STANDARD OPERATING PROCEDURES

FOR PREVENTION OF AND RESPONSE TO GENDER-BASED VIOLENCE

IN NIGER STATE

AUGUST 2021

FOREWORD

Gender-based violence (GBV) refers to harmful acts directed at an individual based on their gender and is a serious problem that is rooted in gender inequality and harmful norms (UNHCR). It is a problem that cuts across all races, social status and has far reaching effects on the physical, social and psychological wellbeing of the survivor. The situation analysis of GBV has revealed its increase across the country, especially in States facing humanitarian situations such as insurgency, banditry attacks, kidnappings, human trafficking, and child labour, among other violent and domestic crimes. In recent times, Niger State has seen an increase in GBV cases as a result of the increased incidence of banditry and kidnappings that has led to the displacement of many people from their homes. This is in addition to the rising cases which the State saw at the onset of COVID-19 pandemic in Nigeria similar to the situation in other parts of the country.

There are many challenges with tackling GBV issues because of the complex combination of factors that lead to and perpetuate GBV in our society. Fear of stigmatization among others has led to under reporting of GBV cases and where the cases are reported, very few end up with the perpetuator getting convicted despite the fact that there are existing laws that deals with GBV issues. In response to this, the government of Niger State under the leadership of the Executive Governor, His Excellency -Alhaji (Dr) Abubakar Sani Bello has deemed it of great concern and planned necessary actions to tackle GBV headlong. This led to the setting up a of the Gender-based Management Committee, to lead the initiatives that will reduce GBV in Niger State.

It has been observed that the absence of standard operating procedures (SOPs) across national and subnational levels is impacting negatively on full implementation of GBV legal, policy and institutional frameworks, as well as the quality, effectiveness, efficacy and accessibility of GBV support and services to victims and survivors. Therefore, it is imperative that a SOP that will guide all responders, victims and survivors in all processes or actions in tackling GBV in Niger State is made available.

The Niger State GBV management committee with support from the National academy of Science (NAS) with funding from the Ford Foundation, has initiated this laudable project for the benefit of the citizens of Niger State. The Ministry of Women Affairs and Social Development is leading in the implementation of the SOPs alongside all partners within and outside the State.

On behalf of the people of Niger State, I believe this SOPs which is user-friendly will avail all and sundry the necessary steps in preventing and responses to gender-based violence in the state.

Dr (Mrs) Amina Abubakar Bello
Wife of the Executive Governor

Chairperson, Niger State GBV management committee

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We appreciate God Almighty for giving us the strength to carry out the activities. Special appreciation to His Excellency, Dr Abubakar Sani Bello, the Governor of Niger State for his support and quick response towards inauguration of the Committee and the Financial & Moral support to kick start the GBV activities in the State.

We acknowledge Nigeria Academy of Science (NAS) our major partner, members of GBV Committee and Staff of the ministry of women Affairs and Social Development.

The Ministry of Women Affairs and Social Development, Niger State wishes to appreciate the support from all members of the Gender-based Violence Management Committee, particularly the wife of the Executive Governor, Dr (Mrs.) Amina Abubakar Bello (Chairperson Gender Based Violence Management Committee) and Hon Fati Tasalla Ibrahim the Honourable Commissioner Ministry of Women Affairs and Social Development (Vice Chairperson Gender Based Violence Management Committee) for their tireless efforts towards the prevention and responses to Gender-based violence in the State which led to the development of the SOPs.

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List of Abbreviations

CAN - Christian Association of Nigeria

CCCM/Shelter/NFI – Camp Coordination and Camp Management/Shelter/Non-Food Items

CMR - Clinical Management of Rape

GBV - Gender-Based Violence

GBVIMS - Gender-Based Violence Information Management Systems

GBV-SS - Gender-Based Violence Sub-sector

HST - Humanitarian State Teams

INGOs - International Non-Governmental Organizations

ISP - Information Sharing Protocol

LGAs - Local Government Areas

HCT - Humanitarian Country Team

MDAs - Ministries, Departments and Agencies

MHPSS - Mental Health and Psycho-Social Support Services

NFIs - Non-Food Items

NGOs - International Non-Governmental Organizations

PEP - Post Exposure Prophylaxis

PFA - Psychological First Aid

PSS/PFA - Psychosocial Support / Psychological First Aid

RFPs - Referral focal points

RSARC - Rayuwa Sexual Assault Referral Centre

SEA - Sexual Exploitation and Abuse

STIs - Sexually Transmitted Infections

SOP - Standard Operating Procedures

UNCRPD - UN Convention on the Rights of Persons with Disabilities

VAPP - Violence Against Persons (Prohibition) Act

WGFS - Women and Girls' Friendly Spaces

WRAPA - Women's Right Advancement Protection Agency

WASH – Water, Sanitation and Hygiene

Definition Of Terms/Concepts

Definitions are provided here to explain key terms used in these SOPs. These definitions draw from a range of GBV resources that are considered international best practice.

Gender-Based Violence (GBV)	GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females.
Trafficking:	It involves an act of recruiting, transporting, transferring or receiving a person through a use of force, coercion or other means, for the purpose of exploiting them, this can be local, Community or to other countries.
Victim	A person against whom an offence is committed.
Survivor	Refers to any person – girl, woman, boy, man, child, adolescent, adult who suffers any act of violence or rights violation. A preferred term for a person who has lived through an incident of Gender-Based Violence.
Perpetrator	A person, group or institution that inflicts, supports or condones violence or other abuse against a person or groups of persons.
First Point of Contact	The first point of contact is defined as any person(s) to whom the survivor first discloses or reports an incident of abuse.
Actor(s)	Refers to individuals, groups, organizations, and institutions involved in preventing and responding to gender-based violence.
Incident	Refers to the specific act of gender-based violence or rights violation.
'At risk' group(s)	Group(s) of individuals more vulnerable to harm than other members of the population because they hold less power, are more dependent on others for survival, are less visible to relief workers, or are otherwise marginalized.
GBV Management	A structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure survivors are informed of all the options available to them; and those issues and problems facing a survivor and their family are identified and followed up in a coordinated way, as well as providing the survivor with emotional support throughout the process.
Confidentiality	An ethical principle associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission.
Disclosure	The process of revealing information about a GBV experience or incident. Disclosure in the context of GBV abuse refers specifically to how a person (e.g., caregiver, health worker, social worker, member of a women's group, friend, teacher) learns about an incident of GBV directly from a survivor.
Identification	Terms "identification" and "involuntary disclose" are commonly used in the case of children when they are too young to speak about the incident and when a third person identifies the violence.
Gender Based Violence Information Management Services	A system for collecting, storing and sharing key information on GBV incidents. It helps harmonize data collection on GBV in humanitarian settings, to provide a simple system for GBV project managers to collect, store and analyses their data, and to enable the safe and ethical sharing of reported GBV incident data.
Informed Assent	The expressed willingness to participate in services. This applies to younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services.
Informed Consent	Approval or assent, particularly and especially after thoughtful consideration. Free and informed consent is given based upon a clear appreciation and understanding of facts, implications and future consequences of an action. In order to give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given, and be able to evaluate and understand the consequences of an action.
Mandatory reporting	Laws and policies that mandate certain agencies and/or persons to report actual or suspected child abuse. Mandatory reporting may also be applied in cases where a person is a threat to themselves or another person. Mandatory reporting is a responsibility for humanitarian actors who hear about

	and/or receive a report of sexual exploitation or abuse committed by a humanitarian actor against a member of the affected population.
Sexual Exploitation and Abuse (SEA)	SEA is a form of GBV that constitutes an abuse of power by aid workers against the affected population. It is based in gender inequality, power imbalance and disrespect of human rights
GBV SS	Gender-Based Violence Sub-sector.
GBV Specialist	Gender-Based Violence Specialist is responsible for managing and overseeing the activities associated with supporting and the provision of holistic care for survivors of GBV, case management, referrals for specialized health care, psychosocial support, and risk reduction.
Working Women Hostel	The objective of the scheme is to promote availability of safe and conveniently located accommodation for working women, with day care facility for their children, wherever possible, in urban, semi urban, or even rural areas where employment opportunity for women exist
Medico legal staff	A medicolegal staff/officer can be a coroner or medical examiner. In either case, the medicolegal officer is responsible for leading an investigation to determine the circumstances under which someone died.

EXECUTIVE SUMMARY

Gender-based violence (GBV) has long been a major problem in Nigeria, with 30% of women and girls aged 15-49 having experienced sexual abuse; and lack of coordination amongst key stakeholders and poor implementation of legal frameworks, combined with entrenched gender discriminatory norms, worsening access of victims and survivors to necessary support and services. The situation has been on the increase across the country since the advent of the COVID-19 pandemic in February, 2020, and has been more protracted especially in States facing humanitarian situations such as insurgency, banditry attacks, kidnappings, human trafficking, child labour, among other violent and domestic crimes.

Niger State, in north-central Nigeria has had its fair share of rising GBV cases. This has prompted the State government to put in place legal, policy and institutional frameworks to stem the tide, particularly with the inauguration of a twenty (20) member Committee headed by the Wife of the Executive Governor, Dr. Amina Abubakar Sani Bello.

This SOP was developed through a qualitative process of desk review of similar SOPs for Borno, Adamawa and Yobe States in Nigeria, the SOP for Pakistan, Inter-Agency SOP for SGBV Prevention and Response in Lebanon, and the USAID GBV M&E Toolkit by consultants. The first draft of the SOP was reviewed by the Niger State GBV Committee, Chaired by the Wife of the Executive Governor of Niger State Dr. Amina Abubakar Sani Bello. The second draft of the SOP was validated at a 2-day validation and training workshop with a view to harness stakeholders' input in the document.

The development of this GBV Standard Operating Procedure (SOP) for Niger State is indeed one of the major efforts of the Committee to facilitate proper implementation of relevant GBV (and other related) legal and policy frameworks, as well as to enhance the quality, effectiveness, efficacy and accessibility of GBV support and services to victims and survivors.

Key objectives of the SOP include—

A). Delivery of prompt, coordinated and comprehensive services to survivors of GBV.

B). Prescription of Standards of professional practice with regards to reporting and referral; coordination of multisectoral actors and the services they provide; information management and sharing; responding to needs of children, young people, women and persons with disabilities; complying with ethics of confidentiality, respect for human rights, etc; avoiding conflicts of interest; and, risk prevention and mitigation.

C). Raise awareness among all key stakeholders about GBV and the referral pathways.

D). Develop a framework for monitoring and evaluation.

The key beneficiaries targeted by this SOP include men, women, boys and girls including persons with disabilities. The SOP is designed for use in key settings including Schools, homes, work places, religious worship centers, IDP camps, etc.

Major areas of GBV response and prevention services covered by the content of this SOP include;

A). Guiding principles for providing GBV response and prevention services; B). Reporting and referral procedures; C). Multisectoral support for GBV survivors; D). Addressing the needs of

specific groups including children, young people, women and persons with disabilities; E). Risk prevention and mitigation; and F). Documentation of Data, monitoring and evaluation.

Finally, this SOP provides 7 procedural tools and templates to guide key GBV response and prevention services including reporting and referral; consent form; dignity kit package; **inter-agency sexual exploitation and abuse (SEA) complaints referral system; etc.**

1.0 INTRODUCTION

1.1 Overview of the Current Situation

Gender-based violence (GBV) has long been a major problem in Nigeria,[1]with 30% of women and girls aged 15-49 having experienced sexual abuse; and lack of coordination amongst key stakeholders and poor implementation of legal frameworks, combined with entrenched gender discriminatory norms, worsening access of victims and survivors to necessary support and services.[2]The situation has been on the increase across the country, especially in States facing humanitarian situations such as insurgency, banditry attacks, kidnappings, human trafficking, child labour, among other violent and domestic crimes.

With the advent of the COVID-19 pandemic, the incidences of GBV increased significantly; attracting global attention. Although prior to COVID-19, the Federal and some State governments have enacted relevant legal, policy and institutional frameworks to mitigate the impact and reduce the prevalence of GBV. The impact of COVID-19 on GBV increase has prompted governments at national and subnational levels to step-up efforts to implement existing laws and policies, as well as provide necessary support and services to GBV victims and survivors.

However, it has been observed that the absence of standard operating procedures (SOPs) across national and subnational levels is impacting negatively on full implementation of GBV legal, policy and institutional frameworks, as well as the quality, effectiveness, efficacy and accessibility of GBV support and services to victims and survivors.

In Niger State, Northcentral Nigeria, cases and incidences of female genital mutilation as well as rape is steadily on the rise. In a recent report by Punch in March 2021, at least Sixty-Two (62) cases of gender-based violence and rape cases were said to be recorded in Niger State in the preceding five months[3]. This statistic is not far behind from the responses in previous years even

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1Ipas. https://www.ipas.org/news/as-sexual-violence-continues-to-rise-in-nigeria-ipas-and-partners-advocate-for-state-level-protections/

2 IGC. https://www.theigc.org/blog/the-shadow-pandemic-gender-based-violence-and-covid-19/

3https://punchng.com/62-gender-based-violence-cases-recorded-in-niger/

though efforts have been made by the Niger State Ministry for Women affairs in support with ACTION AID, and RAISE foundation (a pet project of Dr Amina Bello, the wife of Niger State Governor) to strengthen the prevention, mitigation, reporting and adequate health care for victims of GBV within the State.

As part of efforts to end the increasing prevalence of GBV in Niger state, the State Government inaugurated a twenty (20) member Committee, headed by the Wife of the State Governor, Dr. Amina Abubakar Sani Bello. The Committee also has members from the State Ministries of Justice, Education, Health and Women Affairs, the Niger State Child's Right Agency, the Nigeria Police, Christian Association of Nigeria (CAN), Imam Forum, Rayuwa Sexual Assault Referral Centre (RSARC) and the Women's Right Advancement Protection Agency (WRAPA).

It is thus against this background that the GBV Standard Operating Procedures (SOP) document is developed to facilitate joint referral pathway for all persons at risk of GBV including women, men, boys, girls, as well as other vulnerable persons such as the elderly and those with disabilities who live and/or work in all human settings, including those in humanitarian operations such as Reception Centers, camps and host communities where the Internally displaced persons (IDPs) live.

SOPs are developed to facilitate joint action by all actors to respond to GBV in all settings, including in humanitarian crisis settings. It describes clear procedures, roles, and responsibilities for all actors. Furthermore, all organizations listed above agree to the same procedures, guiding principles and working together for the best interest of women, men, boys and girls in all settings, including those in humanitarian settings in NIGER state.

This SOPs document aligns with all relevant existing gender-focused legal and policy frameworks at international, national and subnational levels, including the Violence Against Persons (Prohibition) Act (VAPP) which is also in force in Niger State to combat Gender Based Violence issues.

1.2 Specific Objectives

a) Survivors of GBV and those at risk will receive prompt and coordinated response from service providers

b) Holistic and comprehensive support and services are provided for survivors of GBV including medical care, psychosocial support, protective care, and legal services (legal advice, representation, mediation and litigation)

c) Standards of professional practice are prescribed and followed with regards to confidentiality, information sharing and recording of sensitive information, avoiding conflicts of interest

d) Awareness is raised among all key stakeholders about GBV and the referral pathways

e) A framework for monitoring and evaluation is developed.

1.3 Need for Standardization

There are numerous challenging barriers in the prevention of and response to GBV in Niger state. These ranges from what is often a misperception of crimes of GBV not being a significant violation of human rights in families, communities and even the state, to limited or ineffectual legislation, support systems and safety nets for those who do attempt to seek support.

There are many challenges that pose barriers to survivors, particularly women and girls including social norms that promote gender-based abuses while discouraging disclosure (e.g., blaming the survivor rather than supporting them), by a culture of impunity for perpetrators that contributes to security risks for survivors and service providers, and insufficient systems at the state, civil society and community levels to comprehensively address GBV. This situation is further exacerbated in emergencies when GBV is known to increase for a variety of reasons including, but not limited to, the breakdown of social structures/protective mechanisms, the weakening of norms regulating social behaviour and traditional social systems, separation from family members, male responsibility for the distribution of goods, lack of opportunity for women's and children's voices/opinions to be heard by decision makers and failure of decision makers to consider the security of women and children in emergencies.

When encountered by a case of GBV, relief workers are often at a loss as to how to best respond given that there are few mechanisms in place to address their immediate or on-going needs.

Often the staff, who interact with the survivor of GBV are not aware of the severe and long-lasting health, emotional and psychosocial problems that survivors face, including death from injuries or suicide. At minimum to respond to the health-related consequences of GBV which can include unwanted pregnancy,

unsafe self-induced abortion, and sexually transmitted infections, including HIV/AIDS. services must be made more readily available and accessible including the development of referral pathways which adhere to a minimum agreed upon standard for responding to GBV survivors. This will improve response by building the capacity of first responders who must be ready and available to support women and children, girls especially who are subjected to GBV.

People with disabilities, particularly women and children, are more vulnerable to different forms of GBV before and during emergencies, as they are more likely to remain without a proper caretaker, or services will not meet their specific needs, including protection.

1.4 Purpose and Scope of this SOPs

These SOPs describe the roles, responsibilities, guiding principles, and procedures for prevention of and response to any form of GBV affecting communities described in Section 2 below. It covers and harmonizes the different services provided by governmental and non-governmental bodies required to respond to and prevent GBV in Niger state including but not limited to drop-in center/shelters, health and psychosocial support, health services, legal support and services, socio-economic empowerment and support, etc. Although there is special emphasis on sexual violence, actions are not to be limited to only sexual violence.

These SOPs address the process of building a coordinated GBV response and prevention programs in all human settings, and during emergency settings and situations such as the COVID-19 pandemic and other forms of health crises; natural disasters such as flooding, and other related environment and climate induced crises; as well as humanitarian crises such as those created by activities of insurgents, bandits, kidnappings, inter and intra community conflicts, etc.

These SOPs are intended to be a State-wide guideline that respond to local peculiarities under a dual but complementary governance and management structure at State and Local government levels.

NOTE: *Throughout this document, the female voice is used ("her", "she") solely for simplicity and ease of reading. The entire document should be taken to apply to any survivor of GBV - women, girls, men, or boys.*

1.5 Setting and Persons of Concern

These SOPs have been developed for use in the following settings: Schools, homes, work places, religious worship centers, IDP camps, etc in NIGER STATE. It will also focus on men, women, boys and girls including those with disability.

2.0 GUIDING PRINCIPLES

Guiding principles are a set of inter-related norms which are considered best practice. The institutions/organizations that convene to be part of this multi-sectoral SOPs mechanism to address GBV agree to adhere, without exception, to the principles that represent the foundation for their interventions/assistance, referral, attitudes, and behaviours in addressing GBV.

Adhering to these guiding principles requires that organizations ensure staff are committed to integrating GBV into their work and are adequately skilled to do so; and aimed at ensuring their programmes are gender sensitive, collaborative and participatory.

Specifically, the survivor-centered approach is one major guiding principle of these SOPs which can guide professionals—regardless of their role—in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which a GBV survivor's rights are respected, safety is ensured, and the survivor is treated with dignity and respect. The approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person's capacity to make decisions about possible interventions[4].

2.1 Guiding principles for all actions

Organizations should:

- Integrate and mainstream GBV interventions into all programmes and all sectors.
- Establish and maintain carefully coordinated, very timely and high quality multi-sectoral and inter-organizational interventions for GBV prevention and response.
- Extend the fullest cooperation and assistance between organizations and institutions in preventing and responding to GBV. This includes sharing situation analyses and assessment information to avoid duplication and to maximize a shared understanding of situations.
- Engage the community fully in understanding and promoting gender equality and gender power relations that protect and respect the rights of women and girls.

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

- Ensure equal and active participation by women and men, girls and boys in assessing, planning, implementing, monitoring, and evaluating programmes through the systematic use of participatory methods.
- Ensure disability-inclusion is mainstreamed across all procedures and levels of GBV intervention and that inclusion is documented and institutionalized such that it is not abruptly brought-in as an afterthought. This includes ensuring that persons with disabilities, their organizations and other disability stakeholders such as experts and service providers are consulted and participate equally in all processes.
- Ensure accountability at all levels to local communities and among all humanitarian actors working in any sector.
- Ensure all staff understand and adhere to ethical and safety recommendations for researching, documenting and monitoring GBV in emergencies[5].
- Ensure all staff, contractors and volunteers involved in prevention of and response to GBV understand and sign a code of conduct on Protection from Sexual Exploitation and Abuse/Sexual Harassment or similar document setting out the same standards of conduct.

2.2 Guiding Principles for Working with Individual Survivors

Safety and Security: Ensure the safety of the survivor, child and family at all times. Remember that she may be frightened, and needs assurance that she is safe. In all types of cases, ensure that she is not placed at risk of further harm by the assailant. If necessary, undertake a safety assessment and ask for assistance from security, police, elders, community leaders or others who can provide security.

Confidentiality: Respect the confidentiality of the survivor, child and their family at all times. If the survivor gives his/her informed consent, share only relevant information with others for the purpose of helping the survivor, such as referring for services. All written information about survivors must be maintained in secure, locked files. If any reports or statistics are to be made public, only the actors who report data each month will have the authority to release such information, guided by the ISP.

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

Informed Consent: All actors must receive informed consent from the survivor, or legal guardian if working with a minor, prior to any response service or sharing of information. If the survivor cannot read and write an informed consent statement will be read up to the survivor and a verbal consent will be obtained. The survivor should have the option to provide limited consent where they can choose which information is released and which is kept confidential.

Respect: Offer information about available support services and respect the choice of the survivor concerning which services she wishes to access. Maintain a non-judgmental manner; do not judge the person or her behaviour or decision. Be patient; do not press for more information if she is not ready to speak about it. Ensure that children are participating in the decision-making process of services they can access, and are involved in all decision-making processes regarding referral and access to services.

Non-Discrimination and Impartiality: Ensure non-discrimination and impartiality in all interactions with survivors and in all service provision. All actors should provide services without discrimination based on age, sex, disability, religion, clan, ethnicity, wealth, language, nationality, status, political opinion, culture, etc. All actors must be impartial.

Do No Harm: When documenting, reporting, monitoring or providing a service to a survivor, ensure that risks are not greater than the benefits to the survivor.

Information: All survivors and those at risk have the right to accurate information on what services are available, how to reach or access the services, the potential risks and consequences of accepting additional services and not accepting additional services. Make sure information is given to children in a manner they understand and is child friendly. Information should be honest and complete. Information should be available in accessible formats; in languages that survivors understand. In addition, information must be available in formats accessible to persons with disabilities (braille, audio or large print for blind or partially sighted people, sign language or subtitled for deaf and in simple infographics for those with intellectual or developmental disabilities.

Best Interest of the Child: In all cases concerning a child, the best interest of the child should be the primary consideration. Apply all the listed guiding principles to children, including their right to participate in decisions that will affect them. A child should be listened to and believed in, and their concerns should be taken seriously. If a decision is taken on behalf of the child, the

best interests of the child shall be the overriding guide and the appropriate procedures should be followed. Best interest determination guidelines can also be consulted.

Disability-inclusive: It is important that all persons of different status, particularly people with disability be considered when documenting, reporting, monitoring or providing a service to a survivor. All Actors should learn and be adequately informed on the peculiarities, requirements and needs of the various disability types and how to comply with the principles of reasonable accommodation and universal access/design when developing, planning and conducting all stages of GBV interventions. It is strongly recommended that Disability-Inclusion experts be engaged to guide Actors where such capacity is lacking.

Privacy and Survivor's Comfort: Ensure privacy before starting interviews with survivors, this includes children. Avoid requiring her to repeat the story in multiple interviews. Only ask survivors relevant questions. Be empathetic. Do not show any disrespect for the individual or her culture or family or situation. Where possible, conduct interviews and examinations by staff of the same sex as survivor unless there is no other staff available. Survivor's comfort must always be taken into consideration, and interview settings must reflect that.

2.3 Adopting a Survivor-Centered Approach

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

A survivor-centered approach involves designing and developing programming that ensures the rights and needs of GBV survivors come first and foremost. This means the survivor should be placed at the centre of each step of the response process, and that every decision should be driven by the survivor's needs, wishes and capacities, in line with her social status which includes but not limited to age, gender, disability, social/economic status, etc.
The survivor-centered approach is considered essential for the following reasons—

- To protect survivors from further harm
- To provide survivors with the opportunity to talk about their concerns without pressure
- To assist survivors in making choices and in seeking help if they want help

- To cope with the fear that they may have about negative reactions (from the community or their family) or being blamed for the violence
- To provide basic PSS/PFA to the survivor
- To give back to the survivor the control they may have lost during the GBV incident

2.4 Care for Child Survivors

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

Work according to the best interests of the child: This important principle should be applied both to decisions relating to individual children and to broader policy matters and decisions relating to groups of children. In each and every decision affecting children, the various possible solutions must be considered and due weight must be given to the child's best interests.

Ensure the safety of the child, and their right to life, survival and development: Ensuring the physical and emotional safety of children is critical during care and treatment. All case actions taken on behalf of a child must safeguard a child's physical and emotional wellbeing in the short term and in the long term.

Comfort the child: Children who disclose sexual or other types of abuse require comfort, respect and support from all service providers. Service providers should believe children who disclose abuse and never blame them in any way for the abuse they have experienced.

Ensure appropriate confidentiality: Information about a child's experience of abuse should be collected, used, shared and stored in a confidential manner. This means ensuring:

- The confidential collection of information during interviews;
- That sharing information happens in line with local laws and policies and on a need-to-know basis, and only after obtaining permission from the child and/or caregiver; and,
- That case information is stored securely.

In the event that service providers are required under local law to report child abuse to the local authorities, mandatory reporting procedures should be communicated to the children and their caregivers at the beginning of service delivery[6].

In situations where a child's health or safety is at risk, limits to confidentiality exist in order to protect the child.

Involve the child in decision-making: Children have the right to participate in decisions that have implications in their lives. The level of a child's participation in decision-making should be appropriate to the child's level of maturity and age. Listening to children's ideas and opinions should not interfere with caregivers' rights and responsibilities to express their views on matters affecting their children. While service providers may not always be able to follow the child's wishes (based on best interest considerations), they should always respect, empower and support children, and deal with their concerns in a transparent manner. In cases where a child's wishes cannot be prioritized, the reasons should be explained to the child.

Treat every child fairly and equally: All children should be offered the same high-quality care and treatment, regardless of their race, religion, gender, family situation or the status of their caregivers, cultural background, financial situation, or unique abilities or disabilities. No child should be treated unfairly for any reason. This ensures all children are given opportunities to reach their maximum potential.

Strengthen children's resiliencies: Each child has unique capacities and strengths, and possesses the capacity to heal. Service providers can assist child survivors to recover by:

- ❖ Removing all attitudinal, institutional, social and environmental barriers that may cause discrimination (especially based on gender and disability) and hinder their access to services and inclusion in the entire procedure of GBV interventions and programs,
- ❖ Treating them with dignity and encouraging others to do the same;
- ❖ Helping them participate in family and community life; and,

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6Currently there is no mandatory requirement in Borno, Yobe and Adamawa States. However, initiatives are underway to facilitate the ratification of the Child rights and GBV protection laws. In the event this becomes a requirement, actors are required to adjust accordingly.

- ❖ Helping them build and maintain healthy relationships.

2.5 Systems and Procedures Essential to Support Implementation

These SOPs address organizations as whole and individual service providers within those organizations (e.g., lawyers, Doctors, nurses, psychologists, Disability-inclusion experts, counselors, data analysts, etc.). As such, it is important to note that both sections apply to organizations. The organizations addressed can make further use of the SOPs, their implementation and further promotion. It is important to note here that there are two broad classifications of organizations that work with survivors.

First: Service delivery/advocacy-based organizations, which provide one or more form of support (e.g., psychosocial, medical, etc.) to the survivor. These can be:

- ❖ Private and public institutions e.g., NGO's, Government Health facilities, CBOs
- ❖ Hospitals,
- ❖ Drop in centers

Second: Institutions that provide shelter and residence to survivors in addition to other services/support. These include:

- ❖ Government facilities such as Dar-ul-amans and Women Crisis Centers
- ❖ Private shelter homes for women and children

International organizations supporting the specific groups might already have organizational systems and procedures in place to guide response to survivors of violence. However, all organizations, whether they are national or international NGOs, government or UN entity must ensure that their organization as well as any implementing partner they have adheres to the minimum standards of service delivery and the guiding principles articulated in this document.

- ❖ Organizations should endorse in writing this SOP Guidelines, ensuring the protection of the dignity and rights of the Survivors.
- ❖ Organizations should ensure that every staff member has read and understood the guidelines. Job descriptions of staff dealing with the survivors should include a section on the endorsement of the Guidelines.

- ❖ Organizations working directly with survivors of violence should ensure that they have written and clearly defined procedures for working with survivors that adhere to the guiding principles and standards outlined in this document.

  These should include:

  a. Special protocol for crisis cases.

  b. Policy on defining misconduct with clients.

  c. Policy for referral procedures

  d. Information on important procedures, e.g., medical, legal,etc.

  e. Policy for follow-up of cases that are ongoing and have been closed.

  f. Policy and guidelines to meet the needs of child survivors

  g. Policy and guidelines to document and meet needs of survivors with disabilities, and the peculiar gender concerns of women and girls.

  h. Procedure for assessing risks or harm to client/survivor and to the staff member.

  i. Initiatives for Self-Care for caregiver.

  j. Job descriptions of the staff dealing with survivors of violence can be reviewed and the following areas and undertakings that reinforce the ethics of dealing with survivors can be added, for example: Importance of maintaining confidentiality, respect, non-judgmental behavior etc.

  k. Consequences of misconduct with clients/survivors.

  l. Policy on taking care and ensure the wellbeing of the children of the survivor

2.6 Post GBV Survival Visitations and Monitoring

To assist the GBV survivors after the experience, there is a need for post GBV survival visitations and monitoring which will be carried out as follows:

- ❖ Follow up-visits will be carried weekly depending on availability of resources by trained staff with GBV survivors concerned at their homes or an agreed safe place of meeting. If

the survivor is not reachable, a meeting will be held a trusted person pointed out by the survivor.

- Provide GBV survivors with information about the whole healing and referral process highlighting potential consequences and benefits of accessing services.
- Engage other sectors to meet in a timely manner other immediate needs raised by the survivor that may further expose them to harm and violence.
- Train staff involved in GBV case management on how to identify suicidal thoughts in survivors.
- Train and ensure all staff comply with an organization's security procedures while on duty
- Ensure staff engage the community in respecting the core humanitarian principles.
- Ensure your organization has a clear code of conduct and that your staff know it.

3.0 REPORTING AND REFERRAL

3.1 Reporting

A survivor of GBV has the right to report an incident of GBV to anyone she chooses.

Survivors should be provided a private, secure and comfortable atmosphere for discussion of their situation, and for identifying options for action. At all times effort should be taken to create, as much as possible, a safe/secure and confidential environment.

In the case of female survivors, preferably the first stage interviewer (first point of contact) should be a woman. For medical support, it is strongly recommended that female practitioners attend to survivors except where such is not available and the situation requires some emergencies.

The first point of contact for survivor can be any one of the following:

- Anyone whom the survivor perceives can be of assistance;
- Community leaders;
- School teachers, parents, peers, friends, health care providers;
- INGO/NGOs; and
- Police or security personnel in the city or in the office of the concerned organization

All actors who are approached by a survivor of GBV for assistance have a duty to provide objective and comprehensive information to the survivor on services available in the community. The actor may refer survivor, as she requests, to service providers as per the agreed upon referral system in that location, including health, psychosocial, security and legal services and should escort the survivor to the service provider.

Additionally, all actors who receive reports are obligated to keep information related to the survivor and the incident confidential, unless the survivor consents to release such information to receive ethical and appropriate services. A survivor has the right to choose not to report an incident; she should still be supported in any way possible, as she chooses.

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

3.1.1 Preparing to Receive Survivors

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

- ❖ Train all staff on GBV guiding principles and standard operating procedures relevant to their specialization.
- ❖ Ensure all staff know the GBV referral focal points (RFPs) for their location and how to access the referral pathways resources detailed in this SOPs, as well as other online sources.[7]

3.1.2 Disclosure procedures

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

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

- ❖ Psychosocial first aid;
- ❖ Information on services that may be able to assist the survivor;
- ❖ Details on how to access these services; and,
- ❖ Appropriate support to help the survivor access these services.

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7 https://www.humanitarianresponse.info/en/operations/nigeria/document/gbv-referral-pathways

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

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

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

Table 1: Disclosure Procedures

PROCEDURE	ACTIONS
Prepare[8]	❖ Be aware of available services including those that are child-friendly, gender-friendly and disability-inclusive and accessible. ❖ Know how to communicate with survivors in a survivor-centered manner. ❖ Increase your knowledge and skills as a non GBV practitioner. ❖ If the survivor is a person with disability, prepare accessible information and communication tools and processes, and if third parties will be needed for this, make sure they are properly briefed and they officially commit to non-disclosure terms and conditions before they are brought-in.
Welcome	❖ Find a safe and quiet space to talk. ❖ Ensure they are not left alone and try to keep them safe. ❖ Ask the survivor what their immediate concerns are ❖ Assess the security and safety of the survivor, evaluating this together. ❖ If they are in danger, identify together actions to help them (e.g., key people to contact, safer locations). ❖ Ask if you can provide help.

8See https://gbvguidelines.org/wp/wp-content/uploads/2018/03/GBV_PocketGuide021718.pdf.

Listen	❖ Act in a respectful manner to build trust with the survivor and listen to them. ❖ Allow the survivor to disclose their distress and seek help. ❖ Do not pressure the person to talk and do not expect them to display particular emotional reactions. ❖ Listen actively (e.g., give your full attention, make reassuring verbal gestures should the survivor be a person with visual Impairment, gently nod your head, make eye contact, use appropriate body language). ❖ Assure the survivor that it is not their fault. ❖ Inform them it is common to feel strong negative emotions in these situations.
Provide information	❖ Inform the survivor they are entitled to protection from violence, abuse and exploitation, and to receive care and support. ❖ Use language they will understand. ❖ Inform the survivor of a realistic timeframe within which services can be expected. If you do not know, contact the service provider to inquire. ❖ For sexual violence survivors, provide information on health services. ❖ Explain to the survivor the importance of seeking health care within 72 hours to minimize risks of sexually transmitted diseases (including HIV/AIDS) and unwanted pregnancies. ❖ For adult survivors, inform them they have the right to decide what services they wish to receive and with whom they wish to share information. Give the survivor time to take breaks and ask for clarifications. ❖ Respect the survivor's right to decide what support they need. ❖ Do not give advice or your opinion on what the survivor should do.
Referral	❖ If the survivor requests or consents to access to services, follow the SOPs for procedures for referral. ❖ Refer the survivor to a GBV Case management service provider, if available in your location for follow up and support.
Close	❖ Finish the disclosure in a positive way. ❖ Reaffirm they are entitled to protection from violence, abuse and exploitation, and to receive care and support. ❖ Reaffirm it is not their fault. ❖ Reaffirm it is common to feel strong negative emotions in these situations. ❖ Reaffirm they have the right to live free from violence and risk of violence.

3.1.3 Mandatory Reporting

As noted above, a survivor is given the freedom to exercise her prerogative to choose not to report and should a survivor opt not to, she should still be supported in any way possible. Consideration should also be given to the safety of the wider community as well as the individual concerned.

However, there may be some incidents in which a person receiving a report of GBV is required to report. For example, incidents of sexual exploitation involving humanitarian workers must be reported.

According to the UN Secretary General's Bulletin on Sexual Exploitation and Abuse, 2003. Protocols and procedures have been established for receiving reports of suspected sexual exploitation and abuse (SEA) perpetrated by humanitarian staff, and investigating reports.9

Other situations for mandatory reporting include—

- ❖ If the survivor threatens their own life or is directly threatening the safety of others, in which case referrals to lifesaving services can be sought.
- ❖ If the survivor is a child, when there are concerns for his/her health or safety.
- ❖ If the survivor is a person with disabilities with significant incapacity to self-represent themselves, and there are concerns for his/her health or safety.

In cases when reporting is mandatory, special procedures will be developed to ensure the safety, dignity, and well-being of the survivor. Survivor will be informed by service providers about the duty to report certain incidents in accordance with laws or policies or in the event that there are concerns for the safety and security of the survivor. This must be included as part of the consent process described in **section 3.2** below. (At minimum, this must include explaining the reporting mechanism to the survivor and what they can expect after the report is made.)

9 IASC GBV Guidelines Action Sheets 4.1 – 4.4 describe the minimum interventions and how to set them up.

3.1.4 Incident Reporting (See Annex VI)

The Gender-Based Violence Incident Report Form is recommended for use by actors engaged in prevention and response to GBV in all settings including humanitarian settings, camps or areas of return.

The Incident Report Form is a tool to be developed in consultation with different sectors and is to be designed to:

- ❖ Provide a brief comprehensive summary of the most relevant information about an individual incident.
- ❖ If survivor consents: be used as an information-sharing tool, to be copied and shared among and between actors or organizations involved in assisting the survivor and/or taking follow-up action.
- ❖ Avoid requiring the survivor to repeat her/his story and answer the same questions during multiple interviews.
- ❖ Collect basic and relevant data for use in monitoring and evaluation of GBV incidents and programmes.
- ❖ Collect data that is consistent across all communities, districts and local government Councils, to enable comparison of GBV data across programmes, settings and jurisdictions.

The Incident Report Form is not an interview guide. Staff who interview survivors must be properly trained in skills for interviewing, active listening, and emotional support necessary for working with survivors.

Separate forms may be needed for interview guides and note taking. It is important to remember that a survivor may be emotionally distressed. Therefore, great care must be taken to interview with compassion and respect. It may be appropriate to complete the form outside of the presence of the survivor.

Mechanisms and procedures for reporting, referral, and co-ordination should be established when designing programmes to prevent and respond to gender-based violence. Meet with organizations

and individuals in your setting to determine each group's information needs and how best to use the completed Incident Report Forms.

In most settings, the following procedure is useful:

- ❖ One organization is designated as the "lead organization" for maintaining all report data, receiving the reports and ensuring immediate assistance. Often, this is either the Community GBV coordinator, or a trained staff from a service provider (i.e. Health or psychosocial). In this setting, the Gender-Based Management committee domiciled in the Ministry of Women Affairs and Social Development is the lead at the State and the same structure at the Local Government Level.
- ❖ Original completed Incident Report Forms are maintained in the lead organization's offices, in locked files and backed up electronically.
- ❖ With survivor's consent (consent of parent/guardian) to share information: Lead organizations give details of the completed Incident Report Form, within 24 hours, to organizations most in need of this information to ensure survivors receives immediate services.
- ❖ Without survivors consent to share information: Lead organization provides information to key focal points within the area of survivor, information includes incident data and non-identifying information (no information that can identify the survivor). This data will facilitate the assessment of any immediate risks of the survivor and assist in identification of other ways to provide support or seek alternatives without engaging the confidentiality and safety of the survivor.
- ❖ Incident Type: Use consistent words/definitions to enable proper data collection, tracking of incident data, monitoring and evaluation: The types of GBV and definitions as described in these SOPs and annexure are recommended to characterize incident type. If needed these definitions can be revised if the context and enabling legal and policy frameworks are also reviewed, but at all times it should be ensured that it is standardized across all local governments and districts in the State.

3.1.5 External Reporting

Reporting to other external actors' such as progress reports to donors, policy papers, or government, should be done by respecting all aspects of the guiding principles ensuring the information does not contain confidential and identifying information about survivors, and ensures risks to safety of the survivor and service provider have been addressed. An internal protocol and guideline should be available within the organization on sharing of information. Individual case information should only be shared if this will have a positive impact on supporting the survivor and if informed consent was given, and agreed upon information sharing protocols should be in place and agreed upon in these situations.

3.1.6 Reporting in the Media

In all cases, survivor should be informed of the implications associated with revealing their case to a media source. And at all times written informed consent must be obtained by the survivor of the non-perpetrating parent or guardian in the case of children.

- ❖ In case a public statement is required to be made regarding a case, any such statement should be given with the verbal and written consent of the survivor or guardian, in case of a minor (provided that the guardian is not the abuser or party to the violence). The organization should appoint one staff member who acts as the focal point of contact with the media.
- ❖ The survivor must never be used for advancing the interest of the activist/s supporter/s and/or the service provider/s or organizations. Using a survivor in such a manner is a form of exploitation, and must never occur.
- ❖ Do not publish a story or an image which might put the survivor, siblings or peers at risk even when identities are changed, obscured or not used.
- ❖ Ensure media do not further stigmatize any survivor; avoid categorizations or descriptions that expose a survivor to negative reprisals - including additional physical or psychological harm, or to lifelong abuse, discrimination or rejection by their local communities.

(See Annex IV for media reporting on GBV check list)

3.2 Informed Consent

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

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

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

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

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

3.2.1 The Steps to Ensure Informed Consent

Step 1: **Provide all information:** To ensure consent is truly informed consent, a GBV prevention, response and humanitarian actor must provide all possible information and options

available to the survivor. They must also explain to the survivor that they have the right to decline or refuse any part of any services.

Step 2: **Ensure the survivor understands the implications of any referral:** Explain the benefits and risks of the service to the survivor. GBV survivors have a right to control how information about their case is shared with other agencies or individuals, and should understand the implications for sharing information so that they can make decisions based on full knowledge before the information is shared.

Step 3: **Explain the limitations to confidentiality**: Make the survivor aware that their information may need to be shared with others who can provide additional services.

Step 4: **Ask for consent:** Ask the survivor if they give consent for you to contact other services and to pass on their name. For non-specialized providers, this can be done verbally. A written document is not advisable, especially if confidentiality procedures are not known or cannot be followed.

Step 5: **Check limitations of consent:** After being made aware of any risks or implications of sharing information about their situation, the survivor has the right to place limitations on the types of information to be shared, and to specify which organizations can and cannot be given the information.

A Consent Form (Annex I) should be used by GBV specialists within the framework of case management when referring the survivor to specialized GBV services. When possible and relevant, the survivor should sign the form to indicate they understand and agree to the care they choose. Before a survivor signs a consent form, the GBV actor should confirm the survivor understands how the provider will use, store and disseminate the information. Service providers should also sign the form.

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

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

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

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

3.2.2 Informed Consent for Survivors with Disabilities

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

The UN Convention on the Rights of Persons with Disabilities (UNCRPD) states that an individual cannot lose their legal capacity to make decisions simply because they have a disability.10 It is therefore important to assume initially that all adult GBV survivors with disabilities can provide informed consent, and to follow the same procedures as described above. Some additions to these procedures are:

- ❖ Asking the survivor if they want some support to help them give informed consent.

10See http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf.

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

3.2.3 Informed Consent/Assent for Child Survivors

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

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

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

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

- Informed assent is the expressed willingness to participate in services.

Table 2: Provides a Summary of the Guidelines for Obtaining Informed Consent/Assent from Children.

Age Group	Child	Caregiver	If no Caregiver Or Not in the Child's Best Interest	Means
0-5	-	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent
6-11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, Written consent
12-14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight.	Written assent, Written consent

15-18	Informed consent	Obtain informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

Exposing child survivors of GBV to multiple interviews is bad practice and should be avoided at all times.

- ❖ At all times having multiple service providers interact with a child survivor of sexual abuse must be avoided.
- ❖ Any actors who can appropriately play a role in responding to cases of GBV against children (e.g. child protection, GBV, protection/legal, and health program staff) must develop joint agreements on how, when, and by whom an interview of a child survivor of sexual abuse should take place.
- ❖ Regular case meetings between agencies involved in the case response (at a local district or camp level) can help to ensure that children and families are not being questioned continuously or intruded upon by several different actors throughout their healing process.

3.3 REFERRAL PROCEDURES

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

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

A GBV referral pathway/directory provides information/details about institutions/organizations, specific service providers (professionals) and contact details. The person/organization who receives the initial disclosure (report) of a GBV incident from a survivor or child should act in accordance with the referral mechanism, which should include opportunities at each stage to move forward or stop.

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

3.3.1 Obtaining Referral Pathways

All GBV prevention, response and humanitarian actors should know how to refer a GBV survivor for support. It is very important to take prompt action in order for the GBV survivor to access quality and timely care. Timely referrals can save lives and prevent further harm and medical consequences in cases of sexual violence and other severe cases. The GBV SS has developed referral guide and pathways (Annex IV and V) which can be accessed by all actors. Additional guidelines on referral pathways are available online[11]

When evaluating services to which a survivor will be referred to, it is important to carefully consider the following criteria prior to referral:

- **Presence**. Is the service regularly available and fully function on the ground?
- **Geographical location**. Does the service reach the population it is meant to serve?
- **Accessibility.** Can survivors and/or communities access this service freely, safely and confidentially?
- **Relevance.** Is the service relevant to the specific (age, gender, disability, etc) needs of the survivor?
- **Accountability**. Who is responsible for following up this service?

3.3.2 Survivor Referral Options

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

1. The survivor can contact or go directly to the service provider and/or GBV case management actor.

[11] https://www.humanitarianresponse.info/en/operations/nigeria/ document/gbv-referral-pathways

2. The GBV prevention, response and humanitarian actor can help the survivor access the services by making a referral.

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

Table 3: Options for survivors' referral for Humanitarian actors who are not GBV Actors Providing Case Management

CHOICE	APPROPRIATE SITUATION	WHAT TO DO
Accompany the survivor	Emergency or urgent GBV cases	Accompany the survivor to the relevant service provider.
Referral by phone using the Referral Pathways	Emergency, urgent or moderate cases if accompanying the survivor is not possible or is not in their best interest.	Any GBV prevention, response or humanitarian actor can call any number in the focal point list to receive direct support for the GBV survivor, or relevant information and assistance to refer the survivor to a GBV specialist.
Referral by email or messaging application	For moderate risk cases	When using email for referral, it should only be sent to the relevant focal point, and others who are not involved in managing the case should not be copied.

3.3.3 Non-Availability of Services

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

3.3.4 Refusal of Services

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

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

3.3.5 Types of Referrals

Referrals can happen in many different directions amongst different actors. All referrals must take due cognizance of, and respond adequately to peculiar concerns and needs of age, disability and gender; particularly where there are intersections across all these status and conditions. The table below indicates types of possible referrals.

Table 4: Types of Referrals

FROM	TO	REFERRAL TYPE
Any actor or community members	Specialised service provider and/or GBV case management actors	Professional care and GBV case management. Should be sensitive to age, disability and gender
GBV case management actors	GBV case management actors	It may be more appropriate for another GBV specialist to provide case management (e.g., in another area). Should be sensitive to age, disability and gender
Child Protection case management actors	GBV case management actors	It may be more appropriate for GBV specialist to provide case management to a child and adolescent survivor of GBV, where the CP case worker does not have specific skills for GBV. Should be sensitive to disability and gender
GBV case management actors	Child Protection case management actors	A child survivor of GBV, especially sexual violence may have other additional needs that can better be met or addressed by a Child protection case worker. These SOPs recognise the need to coordinate on meeting/ responding to the needs of child and adolescent survivors of GBV with other child protection concerns/ needs and call for close collaboration between GBV and CP actors. Should be sensitive to disability and gender
Specialised service provider and/or GBV case management actors	Multi-sectoral response services	To provide timely and quality care to GBV survivors such as medical services.. Should be sensitive to age, disability and gender
GBV case management actors	Other services	During or following the period of time when a survivor is receiving care from specialists, they may also be in need of additional services not directly GBV-related. Should be sensitive to age, disability and gender

3.3.6 Steps in making referrals:

All entry points should observe the following standard steps of referral:

Information, agreement and informed consent. The survivor should be informed about possible referrals for services in a safe, ethical and confidential manner. Prior to any other step of referral, survivor's agreement should be obtained, as well as the informed consent for information sharing should be undertaken.

Intake: While interviewing the survivor in a safe and confidential manner, obtain details to understand more about the incident. Actors should ensure members of their organization who collect information from the survivor are appropriately trained on how to fill out a form (See SEA Intake and Referral Form Annex II) and how to act in accordance with the guiding principles. They should carry out their responsibilities with compassion, in confidentiality, and with respect for the survivor.

Complete and correct information about service providers, i.e. WHO - which institution/organization provide services to GBV survivors, adding contact information of a person (name, telephone number) that can be reached as an entry point to that service WHAT – what sort of assistance they can expect to receive from a specific service provider, adding cost information related to that service WHERE – where exactly is the place (the exact address) of the indicated services. Do not raise survivor's expectations by giving false information/impressions which you will not meet.

Safety assessment: All actors have an important role to play in supporting a survivor through jointly assessing potential risks of further violence, supporting her in her safety planning, as well as offering referrals to a shelter (where appropriate/available).

Referral itself. The referral should be accompanied by a short-written report (See the inter agency referral form in Annex III) and a telephone discussion with the other service provider, as a method for avoiding the situation when the survivor has to repeat the story and answering the same questions during multiple interviews, passing again through the distress caused by the GBV incident. At this stage is important to encourage the autonomy, empowering the survivor to do the referral by itself.

Accompany the survivor to the referred service provider, if needed and possible.

4.0 ROLES AND RESPONSIBILITIES: MULTI SECTORAL SUPPORT FOR GBV SURVIVORS

While some GBV survivors may choose to do away with assistance and still recover from the impacts of the challenge without the support of specialists, many will surely require services such as social support, psychological first aid (PFA) and clinical health interventions, among others.

These services are delivered through a multi-sectoral approach in line with international standards and protocols. A multi-sectoral response to GBV represents a holistic and coordinated approach aimed at harmonizing and correlating programmes and actions developed and implemented by a variety of institutions and actors. All providers must abide by the principles described in these SOPs. Sector-specific tasks, roles and goals towards GBV survivors differ according to the nature of each service, but all providers share roles and responsibilities in dealing with survivors of GBV.

In this section, the key Actors involved in the referral pathway especially at the subnational (state) level in Niger state and their specific roles and responsibilities in the delivery of GBV support and services are identified.

There is the need to develop Networking among key Actors to build referral pathways for a comprehensive response. This will require making a referral data base directory. The referral directory can include services and professionals including but not limited to the following—

- Legal and medical aid
- Police stations
- Financial aid services
- Mental health services (psychologist/ psychiatrist for adults and children),
- Working women hostels,
- Lady doctors (e.g., gynecologist)
- Medico legal staff
- International, State and Local NGOs

- ❖ Burn units
- ❖ Private and government shelters
- ❖ Institutions dealing with drugs dependency and rehabilitation
- ❖ Vocational training institute
- ❖ Local government officials
- ❖ Social Welfare Departments
- ❖ Local committees
- ❖ School facilities in the area
- ❖ Income generation organizations, display and sale centers or any other.
- ❖ Child Protection centers /local orphanages.
- ❖ State General Hospital (SGH) and local primary health centers (PHCs).

4.1 Immediate Assistance

Survivors who report their unfortunate experience of GBV may need immediate basic assistance to ensure their wellbeing, safety and security. Case managers and other GBV service providers can help by providing or arranging such assistance. Material assistance, such as emergency food, non-food items (NFIs) and shelter should be provided through quality and timely referrals. Where there is need for dignity kits, agencies must follow the standardised dignity kit guidance note and package (See Annex VI).

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

- ❖ Assistance should never stigmatize GBV survivors by identifying them as survivors in the specific services they receive or at the locations in which services are provided.
- ❖ Assistance should not expose survivors to additional risks (e.g., domestic violence or robbery after receiving cash or vouchers).
- ❖ Assistance provided by other sectors should be based on the case manager's assessment and evaluation of the survivor's needs and context. The case manager will still be the

responsible person for ensuring quality of assistance and follow-up in line with a survivor-centred approach.

- Assistance should be considered part of the healing process, aimed at addressing immediate needs related to the GBV incident, within a specific timespan, and in line with the action plan agreed between the case manager and the survivor – where appropriate.
- Assistance should be guided by the principles of confidentiality, safety, respect and non-discrimination.

4.2 GBV Case Management

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

Case management offers the chance to identify the immediate needs of GBV survivors, and to develop, implement and monitor an individualized intervention plan, according to identified needs and available resources. A case management-based referral system allows survivors to be active participants in defining their needs and deciding what options best meet those needs. It is useful for persons with complex and multiple needs who seek access to services from a range of service providers, organizations and groups.

4.2.1 GBV Case Management Competencies

GBV Case management is a specialized service provided by agencies with specific GBV expertise. Case managers play an important advocacy role to ensure survivors receive needed services, to monitor the provision of services, and to follow-up with the survivor throughout the process. All agencies already or planning to start GBV case management programming need to know the protocols for GBV Case Management and should familiarise themselves with the SOPs GBV Case Management in Niger State. In addition, GBV case management actors need to consider the following:

Concentrate on the survivor's immediate needs, skills and capacities when the situation is particularly insecure. This will involve, for example, conducting safety planning and providing contacts for essential services.

- ❖ Ensure timeliness of the response. Minimizing the time, it takes to arrange all services is important so survivors are supported as quickly as possible.
- ❖ Ensure that case management is provided by trained, well supervised and experienced staff who have the time and resources to carry out their work.
- ❖ Case management should take place as much as possible in safe and confidential spaces.
- ❖ Avoid home visits to survivors. If safe spaces are not available or accessible, identify another community or service provider centre.

4.2.2 Health/Medical Care

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

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

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

The table below provides a summary of the action involved in the provision of clinical care for women, men, boys and girls who have experienced sexual violence, including rape in emergency settings. This summary will help GBV service providers who are not qualified medical staff understand the type of medical assistance and clinical management that GBV survivors may need, as well as the steps involved in delivering this. Healthcare service providers and medical practitioners who provide treatment to GBV survivors must refer to and follow the detailed guidelines in full, and not rely on this summary.

Table 5: Key Actions involved in the Provision of Clinical Care

STEPS	SURVIVOR-CENTERED APPROACH
Preparation for an Examination	• Introduce yourself. • Limit the number of people in the room to the minimum necessary. If the survivor wishes, ensure that a trained support person or trained health worker of the same sex accompanies the survivor throughout the examination. Ask if they also want to have a specific person present (e.g., family member or friend). • Determine the best way to communicate and adapt to the survivor's communication skill level and language. Avoid medical terminology and jargon. • Obtain informed consent (or a parent's informed consent in the case of a child). • Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you will give. Make sure the survivor understands everything. • Reassure the survivor they are in control of the examination. Explain that they can refuse any aspect of the examination they do not wish to undergo, and that this will not affect their access to treatment or care. • Reassure the survivor that the examination findings will be kept confidential unless the survivor decides to bring criminal charges. • Provide psychological first aid. • Ask the survivor if they have any questions.
Taking the History	• If the history-taking is conducted in the treatment room, cover the medical instruments until they are needed. • Before taking the history, review any documents or paperwork brought by the survivor. Do not ask questions that have already been asked and documented by other people involved in the case. • Avoid any distraction or interruption during the history-taking. • Make sure the survivor feels comfortable. Use a calm tone. If culturally appropriate, maintain eye contact. Be aware of the survivor's body language and your own. • Be systematic. Proceed at the survivor 's own pace. Be thorough, but don't force the survivor. Let the survivor tell their story the way they want to. Document the incident in the survivor's own words. • Avoid questions that suggest blame (e.g., What were you doing there alone?). • Be compassionate and non-judgmental. • Explain what you are going to do at every step.
Collecting Forensic Evidence	The main purpose of the examination of a rape survivor is to determine what medical care should be provided. If applicable, forensic evidence may also be collected to help the survivor pursue legal redress. Do not coarse him/her to agree to your opinions or suggestions. The survivor may choose not to have evidence collected. Respect their choice. Forensic evidence can be collected only if:

<table>
<tr><td></td><td>

- Timing is appropriate (e.g., less than 72 hours or more than 72 hours in contexts where the local law accepts evidence from more than 72 hours);
- Samples can be analysed in the local context;
- Informed consent is obtained; and,
- The chain of evidence can be maintained.

</td></tr>
<tr><td>Performing a Physical Examination</td><td>

The primary objective of the physical examination is to determine what medical care should be provided to the survivor.

- Work systematically according to the medical examination form.
- Use the survivor's history to guide the exam to prioritize the survivor's needs and wishes, to identify and document injuries, and to help guide follow-up care and referrals.
- Make sure the equipment and supplies are prepared.
- Always look at the survivor first before you touch them, and take note of their appearance and mental state.
- Always tell the survivor what you are going to do and ask their permission before you do it.
- Assure the survivor that they are in control, can ask questions, and can stop the examination at any time.

</td></tr>
<tr><td>Prescribing Treatment</td><td>

What you prescribe will depend on when the survivor presented themselves to your health facility, what the survivor experienced, among others.

<table>
<tr><td>Treatment</td><td>Within 72 hours</td><td>72 -120 hours</td><td>After 120 hours</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Prevent sexually transmitted infections (STIs) (gonorrhea, chlamydia, syphilis)</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Prevent HIV transmission (post-exposure prophylaxis)</td><td>Yes</td><td>No</td><td>No</td></tr>
<tr><td>Prevent pregnancy (emergency contraception pill)</td><td>Yes</td><td>Yes</td><td>No</td></tr>
<tr><td>Care for injuries, wounds</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Prevent tetanus</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Prevent Hepatitis B</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Provide mental health care /psychosocial support</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
</table>

</td></tr>
<tr><td>Psychological First Aid and Counselling</td><td>

- All survivors of GBV should be offered psychological support.
- Be aware that emotional reactions of survivors in response to GBV are very personal.
- In caring for survivors of GBV, it is important to be attentive to signs/manifestations of psychological distress/disorder - look, listen, and link.
- In assessing psychological support needed, identify: protective factors and risk factors
- Negative and positive coping mechanisms
- Counselling must take place from the first contact with the patient, including counselling for specific issues such as pregnancy and STIs.

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</table>

	• Tell the survivor they can return to the health service at any time if they have questions or other health problems.
Medical Certificates	• Medical care of a survivor of rape includes preparing a medical certificate. It is the responsibility of the health care provider who examines the survivor to make sure the certificate is completed. • Only the survivor has the right to decide whether and when to use this document.
Follow up Care	• All survivors of GBV will benefit from follow-up medical and psychological care. • With the unstable situation, it is possible the survivor will not or cannot return for follow-up. • Therefore provide maximum input during the first visit, as it may be the only visit.

Important to Note:

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

The first doses of PEP should not be delayed by baseline HIV Testing, the documentation of clinical evidence of assault (appropriate swabs and forensic specimens), STI prophylaxis and hepatitis B vaccination, trauma counselling and referral.

Emergency Contraception should be offered to a woman/girl of reproductive age at risk of pregnancy, after providing all the necessary information and getting her consent.

Each health centre/facility should have post-rape treatment kits 3 which includes PEP, STI antibiotics and emergency contraception, and medical personnel trained in the provision of clinical management of rape (CMR), gender-sensitive sexual assault care and examination
All health facilities should ensure their staffs are committed to providing survivors of GBV with medical care as a first priority. A survivor should not be turned away from accessing health care because she has not first reported to the police. The provision of adequate health care to a survivor is the first priority.

Special Considerations for Child Survivors

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

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

Special Considerations for Male Survivors

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

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

- Be aware that the man or boy may believe they have been 'turned into' a homosexual if the sexual violence was perpetrated by another man. They may be concerned about their future ability to enjoy a 'normal' heterosexuality.

- ❖ Do not make any assumptions about the sexuality of the survivor.
- ❖ Recognize they may be in denial about what has happened, and so their story of the experience may not be consistent or accurate.
- ❖ Do not make any judgements about negative coping mechanisms they may have adopted.
- ❖ Reassure them of their strength. Telling them they are strong and brave for disclosing the GBV incident. This can help revalidate their sense of masculinity and be part of their healing.

4.3 Mental Health and Psycho-Social Support Services (MHPSS)

Mental health and psychosocial support services are essential components of the comprehensive package of care and aim to protect or promote psychosocial well-being and/or prevent distress or treat mental disorders among survivors of GBV and sexual violence. This includes providing PFA and linking survivors with other services, psychosocial interventions (such as groups activities), and, where indicated, specialist mental health care. It also includes engaging the broader community to play a role in protecting dignity, promoting psychosocial wellbeing, and preventing mental health problems associated with GBV and the stigmatization/isolation of the survivor.

MHPSS services should be multilevel, in other words, they should target both persons/individuals and communities (or segments thereof). Community focused psychosocial interventions generally seek to enhance survivor well-being by improving the overall recovery environment. These include strengthening community and family support systems and social considerations in basic services and security. Person-focused interventions concentrate on the individual survivor and the survivor's immediate family and social network. They include psychological first aid and linking survivors with other services, psychological interventions, and, where indicated, specialist mental health care.

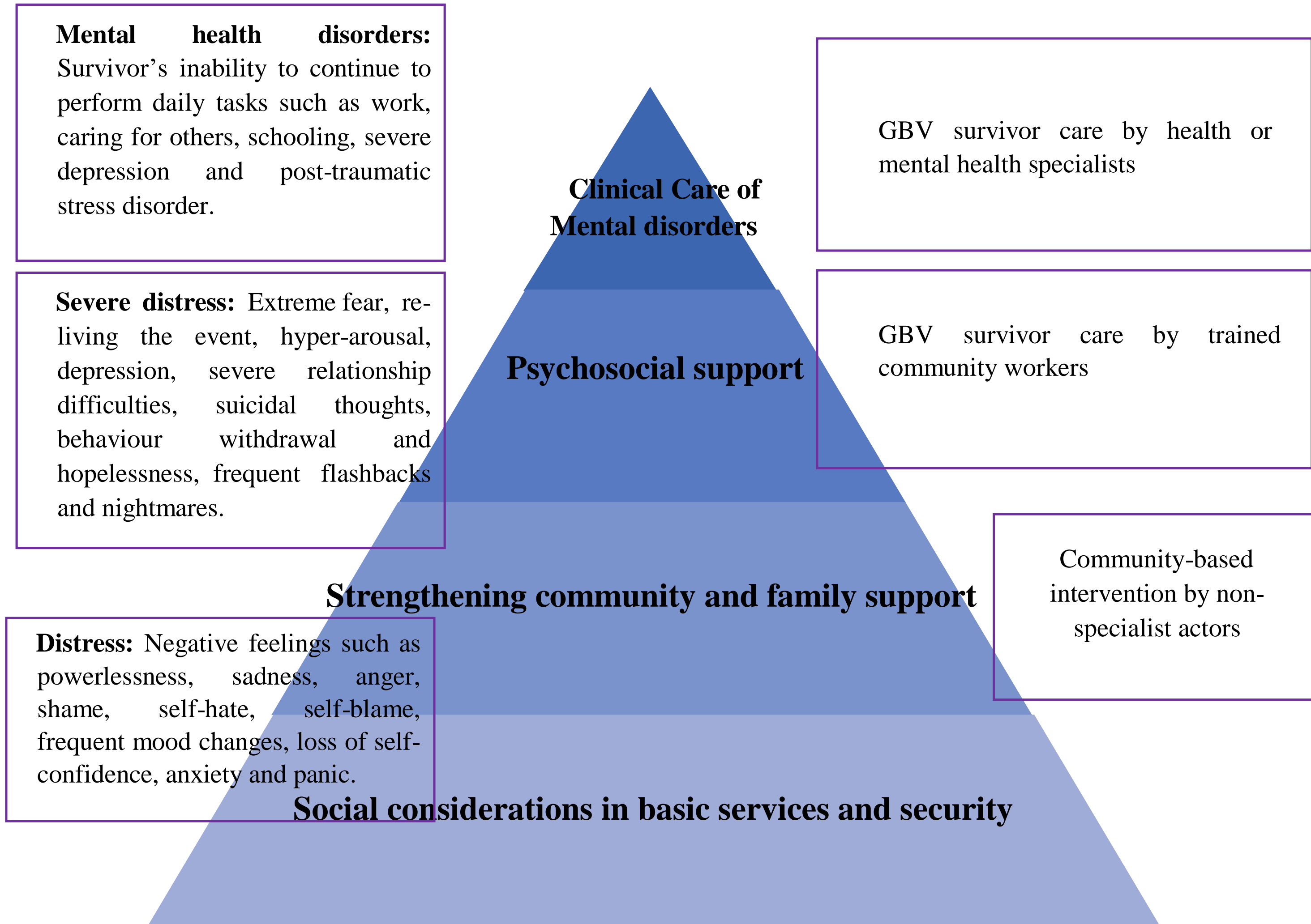
All MHPSS activities with survivors and communities must adhere to the GBV guiding principles of confidentiality, safety, respect and non-discrimination. It is never acceptable to share information about a survivor's case without their explicit informed consent.

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

- ❖ Be familiar with the guiding principles and be able to put them into practice;

- Be familiar with GBV core concepts and definitions; and,
- Assess immediate safety and security risks of the survivor.

Fig. 1: Shows the four levels of MHPSS care for GBV survivors linked to the survivor's mental state and the care provider[12]



12Adapted from the MHPSS Pyramid in IASC, IASC guidelines on mental health and psychosocial support in emergency settings, 2007.

The Figure above shows the importance of ensuring, firstly, that the basic services and security needs of GBV survivors are addressed. Then, from the perspective of MHPSS, the most appropriate support for GBV survivors require more specialized psychosocial support, and some may need clinical care.

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

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

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

Level 4: Clinical care of mental disorders. Provided by trained local health workers, and international medical organizations. This support is intended for survivors with mental disorders such as post-traumatic stress disorders. It seeks to respond to severe behavioural and emotional

disorders, including psychoses. It can include the prescription of psychiatric drugs, as well as a combination of biological, social and psychological interventions.

4.4 Safety and Security Options

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

There may be instances especially due to security concerns when a survivor requires safe shelter. Most often, these shelters are not pre-existing. Thus, it is critical to identify shelter options for survivors at risk. Setting up community based, safe and confidential systems so that survivors can stay with a family member or community leader or at other undisclosed locations. Safety for survivors can be offered through safety networks and foster families that accept a survivor (adult and/or minor) to stay with them for a period of time. Interim care is for unaccompanied or separated children, children formerly associated with armed conflict/groups or other children with specific needs. Such services should represent the best interest for children as described in the guiding principles.

Safe houses/shelter facilities should be considered as a last resort because of the cultural and managerial complexities involved. Service providers offering safe shelter options should adhere to strict protocols and include strategies for addressing longer-term solutions.

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

- ❖ Find strategies that enable the survivor to stay safely with their family when appropriate (e.g., helping the survivor find a resourceful and trustful family member).
- ❖ Identify temporary shelter for the survivor (i.e., a safe, secure and accessible place where they can rest temporarily) with the survivor's family members or in other nearby and accessible locations.
- ❖ Provide financial support and transport to the safe location whenever possible.
- ❖ Involve non-offending caregivers in the healing process, especially when the aggressor is one of the parents of a child GBV survivor.
- ❖ Ensure more frequent and regular follow-up on cases where the survivor is particularly at risk if no alternative relocation solutions could be found.

- For cases at risk of repeat or escalating domestic violence, help the survivor establish a safety plan whereby they can identify mechanisms to decrease trigger points that cause or lead to the aggression (e.g., not being at home alone when the husband comes back from home; inviting other family members when discussing important issues). In such cases, be very cautious never to blame the survivor.
- Identify a safe place to meet the GBV survivor for follow-up visits and agree on a trusted person to contact in case the survivor is not reachable.
- Provide GBV survivors with information about the whole healing and referral process highlighting potential consequences and benefits of accessing services.
- Engage other sectors to meet in a timely manner other immediate needs raised by the survivor that may further expose them to harm and violence.
- Train staff involved in GBV case management on how to identify suicidal thoughts in survivors.
- Train and ensure all staff comply with an organization's security procedures while on duty
- Ensure staff engage the community in respecting the core humanitarian principles.
- Ensure your organization has a clear code of conduct, that your staff know and sign it.

4.5 Legal and Justice Assistance

A quality justice response is crucial in ensuring that relevant laws against violence meet international standards:

- are enforced; keep women and girls safe from violence, including from the re-occurrence of further violence;
- hold perpetrators accountable; and provide for effective reparations for victims and survivors.
- Justice systems, and all actors within the system, must be accountable for ensuring that they deliver on their obligations.

Justice options can include providing legal counselling, assistance and representation for a GBV survivor who wishes to press charges against the perpetrator or in cases related to personal status (e.g., custody law issues, divorce, alimony). Due to the insecurity, uncertainty and judicial vacuum in the area where these SOPs apply, justice assistance is however currently limited. In the absence of established procedures, legal actors should introduce and support innovative practices, such as including social worker's/case workers in sessions in which children are expected to deliver official statements to the police/courts, or advocate those hearings for child survivors should take place in the judge's chambers, in the presence of social worker's/case workers.

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

With respect to justice assistance, actors should:

- Be aware of the legal and justice context in NIGER state.
- Consider the emerging legal systems put in place in across the twenty-five (25) Local Government Areas of Niger State.
- Lay the groundwork for improved access to justice for GBV survivors by putting in place quality health and psychosocial services, and by establishing quality case management and referral systems. These aspects of emergency programming can help facilitate the process for GBV survivors who request legal assistance in the future.
- Inform GBV survivors about procedures, potential consequences and benefits on how they might seek formal justice in the near future (forensic evidence, medical certificate etc.) without making promises that cannot be met.
- Enquire and evaluate whether there are other forms of cultural and informal justice systems the survivor might want to access. While not encouraging traditional informal justice procedures such as mediation, if a survivor decides to access such processes, it is

a duty of a case manager to inform the survivor about how such processes work and the associated risks.

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

With respect to other forms of legal assistance, actors should:

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

4.5.1 Law Enforcement

Law enforcement institutions are responsible for investigating and prosecuting GBV cases that constitute offences under the national laws. In the north, the police are often the first law enforcement institution where GBV survivors disclose their situation. The way in which these security and law enforcement officers respond to GBV situation and address survivor's needs has a significant impact on further actions undertaken by the survivor. Other law enforcement actors that facilitate the work of the police include the National Security and Civil Defence Corps (NSCDC), NAPTIP, the Civilian Joint Task Force and in some cases the military.

Police and other law enforcement officers should ensure that interaction with the GBV survivor takes place in a private place and should be conducted by an officer of the same sex or as preferred by the survivor. During the investigation, the police should provide protection to survivors, if necessary. When applicable, the police officer should visit the scene where the GBV incident took place and gather evidence. The collected evidence will be constituted in a case file which will be submitted to judicial institutions for a criminal lawsuit; in some cases, this can be done only having an official complaint of the survivors.

4.5.2 Procedures

- Referrals should be made to police and NAPTIP ONLY if the child/guardian or survivor has given her/his informed consent.

- If a survivor chooses to report her/his case to the police/law enforcement officer, the officer at the desk will show the survivor/child and guardian to a private interview room
- A specially trained police/law enforcement officer will take the survivor's statement and obtain information relevant to investigation of the alleged crime. If there are female police/law enforcement officers available, they should conduct the interview
- Child/survivor does not need to present a medical form before investigation starts
- Police/law enforcement institution should begin to conduct investigation immediately
- When warranted, police arrest alleged assailant, and file charges with the court
- In the event the police/law enforcement officer maybe required to accompany the survivor for medical checkup and care, survivor's dignity should be upheld and should not be taken in the company of the perpetrator
- All law enforcement officers should be aware of GBV guiding principles and existing services for survivors including referral pathways and should facilitate referral of survivors to appropriate services

4.5.3 Judicial Institutions

Once the case file is submitted by the police/relevant law enforcement agency to the judicial institutions, a criminal lawsuit is initiated. Given the sensitive character of sexual violence forms, judicial response should be different from other types of violence; the hearings should take place in private places and during separate sessions. Extra protection and security measures are put in place during the hearing to ensure the safety of the victim/survivor. The judicial service providers should provide free-of-charge or low-cost counselling about all aspects of the legal process and court representation. The survivor should be treated in a manner that eliminates further victimization and confrontation with the perpetrator should be avoided. In this setting, it is advisable that the State should set up Gender-Based Violence Special Courts.

The survivor has the right to decide to initiate a civil lawsuit for different reasons: divorce, separation of assets, children custody, and compensation for damages suffered by the victim/survivor as a result of GBV (e.g., victimization by professionals by treating victims/survivors in an insensitive or hurtful manner).

Legal actors will assess the national/state justice system for child-friendly procedures. In the absence of established procedures, legal actors should introduce and support innovative

practices, such as including social worker's/case workers in sessions in which children are expected to deliver official statements to the police/courts, or advocate those hearings for child survivors should take place in the judge's chambers, in the presence of social worker's/case workers.

4.5.4 Legal Aid and Counselling

Legal/Access to justice actors should clearly and honestly inform the child and caretaker or survivor of the procedures, limitations, pros, and cons of all existing legal options. This includes: Child friendly legal support; Ensuring child sensitive procedures; Giving information about existing security measures that can prevent further harm by the alleged perpetrator; Giving information about procedures, timelines, and any inadequacies or problems in national/state or traditional justice solutions (i.e., justice mechanisms that do not meet international legal standards); and Informing about available support if formal legal proceedings or remedies through alternative justice systems are initiated.

The table below shows the essential justice/judicial services covering all victim and survivor's interactions with the police/law enforcement and the justice system from reporting or initial contact to ensuring appropriate remedies. The services are grouped according to the broad stages of the justice system: prevention, initial contact; investigation; pretrial / hearing processes; trial / hearing processes; perpetrator accountability and reparations; and post-trial processes. There are also services that must be available throughout the entire justice system: protection; support; communications; and justice sector coordination.

Table 6: Judicial Procedures

STAGES	SERVICES
Prevention	• Conduct awareness about services, laws, policies and procedures
Initial contact	• A positive initial contact experience with the justice system is crucial for victims/survivors of violence.
Investigation	• Assessment & investigation should be started in timely fashion, conducted in a professional manner, meet evidentiary and investigative requirements, and all available means to identify and arrest the suspect are exhausted. Throughout, the survivor's safety, security and dignity are carefully considered and maintained.
Pre-trial processes	• Criminal, civil, family and administrative pre-trial/hearing processes that are non-biased and sensitive to the specific needs of survivors are essential to guaranteeing their right to justice
Trial processes	• Measures should be in place to prevent further hardship and trauma that may result from attending the trial. Ensure that trial processes maximize the

	survivor's cooperation, promote her capacity to exert agency during the trial stage while ensuring that in criminal matters, the burden of seeking justice is on the State.
Perpetrator Accountability + Reparations	• Appropriate sanctions to hold perpetrators accountable for their actions and providing for just and effective remedies to the survivors for the harm or loss suffered by them.
Post-trial processes	• Measures to support healing and rehabilitation

Safety and protection: that protection measures need to be available independent of any process to enable them to stay safely engaged with the justice process.

Assistance and support: legal assistance, practical, accurate and comprehensive information, victim and witness support services and the need for support from outside the justice sector

Communication and information: amongst the various justice service agencies and non-justice sectors, and Justice sector coordination.

4.6 Long-Term Assistance

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

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

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

- ❖ Helping the survivor liaise with organizations providing long-term activities and opportunities to help them fully reintegrate into their communities, empower them and give them tools to protect themselves in the future.
- ❖ Referrals to organizations offering age-tailored vocational and skill-training opportunities, formal and nonformal educational programmes, safe income-generating activities, livelihood activities and cash assistance. Provision of cash assistance should

be tailored to the survivor's needs, should adhere to do no harm principle and should follow international guidance[13].

- ❖ Referrals to families and communities as part of promoting resilience. Community reintegration is an essential part of a survivor's recovery process, for adults as well as children. In the areas where these SOPs apply, GBV case management actors will find it essential to support survivors to reintegrate with families and communities for ongoing support because availability and access to ongoing services for survivors are extremely limited. These kinds of referrals are more informal. They must be guided by the survivor who will decide what and if to disclose information to anyone. This type of referral requires special attention to confidentiality.

Case workers maintains a responsibility to follow up on these services to ensure that assistance does not further stigmatize survivors.

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

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

Skills Building, Livelihoods and Education

Education is one of the basic human rights and provides a safe space for children to learn and develop in addition to that education functions as an integral part of prevention of violations against children as they mature. Skills building targets both children and survivors of GBV to provide a supportive environment and independence. Skills building can as such reduce and eliminate needs for survival sex and other forms of rights' violations.

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

Livelihood projects are an important and integrated part as prevention through livelihoods projects which includes resilience against future shocks. For children and survivors of GBV access to livelihoods activities are part of social reintegration and survival. GBV actors should invest in skills building activities as entry points for offering support and services to survivors. However, they should ensure more meaningful linkages to economically viable opportunities to improve livelihoods and therefore resilience and wellbeing.

Can cash be utilized in GBV response?

Cash can be a key component of survivor-centered GBV case management services in all settings, including humanitarian settings. In situations where core GBV response services (e.g., health or legal services) have associated costs and are not available for free, cash transfers can facilitate access. When clients of GBV case management (i.e., survivors of GBV) are prevented from accessing services due to limited financial resources, cash can help support their recovery and ensure their safety. Cash can be lifesaving; for example, it can help a survivor meet the costs associated, such as rent, temporary shelter, transportation, food, clothing, etc. The flexibility of cash transfers can also enable a timely response to meet urgent needs.

To ensure that cash referrals are appropriately tailored to meet survivors' protection needs and that the introduction of cash assistance minimizes further exposure to harm, cash assistance must be adapted and closely monitored for the survivor's needs through a GBV case management process. Coordination between Cash Working Group and GBV actors at all levels is essential to build the right capacities and develop systems and procedures that effectively meet the specific needs of women and adolescent survivor's needs, while preserving confidentiality and safety.

5.0 ADDRESSING THE NEEDS OF SPECIFIC GROUPS

Prevention and response work should aim to reach and include the unique characteristics and needs of specific groups. Women and girls (especially those with disabilities) are disproportionally affected by GBV, especially child marriage, sexual violence and domestic violence. Hitherto, women and girls in Niger State, Nigeria are seen to be inherently vulnerable. Displaced women and girls who are living in camps and other settlements are especially vulnerable. Divorced and separated women and girls in particular are viewed as responsible for the failure of their marriage and therefore 'bad'. Many may also lack civil documentation or property-related documents. This affects the ability of widowed, divorced and separated women and girls to move freely and access services. This group is nevertheless at particular risk of a number of GBV types, including forced marriage, sexual violence and economic violence.

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

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

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

5.1 Child survivors

Providing care for survivors of GBV who are children is particularly challenging. It requires qualified and trained staff with appropriate competencies and attitudes, working with clear guidelines[14].

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

- ❖ The best interest of the child should always be prioritized.
- ❖ Communication with child survivors should use child-friendly techniques to encourage them to express themselves.
- ❖ If the child survivor wishes, s/he can privately talk with a social worker or counsellor.
- ❖ Where both child protection and GBV actors are available, child survivor should be referred to GBV case workers for specialized care and to child protection actors for other components of child protection case management. Both GBV and Child Protection Case workers should collaborate in the best interest of the child[15]. Both child protection and GBV actors should be trained on how to care for child survivor.
- ❖ After the initial assessment provided, referrals should be made to specific organizations skilled in working with child survivors. Such as Rayuwa Health Foundation in Niger State.
- ❖ The parents or caregiver and the child (depending on the age of the child) should always be informed about the next step, available services, the risks and benefits of accessing them.
- ❖ If the case manager and caregiver are unable to come to an agreement about the provision of services, and in opinion of the case manager that the caregiver is not acting in support of the child's best interest, the service providing organization should intervene.
- ❖ Action needs to be taken if there are suspicions that the perpetrator is a family or household member or the caregiver is in disagreement with the service providers.
- ❖ For children under the age of 14, when parents and/or caregivers are suspected to be perpetrators or complicit in children's abuse, involving an adult that the child trusts, such as a relative, should be prioritized. The child should be supported to identify an adult

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

15 See GBV Case Management SOPs for Nigeria

whom they trust. It is acceptable to proceed with only the child's permission only in cases when the life and/or safety of the child is at risk and therefore immediate support is needed. In such circumstance, the following guidelines also apply:

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

5.2 Adolescent girls

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

Adolescent girls in Niger State, Nigeria are particularly vulnerable group to sexual violence and to child marriage leading to early pregnancy. When working on a case of GBV involving an adolescent girl, the following points should be considered:

❖ Assess the safety of the survivor, including how easy it is for the perpetrator to have access to her and what support she might expect from her family.

❖ Recognize that she may be feeling confused, guilty, scared and sad. Her emotional state may affect what she is willing to disclose and to whom she is willing to talk.

❖ Recognize that she may not understand what has happened to her, and she may not be aware of the possible consequences of sexual violence including pregnancy and STIs.

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

- Pay attention to the development stage of the girl. The ability of a survivor to explain what has happened and to make decisions about services she wishes to access can differ greatly depending on her age and level of education.

Adolescent girls also face the unique GBV risk of child marriage. The management of such a case requires a highly sensitive approach to ensure the girl is allowed to make decisions and not placed at risk of further harm. Regardless of the position a GBV specialist holds on child marriage, they are not in a position to intervene to stop the marriage. The best approach is to understand the situation of the girl and what she wants.

There are two types of case management of child marriage: management of an imminent marriage and management of an existing marriage. The table below shows a summary of case management responses to child marriage, intended to facilitate awareness of non-case management agencies. Always ensure to work closely with GBV case workers and social welfare staff of the Ministry of Women Affairs and Social Development in such situations.

Table 7: Summary of Case Management Response for Child Marriage

<table>
<tr><th colspan="2">FOR IMMINENT RISK CASES</th><th>FOR GIRLS WHO ARE ALREADY MARRIED</th></tr>
<tr><td colspan="3">Get consent to work with the girl</td></tr>
<tr><td colspan="2">Assess: How does she feel about the marriage?</td><td>Assess her needs.</td></tr>
<tr><td colspan="3">Provide information to the girl about the consequences of marriage.</td></tr>
<tr><td colspan="2">Identify with her a supportive family member or other trusted adult.</td><td>Provide information about the services available and make referrals.</td></tr>
<tr><td colspan="2">With the girl's consent, engage the supportive family member or other trusted adult.</td><td rowspan="6">Carry out safety planning.</td></tr>
<tr><td>If person identified is parent or caregiver.</td><td>If person identified is not parent or caregiver.</td></tr>
<tr><td>Discuss pro and cons of child marriage.</td><td rowspan="2">If safe to do so and with the girl's consent, support the identified person to have a conversation with the decision-maker in the family.</td></tr>
<tr><td>Provide information to the identified persons on the consequences of child marriage.</td></tr>
<tr><td colspan="2">If marriage is likely to go forward, focus on risk reduction.</td></tr>
<tr><td colspan="2">Assess the girl's concerns and questions, and potential risks related to her safety and health.</td></tr>
</table>

Carry out safety planning.
Provide information about services and referrals.
Help her identify a supportive person in her life.
Help her identify positive coping strategies.
With her consent, engage—or continue to engage—a supportive adult.

While child marriage is not a new phenomenon in Niger State - Nigeria, the specific nature of the conflict and humanitarian interventions has contributed to this practice. This therefore requires system wide efforts to support meaningful prevention and risk mitigation interventions. The Gender Based Violence and Child Protection Sub Sectors consistently advocate for a concerted effort from agencies/sectors given the interconnectedness of the issues in order to prevent and mitigate risks associated with provision of aid[16].

5.3 People with disabilities

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

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

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

16 See GBV-CP SS Briefing Note: Inter-Agency Efforts Needed to Avert Child, Early and Forced marriages

The following points should be considered when working on a case involving a person with disabilities:

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

5.4 Older Women

Research studies[17] demonstrate how aging is not a factor that protects women from GBV, especially in displacement situations. Older women undergo multiple forms of discriminations, on the basis of gender and age. Age-specific factors, such as physical vulnerability, displacement, possible illness, isolation, dementia, lack of social connections or dependence on relatives or neighbors, put older women at greater risk of violence compared with women of younger age. Older women who experience violence are more likely to have severe consequences such as fear, anger, depression, exacerbation of existing illness, confusion, severe psychosocial distress and life-threatening injuries. Furthermore, they are especially vulnerable to economic abuse, in particular. They experience obstacles as they attempt to secure inheritance and property rights; and face greater challenges in accessing information on available services. Older women could

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

also internalize and normalize abuse and violence with time, or not recognize abusive behaviour, like domestic violence.

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

When working on a case of GBV involving an elderly woman, the following points should be considered:

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

5.5 Male Survivors (Men and Boys)

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

and/or overtly feminine according to the gender norms of the culture.

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

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

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

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

6.0 PREVENTION AND RISK MITIGATION

Although divided in this SOP into two separate sections, prevention and response are inter-related activities. Many elements of GBV response are also preventive measures. Likewise, well considered prevention activities are linked to response actions. Appropriate and effective prevention strategies should be developed to address social norms and factors that contribute to and influence the type and extent of gender-based violence in the community. Prevention activities should be aimed at engaging community structures in meaningful and culturally appropriate ways.

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

Risk reduction activities are actions that aim to reduce the risks that vulnerable persons (especially women and girls) face in all GBV settings, especially in humanitarian and emergency and post-emergency contexts, and to protect those who have already experienced violence from further harm. This process cannot be done without engaging and mobilizing the community to become aware of gender roles and stereotypes, men's power over women, and how the community's silence about this power imbalance perpetuates VAWG.

6.1 GBV Assessments and Research

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

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

Table 8: Ethical and Safety Recommendations that Apply When Collecting Information About Sexual Violence

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

6.2 Women and Girls' Friendly Spaces (WGFS)

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

Depending on the context, WGFS can provide an opportunity for women and girls to gather and socialize informally and/or can be used as a platform for conducting more structured group activities. Core aims may vary;

- ❖ A place where women and girls have easy access, privacy and feel safe.
- ❖ A place where women and girls can obtain information about available services, including GBV services and receive support (either through WGFS or through referrals).

- Reduce emotional distress, through psychosocial support, recreational activities and peer support.
- Provide information on issues relevant to the lives of women and girls.
- Connect women and girls to other services (such as livelihoods or medical services).
- Develop or strengthen women's and girls' social networks, build relationships and create opportunities for experience sharing.
- Empower women and girls so they are able to identify solutions and strategies to address concerns and to act and advocate for themselves.

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

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

These spaces are especially important for reaching adolescent girls in Niger State, Nigeria who experience particular vulnerabilities due to, among other factors, increased risks of suffering sexual violence and child marriage. The GBV Area of Responsibility has developed minimum standards that guide the WGFS programing, as well as making them friendlier for adolescent girls. The GBV SS is committed to continue to raise partner awareness on WGFS standards and on how to promote more inclusive approaches to accommodate women and girls.

WGFS aim to create an empowering and inclusive environment where women and girls attending feel safe, supported, connected, empowered and better informed about their rights and

opportunities. Therefore, the creation of WGFS in Niger State should follow the six guiding principles for establishing WGFS:

1. Do no harm, survivor-centered
2. Build on existing capacity, resources and structures. Existing community support systems (e.g., women's associations) can be identified and strengthened, and community leadership structures can be involved in establishing the WGFS.
    a. Making decisions about how to decorate and arrange the physical space of the WGFS.
    b. Teaching each other skills (e.g., decorating and henna designs).
    c. Leadership and empowerment of women and girls, Women leaders can take on certain responsibilities, such as mobilizing women for particular activities.
3. Participation/ Community-Based Approach - Obtaining and maintaining community buy-in' and involvement
4. Safe and accessible
5. Tailored, yet multi layered integrated support systems
6. Focus on inclusion and sustainability

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

6.3 Dignity Kits

The GBV SS supports the use of standardized dignity kits (see Annex VI) in the context of GBV programming in Niger State to help women and girls maintain their dignity during the humanitarian crisis[18]. Standardized dignity kit package and guidance note developed by the GBV

18 The GBV SS Dignity Kits Guidance Note, 2019

SS: provides what is considered from community consultations as relevant, with the appropriate content that meets the basic minimum dignity of women and girls of reproductive age.

In January 2019, the Humanitarian Country Team (HCT) made bold commitments on the addressing critical gaps in dignity and menstrual hygiene needs of women and girls affected by displacement in the north east, therefore Niger State with current realities of crisis has adopted the same. The HCT outlined the following six critical areas

1. Mobilization of funds for dignity and menstrual hygiene materials
2. Strengthen coordination on procurement/sourcing and distribution of materials to ensure standardization, more timely and effective response
3. Targeted distribution of dignity and menstrual hygiene materials, at individual level as opposed to household level blanket distribution
4. Tap into the agency and capacity of civil society organizations, especially local women groups to promote women's empowerment and long-term sustainability efforts
5. Ensure a comprehensive approach to menstrual hygiene management, beyond provision of materials
6. Integration and mainstreaming: Support enhanced standardization and systemization of menstrual hygiene kit.

Preserving dignity is essential to self-esteem of women and girls of reproductive age in Niger State, Nigeria and is critical to their protection, including GBV risk mitigation and response. The GBV Sub Sector's approach in addressing the Critical Dignity and Menstrual Hygiene Needs of Women and Girls of Reproductive Age seeks to incorporate the above HCT commitments into dignity programming in all GBV responses, including in humanitarian responses.

Organizations that are planning to distribute dignity kits should:

- ❖ Follow and respect the standardized dignity kit package and guidance note
- ❖ Liaise with the GBV SS's Technical Working Group on Dignity Kits to coordinate the location and target population;
- ❖ Coordinate with other actors covering the same areas to avoid duplication of materials;

- ❖ Prioritize the use of dignity kits that are procured and assembled locally;
- ❖ Distribute the dignity kits at regular intervals throughout an emergency;
- ❖ Consider the peculiar needs of women and girls with disabilities in the design, content and distribution of the dignity kits; and,
- ❖ Consider the needs of women and girls of reproductive age that have been displaced and IDPs as beneficiaries.

For other humanitarian sectors

All humanitarian actors must be aware of the risks of GBV and—acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their areas of operation…Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations[19].

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

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

It is the responsibility of all humanitarian actors to work within a protection framework and understand the safety and security risks that women, girls, men and boys face. It is extremely important that assessment and monitoring of general safety issues be an ongoing feature of assistance. This includes exploring—through a variety of entry points and participatory processes—when, why and how GBV-related safety issues might arise, particularly as the result of delivery or use of humanitarian services.

GBV prevention and mitigation strategies should be integrated into programmes from the beginning of an emergency in ways that protect and empower women, girls and others at risk groups. These strategies should also address underlying causes of GBV (particularly gender equality) and develop evidence-based programming and tailored assistance.

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

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

All sectors should train their staff to appropriately and confidentially facilitate safe referrals for survivors who disclose an incident of GBV in the context of service provision.

6.4 Protection from Sexual Exploitation and Abuse (PSEA)

PSEA is an important aspect of GBV prevention. All actors must implement policies and/or practices to ensure PSEA is linked to all GBV prevention, response and humanitarian programmes. This includes Sexual Exploitation and Abuse (SEA) against affected populations committed by those responsible for implementing these programmes.

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

- Sexual harassment and abuse when going unaccompanied to receive aid distributions
- Sexual exploitation at schools and learning centres
- Harassment when receiving health services
- Sexual exploitation by landlords in return for rent
- Sexual exploitation of women and girls at religious centers
- Sexual exploitation of children working near distribution sites Policies and practices.

PSEA should cover:

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

❖ Ensuring the distribution of NFIs are aligned to protect beneficiaries from SEA

6.5 Emergency Response

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

The GBV Sub Sector promotes an integrated and quick response to GBV concerns in an emergency context which provides for minimum service packages[20] in an integrated manner to affected communities and enhances field coordination. A mixed-modality approach, with both static service points and mobile outreach teams, is used to facilitate multiple entry points to services and also supports sector members continue to deliver services in rapidly-changing circumstances. The following activities are prioritised among others:

1. Mobile outreach teams: PFA, information sharing/awareness raising, counselling, referrals.
2. Static service points: PSS, information and referrals, in addition to provision of GBV case management.
3. Dignity kit distributions: providing dignity kits to women and girls of reproductive age.

6.6 Closure of GBV Programmes

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

20 See Standardized dignity kits

early because of funding restriction, security issues and operational restrictions. There should be continuity by the State Government.

The GBV Sub Sector promotes the ethical closure of GBV programmes through requiring the development of an exit strategy that adheres to the following guidelines:

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

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

- ❖ Coordinate with the GBV SS to maximize the success of the above guidelines;
- ❖ Consult with other organizations to identify possible replacement services;
- ❖ Support capacity building for other local actors who can continue to provide services;
- ❖ Consult with both staff and beneficiaries about the closure;
- ❖ Communicate the closure to key stakeholders;
- ❖ Ensure ethical and secure management of data;
- ❖ Stop the intake of cases; and,
- ❖ Explore all possible options to ensure case management can continue (e.g., handover to another case management organization, referral to other organizations in other areas, remote support).
- ❖ Build the capacity of stakeholders for sustainability.

7.0 DOCUMENTATION OF DATA, MONITORING AND EVALUATION

Safe and ethical sharing of GBV related information is critical. Some challenges related to sharing of GBV information include; safety concerns for the survivor, family and those involved in responding, questions around confidentiality and consent, misinterpretation of data (i.e., reported incidents), tensions among partners (due to sharing or not sharing), strained working relationships, among others. Three general categories of GBV information include

1. Individual cases: include details of information on survivor, perpetrator, specific details of the incident. It requires highest level of caution regarding information sharing (safety concerns, survivor-centred principles, etc.). Information on individual cases should only be shared on need-to-know basis i.e., in the context of service provision and with survivor's consent. The level of details to be shared should be limited to what is needed for making a referral.

2. Quantitative GBV incident data: Includes statistics of cases reported to service providers, which must not contain identifiable information i.e., individual survivors and is shared only in accordance with an information sharing protocol. According to ethical standards, this type of information should only be collected through service provision. In general, its less sensitive than individual case data but can still create safety concerns/break confidentiality and numbers can easily be misinterpreted.

3. Other information of GBV risks/trends: Mostly qualitative information, often from existing sources (focus group discussions {FGDs}, community feedback mechanisms, programme. monitoring, etc.), useful for programming, advocacy, coordination, donor reports, situation reports (sitreps), etc. can be analyzed alongside other quantitative data from respective sectors.

Documentation of GBV incident when appropriate by persons with the relevant skills (See GBVIMS) provides critical summary of the most relevant information about an individual GBV incident, if not the case history. Collecting relevant data about each GBV case and gathering them in a database will;

a. generate data for monitoring and evaluating GBV cases progress,

b. offer a clear view on the disclosed cases in a specific area, and

c. help to evaluate the functioning of multi-sectoral response to GBV.

The documentation of a GBV case could be made using standardized forms, hand notes, charts, photographs, paper registries, etc. Actors should ensure they have the required capacity to collect, store and share GBV incident data. All actors, particularly those participating in the GBV Information Management System (GBVIMS) are adequately trained to ensure each organization is collecting the same information which can then be compiled and compared.

The GBV IMS coordination point at GBV Management Committee compiles monthly incident reports for all the various local governments including the state capital and prepare quarterly narrative trend analysis. Monthly incident reports are only available for data gathering organizations as per specific Information Sharing Protocols, while the monthly statistics and quarterly narrative trend analysis is available externally.

7.1 Data Management Protocol

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

7.1.1 Data protection

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

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

- ❖ All staff in contact with the data have a strong understanding of the sensitive nature of the data, and the importance of data confidentiality and security.
- ❖ Staff have been asked to identify security risks specific to their context and to think through the possible implications for clients, their families and communities, and for the organization, if data gets into the wrong hands.

- ❖ Clients and/or their caregivers need to give informed consent to gather and store their data before any information is recorded.
- ❖ Staff are aware that when obtaining informed consent, survivor may highlight particular information they do not want shared with certain people, and that this must be recorded and respected.
- ❖ Signed paper consent forms must be kept in a locked filing cabinet.
- ❖ Information must not be passed on to a third party without the informed consent of clients and/or their caregiver(s).
- ❖ Staff who are working with GBV data are aware of the importance of being vigilant as to who is entering the room where they work and for what purpose.
- ❖ Staff who work with GBV data have signed a data protection agreement.

7.1.2 Information sharing

Information management is critical to effective GBV prevention and responses. Careful attention nevertheless needs to be paid to how information is collected and shared. The highly sensitive nature of GBV poses a unique set of challenges for information management especially in the geographical area where these SOPs apply. A range of ethical and safety issues must be considered and addressed prior to the commencement of data collection or sharing activity[21]. These include:

- ❖ Information about specific incidents of GBV should not be shared.
- ❖ Special care should be taken when distributing information.
- ❖ All guiding principles associated with ethical and safe information collection must be upheld.
- ❖ No identifying information should be included in any of the data summaries.

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21 For more information, refer to WHO, Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies, 2007 and IASC, 2005. [19] See GBVIMS Information Sharing Protocol

- Information that is private, which could identify individuals or particular communities, or that could endanger members of the affected population or staff members, should not be disclosed publicly.

Information that should be shared includes:

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

The following are recommendations on the sharing of quantitative and qualitative information.

QUANTITATIVE INFORMATION: Only aggregated data should be shared. This aggregated data should be shared only among GBV actors and within the GBV SS framework. Each agency sharing aggregate data should have a trained responsible person for completing this task.

QUALITATIVE INFORMATION: Organizations should share the results of their assessments in a timely and accessible manner with the community, the coordination group and other relevant organizations.

Encourage the dissemination of qualitative data (e.g., rapid assessments, safety audit results, situation analyses) to promote a better understanding of the local context through the coordination bodies.

Advocate for harmonization of assessment tools for focus groups discussions, safety audits, service mappings, key informant interviews etc.

7.2 Coordination[22]

Given its complexities, GBV is best addressed when multiple sectors, organizations and disciplines work together to create and implement unified prevention and mitigation strategies[23].

The Niger State Ministry of Women Affairs and Social Development is the lead and coordinating ministry with collaboration with relevant MDAs, NGOs, INGOs and private sectors/entities under shared objectives of ensuring life-saving, predictable, accountable and effective GBV prevention, risk mitigation and response in all context – be it emergency or non-emergency in the State. The GBV Management Committee in Niger State provides overall guidance and strategic orientation to the sub sector. The operational coordination of the GBV SS is from Minna, Niger State with sub working groups in the State capital, at LGAs and/or Camp level, organizations volunteer to lead GBV field coordination with guidance from the Secretariat in Minna. The GBV Management Committee provides support and guidance for the strategic direction and technical advisory on key issues related to GBV protection and response to partners, sectors and the Humanitarian State Teams (HST). The GBV Management Committee is responsible for leadership accountability for GBV commitments and monitors the implementation of the GBV SS strategic framework and annual response plan.

The GBV SS meets monthly in the State Capital and other context highlighted above. Information – both strategic and operational is shared at least monthly between members of the GBV SS. At field level (LGA/Camp) Field Focal Points organize monthly and/or bi-weekly meeting depending in the context, sometimes jointly with protection actors or separately as GBV actors. Case conferencing is convened on need basis and chaired by a GBV Management Committee member. This information and discussions guide the continuous development of response interventions.

Membership is free and open to all humanitarian organizations involved in GBV prevention and response under the goal of reducing risks and mitigating consequences of GBV experienced by women, girls, boys and men in Niger State. This includes UN agencies, international and national

22 See Gender Based Violence Sub Sector – Nigeria Terms of Reference for more information
23 IASC, Guidelines for integrating gender-based violence interventions in humanitarian action: Reducing risk, promoting resilience and aiding recovery, 2015, p.42.

NGOs and international organizations. Organizations are encouraged to be represented by technical staff in GBV and women's empowerment. All potential GBV SS partners are expected to fill an online form to provide baseline information on their services and affirm their commitment to the guiding principles.

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

7.3 Communications: Informing Service Providers About the SOPs

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

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

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

Target groups within communities for these communications include:

- ❖ Service providers
- ❖ Humanitarian actors

- ❖ Camp management
- ❖ Local leadership structures
- ❖ Women's networks
- ❖ Teachers
- ❖ Religious leaders

GBV Sub Sector partners agree to:

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

Annexures

ANNEX I: CONSENT FORM

CONSENT FORM

CONFIDENTIAL Form: Consent for Release of Information

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

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

1.

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

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

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

I would like information released to the following:

(Tick all that apply, and specify name, facility and agency/organization as applicable) YES NO

☐ ☐ Safe shelter/house (Specify)

YES NO

☐ ☐ Psychosocial Support Services (Specify)

YES NO

☐ ☐ Health/Medical Services (Specify)

YES NO

☐ ☐ Law Enforcement/Security Services (Specify)

YES NO

☐ ☐ Legal Assistance Services (Specify)

YES NO

☐ ☐ Livelihood Services (Specify)

YES NO

☐ ☐ Other (Specify type of service, name and agency)

Authorization to be marked by client (or parent/guardian if client is under 18): YES ☐ NO ☐

2.

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

Authorization to be marked by client (or parent/guardian if client is under 18): YES ☐ NO ☐

Signature/Thumbprint of client: ____
(or parent/guardian if client is under 18)

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

Client's Name: ____

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

Contact Number: ____

Address: ____

ANNEX II: INTER-AGENCY SEXUAL EXPLOITATION AND ABUSE (SEA) COMPLAINT INTAKE AND REFERRAL FORM

GUIDANCE FOR RECEIVING, RECORDING & REFERRALS

In the event you have been approached by a community member or colleague (either from the same organization or not) with information regarding an incident of Sexual Exploitation and Abuse (SEA), pay attention to the following while receiving the complaint:

- *React calmly and listen carefully to what is being said.*
- *Reassure the complainant that he or she has right to raise the concern.*
- *Seek consent and address issues of confidentiality (see SOPs for PSEA - key principles), staff members are obliged to report complaints, while reassuring the complainant that information will kept confidential and only be shared on a "need to know" basis*
- *Ask only relevant questions required to gain a clear understanding of the complaint so that it can be passed on via [AGENCY NAME]'s reporting procedures.*
- *Ensure that the survivor/complainant's safety is not at risk.*
- *Consider (prioritize) the survivor's need for services including medical attention and use the available GBV referral pathway if available or seek advice from a GBV specialist.*
- *Recording of information, suspicions or concerns needs to be as clear as possible, as it may be used in subsequent disciplinary or legal action. i.e. Correct names of all involved, identity numbers of witnesses, victims, and if possible photo records of the subject.*
- *The nature of the complaint. An accurate account of what was said by the complainant in her/his own words. A description of any visible sign of abuse or other injuries including a body map, maybe helpful.*
- *Key observations while receiving the complaint: Times, locations, dates given, whether anyone else knows or has been given information, whether survivor has accessed services.*
- *Inform the complainant of the next steps in the procedure.*
- *Report the complaint (using the form below), as per the agency reporting procedure, at the earliest opportunity.*

PLEASE NOTE THIS INFORMATION SHOULD BE KEPT CONFIDENTIAL

Inter-Agency SEA Complaint Intake and Referral Form

Name of Complainant:		Nationality:
Address/Contact Details:		Position/Identity Number:
Age:		Sex:
How does complainant prefer to be contacted? (Give details)		
Name of victim/survivor (if not the complainant):		Nationality:
Address/Contact Details:		Identity No.
Age:		Sex:
Name (s) & address of parents/legal guardian, if under 18:		
Has survivor given consent for completion of this form? YES: ☐ NO: ☐ I DON'T KNOW: ☐		
Is the victim/survivor receiving any type of humanitarian assistance? (Name the organisation/agency providing assistance):		
Date of incident(s):	Time of incident(s):	Location of incident(s):
Brief description of incident(s) in the words of the survivor / complainant:		
Briefly describe service (s) provided to survivor:		
Is the perpetrator a continuing threat to the safety of the survivor, complainant, staff or any beneficiary? Please explain any safety concerns:		
Name of accused person(s):		Position / Job title of person(s):
Agency accused person(s) works for:		
Address or location where accused person(s) works:		
Agency receiving complaint:		
Name of person completing form:		Position / Job title:
Signature:		Date:
Referral to Agency of Concern PSEA Focal Point		
Name of agency / name of person (PSEA Focal Point) report forwarded to:		Date of referral:
Name and position of person report forwarded to:		
Acknowledgment of receipt		
Name & Position / Job title:		Agency:
Signature:		Date received:

Send Completed form to the following confidential email address: nga.psea@humanitarianresponse.info

ANNEX III: INTER-AGENCY REFERRAL FORM FOR SURVIVORS OF GBV

Priority:	Referred via:	Referral Date:
☐ High *(Follow up requested within 24 hours)* ☐ Medium *(Follow up within 3 days)* ☐ Low *(Follow up within weeks)*	☐ Phone: ☐ Email: ☐ In Person:	

Referred To:	Referred By:
Agency/Clinic: Name of the staff: Address: Phone: Email: Contact:	Agency: Name of the staff: Address: Phone: Email: Contact:

For all external referrals, the use of survivor codes instead of names should be discussed and agreed by all actors.		
Name/Survivor Code:		Displacement status:
Address: Phone:	DOB : Sex:	Language:

Name of primary caregiver:	Contact information for caregiver:_______/_____________
Relationship to child: Caregiver is informed of referral? ☐ Yes ☐ No (If no, explain)_______/________________________________	

Services already provided: (include any other referrals made – limited to information only relevant for the referral)		
Agency	**Support**	**Date (incl. ongoing)**

☐ HEALTH: Clinical Management of Rape (CMR) ☐ Specialized psycho-social support ☐ HEALTH: Treatment of injuries ☐ Case Management ☐ HEALTH: other medical care ☐ Livelihood/Education ☐ Legal Counselling /assistance	☐ Material assistance ☐ Protection interview/services ☐ Safe Shelter ☐ Care arrangements ☐ Civic documentation **Provide additional explanation here:**

ADDITIONAL SPECIFIC NEEDS of the SURVIVOR

Child ☐ Child not attending school ☐ Teenage Pregnancy ☐ Child spouse ☐ Child mother ☐ Child engaged in worst form of child labour ☐ Child formerly associated with armed forces/armed groups ☐ Unaccompanied/separated child ☐ Child living with disability **Woman** ☐ Pregnant ☐ Woman head of household ☐ Woman living with disability	**Provide additional explanation here:**

IMPORTANT

Also refer the case to the lead GBV Case Management agency in the location/camp if

- You are unsure how to support a particular person,
- Immediate physical security options (including relocation) are required,
- Best Interest Assessment (BIA/BID) for a child is necessary
- Police/Legal Action is required
- Emergency protection cash assistance for transport is necessary

Consent to Release Information (Read with survivor and answer any questions before s/he signs below)

I, ____, understand that the purpose of the referral and of disclosing this information to ________________________________ is to ensure the safety and continuity of care among service providers seeking to serve this family/person. The service provider, ____, has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information.

Signature of Responsible Party: Date:

Details of Referral:

Survivor has been informed of referral? ☐ Yes ☐ No (If no, explain)___________________________________

If consent has not been signed (especially if referral from hotline), survivor has been explained the process and has verbally consented to release information? ☐ Yes ☐ No

Any contact or other restrictions? ☐ Yes ☐ No (If yes, explain)_

For Sexual Exploitation and Abuse, complete the Inter Agency SEA Intake and Referral Form and send to the following confidential email address: nga.psea@humanitarianresponse.info

Receiving Organization:

Referral received by: Date: Time:	Response provided to referring agency by: Date:

ANNEX IV: REFERRAL GUIDE FOR GENDER BASED VIOLENCE - NIGERIA

Survivors of Gender Based Violence, Sexual Exploitation and Abuse including children have a right to safety and dignity.

People who experience gender-**based violence** (such as rape, sexual assault, domestic violence, exploitation, stalking, verbal abuse, etc.) should be referred for appropriate assistance, for their safety, health, and psychological wellbeing.

Children (under age 18) who are survivors of violence or at risk of harm should be referred to or service provided to them should be in consultation with actors who are trained to handle the special needs of child survivors of sexual abuse, and who are familiar with local procedures relating to the protection of children.

Sexual exploitation and abuse of beneficiaries by humanitarian workers constitutes acts of gross misconduct and is therefore grounds for termination of employment. A Zero Tolerance approach ensures obligation to report any concerns or suspicions.

GUIDELINES FOR RESPONDERS

- Always observe CONFIDENTIALITY, SAFETY, RESPECT, AND DIGNITY
- No decision is made without the INFORMED CONSENT of the survivor
- Have discussions in private settings with same-sex staff
- Be patient, be a good listener, and don't judge
- Don't press for information the survivor doesn't want to share
- Ask only relevant questions, don't make the survivor repeat their story
- Do not laugh, show disrespect or disbelief; NEVER blame the survivor
- At all times, prioritize the safety and security of the survivor as well as involved staff, volunteers and service providers

Informed consent means the person agrees to seek assistance with an understanding of what is involved, and the benefits and risks

The survivor may tell someone about the incident – such as a trusted family member, friend, community leader/ member, etc. – and the person, as needed accompanies her/him to the health centre or psychosocial service or the police – based on what the survivor wishes

Survivor may refer herself/himself to any service provider

IF THE SURVIVOR HAS GIVEN INFORMED CONSENT FOR REFERRAL

IF THERE IS AN IMMEDIATE RISK TO THE SAFETY OF THE SURVIVOR: PRIORITISE SAFETY & SECURITY

Conduct an immediate security and safety needs assessment.

Create a safety plan that addresses both ongoing risks and the additional risk created by reporting the complaint.

Conduct follow-up assessments as necessary.

FOR SEXUAL AND/OR PHYSICAL VIOLENCE: Ensure immediate access to HEALTH / MEDICAL CARE SERVICES (within 3Days/72Hours to reduce the risk of HIV and **5 days, or 120 Hours** to reduce the risk of unwanted pregnancy)

At a minimum, health care must include: Examination and treatment of injuries, prevention of disease and/or unwanted pregnancy, collection of minimum forensic evidence medical documentation, & follow-up care.

GBV Case Management; Mental Health and Psychosocial Support

Counselling, Psychosocial support and critical steps in GBV case management and advocacy to assist survivors in accessing needed services; support and assistance with social re-integration

Where there is a GBV Case Management Agency, refer to them to assist recovery process.

If the survivor wants to pursue Legal Action

The survivor has the right to seek legal counselling regarding his/her complaint

Counselling includes assisting complainants to navigate the investigating body's administrative process and/or the process of pursuing a civil or criminal claim under national laws – Clearly and honestly inform the survivors of the procedures, limitations, pros, and cons of all existing legal options

Direct financial assistance will not be provided as a form of general assistance. However, when necessary survivors/ victims should be helped to find shelter, clothing, food and/or other services when a GBV/SEA incident(s) impedes them from using their own resources

FOR SEXUAL EXPLOITATION AND ABUSE, REFER THE SURVIVOR FOR SERVICES & REPORT INCIDENT (using SEA Intake & Referral Form) TO YOUR AGENCY PSEA FOCAL POINT OR MANAGER OR INVESTIGATIVE BODY OR THE INTER AGENCY PSEA CONFIDENTIAL EMAIL AT nga.psea@humanitarianresponse.info

ANNEX V: NIGERIA: INTER-AGENCY SEXUAL EXPLOITATION AND ABUSE (SEA) COMPLAINTS REFERRAL SYSTEM

- Survivor self-reports an incident of Sexual Exploitation and Abuse (SEA) or Survivor tells someone he/she trusts and the person (s) makes a formal complaint of SEA
- A staff/community member has a genuine concern/knows about SEA happening

Entry points for reporting include, but not limited to the following;

- Toll Free helplines/hotlines, Complaints and feedback boxes in camps and communities,
- Confidential email
- Women and Girls Friendly Spaces (WGFS); Child Friendly Spaces (CFS), adolescent/youth friendly spaces, school and learning centres,
- Health centres/facilities; Protection complaint desks; distribution sites,

Immediate response from person receiving complaint /allegation of SEA

- Provide a safe and confidential environment
- **Using the inter agency SEA intake and referral form, record only the necessary information.** PROTECT the form. DO NOT try to ascertain whether or not the allegation is true or to make any investigation into the allegation.
- Conduct an immediate needs assessment and refer survivor/complainant using the GBV referral pathway for medical, psychosocial and GBV case management services

Report the complaint confidentially to your agency PSEA Focal Point or Manager or Investigative Body, as soon safely as possible – Within 24hours*.

Where the agency reporting channel is compromised, not known, refer the complaint to **PSEA Coordinator** nga.psea@humanitarianresponse.info as soon as safely possible.

If the complaint implicates a staff member of the same organization; Refer complaint internally to the head of the organisation or investigative body

If the complaint implicates a staff member of a different organization; Refer complaint to the PSEA FP/investigative body of the accused person's organisation

If the complaint is a rumour or alleged perpetrator(s) affiliation unknown; Refer internally to the organisation and alert the PSEA Coordinator to ensure the task force takes necessary measures

If the complaint implicates a member of the local community inform complainant of relevant options including reporting to the police if appropriate and survivor is interested in this option

Complaint implicates a security actor: For Nigeria Police Force (NPF) Call PCU – 08057000001, 08057000002; SMS and WhatsApp: 08057000003;

For Nigeria Security & Civil Defence Corps: Call PCR 08033941284, 08033941284

For military, CJTF or Gov't Official refer to nga.psea@humanitarianresponse.info

Investigation initiated in line with IASC & agency investigation policy. Agency carries out relevant administrative and disciplinary measures. Provide **feedback** to the survivor/complainant.

Through the PSEA Coordinator, **the RC/HC should confidentially be notified** that an allegation has been received at the time of referral and Agency of Concern provides **a progress report to the RC/HC** at completion of the process.

ANNEX VI: NIGERIA: STANDARDISED DIGNITY KIT PACKAGE

The items in this standardised kit provide what is considered from the community consultations as relevant, with the appropriate content that meets the basic minimum dignity of women and girls of reproductive age. Key parameters considered during the FDGs to develop this list include: relevance of the items, cultural sensitivity, context, environment, quantity, frequency of distribution, and price. With regard to choosing appropriate quantities of each item there is no one standard solution. SPHERE standards guidelines are that the contents of dignity kits should last for at least one month. This kit is designed to last for a maximum period of 6 months.

Another important consideration is that women and girls are typically the primary caregivers of their extended families and they tend to share the contents of the kits with their families. It is advisable to include larger quantities of some items, to support multiple family members.

SN	Item	Quantity	Comments
1	Sanitary Pads Option 1: Re-washable sanitary pads[22] Option 2: Disposable pads	 2 packs of 6Pcs 6 packs	 Should have considerations for heavy flow and normal flow
2	Under wear(pants)	5 pieces	Range of sizes (Medium, Large and XL)
3	Soap	2 bars	
4	of washing powder	1 pack(1kg)	1Kg of washing powder, at minimum
5	Lotion/Vaseline	500ml	
6	Shaving stick	1 piece	
7	Towel/fleece blanket	1 piece	
8	Hijab/Himar	1 piece	
9	Wrapper	1 piece	6 yards
10	Flash light/torch/solar lantern	1 piece	
11	Whistle	1 piece	
12	Bucket	1 piece	Preference should go to multipurpose buckets that hold at least 10 litres of water.
13	Mat	1 piece	
14	Carry bag	1 piece	

This content may vary over time according to the needs and feedback of the affected population. The GBV subsector will review the contents of the kits based on post-distribution monitoring conducted by organizations every 6 months (the estimated life of the standard kit in an emergency phase), with the first review of contents beginning with the NHF 2019

ANNEX VII: SEXUAL AND GENDER-BASED VIOLENCE REPORTING TEMPLATE 2021

IDENTIFICATION SECTION: SURVIVOR SOCIO-DEMOGRAPHICS

Q.No	*Question*	*Option*	*Response*
I	Date of Birth		
II	Age in completed year		
III	Age in completed year as at the time of incidence		
IV	Sex	Male = 1, Female = 2	
V	State of Origin	Niger=1, Other States=2, ……….FCT-Abuja=37, Foreign National=38	
VI	State of Residence	Niger=1	
VII	State of Incidence	Niger=1	
VIII	LGA of Incidence (Select)		
IX	Town/Locality of Incidence		
X	Civil/Marital Status	Single=1, Married=2, Cohabitating=3, Divorced=4, Separated=5, Widowed=6	
XI	Formal Educational status	No Education=1, Early Childhood Care and Education/Pre- primary=2, primary=3, Junior Secondary=4, Senior Secondary =5, Tertiary=6, Non-formal=7	
XII	Is survivor a person with disability prior to incident?	Yes=1; No=2	2⇨XIV
XIII	What is the nature of Disability	Mental=1, Physical=2, Emotional=3, Psychological=4, All of the above=5	
XIV	Indicate occupation (Where applicable)		
XV	Religion	Christianity=1, Islam=2, Traditionalist=3, Other (Specify)=4	
XVI	Is template completed by the survivor?	Yes=1; No=2	1⇨Freeze Sec. F

SECTION A: SURVIVOR DISPLACEMENT/DISABILITY/MINOR STATUS

QNo	*Question*	*Option*	*Response*
Details of survivor displacement is required in this section			
A1	Did the incident occur under humanitarian circumstances? (Care of displaced persons)	Yes=1; No=2	2⇨A5
A2	Is survivor displaced?	Yes=1; No=2	
A3	Displacement Status at time of report	Asylum Seeker=1; Foreign National=2, Internally Displaced Persons=3, Refugee=4, Resident=5, Returnee=6, Nigerian Resident=7 Others (Specify)=8	
A4	Indicate the stage of Displacement as at the time of incident	Pre-displacement=1, During Flight/Transit=2, During Refuge=3, During Return Transit=4, Post-displacement=5	
A5	Did the survivor suffer any disability as a result of the incident?	Yes=1; No=2	2⇨A7

A6	Type of disability suffered because of the incident. *(Enter all applicable)*	Mental=1, Physical=2, Emotional=3, Psychological=4, All of the above=5	
A7	Is survivor a minor? (Age=0-14yrs)	Yes = 1; No = 2	2⇨Sec.B
A8	Condition of the minor at time of incident	Alone at Home=1, Alone on the Street=2, Alone in School=3, Alone on the playground=4, Others (Specify)=5	
A9	Who was the caregiver of the minor at the time of incident	Parent=1, Grandparent=2, Foster parent=3, Relation=4, Non-relation=5, others specify=6	

SECTION B: TYPE/NATURE OF GENDER BASED VIOLENCE (GBV)

This section deals with the type and nature of GBV			
Q/No	***Question***	***Option***	***Response***
B1	What type of GBV did you experience? *(Please select only ONE option)* *Note*: - *All incidents that involve penetration of all kind including anal, oral, fingering etc. is Rape.* - *All incidents that involve unwanted sexual contact is Sexual Assault.* - *These GBV types are ranked, hence if a higher rank e.g., rape is elicited, record rape as incidence. Otherwise, move down the ranks until the GBV type fits the description.*	**Rape** (Includes gang rape, marital rape) =1, **Sexual Assault** (Includes attempted rape and All sexual violence/abuse without penetration, and female genital mutilation)=2, **Physical Assault** (Includes hitting, slapping, kicking, shoving etc. that are not sexual in nature) =3 **Forced Marriage** (early/minor marriage/non-consent marriage) =4 **Denial of resources, opportunity, or services** (Includes denial of inheritance, earnings, access to school or contraceptives, etc.) =5 **Psychological/Emotional Abuse** (Includes threats of violence, forced isolation, harassment/intimidation, stalking, gesture, etc.) =6 **Harmful traditional practice** (including Female Genital Mutilation and Early Marriage) =7 **Others** (Specify) =8	1⇨B4 2⇨B4 3⇨B4 4⇨B4 5⇨B4 6⇨B4 8⇨B4
B2	What type of Harmful Traditional Practice?	Female Genital mutilation (FGM)=1, Early/Minor Marriage /Forced marriage) =2 Widowhood practices=3 Honor violence=4 Other (Specify)=5	
B3	Were money, goods, benefits/ and or services	Yes=1, No=2	
	exchanged in relation to any of the incidents in B2		
B4	Were you abducted?	Yes=1, No=2	2⇨B7
B5	Type of abduction	Forced Conscription=1, Trafficked=2, Kidnapped=3, Other (Specify)=4	
B6	Has the survivor previously reported this incident anywhere else?	Yes=1, No=2	2⇨B9

B7	Where was report lodged?	With the Police=1, Other law enforcement Agency=2, National Human Right Commission=3, Social Welfare/Women Affairs=4, Community Care Services (NGO, CBO,FBO,CSO)=5, Community Heads=6, Legal Justice Services=7, Media (Print, Social and Electronic) =8, Remand home=9, NAPTIP=10, Religious leader=11, School authority (e.g.,teacher) =12, Other (Specify)=13	
B8	Apart from this incident, has the survivor had any previous incident of GBV perpetrated against her/him?	Yes=1, No=2	2⇨Sec C
B9	How many times have you experienced any form of GBV? (Indicate the type of GBV and number of times it occurred)		

SECTION C: DETAILS OF INCIDENCE

Q/No	***Question***	***Option***	***Response***
C1	Date of the incident		
C2	What time of the Day did the incident take place?	Morning (6am-11.59am) =1, Afternoon (12noon-5.59pm) =2, Evening/night(6.00pm5.59am) =3, Don't know=99	
C3	Did the incident cause any disability?	Yes=1, No=2	2⇨Sec C5
C4	What is the nature of Disability caused by the incident?	Mental=1, Physical=2, Emotional=3, Psychological=4, All of the above=5	
C5	Where did the incident take place?	Survivor's Residence=1, Perpetrator's Home=2, International Border=3, Check Point=4, Health Center/Hospital=5, Market/Shopping Centre=6, Police Station/Security Post=7, Religious Centre (Church, Mosque, Shrine) =8, School/Education Center=9, Unoccupied/Abandoned Building=10, Garden/Park/Open Field=11, Farm/Bush/Forest=12, Water Point=13, Shelter/Safe House=14, Street/Pathway=15, Relief/Palliative Distribution Center=16, Transportation (Motor Park/During Trip) =17, Public Toilet/Latrine=18, Workplace (Factory, Office) =19, Prison/Detention Center=20, (Orphanage Homes) =21, Remand Home=22 Others (Specify)=23, IDP Camp=24	1-23⇨C7
C6	What is the name of IDP Camp?	Specify…………………………..	
C7	Geographical location of Incident	Rural Area=1; Urban Area=2 Slum area=3	

SECTION D: ALLEGED PERPETRATOR INFORMATION

QNo	*Question*	*Option*	*Response*
D1	How many were the alleged perpetrators?	One=1, Two or Three=2, More than 3=4, Don't know=99	
D2	What is the alleged perpetrator's relationship with survivor? *(Please select all applicable)*	Current Partner=1 Former Partner=2 Primary Caregiver=3 Father=4 Brother=5 Other resident family member=6 Other non-resident family member=7 Supervisor/Employer/Co-worker/Employee=8 Teacher/School Official=9 Schoolmate=10 Service Provider/aid worker=9 (red flag PSEA) Host Family=10 House help=11 Driver=12 Security Guard=13 Landlord/Landlady=14 Co-Tenant/Housemate=15 Family Friend/Neighbor=16 Other Refugee/IDP/Returnee=17 Other resident/Community member=18 Armed Robber=19 Other (Specify)=20 Unknown=98 (Include)	
D3	What is alleged perpetrator(s)'s sex	Male=1, Female=2, Both=3	
D4	What is alleged perpetrator(s) age (or age bracket)	Write ages separated by coma if more than one and enter 99 if don't know	
D5	What is the alleged perpetrator(s) occupation	Health Service Providers=1 Social Service Providers=2 Legal Service Providers=3 Security (Police) Service Providers=4 Teachers=5 Non-teaching Staff=6 Community Leaders=7 Religious Leaders=8 Traditional Leaders=9 Civil Servants=10 Accountants=11 Bankers=12 Journalists=13 Human Rights Advocates=14 Politicians=15 Domestic Staff=16 Hotel Staff=17 Farmers=18 Drivers=19 Security guards=20 Artisans/Technicians=21 Armed Forces (Military)=22 Aid workers=23 Other Security Personnel=24	

		Others (Specify)=25 Unknown=99	

SECTION E: REFERRAL PATHWAY DATA

QNo	*Question*	*Option*	*Response*
E1	Was survivor referred to any institution/agency/organization?	Yes=1; No=2	2⇨E9
E2	Where was survivor referred to?	Health/Medical Services=1 Security Services=2 Psychological/Counselling Services=3 Safe House/Shelter=4 Legal Assistance Services=5 Livelihood Services=6 Human Right Services=7 Teacher/School Official=8 Humanitarian/Development Actor=9 Other Government Service=10 Community/Religious/Camp Leader=11 Other Protection Services=12 Others (Specify)=13	1⇨E3 2⇨E4 3⇨E5 4⇨E6 5⇨E7 6⇨E8
E3	Who provided health/medical services?	Service provided by Hospital/Clinic/Health Center=1 Service already received from another agency=2 Service not applicable=3 Service unavailable=4 Service declined=5	
E4	Who provided Police/other security services?	Service provided by Police/Other Security Agencies=1 Service already received from another agency=2 Service not applicable=3 Service unavailable=4 Service declined=5	
E5	Who provided social/psychological/mental health services?	Service provided by Psychologist/Counsellors=1 Service already received from another agency=2 Service not applicable=3 Service unavailable=4 Service declined=5	
E6	Who provided service at Safe house/Shelter?	Service provided by Safe House/Shelter=1 Service already received from another agency=2 Service not applicable=3 Service unavailable=4 Service declined=5	
E7	Who provided legal assistance services?	Service provided Courts/Prosecutors=1 Service already received from another agency=2 Service not applicable=3 Service unavailable=4 Service declined=5	
E8	Who provided livelihood programme services?	Service provided by Social Protection. Programme Officers=1 Service already received from another agency=2 Service not applicable=3 Service unavailable=4 Service declined=5	

E9	Do you want to pursue legal action?	Yes=1; No=2	1⇨SEC F 2⇨E10
E10	Give Reasons for not pursuing legal action	Perpetrator is source of livelihood to survivor = 1, Financial implication = 2, Stigmatization = 3, Family dignity = 4, Mediation = 5, Other (Specify)=6	

SECTION F: ASSESSMENT POINTS

Q/No	***Question***	***Option***	***Response***
F1	What is the survivor's emotional state at the beginning of the interview (*mark all that apply*)	Scared / Fearful = 1 Sad / Depressed = 2 Anxious / Nervous = 3 Angry = 4 Calm =5 Other (Specify) =6	
F2	What is the survivor's emotional state at the end of the interview (*mark all that apply*)?	Calmer than at the start of interview=1 Similar to that at the start of interview=2 More upset than at the start of interview=3 Other(specify)=4	
F3	Will the survivor be safe when she or he leaves?	Yes=1, No=2	
F4	If No, give reasons		
F5	What actions were taken to ensure survivor's safety? (*mark all that apply*)	Safety Plan Created =1 Referral to Community Based Support =2 Referral to Safe House =3 Service provider to follow-up =4 Other Action Taken (please specify) =5	
F6	If raped, have you explained possible health consequences of rape to the survivor (and/or to guardian based on assessment capacity and best interest of survivor if under 18)?	Yes=1, No=2, Not Applicable=3	
F7	Did the survivor give his/her consent to share non-identifiable data in your reports?	Yes=1, No=2	

F8	Give description of the incident		