors includes the following elements:

- At least **one service provider for health, psychosocial support, case management, safety and security** and as appropriate and feasible, legal aid and other support, in a given geographical area.

Tips:

Important to check if these service providers have the capacity and/or willingness /in favor to receive survivors such as men, people with diverse SOGIESC, persons with disabilities, undocumented people etc.

- **Referral pathways that identify all available services, which are regularly updated and in various formats** that can easily be understood (e.g. through pictures/diagrams, audio/video). Supports and services should be listed with details of specific contacts for referrals and information about who can access the service and how. (See example below.)

Tips:

Organize consultations with different groups of people in order to see if the format is well adapted and understood (women with different types of impairment, girls and adolescents etc.). Consider having referral pathways translated into different languages.

- A referral pathway that is **known by community members and representatives of human rights organizations, OPDs, Youth Associations**, etc. Survivors from groups affected by inequality and discrimination may prefer to disclose to a friend/peer/CSO as they may fear being stigmatized and/or discriminated against by GBV actors.

Tips:

Organize awareness activities on GBV risks for groups affected by inequality and discrimination and train these actors on first-line support for GBV survivors and safe referral.

- **Safe and ethical GBV data collection and sharing agreement, including standardized intake and referral forms.**

Tips:

Discuss with other agencies if it is appropriate/useful (for advocacy or service-improvement purposes) to collect data on identity factors such as gender non-conforming data, ethnicity/religion, disability.

- GBV guiding principles that outline how services should be delivered, including provisions for respecting the best interests of survivors.

Tips:

It may have a specific mention on how to ensure the best interests of specific groups, such as children, persons with disabilities, people with diverse SOGIESC, sex workers etc.

- **Clear guidelines for transferring case-management responsibilities between** agencies targeting specific groups, e.g. CP actors transferring CM responsibilities to GBV actors to follow the case of a child survivor of violence.
- Guidance on **how service providers can refer survivors for additional services**, and how to do so safely, confidentially and ethically.

Tips:

Include Non-GBV services that could support survivors with specific needs (e.g. rehabilitation services for injured survivors or an LGBTQIA+ organization providing shelter).

- A mechanism for following up on referrals. For example, a return slip or checklist should be used by referring service providers to indicate the status of services received by the GBV survivor.
- A mechanism for urgent referral/support of people with specific needs (e.g. transportation, interpreter, peer support, covering the cost of services etc.).
- Agreed-upon operating procedures for a coordinated approach to case management, including confidential information-sharing and participation in regular case-management meetings
- To ensure survivors have access to multi sectoral services. This includes agreeing on an information-sharing protocol that details elements of how information will be safeguarded while being shared – for example, databases with coding systems.



Referral Pathway Template

TELLING SOMEONE AND SEEKING HELP (REPORTING)

Survivor tells family, friend, community member; that person accompanies survivor to the health or psychosocial entry point:

Survivor self-reports to any service provider (this can also be a humanitarian or development provider)



IMMEDIATE RESPONSE

The service provider must: provide a safe, caring environment and respect the confidentiality and wishes of the survivor; learn the immediate needs; give honest and clear information about services available. If agreed and requested by survivor, obtain informed consent and make referrals

Medical/health care entry point

[Enter name of the health center(s) in this role]

Psychosocial support entry point

[Enter name of the psychosocial provider(s) in this role]



IF THE SURVIVOR WANTS TO PURSUE POLICE/LEGAL ACTION - OR - IF THERE ARE IMMEDIATE SAFETY AND SECURITY RISKS TO OTHERS

Refer and accompany survivor to police/security - or - to legal assistance/protection officers for information and assistance with referral to police

Police/Security

[Enter specific information about the security actor(s) to contact - including where to go and/or how to contact them]

Legal Assistance Counsellors or Protection Officers

[Enter names of organizations]



AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES

Over time and based on survivor's choices can include any of the following:

Health care	Psychosocial services	Protection, security and justice actors	Basic needs, such as shelter, ration card, children's services, safe shelter, other
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PROGRAMMING TOOL 6:

Final Consent Form for Release of Information

Theme: Action

THIS FORM SHOULD BE READ TO THE SURVIVOR OR GUARDIAN IN THEIR FIRST LANGUAGE. IT SHOULD BE EXPLAINED CLEARLY TO THE SURVIVOR SO THAT THEY CAN CHOOSE ANY OR NONE OF THE OPTIONS LISTED.

A Note about Confidentiality

SURVIVORS HAVE THE RIGHT TO KEEP INFORMATION ABOUT THEMSELVES PRIVATE.

YOU SHOULD EXPLAIN:

- WHAT CONFIDENTIALITY MEANS WITH REGARDS TO YOU SHARING INFORMATION ABOUT THE SURVIVOR'S CASE
- WHAT THE LIMITS TO THIS ARE, INCLUDING ANY MANDATORY REPORTING LAWS (IF ANY EXIST IN YOUR CONTEXT)
- WHAT YOU WILL DO IF/WHEN YOU HAVE TO BREAK CONFIDENTIALITY. (FOR A SAMPLE SCRIPT PLEASE SEE EXAMPLE ON THE RIGHT)

SOMETIMES PEOPLE THINK THAT CONFIDENTIALITY MEANS NEVER TELLING ANYONE ANYTHING ABOUT A CASE —BUT THIS IS NOT WHAT CONFIDENTIALITY MEANS.

CONFIDENTIALITY MEANS THAT YOU DO NOT SHARE INFORMATION ABOUT A SURVIVOR'S CASE UNLESS YOU HAVE THEIR PERMISSION TO DO SO. YOU NEVER WANT TO 'PROMISE' CONFIDENTIALITY.

WHILE IT MAY SEEM LIKE AN IMPORTANT WAY OF BUILDING TRUST, IT IS NOT ACCEPTABLE TO MAKE PROMISES TO SURVIVORS THAT YOU KNOW YOU MIGHT NOT BE ABLE TO KEEP. THIS PERSON HAS ALREADY BEEN BETRAYED AND WOULD ONLY FEEL WORSE.

INSTEAD, FROM THE VERY BEGINNING, BE VERY CLEAR WHAT CONFIDENTIALITY MEANS AND WHAT THE LIMITS ARE IN YOUR CONTEXT. ON THE RIGHT YOU WILL FIND A SAMPLE SCRIPT.

SAMPLE SCRIPT

To explain confidentiality and its limitations, you can say:

It is important for you to know that I will keep what you tell me confidential, including any notes that I write down during our meetings. This means that I will not tell anyone what you tell me, or share any other information about your case, without your permission.

There are only a few situations when I may have to speak with someone else without asking your permission.

If you tell me that you may hurt yourself, I need to tell my supervisor or others who could help keep you safe.

If you tell me that you plan to hurt someone else, I would have to tell [relevant protection authorities] so we could prevent that action.

If a UN or humanitarian worker has hurt you, I would need to tell my supervisor and report what this person has done, so he/she can't hurt anyone else.

If... [Explain mandatory reporting requirements as they apply in your local setting].

Sharing information during these times is meant to keep you safe and get you the best help and care you need. Other than these times, I will never share information without your permission.

INCIDENT ID

CLIENT CODE

--	--

Confidential

Consent for Release of Information [Written]

1.

I, _____,

give my permission for _____

(Name of Organization) to share information about the incident I have reported to them as explained below:

I understand that in giving my authorization below, **I am giving** _____

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

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

I understand that consent means that a person from another agency or service provider (ticked below) may come and speak with me.

At any point, I have the right to change my mind about sharing information with the designated agency/focal point listed below.

I would like my information released to the following:

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

2.

YES NO

☐☐

Security Services (specify):

☐☐

Psychosocial Services (specify):

☐☐

Health/Medical Services (specify):

☐☐

Safe House / Shelter (specify):

☐☐

Legal Assistance Services (specify):

☐☐

Livelihoods Services (specify):

INCIDENT ID

CLIENT CODE

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YES

NO

☐☐

Disability Specific Services or Organizations (specify):

☐☐

Other (specify type of service and agency):

1. Authorisation to be marked by client:

☐

YES

☐

NO (OR PARENT/GUARDIAN
IF CLIENT IS UNDER 18)

I have explained to the client and ensured that the client has understood that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to them or the incident. I have stressed that there will be no way for someone to identify them based on the information that is shared, and that all shared information will be treated with confidentiality and respect.

2. Authorisation to be marked by client:

☐

YES

☐

NO (OR PARENT/GUARDIAN
IF CLIENT IS UNDER 18)

Signature/thumbprint of client: _____
(or parent/guardian if client is under 18)

Caseworker code: _____

Date: _____

INCIDENT ID

CLIENT CODE

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Confidential

Consent for Release of Information [Verbal]

1.

I, _____, have explained the consent process in detail to _____.

I explained that _____ is providing authorization for _____ (Name of Organization) to share information about them as explained below:

I clearly explained to _____ that they are providing their authorization and permission for (Name of Organization) to share the specific case information from their incident report with the service provider(s) they have indicated, so that they can receive help with safety, health, psychosocial, and/or legal needs.

I have explained to and ensured that _____ has understood that the shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance they have requested.

I have explained to and ensured that _____ has understood that consent means that a person from another agency or service provider (ticked below) may come and speak with them. I also explained that at any point, they have the right to change their mind about sharing information with the designated agency/focal point listed below.

_____ would like their information released to the following:
(Tick all that apply, and specify name, facility and agency/organization as applicable.)

Date: _____

INCIDENT ID

CLIENT CODE

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2.

YES

NO

☐☐

Security Services (specify):

☐☐

Psychosocial Services (specify):

☐☐

Health/Medical Services (specify):

☐☐

Safe House / Shelter (specify):

☐☐

Legal Assistance Services (specify):

☐☐

Livelihoods Services (specify):

☐☐

Disability Specific Services or Organizations (specify):

☐☐

Other (specify type of service and agency):

**1. Authorisation to be marked
on behalf of client:**

☐

YES

☐

**NO (OR PARENT/GUARDIAN
IF CLIENT IS UNDER 18)**

I have explained to the client and ensured that the client has understood that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to them or the incident. I have stressed that there will be no way for someone to identify them based on the information that is shared, and that all shared information will be treated with confidentiality and respect.

**2. Authorisation to be marked
on behalf of client:**

☐

YES

☐

**NO (OR PARENT/GUARDIAN
IF CLIENT IS UNDER 18)**

Caseworker signature: _____

By signing this verbal consent form, I confirm that I have solicited informed consent from the survivor.

Caseworker code: _____

Date: _____

Guidelines For Obtaining Informed Consent/Informed Assent From GBV Survivors

Theme: Action

Phase of GBV programme cycle: Response

WHO

This tool can be facilitated by GBV actors undertaking case management.

PURPOSE

This tool emphasises the importance of obtaining informed consent and assent from survivors to share their information when they access services or for referral to other service providers during initial intake interviews.

Understanding Informed Consent

Informed consent is defined as “the voluntary agreement of an individual who has legal capacity to give consent.” To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and legally be able to give their consent.

Determining who is legally able to give consent for certain types of services will depend on the context that you work in – however, usually children under 15 years of age are not legally able to provide consent on their own.

Informed consent can be both written and verbal. Consent is an ongoing process and not a one-time event. It is important never to assume that a survivor’s consent to one service means that they consent to everything.

Understanding Informed Assent

Informed assent is defined as “the voluntary agreement of an individual who does not have legal capacity to give consent.” To provide information for informed assent, the individual must have the capacity and maturity to know about and understand the services to be offered but is not legally able to give their consent. Any individual who is not legally able to give consent, as the result of being under the legal age or having a guardian or caregiver who has court-authorized power to make decisions on behalf of the individual, should still have the full right to give their autonomous consent.

Informed assent means the individual has the right to receive information given in a way that they can understand, and give their assent or dissent.

Difference between Informed Consent and Informed Assent

Consent may only be given by individuals who have reached the legal age as reflected in their current context. Assent is the agreement of someone who is not legally able to provide consent.

Obtaining Informed Consent and/or Informed Assent from Adults

Both soliciting informed consent and/or informed assent (if applicable) must include three key elements:

1. **Disclosure of information:** Providing all possible information and options to a survivor in a way they can understand. This means describing the nature of what, exactly, the individual is consenting to.
2. **Competency:** Determining if they can understand this information and/or their decisions (also referred to as 'capacity to consent'). This includes not only ensuring the survivor has the ability to understand the information and/or decision pertaining to consent itself, but also includes confirmation of their understanding of what it is they are actually consenting to (e.g. referrals to services, information sharing, etc.).
3. **Voluntary decision making:** Ensuring that the decisions of the survivor are voluntary and not coerced by others (e.g. family members, caregivers, or even service providers). Any informed consent procedure includes ensuring that the survivor does not feel forced to give consent.

When conducting the informed consent process, it is important for service providers to remember the following:

1. Assume capacity to consent. All adults have the capacity to make their own decisions unless demonstrated otherwise. This therefore also applies to people

with all types of impairment, including those with intellectual impairments. While family members and caregivers play a significant role in the lives of many persons with disabilities and are a valuable resource in facilitating understanding and communication, they do not necessarily have the legal authority to make decisions for an adult with disabilities.

2. Capacity to consent refers to the ability to make a particular decision at a particular time. Capacity can change over time, but also according to the nature and complexity of the decision.
3. Capacity to consent depends on understanding, and understanding can vary according to how we communicate information. In some circumstances, it can be more helpful to seek consent for smaller steps in a longer process, so that survivors are in control of every part of a process and can stop it at any time.

Example:

Maria has an intellectual disability. She may have the capacity to understand and consent to HIV post-exposure prophylaxis because she understands the concept of taking medicine as a treatment and has taken medicines before to prevent other illnesses. She may, however, find it more difficult to understand what legal assistance means and therefore would not be able to consent to a referral to legal assistance. Consent is an ongoing process and not a one-time event. It is important that we never assume that a survivor's consent to one service means that they consent to everything.

4. If you determine that a survivor does not have the capacity to consent, it is important for you to consult a supervisor to determine the best way to proceed, using the best-interest principle.
5. **The initial informed consent process: consent to receive your organisation's**

Example:

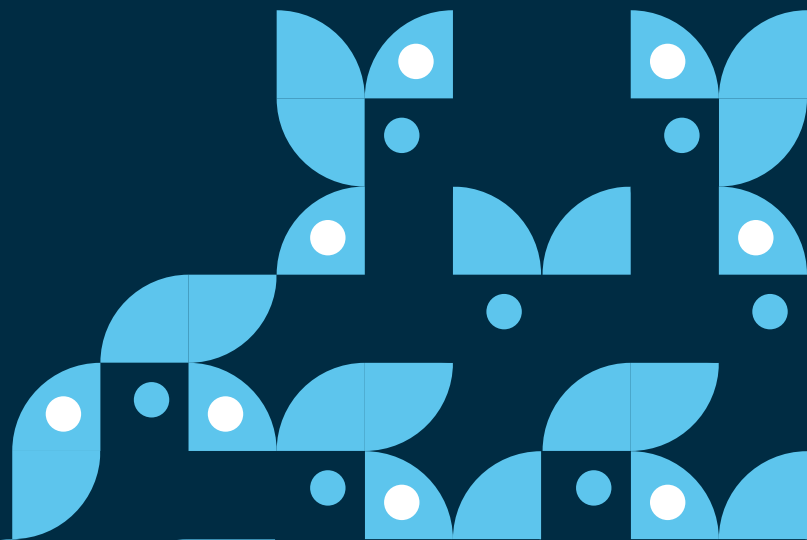
Maria may initially decline or accept referral to an economic empowerment activity. But have we conveyed the information in a way that she can understand it and use it in making her decision? If we discuss her goals, describe the activities to her, explore what she likes and doesn't like about these activities and support her to visit the class without having to make any commitment to participating, then Maria will understand better the activity, and the possible positive and negative outcomes for her, enabling her to make a more informed decision, and enhancing her capacity to consent.

services: When working with a survivor who you are not sure has the capacity to consent, it may be necessary, in the initial informed consent process, to involve another trusted individual who can help facilitate the communication and understanding regarding the services you are offering. A staff member should never make such a decision on their own. Remember that getting a caregiver's consent for your organisation's services does not mean that you have the survivor's or the caregiver's consent for any other interventions.

6. **Consent for referrals and other services:** If caregivers or others are involved, it is important that you continue to use the best-interest principle to ensure that the survivor's wishes and needs remain the focus, and the survivor feels safe. Be sure to observe the survivor's interactions with the caregiver

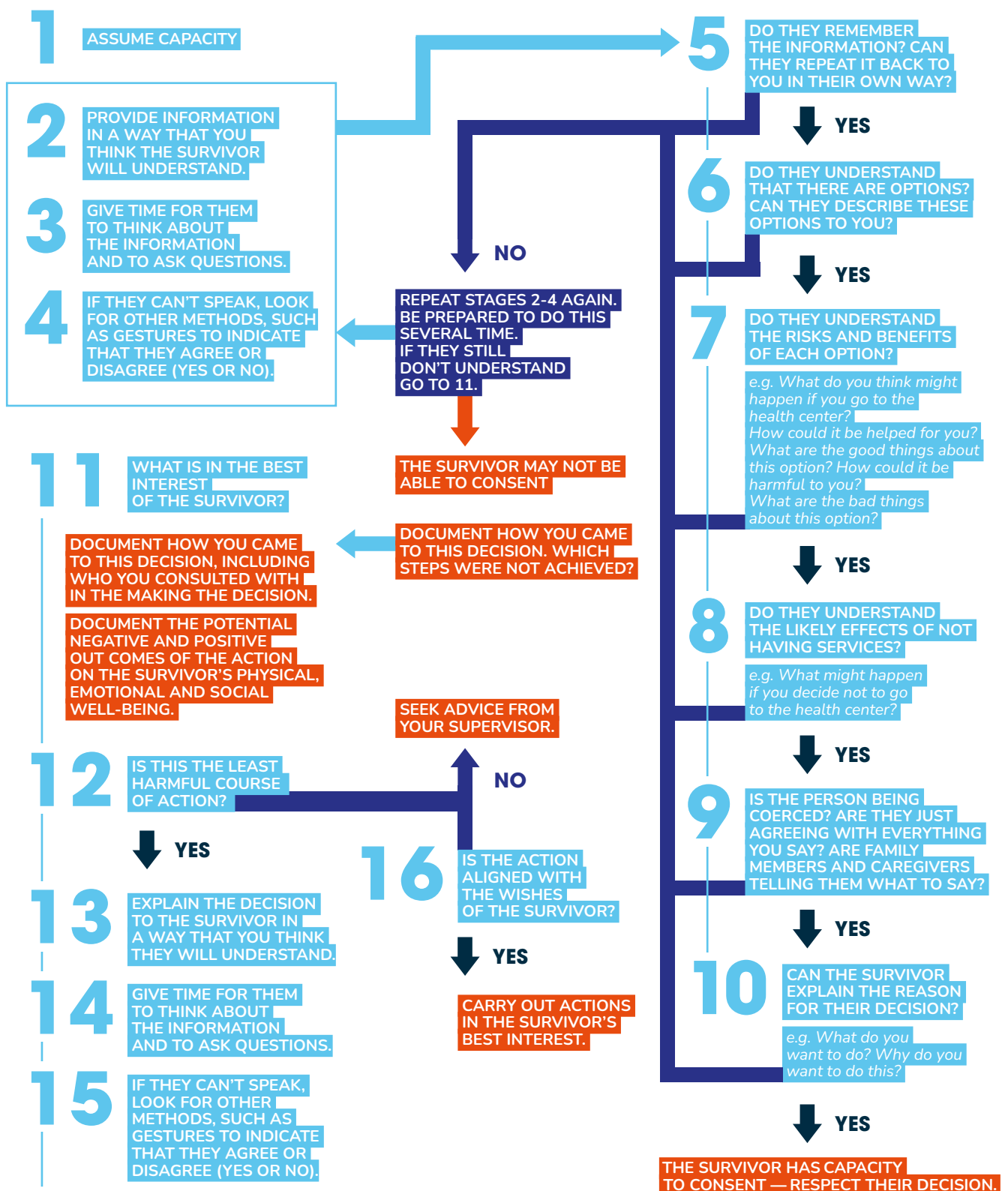
Example:

In the case of Maria, a GBV survivor with a disability, her mother and father may want to pursue justice options for the case. If Maria does not have the capacity to consent to this referral, then caseworkers must ask, "Is this in Maria's best interests?" As she does not understand the legal process, it is unlikely to promote healing and recovery, and may even expose her to further emotional harm as she will have to recount her experiences to others. This referral may not be in her best interests, but rather something the mother and father want to do for their own reasons. Exploring the reasons why they want to seek legal assistance and whether it would be in Maria's best interests to do so can help Maria's parents better understand that such an action does not reflect Maria's needs or interests.



Determining capacity to consent for survivors with disabilities:

Capacity to consent and best interest flow-chart



Adapted from: Consent and persons with intellectual disabilities: The basics
<http://www.intellectualdisability.info/historic-articles/articles/consent-and-people-with-intellectual-disabilities-the-basics>

Informed Consent from Caregivers and Informed Assent from Children

The age at which parental consent is needed for a child depends on the laws of the country. This means that when the child is under the age of legal consent, caregiver consent is required. In the absence of any clear laws or adherence to laws, children under the age of 18 require caregiver consent as a general rule.

INFANT AND TODDLERS (AGES 0–5)

Informed consent for children in this age range should be sought from the child's caregiver or another trusted adult in the child's life, not from the child. If no such person is present, the service provider (caseworker and/or protection officer) will need to be informed. For children in this age range, informed assent will not be sought. The service provider should still explain to the child all that is happening, in very basic and appropriate ways.

YOUNGER CHILDREN (AGES 6–11)

Typically, children in this age range are neither legally able, nor sufficiently mature enough, to provide their informed consent for participating in services. However, they are able to provide their informed assent or 'willingness' to participate. Children in this age range should be asked their permission to proceed with services and referrals which affect them directly. This permission can be verbally provided by the child and documented as informed assent. For children in this age range, parental/caregiver informed consent – whether verbal or written

– is required, along with the child's informed assent. If it is not possible to obtain informed consent from a parent or caregiver, then another trusted adult, identified by the child, who can safely be brought into case management decisions should be approached to consent for the child.

YOUNGER ADOLESCENTS (AGES 12–14)

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

OLDER ADOLESCENTS (AGES 15–17)

Older adolescents, aged 15 years and above, are generally considered mature enough to make decisions, but legally, parental and/or guardian consent is required. In some contexts, 16-year-olds are often legally allowed to make decisions about their own care and treatment, especially for social and reproductive health care services. This means that older adolescents can give their informed consent or

assent in accordance with local laws. Ideally, supportive and non-offending caregivers are also included in care and treatment decision-making from the outset and provide their informed consent as well. However, decisions involving caregivers should be made with the child directly in accordance with local laws and policies. If the adolescent (and caregiver) agree(s) to proceed, the caseworker documents their informed consent using a client consent form or documenting on the case record that they have obtained verbal consent to proceed with case management services.

SPECIAL SITUATIONS

In some situations, it may not be in the interests of the child and/or adolescent to include the caregiver in the informed consent process. These situations need to be identified by the caseworker, and ultimately it is up to the caseworker to identify whether there is a trusted adult in the child's life who can provide consent. If there is no trusted adult to provide consent, the caseworker needs to determine the child's capacity for decision making based on their age and level of maturity. If a child aged under 16 does not assent but caregivers do, OR if both the child and caregiver do not consent, OR the child aged over 16 does not consent, the caseworker needs to determine on a case-by-case basis – based on the child's age, level of maturity, cultural/traditional factors, the presence of caregivers (supportive), and the urgency of GBV response – whether it is appropriate to go against the wishes of the child and/or caregiver to proceed with case management, and assist the child so that they receive needed informal support and, potentially, treatment services.

Guidance on Confidentiality²¹

Survivors have the right to keep information about themselves private. Confidentiality is the fourth guiding principle relating to a survivor-centred approach.

Confidentiality is important:

- As it promotes safety, trust, dignity and empowerment.
- People have the right to choose to whom they will or will not tell their story.
- Breaching confidentiality inappropriately can put the survivor and others at risk of further harm.
- If service providers do not respect confidentiality, others will be discouraged from coming forward for help.

You should explain:

- What confidentiality means with regard to you sharing information about the survivor's case
- What the limits to this are, including any mandatory reporting laws (if any exist in your context)
- What you will do if/when you have to break confidentiality.

21 — Adapted from 36 UNICEF. (2014). Communities Care Program: Transforming Lives and Preventing Violence. UNICEF, New York. Page 52 | Part I

Example:

You may discuss issues related to a case with your supervisor. You need to do this to make sure you are taking the right actions and providing the best possible service. You may also need to discuss case details with other actors involved in helping a survivor in order to ensure adequate coordination and that all a survivor's needs and rights are met.

At all times, you need to make sure that you let the person know who will be involved in a case and why, and get their permission on what information can be shared with whom, while always protecting the identity of the person. If they object, you will need to look at why they are objecting – perhaps they have a good reason – so you need to listen and find out more.

Sometimes people think that confidentiality means never telling anyone anything about a case – but this is not what confidentiality means. Confidentiality means that you do not share information about a survivor's case unless you have their permission to do so. You never want to 'promise' confidentiality. While it may seem like an important way of building trust, it is not acceptable to make promises to survivors that you know you might not be able to keep. This person has already been betrayed and would only feel worse. Instead, from the very beginning, be very clear what confidentiality means and what the limits are in your context.

LIMITATIONS TO CONFIDENTIALITY

This refers to situations in which there may be legal or other obligations that override the individual's right to confidentiality. There can be exceptions to confidentiality, and it is important that the survivor (especially children/young people and their caregivers) know what the limits are.



Limited confidentiality: when?:

There are exceptions to confidentiality, and it is very important that survivors (especially children/young people and caregivers of persons with disabilities) understand what these limits are. These limits include:

Situations in which there are concerns about the immediate physical safety of survivors or co-survivors. This includes situations where there is a threat of ongoing harm to a child and the need to protect them overrides confidentiality, or situations in which the survivor is at risk of harming themselves or others, including threats of suicide.

Situations in which there are mandatory reporting laws that obligate service providers to report to police or other government authorities. In such situations, legal requirements override the question of the survivor's permission. Survivors (and caregivers) should be made aware of these legal requirements as part of the informed consent process.

Situations in which there are mandatory reporting policies for cases of sexual exploitation and abuse that involve humanitarian workers or peacekeeping personnel. In these situations, organisations need to be clear on what the inter-agency protocol is and inform the survivor to whom the case would be reported, what information would be shared, and what the expectations would be regarding the survivor's involvement (i.e. Will the survivor have to file a report, and if so, to whom? Will the survivor have to be interviewed, and if so, by whom?)

For further information see the GBVIMS tools: <https://www.gbvims.com>

Where to go next in the toolkit

This tool is paired with the **Intake Form Guidance and Intake and Initial Assessment form** and should be used when obtaining informed consent or assent before making a referral (see the Inclusive Referral System to GBV Survivors) or sharing survivor's information (see the **Final Consent Form for Release of Information**).





PROGRAMMING TOOL 8:

Intake and Initial Assessment Form Guidance (Adapted from the GBVIMS form)

Theme: Action

Phase of GBV program cycle: Response

WHO

This tool should be used by individuals when conducting intake interviews for a GBV case.

It can be individuals working in direct service provision such as GBV case management, clinical care for GBV survivors, and psychosocial care for GBV survivors. It must be used by individuals trained on GBV guiding principles, GBV case management and GBV data collection. It can be used by organizations using the GBVIMS, or not. Actors that are not trained on GBV guiding principle should not use this form.

PURPOSE

This tool supports the collection of service-based data. These data do not relate to the incidence of GBV but to data based on self-reporting.

Currently, most organizations collecting GBV information determine individually and independently what data they will be collecting from survivors and how to define that data. Consequently, the format, content, and quality of the resulting GBV data varies greatly from one organization to another. This makes comparing data from different service providers, and then effectively analyzing those data, extremely difficult.

This proposed Intake and Initial Assessment

Form Guidance ensures that:

- Service providers are consistently collecting a standardized set of key GBV data points.
- The collection of data on identity factors enables an intersectional analysis.
- Service providers have a better knowledge on who has (or does not have) access to their services.
- Service providers have a better knowledge of contributive factors leading to a GBV incident considering the intersection of identity factors.
- Service providers respect GBV guiding principles such as safety and dignity of survivors during the data collection process and afterwards.

PRESENTATION OF THE TOOL

This Intake and Initial Assessment Form is an adaptation of the GBVIMS Intake and Initial Assessment Form. It has been adapted to reflect the information required for an intersectional approach to case management of GBV cases.

The intake form is not intended to be an extra form or document for your organization to fill out. Rather, it is intended to simplify your data-collection processes by replacing your current intake forms. This is why, despite being a standardized form, this form is also a flexible



tool that you can modify and edit to meet your varying case-management needs and to fit with your context. As such, some fields may be removed or modified. Other questions, however, must remain unchanged to ensure that important, comparable data are collected.

N.B.! Before customizing or modifying any fields on your intake form, you must first determine: Is my organization part of the GBVIMS? Is my organization implementing the GBVIMS on its own or as part of an inter-agency implementation?

If your organization does not use the GBVIMS or is implementing the GBVIMS independent of other organizations in your area, then you can customize and modify the appropriate fields as you see fit.

If your organization is implementing the GBVIMS as part of an inter-agency group, then all decisions regarding changes to the required fields of the intake form should be made at the inter-agency level. This ensures that all organizations participating as a part of the inter-agency group will be using the same intake form and collecting data that can be compiled or compared.

It does not capture all the GBVIMS case-reporting information for tracking on the GBVIMS incident recorder but retains the critical standardized information used



The GBVIMS Intake and Initial Assessment Form is an easy-to-use, customizable template. It is designed to collect a standard set of meaningful GBV indicators across all service providers while reducing variation in how data is collected.

GBVIMS have been implemented in organizations and agencies in the following countries:

Bangladesh, Burundi, Cameroon, Central African Republic, Colombia, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Greece, Guinea, Haiti, Iraq, Jordan, Kenya, Lebanon, Liberia, Libya, Mali, Myanmar, Nepal, Niger, Nigeria, Pakistan, Philippines, Sierra Leone, South Sudan, Tanzania, Thailand, Turkey Cross-Border (Syria), Uganda.

THE INTAKE AND INITIAL ASSESSMENT FORM HAS DIFFERENT TYPES OF QUESTIONS/TEXT:

This Intake and Initial Assessment Form is an adaptation of the GBVIMS Intake and Initial Assessment Form. It has been adapted to reflect the information required for an intersectional approach to case management of GBV cases.

- Questions marked with an (*) are standardized questions from the GBVIMS form that collect data for key GBV data points. These data points should be collected by all service providers using GBVIMS. To know how to fill the field with * please refer to the GBVIMS USERGUIDE: https://gbvims.com/wp/wp-content/uploads/Ch4_Feb2011.pdf
- Those questions followed by the circle symbol () are customizable fields. Italicized text indicates which part of the customizable fields you should adapt.
- Questions/Text which are indicated on the form with the triangle symbol (^) are supplemental to the GBVIMS form. They are intended to collect data on diverse identity factors. These Questions/Text may be modified or removed based upon your organizational and programmatic needs, but also based on the context in which you work. Italicized text indicates which part of the customizable fields you should adapt.
- Questions in bold are either questions from GBVIMS or supplemental ones that are crucial to be able to conduct intersectional analysis.

WHY COLLECT DATA ON IDENTITY FACTORS AT SERVICE-PROVIDER LEVEL?

As we know, individuals with intersecting vulnerabilities are frequently excluded, or unseen, both as a group and in terms of some of their specific challenges in their contexts. People who are part of more than one of these groups are often at greater, compounded risk of experiencing violence, and their multi-level invisibility can mean specific needs remain ignored or are unmet.

The collection of data on identity factors by service providers enables an intersectional analysis:

- on who accesses/does not access services, better to understand who is being left behind,
- to identify those most in need and to respond appropriately to hidden risks and needs, including identifying gaps in service provision and allowing for more appropriate referrals to services,
- to allow service providers to examine the intersectional power relations in their own systems, and to consider their own potential biases, as well as stigmatizing and discriminatory attitudes, that may be contributing to the exclusion of certain groups,
- to improve collaboration between partners engaging with identified groups affected by inequality and discrimination, and to enable the co-creation of an intersectional approach to GBV.

Remember: Intersectional approaches must go beyond including left-out groups in the existing development or humanitarian system to raise fundamental questions about that system and its actors and biases.

ORGANIZATIONS MAY EVEN TAKE THEIR INTERSECTIONAL APPROACHES FURTHER BY:

- focusing on the systems and power relations that drive identified inequalities and vulnerabilities,
- addressing how the invisibility of certain groups is created and reinforced,
- paying attention to multi-dimensional power relations, engaging with individuals, groups and systems that together make individuals vulnerable to violence.

Quick instructions when using the form

- Use the Intake and Initial Assessment Form ONLY in the context of service provision.
- The survivor's safety, comfort, well-being and confidentiality should be a priority during the entire process.
- Ensure the respect of the confidentiality rights of every survivor who accesses the services and strictly maintain information to protect the privacy rights of the survivor. Do not discuss or communicate information with unauthorized individuals or agencies. Before beginning the interview, please be sure to remind the client that all information given will be kept confidential, and that they may choose to decline to answer any of the following questions.
- Incident data should only be collected in contexts where services are available for the survivor to access when they report. Only collect data that will be used for the purposes of case management or referral or service improvements and/or advocacy.
- Select one box only for each data point on the intake form.
- Only work with codes – names of survivors and case/social workers should NEVER be present on the form.
- Ensure questions are asked as part of the conversation. You do not have to follow the order of the questions. Keep the interview open and conversational.
- Maintain an open and survivor-centered approach. Do not assume the survivor's gender identity, sexual orientation, religious background, etc.

Please see Intersectionality in the GBV Tip Sheet for further information.

HOW to fill in the different section of the form

To learn how to fill in the sixth section and the fields marked with * please look at the USERGUIDE developed by the GBVIMS:

https://gbvims.com/wp/wp-content/uploads/Ch4_Feb2011.pdf

The section below will provide guidance only on supplemental questions and/or fields with a ^. It will also show how to interpret some data to be able to adapt your response so as better to fit the specific needs of the survivor in all their diversity.

Administrative Information

1. Administrative Information

CLIENT CODE:	DATE OF INTERVIEW (DAY/MONTH/YEAR)*:	DATE OF INCIDENT (DAY/MONTH/YEAR)*:
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☐ Reported by the survivor or reported by the survivor's escort and the survivor is present at the reporting*

☐ Reported by someone other than the survivor and the survivor is not present at the reporting*

*If reported by someone other than the survivor, what is their relationship to the survivor?**

2. General Survivor Information

Be careful when collecting data relating to identity factors.

You do not have to follow the order of the questions. Keep the interview open and conversational.

Always put into practise the 'Know and Tell Why' before questioning about identity factors such as gender, religion and nationality.

For more information refer to the Intake and Initial Assessment Form Guidance.

DATE OF BIRTH (DAY/MONTH/YEAR)*: Approximate if necessary	GENDER*^: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender non-conforming
FIRST LANGUAGE^: SECOND LANGUAGE^X:	CLAN OR ETHNICITY:
COUNTRY OF ORIGIN*():	CURRENT CIVIL/MARITAL STATUS*:
NATIONALITY (if different from country of origin):	<input type="checkbox"/> Single
RELIGION:	<input type="checkbox"/> Divorced/Separated
NUMBER, AGE AND GENDER OF CHILDREN AND OTHER DEPENDENTS (if applicable):	<input type="checkbox"/> Married/Cohabiting <input type="checkbox"/> Widowed

Gender non-conforming data

When appropriate, it is useful not only to have the binary 'male/female' but to add an option such as 'gender non-conforming' or 'gender fluid'. It can give a choice for people who identify themselves outside the gender binary box. People are gender non-conforming when the way they present themselves is not what would be expected for someone of their gender or assigned sex at birth.

Currently, GBV data collection efforts focus mainly on binary cisgender sex-disaggregation of data.

This binary focus excludes transgender and gender-nonconforming populations, thereby further discriminating against them and silencing their voices. Starting to collect, analyze, and use binary cisgender as well as multinomial transgender and gender-nonconforming data is a first step in ensuring that GBV data are inclusive and representative of all.

DO recognize that it can be sensitive in many contexts to collect/use such kinds of data. This is why this section should be ALWAYS contextualized.

DO connect with human rights/LGBTQIA+ activists in your country in order to define which term will be more appropriate, and if the collection of gender non-conforming data is relevant.

Language

We know that language can be a barrier for survivors accessing services. Refugees and migrants who do not speak the local languages may not have access to information about services. Speaking about GBV experiences is not easy, and survivors may feel more comfortable providing details about the incident and expressing their feelings in their own language. In some cases it can be appropriate to use an interpreter in order to get accurate data. Collecting data about languages during the first interview can help the service provider identify if there is a need for interpretation at this stage and during the case management process.

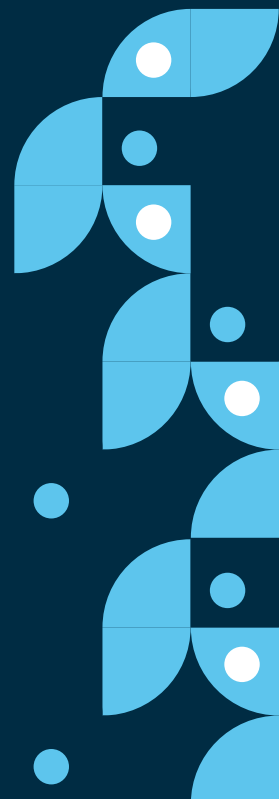
OCCUPATION :			
DISPLACEMENT STATUS AT TIME OF REPORT*:			
<input type="checkbox"/> Resident	<input type="checkbox"/> IDP	<input type="checkbox"/> Refugee	<input type="checkbox"/> Stateless Person
<input type="checkbox"/> Returnee	<input type="checkbox"/> Foreign National	<input type="checkbox"/> Asylum Seeker	<input type="checkbox"/> N/A
SPECIFIC NEEDS / VULNERABILITIES* ^ (check all that apply)			
<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Unaccompanied Minor	<input type="checkbox"/> Pregnant/Lactating Woman ^	
<input type="checkbox"/> Mental Disability	<input type="checkbox"/> Separated Child	<input type="checkbox"/> Elderly Person ^	
<input type="checkbox"/> None	<input type="checkbox"/> Other Vulnerable Child	<input type="checkbox"/> Asylum Seeker	<input type="checkbox"/> N/A

Is the Client a person with disabilities?

In the GBVIMS, the idea is to indicate if the client is suffering from a long-term impairment. Short-term impairments, such as a broken leg, will not be considered a disability. This should be as reported by the survivor or as assessed by the service providers.

In order to get accurate data about disabilities it is not recommended that a survivor is asked directly if they have a disability and/or to make assumptions about their disability status. Furthermore, in the GBVIMS, there are only two options: Physical Disability and Mental Disability, which means that data relating to other types of disability cannot be collected and that 'invisible' disabilities may be overlooked.

Acknowledging this, we propose that the actors not part of the GBVIMS use the WGSQ instead to identify functioning limitations and assess what materials or assistance may be required – sign-language interpreter, easy to read, pictorial. Please note that disaggregation by type of disability is not always possible and it can be hard to reconcile the Washington Group with the categories proposed by the GBVIMS.



2. 1 Questions on Functioning

	NO, NO DIFFICULTY	YES, SOME DIFFICULTY	YES, A LOT OF DIFFICULTY	CANNOT DO AT ALL
1. DO YOU HAVE DIFFICULTY SEEING, EVEN IF WEARING GLASSES?				
2. DO YOU HAVE DIFFICULTY HEARING, EVEN IF USING A HEARING AID?				
3. DO YOU HAVE DIFFICULTY WALKING OR CLIMBING STEPS?				
4. DO YOU HAVE DIFFICULTY REMEMBERING OR CONCENTRATING?				
5. DO YOU HAVE DIFFICULTY WITH SELF-CARE SUCH AS WASHING ALL OVER OR DRESSING?				
6. DO YOU, USING YOUR USUAL LANGUAGE, HAVE DIFFICULTY COMMUNICATING, FOR EXAMPLE UNDERSTANDING OR BEING UNDERSTOOD?				

FUNCTIONAL LIMITATION [^] (using WGSQ)

- ☐ Cognitive [^]
- ☐ Physical [^]
- ☐ Hearing [^]
- ☐ Vision [^]
- ☐ Speech and Language [^]

IF CLIENT RESPONDED 'YES' TO ANY OF QUESTIONS 1-6 ABOVE:
WHERE DOES THE CLIENT LIVE?

<input type="checkbox"/> Private home	<input type="checkbox"/> Institution	<input type="checkbox"/> Other (please specify)
DOES THE CLIENT HAVE A CAREGIVER?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	

If 'yes', what is the caregiver's relationship to the client? _____

2. Questions on Functioning

The questions in 'Section 2-1: Questions on Functioning' on the Intake and Initial Assessment Form are from the Washington Group Short Set on Functioning – Enhanced Question set.

These questions can be used to identify people with functional limitations but should not be used for diagnostic purposes

How to ask the questions

- Before engaging in this section the interviewer should say: "I would like to ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM. It can help us identify if there is a need for specific assistance".
 - The interviewer should ask the questions exactly as they are worded.
 - The interviewer should avoid any verbal references to 'disability'.
1. More information on how to ask the Washington Group Questions can be found at https://humanity-inclusion.org.uk/sn_uploads/document/2018-How-to-ask-the-WGQs-leaflet-Final.pdf
 2. If the survivor is aged under 18, you will need to use the WG-UNICEF Modules on Child Functioning:
<https://data.unicef.org/resources/module-child-functioning/>
 3. Aged 2-4 years:
https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/Washington_Group_Questionnaire_4_-_WG-UNICEF_Child_Functioning_Module_ages_2-4_.pdf
 4. Aged 5-17 years:
https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/Washington_Group_Questionnaire__5_-_WG-UNICEF_Child_Functioning_Module__ages_5-17_.pdf
 5. Note: Both of the WG-UNICEF Module on Child Functioning question sets are designed for administration to parents (or primary caregivers).
 6. More information on the Washington Group Questions can be found at <https://www.washingtongroup-disability.com/>
 7. The Washington Group Short Set, Extended Set and Short-Set Enhanced Question Sets have been translated from English into the official UN languages (Arabic, Chinese, French, Russian and Spanish) and two other commonly used languages (Portuguese as used in Brazil and Portugal, and Vietnamese). Those translations can be found at <https://www.washingtongroup-disability.com/resources/translations-of-wg-question-sets/>.

How to interpret answers on functioning

Questions on functioning will help you identify functioning limitations and be able to provide better care, adaptation and/or assistance for survivors with functional limitations.

To have concrete examples of what to ask/how to react when interviewing a person with functional limitations you may use TOOL 6 from the GBV Disability Toolkit: Guidance on Communicating with Persons with disabilities:

<https://www.womensrefugeecommission.org/wp-content/uploads/2020/04/GBV-Disability-Toolkit-English.pdf>

2. Do you have difficulty seeing, even if wearing glasses?

If the client's answer is: 'Yes, a lot of difficulty' or 'Cannot do at all' then you can check the 'vision' functional limitations box.

You may also ask:

- "would you like documents in alternative formats, such as Braille or large print"? In some contexts where people have access to computers, people with vision impairments may prefer electronic documents that are accessible through screen reader software (e.g. Word documents).
- "would you like assistance to get from one place to another?" Ask for instructions on how they would like to be assisted and where they would like to go. Some people prefer verbal guidance, whereas others may prefer for you to guide physically.

2. Do you have difficulty hearing, even if using a hearing aid?

If the client's answer is: 'Yes, a lot of difficulty' or 'Cannot do at all' then you can check the 'hearing' functional limitations box.

3. Do you have difficulty walking or climbing steps?

If the client's answer is: 'Yes, a lot of difficulty' or 'Cannot do at all' then you can check the 'physical' functional limitations box.

4. Do you have difficulty remembering or concentrating?

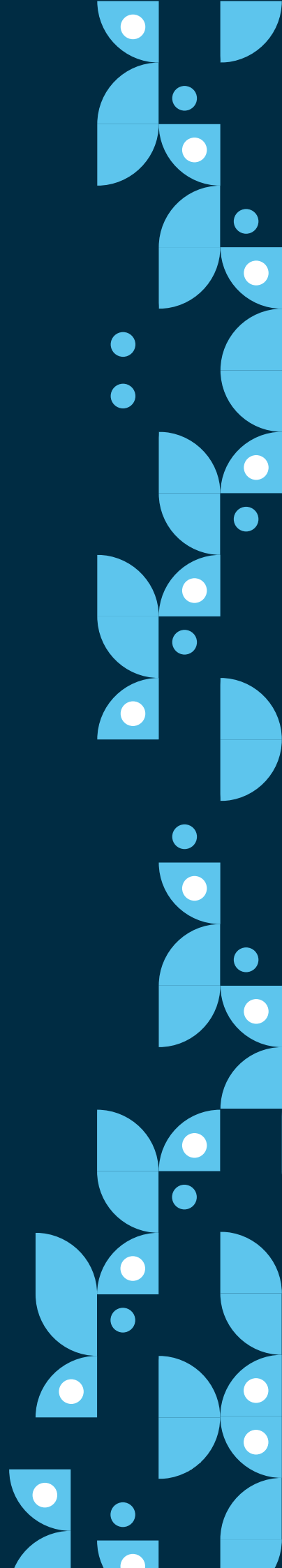
If the client's answer is: 'Yes, a lot of difficulty' or 'Cannot do at all' then you can check the 'cognitive' functional limitations box.

5. Do you have difficulty with self-care such as washing all over or dressing?

If the client's answer is: 'Yes, a lot of difficulty' or 'Cannot do at all' then you can check the 'physical' functional limitations.

6. Do you, using your usual language, have difficulty communicating, for example understanding or being understood?

If the client's answer is: 'Yes, a lot of difficulty' or 'Cannot do at all' then you can check the 'speech and language' functional limitations.



3. Brief Details of the Incident

<p>TYPE OF INCIDENT VIOLENCE*: (PLEASE REFER TO THE GBV CLASSIFICATION IN THE NEXT COLUMN AND SELECT ONLY ONE. FOR MORE INFORMATION, PLEASE REFER TO THE GBV CLASSIFICATION TIP SHEET)</p> <p><input type="checkbox"/> Rape (includes gang rape, marital rape)</p> <p><input type="checkbox"/> Sexual Assault (includes attempted rape and all sexual violence/abuse without penetration, and female genital mutilation/cutting)</p> <p><input type="checkbox"/> Physical Assault (includes hitting, slapping, kicking, shoving, etc. that are not sexual in nature)</p> <p><input type="checkbox"/> Forced Marriage (includes early marriage)</p> <p><input type="checkbox"/> Denial of Resources, Opportunities or Services, including removal of assistive devices Psychological / Emotional Abuse</p> <p><input type="checkbox"/> Non-GBV (specify):</p>	<p>Did the reported incident involve penetration? If yes, classify the incident as 'Rape'. If no, proceed to the next incident type on the list.</p> <p>Did the reported incident involve unwanted sexual contact and/or forced sterilization? If yes, classify the incident as 'Sexual Assault'. If no, proceed to the next incident type on the list.</p> <p>Did the reported incident involve physical assault? If yes, classify the incident as 'Physical Assault'. If no, proceed to the next incident type on the list.</p> <p>Was the incident an act of forced marriage? If yes, classify the incident as 'Forced Marriage'. If no, proceed to the next incident type on the list.</p> <p>Did the reported incident involve the denial of resources, opportunities or services? If yes, classify the incident as 'Denial of Resources, Opportunities or Services'. If no, proceed to the next incident type on the list.</p> <p>Did the reported incident involve psychological/emotional abuse? If yes, classify the incident as 'Psychological/Emotional Abuse'. If no, proceed to the next incident type on the list.</p> <p>Is the reported incident a case of GBV? If yes, start again at number 1 and try again to reclassify the incident (if you have tried to classify the incident multiple times, ask your supervisor to help you classify this incident). If no, classify the incident as 'Non-GBV'</p>
<p>Note: these incidents will be entered into the incident recorder if using GBVIMS</p>	<p>WERE MONEY, GOODS, BENEFITS, AND/OR SERVICES EXCHANGED IN RELATION TO THIS INCIDENT? *</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES (please describe)</p>
<p>TYPE OF ABDUCTION AT TIME OF THE INCIDENT*:</p>	

3. Type of Incident/Violence GBV Classification Tips

As discussed above, data collection can be of great use. Once analyzed, especially with an intersectional lens, it can inform programming, increase safety and improve services so that no one is left behind.

This tool uses the classification of GBV set forth in the GBVIMS Gender-Based Violence Classification Tool.

The GBV Classification Tool consists of six core types of GBV used by the GBVIMS to classify reported GBV incidents: Rape, Sexual Assault, Physical Assault, Forced Marriage, Denial of Resources Opportunities or Services, and Psychological/Emotional Abuse (defined below).

It is important to remember that only one type of GBV should be indicated, even if multiple types apply.

To classify an incident, simply ask yourself the questions provided to the right of the types of GBV in their given order; the first incident type on the list that matches the description of the case (when the answer is 'Yes') should be the type used to classify the incident. The questions are listed on the intake form as a resource for the caseworker to use while classifying the incident. These questions should not be asked of the survivor during the interview. This field can, therefore, be filled in after the interview if the caseworker chooses.

If the incident is not an act of gender-based violence, select 'Non-GBV' and explain why.

These tips expand upon the classification of GBV set forth in the GBVIMS Gender-Based Violence Classification Tool to include specific violence that people with intersecting identities are at higher risk of experiencing.

1. Rape: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.

- The perpetrator may be a family member.
- Please note that non-consensual

penetration within a marriage or other romantic relationship is still rape.

2. Sexual Assault: any form of non-consensual sexual contact that does not result in or include penetration.

- Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks, but also FGM/C.
- Violence that women with disabilities, but also gender non-conforming people, are at higher risk of experiencing such as: enforced sterilization, forced abortion, invasive contraception, or forced gender-reassignment surgeries, should also be classified as sexual assault.
- The perpetrator may be a family member.

3. Physical Assault: an act of physical violence that is not sexual in nature.

- Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks, or any other act that results in pain, discomfort or injury.
- The administration of electroshock treatment and the use of chemical, physical or mechanical restraints may be classified as physical assault.

4. Forced Marriage: the marriage of an individual against their will.

- This includes when a survivor is forced to marry their perpetrator.

5. Denial of Resources, Opportunities or Services: denial of rightful access to economic resources, assets, or livelihood opportunities, education, health or other social services.

- Examples include: a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, removal of an assistive device from a woman with disabilities, denial of legal and decision-making capacity for a woman with disabilities, etc.
- Reports of general poverty should not be

recorded.

6. Psychological/Emotional Abuse: infliction of mental or emotional pain or injury.

- Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation or seclusion, abandonment or neglect, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, 'outing' a person with diverse SOGIESC (meaning to reveal someone publicly as being Queer without their consent) etc.

Case Contexts

In addition to the six core types of GBV, the Intake and Initial Assessment Tool includes questions that are designed to gather information that can allow for a more detailed analysis of the GBV incident and the context surrounding it.

The following 'case contexts' describe GBV incidents by giving information about the power relationships, or context in which the act of GBV occurred.

It is important to note that even though certain acts are not punishable by the laws of a certain country, they can still be GBV. Rape within marriage is an example of this.

Intimate Partner Violence is defined by the relationship between perpetrator and survivor and may include multiple forms of violence (rape, sexual assault, physical assault, psychological/emotional abuse), which can lead to inconsistencies in the recording of incidents.

- By analysis of the type of GBV and the survivor's relationship with the perpetrator, one is able to identify and analyze which incidents took place within the context of an intimate partner relationship. **Intimate partner violence** includes violence between same-sex couples.

Child Sexual Abuse is defined by the age of the survivor. It includes different forms of sexual violence, which can lead to inconsistencies in the recording of incidents.

- By analysis of two incident types (sexual

assault and rape) and the age of the survivor, one is easily able to analyze which reported incidents were child sexual abuse cases.

Early Marriage is defined by the age of the survivor at the time of a forced marriage. A marriage that happens before the age of 18 years is an early marriage. However, a marriage where both individuals are 18 years or older but other factors make them unready to consent to marriage, such as their level of physical, emotional, sexual, and psychological development, or a lack of information regarding their life options, is also considered an early marriage.

- Analysis of the incident type and the age of the survivor identifies those incidents that took place in the context of an early marriage.

Possible Sexual Exploitation and Transactional Sex are defined by the power relationship between survivor and perpetrator, as well as the circumstances surrounding the incident – not the actual act of violence (i.e., rape or sexual assault), which can lead to inconsistencies in the recording of incidents.

- The Intake and Initial Assessment Tool includes a question in which 'yes/no' can be indicated in response to the question 'were money, goods, benefits and/or services exchanged in the context of the reported incident?' which can give a sense of whether the sexual violence being reported is exploitative in nature.

Possible Sexual Slavery is defined by the circumstances during which multiple acts and various forms of sexual violence are perpetrated over a period of time. The incident recorder is only able to capture one unique incident at a time.

- The Intake and Initial Assessment Tool includes a question for indicating whether the incident was perpetrated while the survivor was: a) being forcibly transported (trafficked); b) being forced to join an armed group (forced conscription); c) held against their will, abducted, or kidnapped.

Harmful Traditional Practices are defined by the local social, cultural and religious values

where the incident takes place. To distinguish those acts of GBV that are harmful traditional practices specific to the context in which they took place, the Intake and Initial Assessment Tool includes a question to indicate whether the GBV was a type of harmful traditional practice.

- The responses must be customized locally to define the incident as one of up to four relevant types of harmful traditional practices found in that context.
- Examples of harmful traditional practices are: early and child marriage, female genital mutilation (FGM), corporal punishment, rites of passage and scarification.

Violence against Women and Girls with Disabilities requires that the survivor has a disability, and may involve multiple forms of violence, including physical, sexual, psychological, and economic.

- The Intake and Initial Assessment Tool includes the 12 Washington Group Short Set – Enhanced Questions, which indicates whether or not a survivor may have a disability.
- Please note that a disability may or may not be visible.

These Classification Tips are adapted from the GBVIMS GBV Classification Tool, which is designed to be used with the GBVIMS system and Incident Recorder. Please refer to the GBVIMS GBV Classification Tool for more information. [<https://gbvims.com/wp/wp-content/uploads/Annex-B-Classification-Tool.pdf>]. For further information on the GBVIMS tools: <https://www.gbvims.com>.

4. Alleged Perpetrator

Be aware that in cases of same-sex relationships missing / sexual violence perpetrated by someone with the same sex as the client, such information cannot be disclosed by the survivor.

5. Planned Action

When conducting referrals, you may add actors that can provide further and more specialized support for specific groups, such as persons with disabilities or people with diverse SOGIESC.

In the section ‘If no, why not?’, it can be also useful to provide information in cases where identity factors are the main reason, e.g. no referral to the police was carried out as the survivor came from the diverse SOGIESC community and it may put them at risk; or no referral to a safe shelter as the shelter in our area does not accept women with children over 5 years-old.

These elements can feed your advocacy and may illustrate gaps in term of the inclusion of survivors in all their diversity.

6. Assessment Point

In order to facilitate access for other services, and especially for survivors with specific needs, it can be appropriate to discuss with the survivor what kind of adaptation/accommodation/assistance they may need.

What actions can be taken to facilitate access to services (i.e., sign-language interpreter, transportation costs, follow up by phone, etc.)? ^

Where to go next in the toolkit

Refer to the Guidelines for Obtaining Informed Consent for more information on obtaining informed consent or assent from a survivor before referring them to services or sharing any of their information.

The Tool Inclusive Referral System can be used after the initial intake to guide specialized GBV actors in making appropriate referrals.

Complementary Resources

[Washington Group on Disability Statistics Website](#)

[Translations of Washington Group Questions](#)

[Child Functioning Questions for 2-4-year-old](#)

[Child Functioning Questions for 5-17-year-old](#)

[GBVIMS Classification Tool](#)

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Intake and initial assessment form

Theme: Action

BEFORE BEGINNING THE INTERVIEW, PLEASE REMIND THE CLIENT THAT ALL INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL AND THAT THEY MAY CHOOSE TO DECLINE TO ANSWER ANY OF THE FOLLOWING QUESTIONS.

Questions marked with an (^) are questions that are either not included in, or have been changed from the GBVIMS form. These questions collect data on diverse identity factors, enabling an intersectional analysis.

Questions in bold are either questions from GBVIMS, or are supplemental, that are crucial for conducting intersectional analysis.

1. ADMINISTRATIVE INFORMATION

STAFF CODE:	DATE OF INTERVIEW (DAY/MONTH/YEAR)*:	DATE OF INCIDENT (DAY/MONTH/YEAR)*:

☐

Reported by the survivor or reported by the survivor's escort and the survivor is present at the reporting* (this incident will be entered into the incident recorder)

☐

Reported by someone other than the survivor and the survivor is not present at the reporting* (this incident will not be entered into the GBVIMS incident recorder)

*If reported by someone other than the survivor, what is their relationship to the survivor?**

2. GENERAL SURVIVOR INFORMATION

Be careful when collecting data relating to identity factors.

You do not have to follow the order of the questions. Keep the interview open and conversational.

Always put into practise the 'Know and Tell Why' before questioning about identity factors such as gender, religion and nationality. For more information refer to the Intake and Initial Assessment Form Guidance.

DATE OF BIRTH (DAY/MONTH/YEAR)*: Approximate if necessary	GENDER*^: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Gender non-conforming

COUNTRY OF ORIGIN*:	CURRENT CIVIL/MARITAL STATUS*:			
NATIONALITY (if different from country of origin):	<input type="checkbox"/> Single			
RELIGION:	<input type="checkbox"/> Divorced/Separated			
NUMBER, AGE AND GENDER OF CHILDREN AND OTHER DEPENDENTS (if applicable):	<input type="checkbox"/> Married/Cohabiting <input type="checkbox"/> Widowed			
OCCUPATION :				
DISPLACEMENT STATUS AT TIME OF REPORT*:				
<input type="checkbox"/> Resident	<input type="checkbox"/> IDP	<input type="checkbox"/> Refugee	<input type="checkbox"/> Stateless Person	
<input type="checkbox"/> Returnee	<input type="checkbox"/> Foreign National	<input type="checkbox"/> Asylum Seeker	<input type="checkbox"/> N/A	
SPECIFIC NEEDS / VULNERABILITIES* ^ (check all that apply)				
<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Unaccompanied Minor	<input type="checkbox"/> Pregnant/Lactating Woman ^		
<input type="checkbox"/> Mental Disability	<input type="checkbox"/> Separated Child	<input type="checkbox"/> Elderly Person ^		
<input type="checkbox"/> None	<input type="checkbox"/> Other Vulnerable Child	<input type="checkbox"/> Asylum Seeker	<input type="checkbox"/> N/A	

2. 1 QUESTIONS ON FUNCTIONING

	NO, NO DIFFICULTY	YES, SOME DIFFICULTY	YES, A LOT OF DIFFICULTY	DATE OF INCIDENT (DAY/MONTH/ YEAR)*:
1. DO YOU HAVE DIFFICULTY SEEING, EVEN IF WEARING GLASSES?				
2. DO YOU HAVE DIFFICULTY HEARING, EVEN IF USING A HEARING AID?				
3. DO YOU HAVE DIFFICULTY WALKING OR CLIMBING STEPS?				
4. DO YOU HAVE DIFFICULTY REMEMBERING OR CONCENTRATING?				
5. DO YOU HAVE DIFFICULTY WITH SELF-CARE SUCH AS WASHING ALL OVER OR DRESSING?				
6. DO YOU, USING YOUR USUAL LANGUAGE, HAVE DIFFICULTY COMMUNICATING, FOR EXAMPLE UNDERSTANDING OR BEING UNDERSTOOD?				

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FUNCTIONAL LIMITATION ^ (using WGSQ)

- ☐ Cognitive ^
- ☐ Physical ^
- ☐ Hearing ^
- ☐ Vision ^
- ☐ Speech and Language ^

Intake and Initial Assessment Form – Adapted from GBVIMS
GBV Response Tool – Intersectionality Toolkit

**IF CLIENT RESPONDED ‘YES’ TO ANY OF QUESTIONS 1-6 ABOVE:
WHERE DOES THE CLIENT LIVE?**

- ☐ Private home ☐ Institution ☐ Other (please specify)

DOES THE CLIENT HAVE A CAREGIVER?

- ☐ Yes ☐ No

If ‘yes’, what is the caregiver’s relationship to the client? _____

2.2 SUBSECTION FOR CHILD SURVIVORS (UNDER 18 YEARS OLD)*
IS THE CLIENT AN UNACCOMPANIED MINOR, SEPARATED CHILD, OR OTHER VULNERABLE CHILD?*
**IF THE SURVIVOR IS A CHILD (UNDER 18 YEARS
OLD) DO THEY LIVE ALONE?***

(if ‘No’, answer the next four questions)

- ☐ Yes ☐ No

DOES THE SURVIVOR LIVE IN AN INSTITUTION?^

- ☐ Yes ☐ No

**IF THE SURVIVOR LIVES WITH A CARETAKER, WHAT IS THE RELATION BETWEEN THEM AND THE
CARETAKER?***

- ☐ Parent/Guardian ☐ Relative ☐ Spouse / Cohabiting ☐ Other:

CURRENT CIVIL/MARITAL STATUS*:

- ☐ Single ☐ Divorced/Separated ☐ Married/Cohabiting ☐ Widowed
- ☐ Unknown ☐ NA

WHAT IS THE CARETAKER’S PRIMARY OCCUPATION? *:

3. BRIEF DETAILS OF THE INCIDENT

<p>TIME OF DAY THAT THE INCIDENT TOOK PLACE*:</p> <p><input type="checkbox"/> Morning (sunrise to noon)</p> <p><input type="checkbox"/> Afternoon (noon to sunset)</p> <p><input type="checkbox"/> Evening/night (sunset to sunrise)</p> <p><input type="checkbox"/> Unknown/Not Applicable</p>	<p>INCIDENT LOCATION/WHERE THE INCIDENT TOOK PLACE*():</p>
<p>GEOGRAPHICAL AREA WHERE INCIDENT OCCURRED, BE AS SPECIFIC AS POSSIBLE (E.G. AREA, SUB-AREA, CAMP, TOWN, SITE)*():</p>	

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CONTINUATION

<p>TYPE OF INCIDENT VIOLENCE*: (PLEASE REFER TO THE GBV CLASSIFICATION IN THE NEXT COLUMN AND SELECT ONLY ONE. FOR MORE INFORMATION, PLEASE REFER TO THE GBV CLASSIFICATION TIP SHEET)</p> <p><input type="checkbox"/> Rape (includes gang rape, marital rape)</p> <p><input type="checkbox"/> Sexual Assault (includes attempted rape and all sexual violence/abuse without penetration, and female genital mutilation/cutting)</p> <p><input type="checkbox"/> Physical Assault (includes hitting, slapping, kicking, shoving, etc. that are not sexual in nature)</p> <p><input type="checkbox"/> Forced Marriage (includes early marriage)</p> <p><input type="checkbox"/> Denial of Resources, Opportunities or Services, including removal of assistive devices Psychological / Emotional Abuse</p> <p><input type="checkbox"/> Non-GBV (specify):</p>	<p>Did the reported incident involve penetration? If yes, classify the incident as 'Rape'. If no, proceed to the next incident type on the list.</p> <p>Did the reported incident involve unwanted sexual contact and/or forced sterilization? If yes, classify the incident as 'Sexual Assault'. If no, proceed to the next incident type on the list.</p> <p>Did the reported incident involve physical assault? If yes, classify the incident as 'Physical Assault'. If no, proceed to the next incident type on the list.</p> <p>Was the incident an act of forced marriage? If yes, classify the incident as 'Forced Marriage'. If no, proceed to the next incident type on the list.</p> <p>Did the reported incident involve the denial of resources, opportunities or services? If yes, classify the incident as 'Denial of Resources, Opportunities or Services'. If no, proceed to the next incident type on the list.</p> <p>Did the reported incident involve psychological/emotional abuse? If yes, classify the incident as 'Psychological/Emotional Abuse'. If no, proceed to the next incident type on the list.</p> <p>Is the reported incident a case of GBV? If yes, start again at number 1 and try again to reclassify the incident (if you have tried to classify the incident multiple times, ask your supervisor to help you classify this incident). If no, classify the incident as 'Non-GBV'</p>
<p>Note: these incidents will be entered into the incident recorder if using GBVIMS</p>	
<p>WAS THIS INCIDENT A HARMFUL TRADITIONAL PRACTICE? *</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES (please describe)</p>	<p>WERE MONEY, GOODS, BENEFITS, AND/OR SERVICES EXCHANGED IN RELATION TO THIS INCIDENT? *</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES (please describe)</p>

TYPE OF ABDUCTION AT TIME OF THE INCIDENT*:		
<input type="checkbox"/> None	<input type="checkbox"/> Trafficked	<input type="checkbox"/> Other Abduction / Kidnapping
<input type="checkbox"/> Detention/Torture	<input type="checkbox"/> Forced	
HAS THE CLIENT REPORTED THIS INCIDENT ANYWHERE ELSE? * ^ (if yes, select the type of service provider and write the name of the provider where the client reported); (select all that apply).		
<input type="checkbox"/> No		
<input type="checkbox"/> Health/Medical Services		
<input type="checkbox"/> Psychosocial/Counselling Services		
<input type="checkbox"/> Police/Other Security Actor		
<input type="checkbox"/> Legal Assistance Services		
<input type="checkbox"/> Livelihoods Programme		
<input type="checkbox"/> Safe House/Shelter		
<input type="checkbox"/> Other (specify)		
HAS THE CLIENT HAD ANY PREVIOUS INCIDENTS OF GBV PERPETRATED AGAINST THEM? * <input type="checkbox"/> Yes <input type="checkbox"/> No		
*If yes, include a brief description which also mentions when and where that happened.		

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4. ALLEGED PERPETRATOR INFORMATION

<p>NUMBER OF ALLEGED PERPETRATOR(S)*:</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> More than 3</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Non-GBV (specify):</p>	<p>SEX OF ALLEGED PERPETRATOR(S)*:</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Both female and male perpetrators</p>
<p>AGE GROUP OF ALLEGED PERPETRATOR(S) (if known or can be estimated):</p> <p><input type="checkbox"/> 0 – 11</p> <p><input type="checkbox"/> 12 – 14</p> <p><input type="checkbox"/> 15 – 17</p> <p><input type="checkbox"/> 18 – 25</p> <p><input type="checkbox"/> 26 – 40</p> <p><input type="checkbox"/> 41-60</p> <p><input type="checkbox"/> 61+</p>	<p>ALLEGED PERPETRATOR RELATIONSHIP WITH SURVIVOR*: (select the first ONE that applies)</p> <p><input type="checkbox"/> Intimate partner / Former partner</p> <p><input type="checkbox"/> Primary caregiver</p> <p><input type="checkbox"/> Family other than spouse or caregiver</p> <p><input type="checkbox"/> Supervisor/Employer</p> <p><input type="checkbox"/> Teacher/School official</p> <p><input type="checkbox"/> Service Provider</p> <p><input type="checkbox"/> Co-tenant/Housemate</p> <p><input type="checkbox"/> Schoolmate</p> <p><input type="checkbox"/> Family Friend/Neighbour</p> <p><input type="checkbox"/> Other refugee/IDP/returnee</p> <p><input type="checkbox"/> Other resident community member</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> No relation</p> <p><input type="checkbox"/> Unknown</p>

5. PLANNED ACTION / ACTION TAKEN: ANY ACTION / ACTIVITY REGARDING THIS REPORT.

WHO REFERRED THE CLIENT TO YOU?*	
<input type="checkbox"/> Health/Medical Services	<input type="checkbox"/> Teacher/School Official
<input type="checkbox"/> Psychosocial/Counselling Services	<input type="checkbox"/> Community or Camp Leader
<input type="checkbox"/> Police/Other Security Actor	<input type="checkbox"/> Safe House/Shelter
<input type="checkbox"/> Legal Assistance Services	<input type="checkbox"/> Other Humanitarian or Development Actor
<input type="checkbox"/> Livelihoods Programme	<input type="checkbox"/> Other Government Service
<input type="checkbox"/> Self-Referral/First Point of Contact	<input type="checkbox"/> Other (specify)
DID YOU REFER THE CLIENT TO A SAFE HOUSE/SAFE SHELTER? *	DATE REPORTED OR FUTURE APPOINTMENT DATE (DAY/MONTH/YEAR) AND
<input type="checkbox"/> YES	Time:
<input type="checkbox"/> NO If 'No', Why not?	Name and Location:
	Notes (including action taken or recommended action to be taken):
DID YOU REFER THE CLIENT TO HEALTH/MEDICAL SERVICES? *	DATE REPORTED OR FUTURE APPOINTMENT DATE (DAY/MONTH/YEAR) AND
<input type="checkbox"/> YES	Time:
<input type="checkbox"/> NO If 'No', Why not?	Name and Location:
	Notes (including action taken or recommended action to be taken):
DID YOU REFER THE CLIENT TO PSYCHOSOCIAL SERVICES?	DATE REPORTED OR FUTURE APPOINTMENT DATE (DAY/MONTH/YEAR) AND
<input type="checkbox"/> YES	Time:
<input type="checkbox"/> NO If 'No', Why not?	Name and Location:
	Notes (including action taken or recommended action to be taken):

5. PLANNED ACTION / ACTION TAKEN: ANY ACTION / ACTIVITY REGARDING THIS REPORT. (CONTINUATION)

<p>DOES THE CLIENT WANT TO PURSUE LEGAL ACTION? *</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> Undecided at Time of Report</p>	
<p>DID YOU REFER THE CLIENT TO LEGAL ASSISTANCE SERVICES? *</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO If 'No', Why not?</p>	<p>DATE REPORTED OR FUTURE APPOINTMENT DATE (DAY/MONTH/YEAR) AND</p> <p>Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>
<p>DID YOU REFER THE CLIENT TO THE POLICE OR OTHER TYPE OF SECURITY ACTOR? *</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO If 'No', Why not?</p>	<p>DATE REPORTED OR FUTURE APPOINTMENT DATE (DAY/MONTH/YEAR) AND</p> <p>Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>
<p>DID YOU REFER THE CLIENT TO A LIVELIHOODS PROGRAMME?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO If 'No', Why not?</p>	<p>DATE REPORTED OR FUTURE APPOINTMENT DATE (DAY/MONTH/YEAR) AND</p> <p>Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>

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<p>DID YOU REFER THE CLIENT TO AN ACTOR SUPPORTING PERSONS WITH DISABILITIES? ^</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO If 'No', Why not?</p>	<p>DATE REPORTED OR FUTURE APPOINTMENT DATE (DAY/MONTH/YEAR) AND</p> <p>Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>
<p>DID YOU REFER THE CLIENT TO AN ACTOR PROVIDING SUPPORT TO MARGINALISED GROUPS SUCH AS LGBTQI, RELIGIOUS MINORITY ETC.) ^</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO If 'No', Why not?</p>	<p>DATE REPORTED OR FUTURE APPOINTMENT DATE (DAY/MONTH/YEAR) AND</p> <p>Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>
<p>DID YOU REFER THE CLIENT TO A LIVELIHOODS PROGRAMME?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO If 'No', Why not?</p>	<p>DATE REPORTED OR FUTURE APPOINTMENT DATE (DAY/MONTH/YEAR) AND</p> <p>Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>

INCIDENT ID

CLIENT CODE

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Confidential**6 - ASSESSMENT POINT**

<p>DESCRIBE THE CLIENT'S EMOTIONAL STATE AT THE END OF THE INTERVIEW:</p> <p><input type="checkbox"/> Scared / Fearful</p> <p><input type="checkbox"/> Sad / Depressed</p> <p><input type="checkbox"/> Anxious / Nervous</p> <p><input type="checkbox"/> Angry</p> <p><input type="checkbox"/> Calm</p> <p><input type="checkbox"/> Other</p>	<p>DESCRIBE THE CLIENT'S EMOTIONAL STATE AT THE END OF THE INTERVIEW:</p> <p><input type="checkbox"/> Scared / Fearful</p> <p><input type="checkbox"/> Sad / Depressed</p> <p><input type="checkbox"/> Anxious / Nervous</p> <p><input type="checkbox"/> Angry</p> <p><input type="checkbox"/> Calm</p> <p><input type="checkbox"/> Other</p>
<p>WILL THE CLIENT BE SAFE WHEN THEY LEAVE?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO If 'No', Why not?</p>	<p>OTHER RELEVANT INFORMATION? ^</p>
<p>WHAT ACTIONS CAN BE TAKEN TO FACILITATE ACCESS TO SERVICES (I.E. SIGN LANGUAGE INTERPRETER, TRANSPORTATION COSTS, ETC.)?</p>	
<p>IF RAPED, HAVE YOU EXPLAINED THE POSSIBLE CONSEQUENCES OF RAPE TO THE CLIENT (AND CAREGIVER IF CLIENT IS UNDER 14 YEARS OF AGE OR A PERSON WITH A DISABILITY)?</p>	<p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p>
<p>DID THE CLIENT GIVE THEIR CONSENT TO SHARE THEIR NON-IDENTIFIABLE INFORMATION IN YOUR REPORTS? *</p>	<p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p>

Refer to the Guidelines for Obtaining Informed Consent for information on obtaining informed consent or assent from a survivor and have them give verbal or written consent on the Final Consent for Release of Information form before referring them to services or sharing any of their information.

THIS IS THE END OF THE INTAKE AND INITIAL ASSESSMENT FORM

Intake and Initial Assessment Form – Adapted from GBVIMS
GBV Response Tool – Intersectionality Toolkit





APPENDIX

Annexes:

LIST OF ANNEXES (TO BE FOUND IN ATTACHED DOCUMENT READY-TO BE PRINTED)

- Staff Attitude Scale
 - SERVICE GAP ANALYSIS — Part B: Quality Checklist for Working with Groups Affected by Inequality and Discrimination
 - SERVICE GAP ANALYSIS — Part C: Action Plan and Monitoring Tool
 - Referral pathway template
 - CONFIDENTIAL Consent for Release of Information [Written]
 - CONFIDENTIAL Consent for Release of Information [Verbal] Intake and Assessment Form
- You can find the following annexes ready to be printed in this link:*
<<ENTER LINK>>:

An additional resource: the “How-To Guide: Intersectionality in practice”

Since 2017, the HI Making It Work Gender and Disability project has been working alongside 21 women-led organizations across Africa in Benin, Burundi, Cameroon, Kenya, Malawi, Mali, Nigeria, Senegal, Togo, Uganda and Rwanda. The MIW project aims at increasing the visibility of women and girls with disabilities and supporting women-led organisations implementing sustainable practices to fight gender-based violence.

HI-MIW published on the 8th of March 2022 the How-To Guide: Intersectionality in Practice co-developed with Inclusive Friends Nigeria (IFA). It is a practical guide to support organizations to adopt an intersectional approach in their work.

The How-To Guide is providing steps and tools to adopt an intersectional approach to design and initiate projects that will leave no woman behind. Although it was developed with a targeted intersectional approach where gender is at the center of the factors of discrimination, the How-To Guide can be used to approach any context and considers all the factors of discrimination to analyze the lived experiences of individuals of all genders and (dis)ability status. The How-To Guide is organized in 2 different tools, as follows. Each tool is made of activities, explanations and propositions for organisations to embark on the journey of intersectionality.

TOOL 1 — EXPLORING WHO WE ARE

The aim of Tool n°1, “Exploring who we are”, is to question ourselves in order to raise awareness and thus think about who we are, what biases we have, where we are situated in the social space, what power dynamics we are involved in, and how these factors might impact our actions and our work.

Part I — Self-Reflection: My identity factors

- Activity 1-1: Define your own identity factors and multiple identities
- Activity 1-2: Questioning bias and prejudices

Part II — About your organization

- Activity 2-1: My vision of diversity in my organization
- Activity 2-2: Analyzing diversity in my organization

TOOL 2 — WORKING WITH AND FOR THE MOST AT-RISK WOMEN

This tool does focus on the phase of the project where you define:

- Who to work with, using an intersectional approach ; and
- How to reach the persons/ the group or groups you want to work with

Part I — Analyzing context with an intersectional lens

Part II — Identifying and engaging with the women/persons you want to work with

The following links to the How-To Guide in English and French are provided hereafter.

Link to the How-To Guide in English in PDF

Link to the How-To Guide in English in Word

Link to the How-To Guide in French in PDF

Link to the How-To Guide in French in Word

Glossary

The definitions provided here are intended to provide additional context for the specific content of this toolkit and are focused on highlighting issues relating to gender and related intersectional issues. Definitions are included here as a baseline starting point for shared understanding between practitioners.

ACCESSIBILITY: Appropriate measures to ensure peoples with disabilities access (services) on an equal basis with others.

BIAS: A prejudice against something or someone. Biases are often based on stereotypes and result in harmful attitudes and discriminatory practices, either direct or indirect. Many people may be unaware of their biases formed from lifelong social norms, which discriminate against certain groups of people.

CASE MANAGEMENT: It is a multisectoral process which assesses, plans, implements, coordinates, monitors and evaluates available resources, options and services to meet survivors' needs and to promote quality, effective outcomes. It is useful for survivors with complex needs who access services from a range of service providers.²² Case management is the process of helping individual survivors, or children and their families through direct social-work type support, and information management.

CISGENDER: A term for people

whose gender identity, expression or behavior aligns with those typically associated with their assigned sex at birth.

DISABILITY: Physical or mental impairment that affects a person's ability to carry out normal day-to-day activities.

DISCRIMINATION: Direct discrimination: occurs when certain people are treated less favorably than other people because of a different personal status.

INDIRECT DISCRIMINATION: occurs when laws, policies, or practices, which may appear neutral, have a disproportionately negative impact on certain people.

DO NO HARM: It is a key ethical principle and obligation that guides any humanitarian, human rights or accountability interventions. It imposes upon intervening actors the duty to analyze the possible negative impacts of their actions, particularly on victims, witnesses, and affected populations, and to accordingly put in place measures to prevent or minimize such harm.²³

EXCLUSION: The consequences that discrimination and violence may have in the lives of groups affected by inequality. There may be conscious and subconscious ways in which we relegate excluded groups to subordinate positions, making them feel as if they are less important than those who hold more power or privilege in the community.

GENDER: Gender refers to the roles, behaviors, activities, and attributes that a given society at a given time considers appropriate for men and women.²⁴

GENDER BASED VIOLENCE (GBV): An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between females and males.²⁵ The nature and extent of specific types of GBV vary across cultures, countries and regions.

GENDER EXPRESSION: It is how a person publicly expresses or presents their gender. This can include behavior and outward appearance such as dress, hair, make-up, body language and voice.

22 — UNFPA, Managing Gender-based Violence Programs in Emergencies, 2012, p35: <https://www.unfpa.org/publications/managing-gender-based-violence-programmes-emergencies>

23 — UK Foreign & Commonwealth Office, International Protocol on the Documentation and Investigation of Sexual Violence in Conflict, Second edition ("PSVI Protocol"), 2017, p85.

24 — UN Women, "OSAGI Gender Mainstreaming - Concepts and definitions", <https://www.un.org/womenwatch/osagi/>

GENDER IDENTITY: Person's internal and individual experience of gender. This could include an internal sense of being a man, woman, both, neither or another gender entirely. A person's gender identity may or may not correspond with social expectations associated with the sex they were assigned at birth.

HETERONORMATIVITY: Heteronormativity is an expression used to describe or identify a social norm relating to standardized heterosexual behavior, whereby this standard is considered to be the only socially valid form of behavior and anyone who does not follow this social and cultural posture is placed at a disadvantage in relation to the rest of society.

IDENTITY: Different aspects of one's experience based on the characteristics (e.g. age, class, ethnicity, etc.) and roles (e.g. mother, athlete, student, leader, etc.) that connect individuals to specific groups in society and make each person uniquely who they is.

One's identity influences how one sees the world, chooses to act, and is treated by others. While some parts of identity (e.g. skin color) are

quite public, other aspects (e.g. sexual orientation) may be kept hidden, due to fear for one's safety or fear of stigma, rejection, or judgement.²⁶ It is important to note that identity is both chosen and imposed.

INCLUSION: The process of improving the way people participate in the community and how they access services and resources.

Inclusion is particularly important for diverse women and girls who face discrimination, increased risk, and additional barriers to participation and access to services. Inclusion involves proactively addressing barriers and risk to ensure everyone can meaningfully participate and benefit from services. Inclusion involves enhancing opportunities, access to resources, voice, and respect for rights.²⁷

INFORMED ASSENT: Assent is a term used to express willingness to participate in research by persons who are by definition too young to give informed consent but are old enough to understand the proposed research in general, its expected risks and possible benefits, and the activities expected of them as subjects. Assent by itself is not

sufficient, however. If assent is given, informed consent must still be obtained from the subject's parents or guardian.

Informed consent: Implies that individuals involved are legally capable of consenting and that all relevant information concerning the intervention, its implications and its consequences have been provided²⁸, in a language that is fully understood²⁹. It implies that before consenting, individuals involved must be fully aware of and understand precisely all the parameters concerning the intervention and what it entails³⁰.

INTERSECTIONALITY: This feminist framework created by Kimberlé Crenshaw³¹ explains how interlocking systems of oppression mean that women and girls experience violence and discrimination differently based on their race, class, age, disability, sexual orientation, gender identity, ethnicity and religion.

An intersectional approach requires that action to achieve social justice be informed by an understanding of the multiple experiences of inequality faced by women and girls, rather than prioritizing the experience or needs of one group of women over another.

25 — UNICEF, "Glossary of Terms and Concepts", 2017, p2: <https://www.unicef.org/rosa/media/1761/file/Gender%20glossary%20of%20terms%20and%20concepts%20.pdf>

26 — Raising Voices, "Get Moving! Facilitator's Guide," 2012, p47: https://prevention-collaborative.org/wp-content/uploads/2021/08/GBV_Prevention_Network_2012_Get_Moving.pdf

27 — HelpAge International, "Humanitarian Inclusion Standards for Older People and

Persons with disabilities," ADCAP, 2018, p11: <https://reliefweb.int/report/world/humanitarian-inclusion-standards-older-people-and-people-disabilities>

28 — Standard Operating Procedures for Gender-Based Violence Prevention and Response, 2018, p35-38

29 — Care International Secretariat, Communications involving survivors of gender-based violence policy and guidelines, 2014, p. 2, at [https://insights.careinternational.org.uk/images/in-practice/GBV/GBV-Comms-](https://insights.careinternational.org.uk/images/in-practice/GBV/GBV-Comms-Policy-and-Guidelines.pdf)

[Policy-and-Guidelines.pdf](https://insights.careinternational.org.uk/images/in-practice/GBV/GBV-Comms-Policy-and-Guidelines.pdf)

30 — Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies 2007, op. cit., p. 22.

31 — Kimberlé Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," University of Chicago Legal Forum, Vol. 1989 Issue 1: <https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi>.

PARTICIPATION: Meaningfully involving groups affected by inequality and discrimination in decision-making and action both in their communities and within the wider humanitarian and development system. Women and girls' participation promotes community resilience by building on the existing capacities and resources of diverse women and girls. Participation of diverse women and girls from the affected community, individually and through local women's movements and groups, can enhance local capacity, foster ownership, build resilience and improve sustainability.³² Participation is a key aspect of empowerment and results in better humanitarian and development outcomes.

PATRIARCHY: A social system that affords men the most systemic privileges and power and most often oppresses women, girls, people with diverse sexual orientations, gender identities and sex characteristics (SOGIESC), treating them as inferior.

People-centered approach: A human-centered design principle that focuses on co-creating proper solutions. It ensures that we see people as unique individuals with valuable gifts and contributions.

POWER: Power is the ability to influence your own or others' experiences.

PRIVILEGE: Certain social advantages, benefits, or degrees of prestige and respect that an individual has by virtue of belonging to certain social identity groups.

PRONOUNS: A word that refers to either the person talking (I or you) or someone or something being talked about (she, he, it, them, they or this). Transgender women and girls face difficulty when the pronoun they identify with does not match the sex they were assigned at birth or others' perception of their gender identity. Respecting a person's pronoun(s) is a simple act of inclusion.

REASONABLE ACCOMMODATION: The necessary and appropriate modifications and adjustments where needed in a particular case and that do not impose a disproportionate or undue burden, to ensure that women and girls with disabilities are comfortable, or exercise on an equal basis with others all human rights and fundamental freedoms.³³

REFERRAL PATHWAY: It is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health

and psychosocial support, police assistance and legal/justice support.³⁴

SEXUAL ORIENTATION, GENDER IDENTITY, GENDER EXPRESSION AND SEX CHARACTERISTICS (SOGIESC):

The umbrella term for people with diverse sexual orientations, gender identities, gender expressions and/or sex characteristics.

SURVIVOR: A person who has experienced gender-based violence. 'Survivor' is the preferred term in rights-based work because it implies resiliency.

SURVIVOR CENTERED APPROACH

IN GBV: Establishing a relationship with the survivor that promotes their emotional and physical safety, builds trust and helps them to restore some control over their life.

SYSTEM OF OPPRESSION:

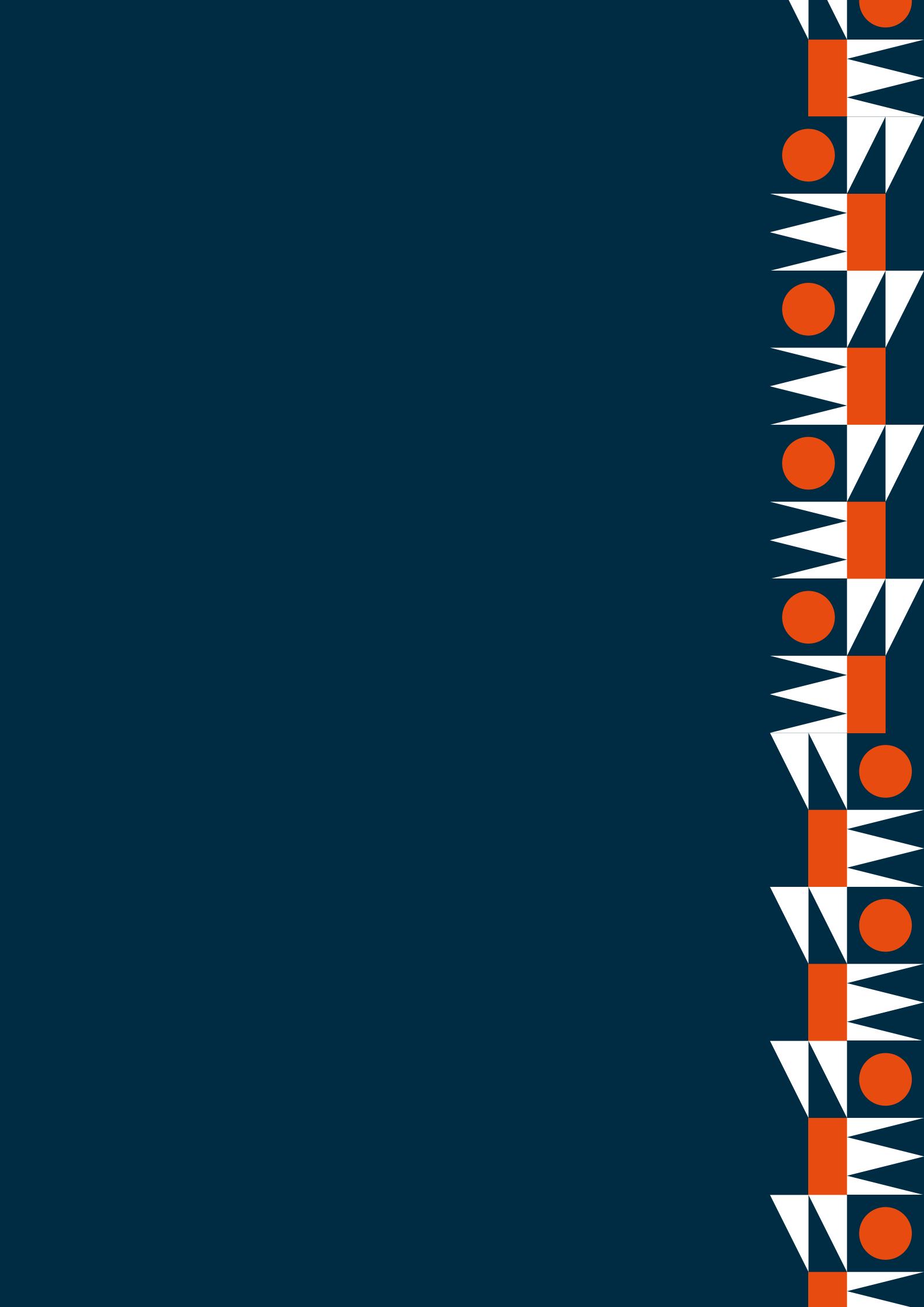
Any system designed to hinder a group of people from a non-dominant group from accessing the resources and privileges available to people from a dominant group.

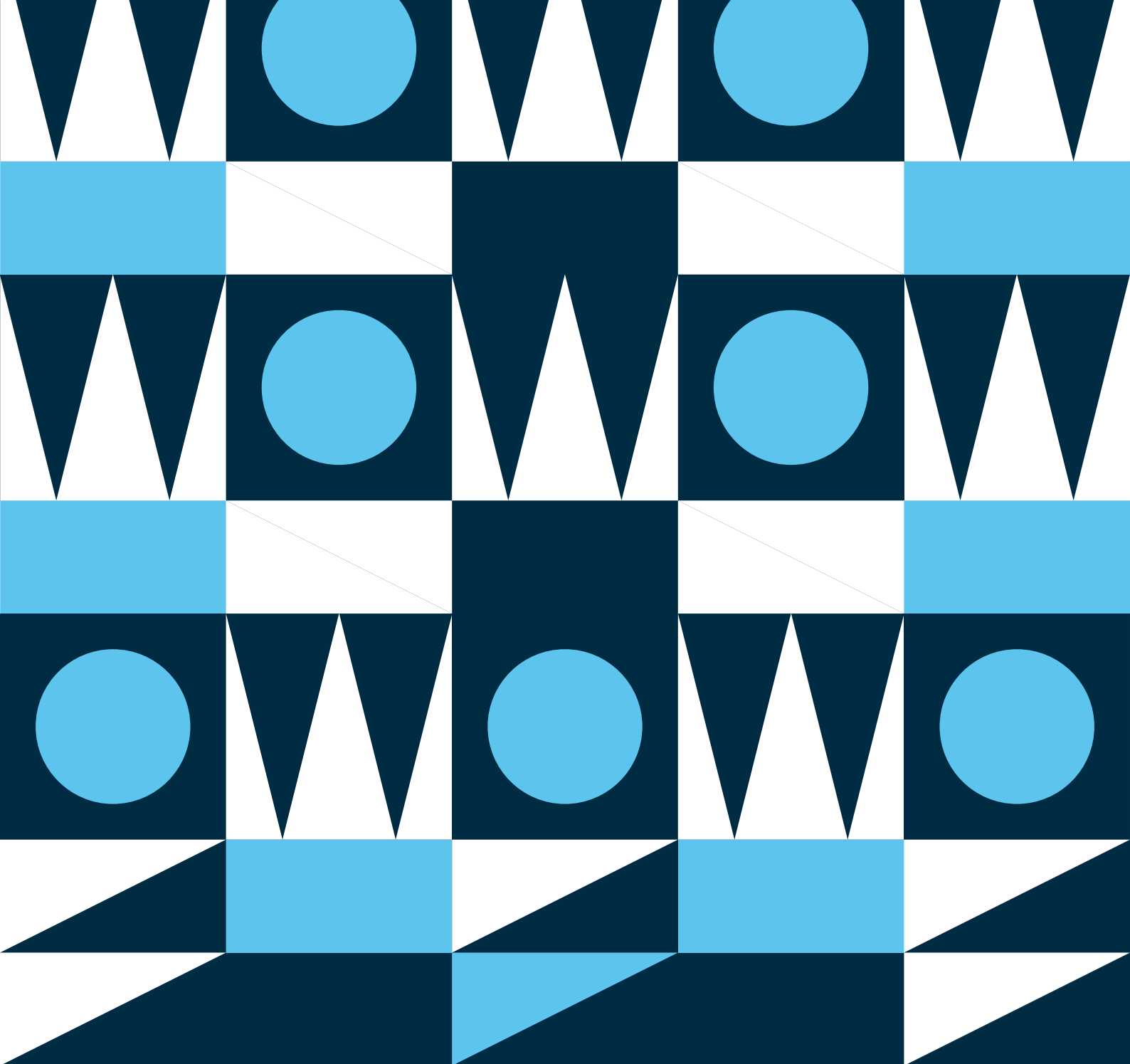
UNIVERSAL DESIGN/ACCESS: A way of ensuring accessibility through the design of products, environments, programs and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.

32 — ActionAid, "On the Frontline: Catalysing Women's Leadership in Humanitarian Action," 2016, p5: <https://bit.ly/3n2OYJx>.

33 — Committee on the Rights of Persons with disabilities (CRPD), "Convention on the Rights of Persons with disabilities," Article 2: <https://bit.ly/3LZC1xL>.

34 — IASC, Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, p64: https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf





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