GENDER-BASED VIOLENCE GUIDANCE

FOR DEVELOPMENT PROGRAMS

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Chrysalis
Catalyzing change

Contents

This GBV guidance builds upon CARE'S 2014 Guidance for Gender Based Violence (GBV) Monitoring and Mitigation within Non-GBV Focused Sectoral Programming, expanding this **beyond risk mitigation** *and adding* **additional guidance** *for GBV prevention, response and advocacy programming. This guidance draws from the Inter-Agency Standing Committee's Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (GBV Guidelines) and complements existing CARE resources relevant to GBV including CARE's GBViE Guidance Note, Safer Programming guidance and the CARE International Safeguarding Policy.*

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CARE's Gender-Based violence Guidance for Development Programs (GBV guidance) is accompanied by a range of supporting resources.

GBV PRINCIPLES & APPROACHES

- Differentiating Between GBV Risk Mitigation, Response, and Prevention
- Roles & responsibilities of GBV specialists & non-GBV specialists
- Ethical principles
- Intersectionality
- Key considerations for groups at risk of GBV
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- DOs & DON'Ts when responding to a GBV disclosure
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- Organizational policies to support GBV integration
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- Climate Justice
- Education
- Right to Food, Water & Nutrition
- Right to Health
- Women's Economic Justice
- Women's Voice & Leadership

These accompanying resources are available from care.org/gbv-guidance.

About this guidance

WHAT is the purpose of this guidance?

This guidance supports CARE program staff across **all impact areas** to **reduce GBV risks** and follow **ethical best practice**.

It provides step-by-step information and tools for how to weave GBV throughout the project cycle.

WHO is this guidance for?

This guidance is for staff implementing development programs.

It is intended for **GBV specialists** and for CARE staff who are **not GBV experts**. It is for staff implementing **standalone GBV projects** and staff implementing projects across **other impact areas** and sectors which plan to integrate GBV approaches.

The focus of this guidance is **development programming** in any country where CARE works, which may include **fragile, nexus and chronic contexts**. It is not intended for staff implementing projects in **acute emergency settings**, who should refer to CARE's GBViE Guidance Note.

HOW does this guidance support staff?

This guidance is divided into two sections.

PART I supports program staff by:

- Providing **standard language on GBV** and **why CARE focuses on this**
- Explaining **how CARE approaches GBV**
- Explaining CARE's **minimum standards for integrating GBV** across different types of programming
- Outlining the **ethical principles** which guide CARE's GBV work

PART II supports program staff by:

- Providing detailed implementation guidance across the project cycle through CARE's **10 steps for GBV integration**
- Linking to supporting tools and resources

WHERE can staff find more information?

Further details of **CARE's GBV programming**, information on **key principles** and resources to support **GBV integration across all impact areas** are available from care.org/gbv-guidance.

CARE staff can also access these from the **GBV Hub** on CARE Shares.

Photo: Credit GMB Films/CARE

CARE'S RESPONSIBILITY TO ELIMINATE GENDER-BASED VIOLENCE

What is Gender-Based Violence?

Gender-based violence (GBV) is any form of **violence against an individual based on that person's biological sex, gender identity or expression**, or perceived adherence to socially defined expectations of what it means to be a man or woman, boy or girl. It is a pervasive and systemic human rights violation which disproportionately affects women and girls.

GBV includes **physical, sexual and psychological abuse**, **threats**, **coercion**, arbitrary **deprivation of liberty**, and **economic deprivation** whether occurring in public or private spheres. Examples of GBV include but are not limited to intimate partner violence; early and forced marriage; "honor" killings; female genital cutting/mutilation; economic deprivation; female infanticide; child sexual abuse and exploitation; trafficking in persons; sexual coercion, harassment and abuse; neglect; violence against widows, violence against people identifying as LGBTQI+, and elder abuse.[1]

GBV is rooted in **unjust and unequal power relations, structures and rigid social and cultural norms**.[2] Gender inequality and patriarchy[3] fuel GBV by reinforcing **unequal power relations** between women and men, **gender roles**, and **social norms** that lead to the acceptance of violence. This **normalization of GBV** can mean that people don't recognize that violence is wrong and harmful, and prevent them from accessing post-GBV care.

Unequal gender roles and social norms may also be **enforced through the use of violence**. For example, women and LGBTQI+ people who do not conform to traditional gender roles often face GBV.

Gender-based violence is any form of violence against an individual based on that person's biological sex, gender identity or expression, or perceived adherence to socially defined expectations of what it means to be a man or woman, boy or girl.

Adapted from the Interagency Gender Working Group's definition of GBV.

For more information on the state of gender justice globally, visit genderinpractice.care.org.

[1] Interagency Gender Working Group

[2] CARE GBV Strategy (2015)

[3] Patriarchy is defined by bell hooks as "a political-social system that insists that males are inherently dominating, superior to everything and everyone deemed weak, especially females, and endowed with the right to dominate and rule over the weak to maintain that dominance through various forms of psychological terrorism and violence". bell hooks: The Will to Change: Men, Masculinity, and Love (2004).

Why does CARE prioritize GBV?

GBV is a human rights violation

CARE believes **eliminating GBV is critical to promoting equality and justice**. GBV is a symptom of oppression which is **used as a tool to dominate, intimidate and reinforce gender inequalities** within and across groups. It is intentional harm committed against people based on their gender identity, gender expression or sexual orientation, and has serious and often life-long impacts including physical and mental health consequences on survivors, families, communities and economies. GBV takes place in **all spheres of life** and is used to prevent people, particularly young women, from **making choices about their bodies, health, education, work, and lives**.

CARE aims to ensure that women, girls and others most at risk of GBV from diverse backgrounds are **safe, respected, valued** and have their **rights upheld**. We cannot achieve this without acknowledging GBV is both **a driver and a consequence of poverty, social and political exclusion, conflict and gender inequality** and taking action to address this.

Global crises—such as climate change, the COVID-19 pandemic and the impact of conflict on global food security—**exacerbate risks** and will have long-term consequences for GBV. CARE recognizes the importance of **addressing GBV risks throughout all our programming** if we wish to achieve social justice.

CARE'S GENDER EQUALITY & INCLUSION POLICY SPECIFICALLY HIGHLIGHTS GBV

Commitment #4: Identify potential programming risks of backlash and exposure to gender-based violence (GBV) throughout the program/project cycle and put in place mechanism to reduce risks and take deliberate action to protect, do no harm, and mitigate these unintended risk factors, regardless of sectoral focus, in all program contexts.

1 in 3 women in the world experiences sexual or physical violence—usually by her intimate partner—in her lifetime.[A]

38% of murders of women in the world are **committed by their intimate partners**.[A]

GBV causes some countries to **lose up to 4% of their GDP** because violence pushes women out of the workforce & girls out of school.[B]

45% of women across 13 countries reported they or a woman they know has **experienced some form of violence since COVID-19**.[C]

The effects of COVID-19 could potentially lead to **10 million additional child marriages in the next decade** that could have been averted.[D]

GBV often leads to more violence, with men being 2.7 times more likely to use physical violence against an intimate partner if they had witnessed their mothers being beaten.[E]

A WHO: Violence against women Prevalence Estimates (2018).
B World Bank: Voice and Agency: Empowering Women and Girls for Shared Prosperity (2014).
C UNSDG: The Sustainable Development Goals Report 2022.
D UNICEF: COVID-19: A threat to progress against child marriage (2021).
E American Journal of Public Health: African men's having witnessed abuse of their mothers during childhood on their levels of violence in adulthood. (Abrahams, N. and R. Jewkes, American Journal of Public Health, 2005. 95(10): p. 1-6.)

Failure to take action has far-reaching consequences

GBV is a known **barrier to achieving project goals** across CARE's impact areas for achieving Vision 2030. Some project activities, recruitment practices or data collection efforts may expose women and girls to GBV, making them reluctant to participate in activities which may be integral to the success of the program. It is vital CARE takes a **proactive approach to preventing and addressing GBV risks** throughout all of our programming.

IMPACT AREA	EXAMPLES OF HOW GBV AFFECTS IMPACT AREAS	EXAMPLES OF HOW PROJECTS COULD AFFECT GBV
Gender Equality	GBV enforces and sustains gender inequality. Gender equality cannot be achieved without addressing GBV.	Interventions that seek to reduce gender inequality and re-envision gender norms can generate backlash. All gender equality interventions should be closely monitored for any increase in GBV.
Right to Food, Water, and Sanitation	Access to food, water and sanitation can all be blocked by GBV. Intimate partner and household violence can include control over household resources and women's mobility, affecting the ability of women and girls to purchase food or menstrual hygiene supplies. Women and girls are the primary water gatherers, and they may be at risk of harassment or violence in the act of gathering water.	Programs that promote the right to food, water, and sanitation should pay attention to potential barriers related to GBV in their initial gender analysis and design process. Efforts to improve access may instead endanger intended beneficiaries. For example, food security programs that employ only male distribution workers may lead to demands for sexual acts in exchange for food aid.
Women's Economic Justice	GBV can limit women's earning potential and their ability to control their own income. For example, child marriage and school-based violence can keep adolescent girls from completing their education. Male partners might threaten or harm female partners who earn money. Workplace sexual harassment can prevent women from advancing or staying in their jobs.	Economic justice programs that do not take into account social norms around women's economic participation may put women at further risk of GBV if these norms limit women's mobility or discourage women's income earning. All programs seeking women's economic justice should avoid harm by understanding and addressing local norms and identifying any GBV-related barriers to economic participation.
Right to Health	GBV has grave physical, mental and reproductive health consequences not limited to death, disability, miscarriage, alcohol and drug abuse, and post-traumatic stress disorder. Some forms of GBV, such as reproductive coercion and disrespect and abuse in childbirth, directly interfere with women's right to access the health care they need. Health providers are often first responders for GBV survivors, and potential entry points into pathways of care.	Programs that increase access to reproductive health care in particular must plan carefully to ensure that women and girls do not suffer backlash from family members who oppose contraception due to culture, religion and traditional ideas about masculinity. For example, a woman in an abusive relationship may wish to keep her decision to use contraception private, but an untrained health provider might inadvertently disclose her contraceptive use to her abuser, or seek his permission to fulfill her request.
Climate Justice	The climate crisis is increasing competition for resources and generating insecurity, exacerbating gender inequality and GBV. Extreme climate events can increase the severity of violence in an abusive relationship because women are separated from support networks that offer protection.	Programs should plan for increases in intimate partner violence, child marriage, and other types of GBV that are often used to reinforce male privilege and control over resources following environmental degradation. There is also a risk of women leading action on climate issues being targeted for their participation.

Photo: Tapash Paul/CARE

CARE'S APPROACH TO GBV

HOW DOES CARE PRIORITIZE GBV?

Gender equality is a core principle of CARE's Vision 2030. Eliminating GBV is one of three priorities critical to achieving gender equality.

PROMOTE GENDER EQUALITY FOR ALL

Gender-based violence
Eliminate gender-based violence

Education
Increase equal access to inclusive education and skills development

Women's voice & leadership
Increase women's and girls' voice and leadership

Vision 2030 provides the overarching theory of change for ensuring gender equality and this guides how we address GBV. CARE believes eliminating GBV requires a holistic approach to dismantle patriarchal structures and transform power relations by **empowering women and girls in all their diversity**; engaging with **women's rights and social movements**; **transforming institutions and norms**, and **strengthening state institutions, policy and legal frameworks**.

Build AGENCY
Women & girls have the information, power and resources to make informed choices, assert their voices and realize their rights to a life free of violence.

Change RELATIONS
Women and girls in all their diversity and ages build healthy, respectful and non-violent relationships within families and communities; women and gender equality organizations participate in design and delivery of GBV services.

Transform STRUCTURES
Governments, humanitarian agencies and service providers adopt, fund, implement and are accountable for GBV policies and programs; social norms proscribe violence against women and girls in all their diversity..

CARE's Gender Equality Framework: Eliminating Gender-Based Violence

By 2030 CARE aims to reduce gender-based violence for 7 million people.

To advance gender equality in line with Vision 2030, all CARE projects have the responsibility to integrate attention to GBV in project design, implementation, and evaluation.

WHAT IS CARE'S APPROACH TO ELIMINATING GBV?

CARE's programming to eliminate GBV consists of three main program pillars—**risk mitigation**, **prevention** and **response**—which help achieve our outcomes under the Gender Equality Framework. Alongside these we also engage in **advocacy** in support of our GBV goals.

Addressing Gender-Based Violence

Risk Mitigation

Interventions to reduce the risk of GBV exposure

GBV risk mitigation aims to make all programming safer and more inclusive, accessible and effective, transforming typical aid structures which may not consider the safety and needs of women, girls and other populations at risk.

GBV risk mitigation can and should be carried out by **all program staff** across all impact areas.

EXAMPLES INCLUDE:

A WASH project assesses routes women use to gather water for safety risks and ensure latrines have adequate locks.

A women's leadership project analyzes how women may be targeted for speaking in public spaces and engages local leaders in support of women's participation.

Prevention

Interventions to stop GBV from occurring in the first place

GBV prevention aims to address the root causes of GBV. It mobilizes communities to address harmful social norms and change relations between women, their families and the wider community.

GBV prevention should be **guided by GBV specialists** and **supported by all program staff**.

EXAMPLES INCLUDE:

A Village Savings & Loans Association (VSLA) project conducts couples' counselling sessions to proactively address anticipated changes in gender roles at the household level.

A dignified work project engages with employers on their legal obligations to address sexual harassment in the workplace.

Response

Interventions to address the consequences of GBV after it has occurred

GBV response aims to ensure GBV survivors have access to timely, high-quality, life-saving information, services and support, so they can recover and regain agency and control over their lives.

GBV response should be **provided by GBV specialists**.

EXAMPLES INCLUDE:

A sexual & reproductive health (SRHR) project provides training to health providers on offering effective GBV first-line support should survivors disclose GBV.

A GBV project provides specialized training to health providers on the clinical management of rape.

Advocacy: Interventions to develop and strengthen the passage and implementation of policies, legislation and systems that prevent and respond to GBV, punish all forms of GBV and uphold survivor rights.

➡ Refer to Part II for details of how CARE integrates GBV risk mitigation, prevention, response and advocacy into the project cycle.

What forms of GBV does CARE focus on?

CARE's programs around the globe address **multiple forms of GBV**, with a particular focus on:

- **Intimate partner violence** (IPV)
- **Sexual violence, harassment, exploitation and abuse**
- **Child, early and forced marriage** (CEFM) and other harmful traditional practices
- **Gender norms equality**, toxic masculinities, homophobia and transphobia
- **Economic exploitation and exclusion** of women and girls

Who does CARE reach?

CARE works with women and girls in all their diverstity who have **suffered and are at risk of suffering sexual, physical, psychological and economic violence** based on their sex, gender identity, sexual orientation, age, religion, class, caste, marital status, socio-economic status, disability or other intersecting identities.

CARE works in stable or development contexts providing long-term development assistance, as well as in fragile and emergency contexts providing humanitarian aid, including those affected by crises, those living in conflict-affected areas, and those who have been displaced.

Who does CARE work with?

CARE works through multiple entry points to prevent and respond to GBV at the individual, household, community, national and global levels.

CARE works together with **feminist, women-led and women's rights organizations**, **youth and LGBTQI+ organizations, associations and movements**, and with **gender champions** in cultural and religious institutions, governments, businesses and donors.

CARE also engages **men and boys** to challenge discriminatory gender practices, re-envision harmful gender norms, promote positive masculinities, spark dialogue, and teach non-violent conflict resolution strategies.

Further information on key GBV projects led by CARE—including projects focused on **child, early & forced marriage**, **intimate partner violence**, and **gender norms equality**—is available in CARE's **GBV impact brief**.

Further information on the **importance of an intersectional approach for GBV programming** is detailed in the accompanying resources for this guidance, available from care.org/gbv-guidance.

This guidance mainly focuses on development contexts, but may also be applicable for fragile, nexus and chronic contexts. For more information on CARE's approach to **GBV in emergency settings**, see this summary brief for CARE's **GBViE Guidance Note**.

Read the **GBV impact brief** for further details of the impact of CARE's GBV projects or visit care.org/gbv for more information.

HOW DOES CARE APPLY THIS IN OUR PROGRAMMING?

CARE focuses on two main ways of implementing GBV programming: **integrated** and **standalone**.

Integrated GBV programming

Projects across any impact area which weave GBV considerations & approaches throughout the project cycle.

CARE's goal for GBV integration is for all projects to mitigate GBV and respond appropriately to disclosures of violence. **GBV integration is a requirement for projects across all impact areas.**

Standalone GBV programming

Projects focused entirely on GBV through explicit risk mitigation, prevention, response or advocacy interventions.

Standalone GBV projects start with risk mitigation and responding to disclosures, but go beyond this through prevention, response and/or advocacy interventions.

Both approaches will follow similar steps to ensure that, *at minimum*, they do no harm by **mitigating GBV risks** and **following ethical best practices.**

Projects across **any impact area** may integrate additional prevention, response or advocacy activities into their programming; **standalone GBV projects** will place greater emphasis on in-depth prevention, response or advocacy interventions in addition to risk mitigation.

A series of **scenarios detailing risks and opportunities** for CARE's impact areas is included in the accompanying resources for this guidance, available from care.org/gbv-guidance. These include scenarios for:

- Right to Food, Water & Nutrition
- Right to Health
- Women's Economic Justice
- Women's Voice & Leadership
- Climate Justice
- Education

CARE has an ethical imperative to reduce risks of GBV and respond appropriately to disclosures of violence.

Each impact area must intentionally work to advance gender equality, including by addressing GBV.

Integrated GBV programming

All projects must start with GBV risk mitigation. However, CARE aims to go beyond risk mitigation to integrate GBV considerations across the whole project cycle.

GBV risk mitigation

GBV risk mitigation refers to interventions that **reduce the risk of GBV exposure**. It aims to make all programming safer and more inclusive, accessible and effective, transforming typical aid structures which may not consider the safety and needs of women, girls and other populations at risk.

Mitigating GBV is an ethical responsibility to the communities we serve and partner with. GBV risk mitigation can and should be carried out by all program staff across all impact areas.

Regardless of sector, at the beginning of new programming and at specific points during program implementation, it is critical to **identify the GBV-related risks that may arise during or because of the project**. Teams should keep in mind that programming which leads to increased gender inequality will most likely also increase the risk of GBV.

CARE's Risk Mitigation programming focuses on:

- **Building skills to identify and mitigate GBV risks** within specific sectors, service modalities, and programs.
- **Engaging meaningfully** with women, girls, and other marginalized groups to reduce risk and improve safety.
- **Identifying critical entry points** for GBV risk mitigation and learning strategies to effectively mitigate GBV risks throughout the project cycle.
- Understanding and learning to apply **principles of safe and ethical analysis of GBV risks** to improve programming.[4]

ALL development actors who interact with affected populations have the responsibility to act intentionally to mitigate the risks of GBV and respond compassionately and appropriately to disclosures of GBV.

Why do projects without an explicit focus on GBV need to consider GBV risks?

CARE is committed to GBV integration across all sectoral programming to **strengthen the quality and sustainability of our work**. Violence, harmful gender norms and unequal power relations **reduce access to information, services, and resources across all sectors**. This can prevent programs from achieving their intended outcomes.

All CARE programs—even if they have no explicit focus on GBV—should actively strive to integrate GBV to **achieve goals**, **safeguard against unintended harm**, and **ensure the safety and well-being of CARE staff and partners**.

The GBV integration process supports projects to identify where their programming may benefit from further prevention, response & advocacy activities.

[4] This section has been adapted from the IASC's GBV Guidelines.

CARE's minimum standards for integrating GBV across all programming

GBV integration is an approach which supports programs to do no harm by weaving GBV considerations throughout the project cycle.

At minimum, all CARE projects must take steps to do no harm by:

- **Identifying and reducing the risks of GBV caused by CARE's presence or activities in a community**
  Project outcomes may have unintended consequences. Staff should analyze whether these could lead to risk of GBV and take steps to address this.
- **Responding to GBV disclosures by providing timely, appropriate, and empathetic referrals to GBV services**
  Staff from any program could have someone disclose GBV to them. They should know how to respond appropriately to avoid further harm and where to refer the survivor for care.
- **Integrating attention to GBV into programs and monitoring and evaluation strategies**
  Considering GBV across program and Monitoring, Evaluation, Accountability & Learning (MEAL) processes allows project staff to understand how the project is affecting risk and how project outcomes are affected by addressing GBV.

Standalone GBV programming

Standalone GBV projects in a development context have a **primary outcome of addressing gender-based violence**, with explicit prevention, response and/or advocacy objectives. Like all CARE projects, standalone prevention, response or advocacy projects will start with CARE's minimum standards to ensure they do no harm.

Many countries may design programs with prevention, response and/or advocacy interventions which span multiple impact areas, such as Right to Health or Women's Economic Justice. Activities may be implemented directly by CARE or with partners.

CARE staff must understand the difference between prevention and response, and what aspects require specialized training or expertise.

All standalone GBV programming should follow the minimum steps for doing no harm by following the GBV integration process.

Standalone GBV programming has a greater level of depth and focus on addressing GBV.

GBV prevention

GBV prevention aims to **stop GBV from occurring in the first place**. CARE works with women, men, adolescents and youth, girls, boys, communities and local organizations to transform harmful gender norms and attitudes that perpetuate GBV, and promote healthy, equitable and non-violent relationships. CARE works to protect the rights of GBV survivors and groups at risk of violence. This can include **primary prevention efforts** that aim to stop GBV before it occurs and **secondary prevention efforts** that aim to prevent GBV from continuing or escalating.

GBV prevention needs to be **guided by trained gender and GBV specialists**, and non-GBV experts can and should support these efforts.

Prevention is often the most challenging component of GBV programming since it aims to **address root causes** by **transforming attitudes and behaviors** that enable GBV. CARE prioritizes **partnerships with local feminist, women's rights and women-led organizations**, as well as local stakeholders, to undertake prevention efforts.

CARE's GBV prevention programming focuses on:

- **Re-envisioning social and gender norms**
- **Empowering** women and girls in all their diversity
- **Engaging couples, men, boys and other key stakeholders** to promote non-violent con lict resolution
- **Raising awareness** of life-saving services
- **Strengthening community mechanisms**

Further details of CARE projects focused on transforming inequitable gender norms is available from the promising practices section of genderinpractice.care.org.

GBV response

GBV response addresses the **consequences of GBV after it has occurred**. Response interventions establish or strengthen service delivery mechanisms which respond to incidents of GBV, such as health, legal, or social services. GBV response efforts have explicit GBV objectives to **save lives, reduce health impacts, ensure safety and protection**, and **meet the basic needs of GBV survivors.**

GBV response should **only be conducted by trained GBV specialists**. Non-GBV specialists can and should support these efforts, such as by conducting referral mapping and providing referrals to survivors who disclose they have experienced GBV.

The primary objective of response programming is to empower survivors of GBV by providing them with **access to services** to help heal and regain control and agency over their lives, and **information on their rights** and remedies to seek justice. It should ensure deliberate and systematic linkages between GBV and SRHR efforts for **integrated, survivor-centered response** efforts. These can include but are not limited to:

- **First-line support**—the immediate, brief, empathetic counseling, safety planning and referrals given to a survivor upon a GBV disclosure
- **Healthcare** including clinical management of rape, and sexual and reproductive health services
- **Legal support**
- **Psychosocial support** and psychosocial first aid
- **Economic support** and **livelihoods opportunities**
- **Strengthening referral systems**
- **Shelter/safe accommodation**

Further information on GBV response services is available in the Essential Services Package for Women and Girls Subject to Violence from UN Women, UNFPA, WHO, UNDP & UNDOC.

GBV advocacy

Advocacy is integral to achieving CARE's vision. It complements and **multiplies the impact of direct programming** and is a proven and effective approach to **scale and deepen our reach and impact**.

CARE works to develop and strengthen the passage and implementation of policies, legislation and systems that prevent and respond to GBV, punish all forms of GBV and uphold survivor rights.

CARE specifically recognizes the **central role of feminist activism** in promoting gender equality and addressing GBV, and the importance of feminist principles to enabling social justice more broadly.

Advocacy is one of CARE's key pathways for impact at scale. Read more in this paper on CARE's approach to Impact at Scale and in the Advocacy Roadmap.

➡ Refer to **Part II** for further guidance on designing prevention, response and advocacy interventions.

Photo: Credit CARE India

GBV BEST PRACTICE PRINCIPLES

STAFF ROLES AND RESPONSIBILITIES

GBV specialists

A **GBV specialist** is a professional with specialized GBV knowledge and expertise. They have received GBV-specific professional and/or academic training, and/or have considerable experience working on GBV. Their responsibilities can include:

- Identifying the specific needs of GBV survivors.
- Designing and implementing specialized GBV response and prevention interventions.
- Ensuring interventions meet required standards through training and following standard operating protocols (SOPs).
- Developing or strengthening GBV referral pathways in coordination with relevant service providers and actors.
- Conducting GBV training for staff or partners.
- Conducting MEAL activities and GBV data collection.

Non-GBV specialists

All development staff who are **not GBV specialists**, regardless of sector, must ensure that their programming is as safe and accessible as possible. Staff across all impact areas who interact with affected populations have the responsibility to:

- Act intentionally to **mitigate the risks of GBV**
- Respond compassionately and appropriately to **disclosures of GBV.**

Non-GBV specialists should follow the steps in **Part II** of this guidance to **mitigate risks** and ensure they understand how to ethically **respond to a disclosure of GBV**.

However, staff without specialized training on GBV should NOT engage in GBV-specialized research, programming, post-GBV care, certain kinds of service delivery or MEAL. Engaging in these activities without specialized training and expertise can inadvertently increase the risk of harm to both the survivor and the staff member. For example, an abuser could target the survivor or staff member for additional violence if an intervention is conducted without privacy and confidentiality.

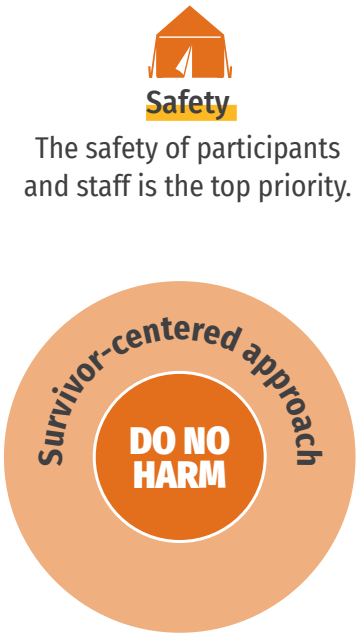
Further information to support understanding of **roles and responsibilities of GBV and non-GBV specialists** is included in the accompanying resources for this guidance, available from care.org/gbv-guidance.

Certain types of GBV interventions require comprehensive training to avoid causing harm to the people and communities CARE works with, and to our staff.

ETHICAL PRINCIPLES

All CARE programs must follow our programming principles as outlined in the Program Strategy Resource Manual. There are also specific ethical principles relating to GBV which staff should be aware of and reflect within programming, irrespective of focus or setting.

At the heart of this is the principle of **do no harm** and the importance of following a **survivor-centered approach**. All staff must ensure they understand the **key principles** below and practice these in their work. Projects will need to determine how best to practically apply the principles in relation to specific project activities and contexts.



Respect

All actions taken should be guided by respect for the choices, wishes, rights & dignity of the survivor.

Safety

The safety of participants and staff is the top priority.

Privacy

Individuals have a right to be free from intrusion or interruption, without being seen or heard.

Non-discrimination

All individuals should receive equal and fair treatment.

Informed consent

Individuals should receive & understand information about the activity prior to giving their consent to participate.

Center local expertise

Actions should be informed by the perspectives of local stakeholders and women's rights organizations.

Intersectionality

All actions should take into account the unique & interconnected needs of diverse individuals.

Confidentiality

Information relating to individuals must be kept strictly private unless the individual gives consent for sharing

Further resources to support understanding of **ethical principles for GBV programming**, including **do no harm** and a **survivor-centered approach** are included in the accompanying resources for this guidance, available from care.org/gbv-guidance.

Do no harm

Do no harm means no activity should cause intended or unintended harm at any point. Harm includes, but is not limited to, GBV. For CARE development programs, doing no harm means considering both the **potential risks** associated with programming and how an intervention might **unintentionally increase the risk of**, or exacerbate, conflict and violence.

> *For example, could the project:*
>
> - *Reinforce power imbalances (for example within a couple or between a boss and employee) that can lead to GBV perpetration?*
> - *Increase the risk of GBV for project participants, staff, and service providers?*
> - *Re-traumatize GBV survivors by forcing them to re-live painful memories?*
> - *Falsely raise the survivor's hopes for justice or care, if services and systems cannot respond effectively?*
> - *Jeopardize CARE's ability and standing in the community or country to successfully implement future projects?*

All programs should be aware of **GBV-related risks associated with their programming**, how **programming can potentially increase risk**, as well as how it can **actively lower such risks**.

Survivor-centered approach

A survivor-centered approach prioritizes the survivor's self-determination, choices, agency, autonomy, needs, wishes, and rights over secondary considerations such as social norms or organizational reputation.

It increases the survivors' ability to make informed decisions about their own care, recovery, and justice.

> *For example, if a person discloses that they have experienced GBV, it is the duty of the person responding to provide appropriate referrals to GBV support services while maintaining the confidentiality and privacy of the survivor. However, a survivor-centered approach also means that staff should respect the wishes of survivors who decide not to report or seek out additional assistance. There can be many valid reasons a survivor chooses not to report violence, such as financial dependence on the perpetrator, the safety of children, or a lack of faith in the criminal justice system.*

To avoid harm, programs should never:

- Reinforce gender inequitable stereotypes and beliefs, as those reaffirm the perpetration of GBV.
- Ask women to challenge male intimate partners without clear, evidence-based, gender transformative approaches, including approaches that engage men and boys in positive ways to promote behavior and norm change.
- Seek to implement any GBV programming without staff technical expertise (GBV training), dedicated GBV-specialized staff or consultant time and funding.
- Ask individuals about their direct experience of violence.
- Provide advice or counseling to a GBV survivor (only trained GBV service providers should do that).
- Force a GBV survivor to reconcile with the perpetrator, report the incident, or seek services against their will, which violates a survivor-centered approach and do no harm principles.

Key principles to guide GBV programming

Safety: The safety and security of participants and staff is the top priority and should infuse all program decisions. Even when working within a project that may not seem risky, individuals may still be vulnerable because of their participation. Particular caution is required for research or programs that address socially sensitive issues, such as child abuse, informal economic activity, HIV/AIDS, and police activity. As change agents, CARE and implementing partner staff can also be just as much, if not more, at risk than program participants. It is important to take measures to mitigate risks to both the psychological and physical safety of staff as well as participants.

Respect: Respect for individuals entails affirming each person's dignity, independence, and freedom to make their own decisions by providing individuals with the necessary information to make informed decisions about whether or not to participate in the project activities. As aid workers, respect for individuals also means being aware of differences in power between staff and participants and taking measures to balance that power differential.

Non-discrimination: Individuals should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation, political beliefs or any other characteristic.

Confidentiality: Confidentiality refers to the treatment of information that an individual reveals to program staff during the course of their participation in program activities.

Privacy: Privacy is being free from intrusion or interruption, without being able to be seen or heard. Protecting participants' privacy ensures that their information is confidential, as disclosure of sensitive information has the potential to put the participant or others at risk.

Informed Consent: Informed consent requires giving participants the opportunity to make an informed decision about whether or not to participate in any intervention, service, data collection, or communications activities. This requires three elements: information, comprehension, and voluntary consent.

Intersectionality: CARE must ensure that our programs are inclusive—in other words, that they take into account different people's needs. CARE projects should keep in mind the diversity and intersectionality[1] of project participants and the different ways they might be at risk of and experience GBV in project design, implementation and evaluation.

Center local expertise: In keeping with CARE's Vision 2030 to partner with feminist movements, women-led and women's rights organizations and other actors committed to gender equality, CARE must work closely with local women's rights organizations, networks and activists. CARE should first consider local expertise for consultancies and source persons with the required expertise based in the Global South before looking to international consultants.

[1] Intersectionality means the layers of inequality that a person might experience. For example, a poor woman from an ethnic minority may experience different types of GBV and less access to services than a rich woman from an ethnic majority.

The accompanying resources for this guidance include further detail on:

- **Ethical principles for GBV programming**
- **The importance of an intersectional approach for GBV programming**
- **Key considerations for groups at risk of GBV**
- **GBV research ethics**

These are available from care.org/gbv-guidance.

PRINCIPLES IN PRACTICE: COMPLYING WITH MANDATORY REPORTING

In some instances and countries, there are laws that mandate the reporting of specific types of GBV (i.e. against children and adolescents) or specific acts (such as trauma via a gun or knife). Relevant local laws regarding mandatory reporting and what age a person is considered a minor should be identified as part of the gender analysis.

Every effort should be made to comply with laws in a way that upholds a survivor-centered approach. This means explaining any reporting requirements to the individual, only disclosing to the individuals or institutions required by law, and giving the survivor the option to self-disclose and/or seek alternatives, such as reporting GBV after they are removed from the immediate risk of harm by the perpetrator. All CARE staff should understand what is required by the law in their country.

In accordance with CARE's Safeguarding Policy on Protection from Sexual Harassment, Exploitation and Abuse, & Child Abuse (PSHEA-CA), all CARE staff, partners, and related personnel are mandated to report PSHEA-CA concerns through the appropriate reporting mechanisms.

PRINCIPLES IN PRACTICE: RESEARCH ETHICS

Non-GBV specialists can cause harm by conducting GBV research or even handling personal data without the requisite training, and without key safety, privacy, and confidentiality measures in place to protect personal information.

> *For example: An international organization conducted a study in a country in sub-saharan Africa. They did not budget for training the data collectors. A development worker organized focus groups to learn about community members' experiences. The worker asked participants to talk about their experiences with GBV. One focus group participant had been sexually assaulted, and was re-traumatized when asked to discuss this experience so publicly. Another participant disclosed she was experiencing violence from her husband. Unfortunately, the discussion was not kept private. The woman's husband learned she had discussed his abuse and escalated the violence.*

Further information on **GBV research ethics** is included in the accompanying resources for this guidance, available from **care.org/gbv-guidance**.

PART II

Photo: Credit Valerie Fernandez/CARE

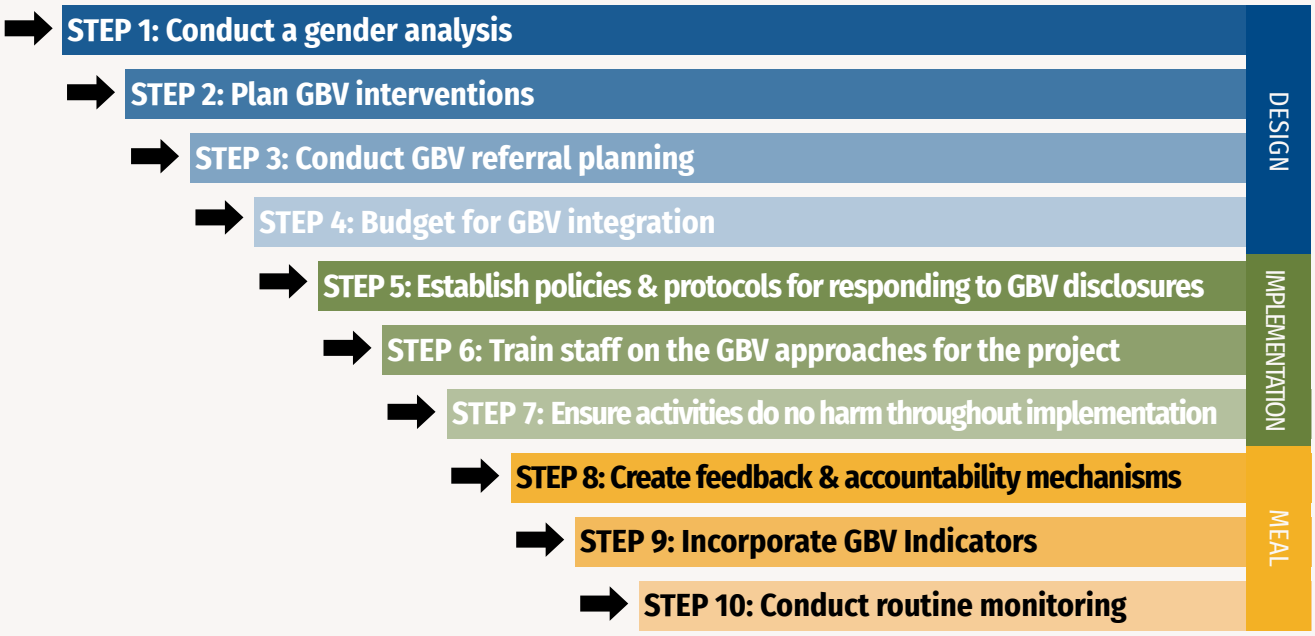
STEP-BY-STEP PROGRAM GUIDANCE

All CARE projects have the responsibility to integrate attention to GBV in project design, implementation, and evaluation.

This section provides step-by-step guidance for program staff on how to integrate GBV considerations at each stage of the project cycle.

CARE's 10 steps for GBV integration are the same for projects across all impact areas, including standalone GBV projects, as all projects must include minimum actions to ensure they do no harm. Standalone projects will go into greater depth when planning their prevention, response and advocacy activities.

GBV INTEGRATION ACROSS THE PROJECT CYCLE



These steps are organized around the different stages of the project cycle, with specific guidance for actions to take for **design**, **implementation** and **MEAL**.

PROGRAM GUIDANCE: 10 STEPS FOR GBV INTEGRATION

Projects should aim to follow all steps for GBV integration in order. Each step includes links to additional tools and relevant resources, which are available from care.org/gbv-guidance.

DESIGN

STEP 1: CONDUCT A GENDER ANALYSIS
- 1.1: What to include
- 1.2: Sources of information
- 1.3 Ethical principles for GBV research

STEP 2: PLAN GBV INTERVENTIONS
- 2.1: Developing a GBV integration plan
- 2.2: Designing GBV prevention programming
- 2.3: Designing GBV response programming
- 2.4: Designing GBV advocacy programming
- 2.5: Whom to engage

STEP 3: CONDUCT GBV REFERRAL PLANNING
- 3.1: Identifying or developing a referral map
- 3.2: Planning referral pathways

STEP 4: BUDGET FOR GBV INTEGRATION

IMPLEMENTATION

STEP 5: ESTABLISH POLICIES AND PROTOCOLS FOR RESPONDING TO GBV DISCLOSURES
- 5.1: What to include in GBV policies and protocols
- 5.2 Implementing GBV policies and protocols

STEP 6: TRAIN STAFF ON THE GBV APPROACHES FOR THE PROJECT
- 6.1: Training for all program staff
- 6.2: Training for staff providing first line support
- 6.3 Training to support specific GBV interventions

STEP 7: ENSURE ACTIVITIES DO NO HARM THROUGHOUT IMPLEMENTATION
- 7.1: Monitoring project activities for any effect on GBV
- 7.2: Ensuring project materials do no harm
- 7.3 Managing external communications and advocacy

MEAL

STEP 8: CREATE FEEDBACK & ACCOUNTABILITY MECHANISMS

STEP 9: INCORPORATE GBV INDICATORS

STEP 10: CONDUCT ROUTINE MONITORING
- 10.1: Disaggregate data
- 10.2 Periodic evaluations
- 10.3 Analyze data & share findings

Use the **linked headings** above to go to the relevant step in this document.

3 The **numbers at the top of each page** are linked to allow navigation between steps.

STEP The **STEP box** in the top left corner of each page links back to the list of all 10 steps for GBV integration.

Before following these steps, it is important to read **PART I** of this guidance to ensure full understanding of best practice principles for GBV programming.

STEP 1: Conduct a gender analysis

Gender and GBV analysis is a process of identifying and examining the unique drivers, experiences, and outcomes of violence for women, men and other genders.

Regardless of sector, at the beginning of new programming and at specific points during program implementation, it is critical to understand the GBV situation of the project setting. A gender and GBV analysis identifies GBV risks that may arise during or because of the project, and collects information on GBV drivers, policies, trends, services, barriers to access, and community needs.

When conducting a gender & GBV analysis, refer to the accompanying resources for this guidance, which include further details of:

- **Key considerations for different groups at risk of GBV**
- **The importance of an intersectional approach for GBV programming**
- **GBV research ethics**
- **Key GBV terms used by CARE** with definitions

These are available from care.org/gbv-guidance.

1.1 What to include

Any effort to integrate GBV must first examine:

Drivers of GBV in the project context

Most frequent types of GBV perpetrated and against which populations

Local actors available to support GBV survivors with referral services

How to ensure project participants have access to GBV information & services

Questions about GBV must be integrated into any gender analysis and/or rapid gender analysis (RGA). See the box below for a list of potential questions to include in a gender and GBV analysis. The focus, structure and depth of the analysis should be determined by the scope of the project.

Project staff should ensure analysis reflects the **diversity and intersectionality** of participants so their needs are taken into account. Those conducting a gender and GBV analysis should refer to the accompanying resource on **key considerations for groups at risk of GBV**, available from care.org/gbv-guidance, for further guidance.

For GBV programs that focus on advocacy, it is also necessary to analyze the political, economic, and socio-cultural landscape, and the broader contextual dynamics that shape gender relations and GBV. For example, is polygamy legal in this setting? Are LGBTQI+ populations criminalized? Further information is available in International Alert's How to Guide to Conflict Sensitivity and the PESTLE Analysis Framework in CARE'S Advocacy Handbook (see p. 10).

SAMPLE QUESTIONS FOR GBV ANALYSIS [1]

Gender analysis for GBV integration seeks to answer the following kinds of questions:

1. What expectations and stereotypes dictate women, men and other genders' roles, behaviors, inequalities, and relations in the project setting?
2. Are these expectations and stereotypes reinforced by structural inequality (political, economic and social systems, practices and institutions)?
3. Do power differences between genders lead to discrimination, subjugation and exclusion?
4. Based on data from existing data sources (such as the National Demographic and Health Survey or published journal articles), what are the most common types of GBV in this setting, and which populations are most at risk?
5. Who are the most common perpetrators of GBV?
6. Does intersectionality shape people's experiences of violence, discrimination, inequality or oppression?
7. Based on existing data sources, what percentage of the population justifies the use of GBV?
8. What risks for GBV exist at the individual, community and societal levels? What protective factors exist at these levels?
9. What is the age of majority in the project country? Are there any laws that require mandatory reporting of GBV against children, minors, or other dependents (those incapable of making decisions for themselves, e.g. due to a cognitive disability)?
10. What barriers do survivors face in accessing post-GBV care?
11. How might the project affect (positively or negatively) women's, girls', and other marginalized groups' access to rights, services or resources? What about men's access?
12. How might the project affect attitudes beliefs and practices regarding male and female gender roles and how to resolve conflict?
13. Is it possible that the project could reinforce inequitable gender norms, perceptions, discriminatory attitudes and practices (e.g., by reinforcing rigid roles for men and women)?
14. Could targeting women or a particular population for an intervention cause tensions, conflict or violence in the family or community, or safety issues (e.g., household recipients of cash transfers or vouchers)[2] ?
15. Could the project challenge unequal gender norms or roles in ways that could lead to increased risk of GBV (e.g., male expectations of being the primary household provider)?
16. How might the aforementioned gender norms and tensions increase the risk of GBV? What actions could the project take to lower these risks?
17. What stakeholders have been engaged or will be engaged? Have women's rights organizations been involved in bid design or will they be involved during project implementation?
18. What impact could the project have on community perceptions regarding sexuality, including sexual diversity?

1 This list has been informed by the Informed by the Coalition of Feminists for Social Change (COFEM) Tip Sheet 1 & 2 (2018).

2 Delivery mechanisms, like other aspects of CVA design, are not inherently 'safe' or 'risky' – this will depend on the context and can be determined through consultations with affected communities and individuals, financial service providers and other humanitarian actors through coordination mechanisms.

1.2 Sources of information

A gender and GBV analysis can use a combination of **secondary (existing)** data and **primary (new) participatory** data collection methods from a variety of sources. Some settings may have ample secondary data, while others may not, or the available data may be unreliable. Reliable secondary sources should be used as much as possible, but in situations where there is not enough available and reliable data, the gender and GBV analysis will necessitate primary data collection; for example, focus group discussions with community members or key informant interviews with stakeholders about general GBV knowledge, attitudes, or practices.

Non-GBV specialists should never ask about personal experiences of GBV. Only a GBV specialist who has specific training on GBV research ethics and who has received clearance for the research from the Institutional Review Board can do this.

For more further information see the additional guidance on **GBV research ethics** available from care.org/gbv-guidance.

COMMON SOURCES OF INFORMATION

The table below details potential **sources of information** to inform a gender and GBV analysis.

	SECONDARY SOURCES	PARTICIPATORY METHODS
Drivers of GBV in the project context	• Demographic and Health Survey (DHS) • Quantitative and qualitative studies • Existing gender analysis, grey literature (e.g. program evaluations)	• Local women's organizations and key informants • Participatory data collection (e.g. Measuring attitudes toward gender tool) • Social Analysis & Action (SAA)
Most frequent types of GBV perpetrated and against which populations	• Demographic and Health Survey (DHS) • International Men and Gender Equality Survey • Quantitative and qualitative studies • Reports from non-governmental organizations	• Local women's organizations and key informants • Participatory data collection (e.g. Forms of Violence tool)
Local actors available to support GBV survivors with referral services	• Qualitative data from NGOs • Existing GBV referral maps and directories • Government ministries, local health facilities and police stations	• Transect Walk (Social and Resource mapping variation) • Local women's organizations and key informants e.g. national GBV coordination body where available
How to ensure project participants have access to GBV information & services	• Qualitative data from community members • Quantitative and qualitative studies	• **Transect Walk** (Social and Resource mapping variation) • Women's groups, adolescent girls, and key informants e.g. women leaders

A **safety audit** is a useful tool to **identify potential GBV risks at the project site**. This uses visual observation to assess GBV risks based on the physical layout and structures in a specific geographic location, while also looking at resource availability and provision of essential services and assistance. Safety audits are best done in collaboration with other organizations and can be conducted in a participatory way to directly include community members—particularly women, girls, and marginalized groups.

➡ Learn more about **safety audits** in the accompanying GBV integration resources available from care.org/gbv-guidance.

STOP
Consult GBV specialist

Everyone involved with a safety audit should be trained by a GBV specialist.

KEY CARE TOOLS

Existing tools such as CARE's Social Analysis and Action (SAA) model and Gender Marker can help in the process of GBV analysis and integration, as long as they are adapted to incorporate GBV.

➡ Social Analysis and Action (SAA)

The Social Analysis and Action (SAA) model is CARE's signature approach to gender norms. SAA is a facilitated process through which individuals explore and challenge the social norms, beliefs, and practices that shape their lives and health. It offers many suggestions of how to meaningfully engage communities in assessments, analysis, and action. Questions about GBV in *general* can be integrated into the SAA process, but not questions that ask people about their own experiences of GBV.

➡ Gender Marker

All CARE projects and proposals must undergo a gender review using CARE's Gender Marker, which scores the project or proposal on a quantitative scale of 0-4 points:

The Gender Marker is an essential starting place to ensure that CARE interventions address harmful gender norms and practices, many of which can be drivers of GBV, but it does not specifically cover the identification of GBV risks.

➡ Rapid Gender Analysis (RGA)

CARE's Rapid Gender Analysis Tool can help ensure the project design takes key gender issues and GBV risks into consideration. The team should critically assess the proposed activities and their potential impact concerning gender equality and the risk of GBV in the project's context and setting.

1.3 Ethical principles for GBV research

Only those trained in GBV research methods and ethics should plan and undertake data collection on individuals' experiences of GBV. Only projects with a focus to prevent or respond to GBV should collect such data on experiences of GBV as it is risky, and it should only be done when programming seeks to directly reduce GBV.

Projects that conduct data collection related to GBV must train data collectors and study teams on GBV research methods and ethics, and may have to apply for ethical approval through an institutional review board (IRB). For more further information see the additional guidance on **GBV research ethics** available from care.org/gbv-guidance.

CARE's Ethical Guidelines for Programming and Research and Safer Programming Guidance is a starting place for all programs to understand CARE's ethical principles around general safety, participation of participants, informed consent, and transparency. However, these guidelines do not go into much detail on GBV.

ETHICAL PRINCIPLES FOR GBV DATA COLLECTION

The following **ethical principles**[1] must be respected for all primary data collection on GBV:

- The safety and security of research subjects and the research team is paramount and should guide all research decisions.
- When documenting GBV, the potential benefits to the respondents or targeted communities must be greater than the risks involved to them.
- Information gathering and documentation must be done in a manner that presents the least risk to respondents, is methodologically sound, and builds on current experiences and good practice.
- Strong justification/rationale must be provided if the data to be collected is similar to data already collected in the same geography in the recent past.
- Before conducting research, the local availability of care and support services for survivors/victims must be ascertained (once this is done also ascertain the quality of these); if services are not available in the community or cannot be made available by the research team then research should not be undertaken.
- The confidentiality of individuals and the information they reveal must be protected at all times.
- Informed consent must be given by anyone participating in research on GBV.
- All members of the data collection team must be carefully selected and trained for the research, as well as receive on-going support through the research process.
- If children (anyone under 18) will be research subjects, special safeguards must be put into place.

Further information to support **GBV research ethics** and **Key considerations for children and adolescents** is included in the accompanying resources for this guidance, available from care.org/gbv-guidance.

[1] UNWOMEN and WHO: RESPECT Framework Monitoring and Evaluation (M&E) Guidance (2020).

STEP 2: Plan GBV interventions

All projects must include minimum actions to ensure they do no harm. These GBV interventions should be planned at program design stage.

A **GBV integration plan** is one way to ensure CARE's minimum standards for integrating GBV are met. All projects should start with a GBV integration plan, then standalone GBV projects will go into greater depth when planning their prevention, response and advocacy activities.

What is a GBV integration plan?

A GBV integration plan is a concise, action-oriented tool which responds to the findings of the gender and GBV analysis. It should be woven into the project workplan during the design process.

The plan describes **key activities and programmatic principles which will be applied** throughout the project cycle, by when, and by whom. For example, if the human resources team needs to be consulted to implement GBV training, they will be included as a responsible actor and consulted on the plan's development.

The plan **defines actions that can be taken to address the GBV issues identified in the gender analysis** (see **Step 1**). It highlights what priorities and gaps need to be addressed when planning new programs or adjusting existing programs and how these can be safely addressed by the program—such as through providing lighting on pathways to services to reduce GBV risk or consulting women on the location of water points.

The GBV integration plan should ideally be **available in the local language** for all project staff and participants. It should be detailed enough to minimize ambiguity, but not so detailed and technical that it becomes hard to understand for people who are not technical specialists. If this would limit the scope of the GBV integration strategy, a summary in the local language could be an option.

The GBV integration plan for each project is a **live document** which can be **updated throughout the project.** Teams should plan to **revisit the GBV integration plan at regular intervals** to reflect and adjust where necessary.

A template to support development of a GBV integration plan is included in the accompanying resources for this guidance, available from care.org/gbv-guidance.

Gaps identified in a GBV integration plan might include:

- Lack of participation by the affected population in the planning, design, implementation, and M&E of programs.
- Lack of age-appropriate, gender-sensitive, and culturally appropriate ways of including the participation of community members and marginalized groups.
- The need for GBV capacity building across sectors, but particularly for first-responders, health providers, the criminal justice system, policymakers, civil society, program implementers, and donors.
- Lack of access to GBV prevention, risk mitigation, and response information and service activities.

A GBV integration plan prompts project teams to take proactive action to address gaps and adapt programming.

PROGRAM EXAMPLE: CARE's Ayadi Project in West Bank & Gaza (2015-2018) proactively considered women's needs, feedback, and open communication during project design and implementation, especially regarding GBV. The project team recruited female community facilitators who women participants trusted and respected to serve as a communications channel, training them to respond to GBV disclosures and refer to services. Additionally, the project partnered with key actors that were a part of the violence against women national referral system to ensure that the project communities were integrated into their awareness raising and psychosocial support programming. Learn more here.

PROGRAM EXAMPLE: CARE's Southern Africa Nutrition Initiative (SANI) project (2016-2021) addressed undernutrition in women and children in Malawi, Mozambique and Zambia. Several project activities proactively took GBV into account. Water Management Committees, for instance, included diverse age groups of women in order to better understand the community's concerns, address gender-specific needs, and eliminate risks; for example, women advocated for separate latrines for each gender which were close to the community as a way to eliminate the risk of GBV. Additionally, to mitigate the risk of intimate partner violence associated with participation in VSLAs in Malawi, gender dialogue sessions were organized and provided women with the opportunity to discuss their financial autonomy and issues of joint money management. Read the evaluation here.

When developing a GBV integration plan, refer to examples of specific GBV interventions for CARE's impact areas in the series of **scenarios detailing risks and opportunities** for each impact area. These include scenarios for:

- **Right to Food, Water & Nutrition**
- **Right to Health**
- **Women's Economic Justice**
- **Women's Voice & Leadership**
- **Climate Justice**

These are available from care.org/gbv-guidance.

2.1 Developing a GBV integration plan

At minimum, a GBV integration plan should cover the following:

- **Analysis of GBV risks:** Matrix with key findings from gender and GBV analysis and actions to address findings (such as mitigating risks, addressing gender norms around GBV, etc).
- **Staff training process:** List of trainings the project will conduct to support GBV integration, such as GED/REDI and SAA trainings, GBV first-line support training or other training identified as necessary for GBV integration in the project.
- **GBV referral mechanism:** Referral pathway or directory of services of post-GBV care for survivors, including medical care, shelter, psychosocial support, legal aid, etc.
- **Feedback and accountability mechanisms:** Details of existing or planned feedback and accountability mechanisms. These solicit, listen to, collate, and analyse feedback from members of the community where CARE operates.
- **Roles and responsibilities:** Details of the specific roles and responsibilities of project staff based on whether or not they are GBV specialists.
- **Confidential information management:** Details of data security measures to manage private and confidential information.
- **Links to relevant policies:** Relevant CARE policies project staff should familiarize themselves with.
- **Plan for community engagement in GBV integration:** Details of how this GBV integration plan should be shared and reviewed within the community.

INFORMATION, TEMPLATES AND RESOURCES TO GUIDE DEVELOPMENT OF A GBV INTEGRATION PLAN

The table below details sources of further guidance for each section of the GBV integration plan.

GBV INTEGRATION PLAN CONTENTS	FURTHER INFORMATION, TEMPLATES & RESOURCES
Analysis of GBV risks	➡ Sample **GBV risk matrix** included in the accompanying resources. ➡ **Impact Area scenarios** with sector-specific examples.
Staff training process	➡ Further details in **Step 6**. Additional information on **Staff training to support GBV integration** included in the accompanying resources.
GBV referral mechanism	➡ Further details in **Step 3**.
Feedback and Accountability Mechanisms	➡ See CARE's Guidance for Creating and Managing Effective Community Feedback and Accountability Mechanisms for further information.
Roles and responsibilities	➡ Further details in **PART I** of this guidance and in **Step 3**. ➡ Further details in the overview of **Roles & responsibilities of GBV & non-GBV specialists** in the accompanying resources.
Confidential information management	➡ CARE's **Gender MEL Toolkit** includes Ethical considerations for GBV research for further guidance.
Links to relevant policies	➡ Details of **Policies to support GBV integration** included in the accompanying resources.
Community engagement plans	➡ See CARE's Tipping Point project's Community Partcipatory Analysis Toolkit

2.2 Designing GBV prevention programming

GBV prevention may be a core part of standalone GBV projects if this is the focus of their objectives. However, projects across other impact areas may also choose to include prevention activities, depending on the findings of the gender and GBV analysis.

CARE employs the approaches below for GBV prevention, often using a combination of these approaches:

Transforming social norms: Promoting gender and social norms change and building awareness of discriminatory practices and beliefs can help transform unequal power relations between groups, and contribute to sustainable change. Interventions that transform social norms help to prevent harmful practices and violence.

Empowering women and girls in all their diversity: Empowering women and girls in all their diversity, to make decisions individually and collectively, to take up leadership within homes and communities, will not only support girls to remain and thrive in school, women to remain and thrive in the workplace, but will also lead to economic empowerment and independence. This can support GBV survivors to leave abusive relationships or mitigate the violence.

Supporting laws, policies and frameworks to end GBV: Each State is ultimately responsible to ensure the safety and dignity of all its people. Therefore supporting efforts to strengthen and implement laws, policies and frameworks to ensure protections and safeguards against GBV is critical. Promoting survivor-centered approaches to GBV related laws, policies and services is vital.

Raising awareness of life-saving services: GBV survivors are not always aware of health, legal aid, psychosocial support, child protection, shelter, and other post-GBV services. As part of secondary prevention, CARE conducts referral mapping and provides information about local support available to GBV survivors.

Strengthening community mechanisms: Eliminating GBV requires working at all levels. Empowered women and girls must be supported by men and boys, religious and local leadership who believe in gender equality and the need to end GBV. Strengthening community mechanisms by supporting community dialogues to promote changes in social norms, and strengthening community governance and feedback and accountability mechanisms is crucial.

CHECKLIST FOR GBV PREVENTION PROJECTS

- ☑ The project aims to challenge and transform norms, attitudes and behaviors that enable GBV to take place, including gender discriminatory laws, policies and practices
- ☑ The project reduces or eliminates the underlying factors that place people at risk of using or experiencing violence including gender discriminatory laws, policies, social norms and practices (e.g. non criminalization of marital rape, harmful traditional practices such as FGM/C or child marriage)
- ☑ The project actively promotes gender equality and respectful relationships between women and men (not excluding other gender identities and sexual orientations).
- ☑ The project meaningfully engages participants, local organizations and stakeholders in design, implementation and evaluation of interventions.

2.3 Designing GBV response programming

GBV response may be a core part of standalone GBV projects if this is the focus of their objectives. However, projects across other impact areas may also choose to include response activities, depending on the findings of the gender and GBV analysis.

GBV response should be provided by GBV specialists

CARE employs the approaches below for GBV response, often in partnership with others and **always under the expertise of GBV specialists**:

- **Safe Spaces for Women and Girls:** Establishing spaces which provide physical and emotional safety; access to multi-sectoral GBV response services; opportunities for women and girls to re-build social networks; psychosocial support; and targeted skills-building.
- **Post-GBV care:** Providing (directly or through partners) lifesaving services including first-line support, medical care, psychosocial support, case management, safety, shelter, legal aid, and referrals to additional services.
- **Cash and voucher assistance:** Delivering cash transfers or cash voucher assistance to women and survivors of GBV as complementary to case management.
- **Referral System Strengthening:** Developing or updating referral maps of post-GBV services, linking GBV survivors to appropriate services through referrals, and working with local stakeholders to develop or strengthen referral pathways and follow-up mechanisms.

It is critical that survivors of violence receive the highest quality and effective support services. Most types of services have their own best practice standards that can be adapted to the program context. The goal is for all response services to adopt a survivor-centered, rights-based approach. The checklist below includes common best practices for all types of services to be used by projects seeking to set up, expand or strengthen response services.

BEST PRACTICE STANDARDS FOR GBV RESPONSE SERVICES

- ☑ Services must be provided in an environment that is safe for women, children, adolescents and men, with the safety of staff members also prioritized.
- ☑ Individuals must be treated with compassion, dignity and respect and their human rights recognized and upheld when accessing and using services.
- ☑ Services must be provided in a timely manner, particularly emergency medical care for sexual assault survivors within 72 hours.
- ☑ Services must be appropriate and accessible to all groups who need them (e.g. those with disabilities, LGBTQI+, language use, age).
- ☑ Policies and procedures need to be established and implemented to ensure survivors' informed consent is obtained for services or sharing of information, and to maintain their privacy and confidentiality.
- ☑ Coordination between service providers should be expanded and strengthened to facilitate cooperation and collaboration to ensure the best possible services.
- ☑ CARE must invest in the professional development of staff so that individuals and communities receive quality service from skilled workers.
- ☑ Project staff and service providers must commit to and practice non-violence and a zero-tolerance approach to GBV.
- ☑ Advocacy should be appropriate, participatory and effective so that survivors of violence are able to realize their rights.

See the Essential Services Package for Women and Girls Subject to Violence (UN Women, UNFPA, WHO, UNDP & UNDOC) for guidance to identify essential services to be provided to all women and girls who have experienced GBV.

2.4 Designing GBV advocacy programming

GBV advocacy may support standalone GBV projects, or GBV considerations may be part of broader advocacy efforts within CARE.

CARE's GBV advocacy is guided by **feminist principles** and applies an **intersectional lens**. CARE believes understanding how different types of discrimination or oppression combine and compound is critical to developing principled and effective advocacy to advance social and gender justice goals.

➡ Further information on **the importance of an intersectional approach for GBV programming** and **key considerations for groups at risk of GBV** is included in the accompanying resources for this guidance, available from care.org/gbv-guidance.

The checklist below is based on principles informed by feminist activism and should be used to assess how CARE collaborates with women-led organizations (WLOs) and women's rights organizations (WROs) when determining and undertaking advocacy.

BEST PRACTICE STANDARDS FOR FEMINIST GBV ADVOCACY

- ☑ Adopt inclusive and intersectional approaches to advocacy by:
  - Centering the voice and agency of survivors, women and girls.
  - Including men and boys in GBV advocacy efforts to challenge and transform gender biases.
  - Promoting greater engagement of WLOs and WROs, with other marginalized or excluded groups.
  - Promoting space for intergenerational collaboration and collective action.
  - Supporting the inclusion of WLOs and WROs in other forms of coalitions (across sectors).
- ☑ Create collaborative spaces where CARE proactively learns and partners with WLOs and WROs in the design of interventions.
- ☑ Encourage and enable WLOs and WROs to lead development and humanitarian programming and advocacy especially in negotiating with decision makers.
- ☑ Invest in WLOs and WROs through funding and capacity building of organizations, networks and individuals to help sustain their efforts.
- ☑ Invest time in trust building with and among WLOs and WROs that recognizes the legitimate concerns and criticisms against international NGOs and development actors.
- ☑ Share resources, knowledge and learning with WLOs and WROs.
- ☑ Be flexible, realistic and proactive when working with WLOs and WROs.
- ☑ Support both formal and informal changes through advocacy efforts and reinforce links between CARE's advocacy and programming work
- ☑ Strengthen partnerships and collaboration with diverse of groups (e.g. informal groups and networks) to strengthen learning and the legitimacy of advocacy.

CARE's Global Advocacy Roadmap 2022-23 sets out the first steps on the pathway to influencing change in line with Vision 2030.

See CARE's Advocacy Handbook for how to integrate advocacy into programming.

2.5 Whom to engage

To achieve CARE's global vision and mission, we must engage with diverse organizations in a variety of ways—formal and informal, in one-to-one relationships and in multi-stakeholder alliances. Ideally, CARE should take on the role of a convenor, a connector and supporter of civil society, and should lead only when the gender analysis clearly identifies a gap or need. No single actor or organization can address all elements of GBV risk mitigation, prevention, response and advocacy; therefore, strategies which engage multiple stakeholders in a holistic and coordinated manner are essential.

When developing a GBV integration plan the following groups should be assessed and engaged:

- Key stakeholders and actors providing **GBV services in the community.**
- GBV, gender, and diversity **specialists**.
- Males and females of all ages and backgrounds of the **affected community**, particularly women, girls and other marginalized groups (e.g., people with disabilities, LGBTQI+ people, etc.).
- **Community leaders** (traditional, religious, political, activist, etc.).
- Relevant **community-based organizations** (e.g., organizations for women, adolescents/youth, persons with disabilities, older persons, etc.).
- Relevant **local and national governments**, including gender Ministry staff or gender specialists in other Ministries, where available.

IMPORTANT NOTE: Do not seek out or ask the community about individual cases of violence.

Don't forget that asking survivors of GBV about their experiences may cause additional harm or trauma.

How to ensure meaningful participation

- Pay attention to how diverse forms of marginalization, power dynamics and violence could influence how particular groups engage with the project. Prioritize their meaningful participation, safety and autonomy.
- Clearly articulate why and how the different stakeholders will be engaged (i.e. men and power holders) in a manner that does not reinforce gender inequality or GBV risks.

Following development of the GBV integration plan, these groups should continue to be engaged in GBV integration efforts at every stage of the project cycle. The project should re-engage with the community to revise the plan, reflect, and adjust where necessary.

In an effort to transform CARE's relationships, CARE's partnership standards need to be adapted, to reflect mutuality and respect, greater flexibility in terms of how risks are shared and compliance requirements are met, commitment to investing more in creating more equitable partnerships and ensuring balanced accountability.

➡ Further detail of CARE's partnership approach is available in CARE's Role In Supporting Social Movements: A Feminist Perspective (March 2020) and Partnership in CARE (January 2021).

STEP 3: Conduct GBV referral planning

A GBV referral is an offer of information about a service that can support a GBV survivor. Referral services are external services typically provided by government, private or non-governmental service providers.

For example, it could include the location of the nearest health facility that can offer immediate medical care for a rape survivor; or it could include making a call on behalf of a GBV survivor to the nearest emergency shelter to find out if they have an available bed. During the design phase, all CARE programs should:

- Check to see if a **recent referral directory or pathway already exists** for their geographic area.
- If it does not already exist, **work with key stakeholders to map services into a referral directory** and **develop a referral pathway** which describes the steps a survivor should follow to receive post-GBV care.

KEY DEFINITIONS: REFERRALS

Referral mapping is the process of identifying organizations and institutions which provide services to GBV survivors and collecting their information.

Referral directories are lists of post-GBV services compiled through mapping.

Referral pathways are flow charts or job-aids which visually depict the steps a GBV survivor should go through to access care. *See Step 3.2 for a sample referral pathway.*

IMPORTANT NOTE: Providing information to survivors in a safe, ethical, and confidential manner about their rights and options to report GBV and access care is a **responsibility of ALL development actors** who interact with affected populations. Survivors should never be forced to report GBV or seek services against their will, except when the survivor is a minor or dependent and mandatory reporting is required by law.

3.1 Identifying or developing a referral map

In development settings, check if a map of GBV services already exists.

- **Search** the websites of—and **speak to**—people from Ministries or responsible government institutions for health, women, and social affairs; major national and international NGOs working on GBV; and local women's rights and women-led organizations.
- If mapping has been done within the past ~5 years, **check** whether the project site is included in its geographic coverage. If it was done prior to one year ago, make sure the resources are still available during the hours listed through calls and **site visits**.
- If the referral directory does not exist or is out of date, use the GBV referral mapping tool to **create an updated directory** and periodically check that the directory is up to date by calling and visiting service sites.

Ideally, a GBV specialist should validate that the institutions and organizations included in the directory provide **provide survivor-centered care and do no harm**. This means ensuring services will not unintentionally increase the risk of GBV and that care is provided in line with the principles of safety, confidentiality, respect and non-discrimination.

➡ A sample **referral mapping tool for development contexts** is included in the **GBV integration resources** which accompany this guidance, available from care.org/gbv-guidance.

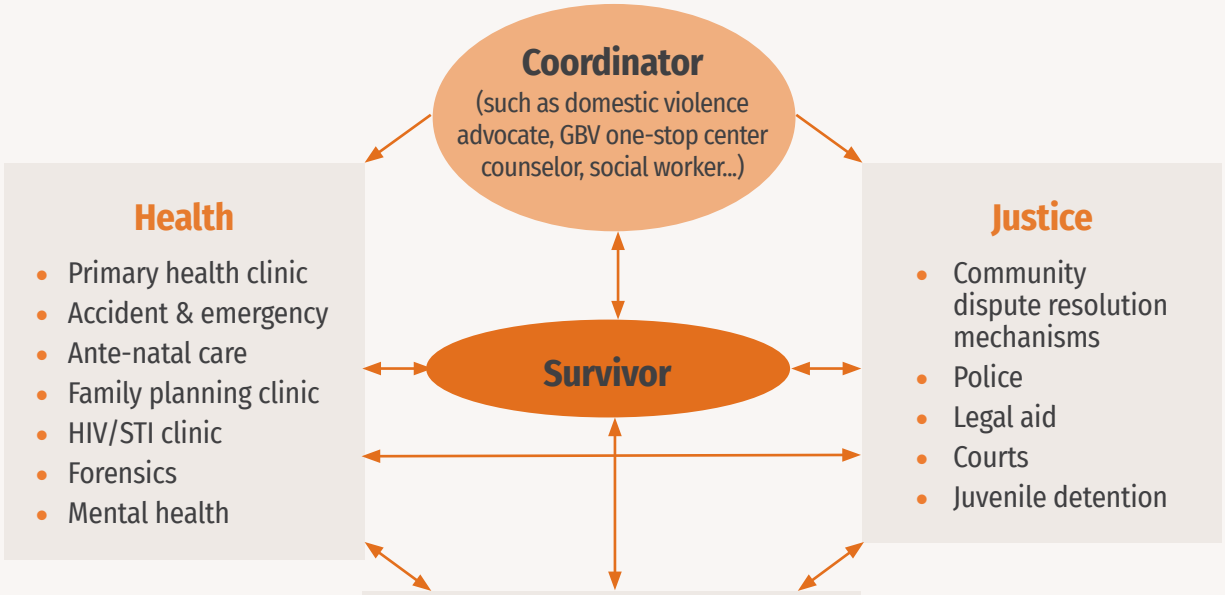
Mapping the location, hours and types of services is not the same as assessing the quality of services, which requires specialized, additional training. Only GBV specialists with **specific training in quality assessment and assurance** can assess the quality of post-GBV services.[1] **Non-GBV specialists should not assess the quality of services**, but should consult a GBV specialist and make reasonable judgments about whether or not it is safe, appropriate or helpful to refer a survivor there.

3.2 Planning referral pathways

Referral pathways explain how a survivor will navigate the services identified in the referral mapping process.

SAMPLE STEPS FOR DEVELOPING REFERRAL PATHWAYS FOR POST-GBV CARE

Step 1: Identify likely points of entry for GBV survivors & who will provide first-line support. → **Step 2: Identify referral linkages with other sectors and services.** → **Step 3: Identify the person responsible for coordinating care & follow-up visits.**



Health

- Primary health clinic
- Accident & emergency
- Ante-natal care
- Family planning clinic
- HIV/STI clinic
- Forensics
- Mental health

Justice

- Community dispute resolution mechanisms
- Police
- Legal aid
- Courts
- Juvenile detention

Social services / NGOs

- Women's support groups
- Shelter
- Livelihood/employment/CVA/VSLA
- Women & girls' safe spaces
- Faith-based organizations
- Disability services
- Child protection services
- Mental health support services
- Legal aid

Adapted from World Health Organization: Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence - A manual for health managers (2017).

The project's referral pathway should be included in **Step 5: Establish policies and protocols for responding to GBV disclosures**.

[1] For quality improvement or assurance for GBV health services, see Jhpiego, CDC, PEPFAR, WHO: GBV Quality Assurance Standards (2018).

STEP 4: Budget for GBV integration

Budgets often fail to include the true costs required to ensure the principle of do no harm is applied throughout the project cycle.

Recruiters and project staff may not be aware of the specialized training and expertise required to integrate attention to GBV. Gender and GBV analysis, training, project implementation, and M&E all require human and financial resources which must be taken into account.

At the **project design stage**, ensure that the project budget allocates sufficient funding for the following:

- **Gender analysis** for GBV integration.
- Payment of **GBV specialist staff** or consultants, as relevant.
- Necessary **gender and GBV training** for project staff, including space for reflection and understanding of the do no harm and survivor-centered approaches.
- **Employment, consultation, and meaningful participation** of individuals from the target or beneficiary community and ensuring their leadership in project activities. This may include budgeting for transportation reimbursements and refreshments.
- Potential financial support for **survivors to travel to referral services**.
- Design, printing, and distribution of any **information, education, and communication (IEC) materials** such as posters, brochures, wall paintings, social media campaigns, videos, etc.
- **Advocacy meetings** with stakeholders and the donor community to recognize GBV interventions as lifesaving, and increase support for GBV interventions.
- **Advocacy for government policies** and budgets to address GBV.
- **Monitoring and evaluation costs** related to GBV-specific data collection, evaluation, and indicator adaptation.

This list highlights the *minimum* that must be in place when budgeting for an integrated intervention or a standalone project. It is not an exhaustive list, which should be determined by the project's goals, needs of the community, and donor requirements.

➡ CARE's Gender Mini-Guide for business development details basic gender costs to include in a proposal. More detailed **GBV Budget Guidance** with sample budget templates for common CARE GBV interventions will be available from CARE's GBV Hub on CARE Shares from late 2022.

STEP 5: Establish policies and protocols for responding to GBV disclosures

All staff who interact with program participants should be able to respond in a safe and appropriate way in the event a survivor of GBV chooses to disclose their experience.

Responding to a disclosure means reacting immediately, appropriately, and empathetically when an individual reports that they have been subjected to GBV. This is also known as **GBV first-line support**. Responding to a GBV disclosure should not be confused with *GBV response*, which refers to the post-GBV care offered to a survivor, such as health care, shelter, legal aid, etc. All staff must understand what they should and should not do in the event someone discloses to them that they have experienced GBV.

What is GBV first-line support?

First-line support is the immediate, brief, empathetic counseling given to a survivor upon a GBV disclosure. It goes beyond the DOs and DON'Ts of responding to a disclosure, which all staff should be aware of. The WHO defines "first-line support" using the acronym "LIVES": *Listening, Inquiring, Validating, Ensuring safety, and Support through referrals*. It is often also referred to as "psychological first aid", but also includes safety planning and providing referrals. Evidence shows that if a survivor receives GBV first-line support upon disclosure of GBV, they are more likely to seek necessary care.

CARE's **GBV first-line support training** is available to CARE staff from the **GBV training page** on CARE Shares.

Referral protocols are documents describing how staff must respond to a GBV disclosure; the roles and responsibilities of each referral partner; what is expected of them in terms of privacy, confidentiality, and respect for the survivor's wishes and dignity; and how data will be collected, managed and analyzed. Referral protocols will be informed by planning conducted in earlier steps. Details of planned referral pathways should be drafted during the design stage—see **Step 3: Conduct GBV referral planning** for more information. Details of how confidential information will be managed and the roles of specific staff should be included in the GBV integration plan drafted at design stage—see **Step 2.1: Developing a GBV integration plan**.

At implementation stage this information is used to create **clear referral protocols for the project**. It is important these protocols are documented and **staff understand their roles and responsibilities.**

When developing protocols refer the accompanying resources for this guidance, which include details of:

- **Staff training to support GBV integration & progamming**
- **Policies to support GBV integration & progamming**
- **Roles & responsibilities of GBV & non-GBV specialists**
- **DOs & DON'Ts when responding to a GBV disclosure**

These are available from care.org/gbv-guidance.

IMPORTANT NOTE: It is the responsibility of GBV specialists to provide care and services to survivors of GBV. Those who are not GBV specialists should NOT attempt to proactively identify survivors through screening* or provide any form of GBV-specialized services to survivors including counselling. When non-GBV specialists attempt to provide services without training, it can lead to direct harm to GBV survivors.**

* WHO recommends against universal GBV screening because it can overwhelm already overburdened health systems, retraumatize a survivor or falsely raise a survivor's hopes for justice. World Health Organization: Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (2013)

** For example, harm encountered has included forcing a rape survivor to marry the perpetrator or forcing a survivor to report the incident to the police against their will, in a country where police have themselves been convicted of sexual assaulting women and girls.

How does GBV integration & programming intersect with PSHEA?

Sexual harassment, exploitation and abuse (SHEA) are forms of GBV perpetrated by those working in, or with, development or humanitarian organizations. SHEA is a violation of international human rights conventions, including the Convention on the Elimination of All Forms of Discrimination Against Women, the United Nations Declaration on the Elimination of Violence Against Women.

Protection from sexual harassment, exploitation and abuse (PSHEA) relates to **organizational measures put in place to protect program participants, communities and staff from harm perpetrated by development or aid workers.** CARE staff must understand and be held accountable to CARE's PSHEA policy. GBV integration, however, goes beyond enforcement of PSHEA policies to include attention to GBV that could be beyond the project, no matter whom the perpetrator is.

5.1 What to include in GBV policies and protocols

A protocol for responding to disclosures of GBV should include detail for:

- **Disclosures relating to CARE staff or partners**
  How staff should respond to suspected or reported sexual harassment, exploitation, and assault by CARE staff or partners, in line with the PSHEA policy.
- **Disclosures resulting from CARE programming**
  How staff should respond to disclosures of GBV resulting from CARE programming.
- **Disclosures unrelated to CARE programming**
  How staff should respond to reports of GBV not resulting from CARE programming.

KEY POINTS FOR INCLUSION IN GBV POLICIES OR PROTOCOLS

- **Appropriate language:** Suggest empathetic and appropriate language to respond to the disclosure, drawing upon the DOs and DON'Ts of responding to a GBV disclosure, included in the accompanying resources for this guidance, and GBV first-line support training (see above).
- **Methods of support**: Specify **how** a survivor will be referred and to whom. This may include providing a printed referral directory or offering to call a GBV One Stop Center or GBV Advocate on their behalf or together with them.
- **Referral pathways**: Include the referral pathway and note **special steps to take for children and minors** and for survivors who have been sexually assaulted within the past 72 hours (who need **emergency medical attention**). This should clearly explain what instances of GBV constitute SHEA and must be reported through CARE's PSHEA mechanisms.
- **Privacy & confidentiality:** Specify how staff should keep the **survivor's information private and confidential**, following the key principles to guide GBV programming in **PART I** of this guidance. Details may include:
  - Clearly stating that project staff must never share information related to a particular survivor or case with anyone outside of those involved directly in the survivor's care.
  - Specifying how survivors' information will be kept securely, such as in a password-protected electronic system or in a locked room or cabinet that only specific staff involved in the survivor's care have access to.
- **Data management**: Define whether the project will track data such as how many disclosures it receives, what referrals were provided, whether or not the survivor accessed the referral service, and whether or not there was any follow up. This should link with the points on confidentiality and be limited to the data needed to analyze trends (See Step 7.1 below).
- **Staff safety & support**: Include detail of the availability of services for staff—including support for dealing with stress and trauma—and CARE's zero-tolerance policy for SHEA.

Why should GBV policies & protocols also mention staff?

Project staff, partners and service providers may face threats to their personal safety from GBV perpetrators or their supporters if privacy and confidentiality considerations are not upheld. Additionally, project staff may be at risk of GBV themselves in their homes, in the office, or during site visits and travel.

Projects must address potential vicarious trauma resulting from handling the sensitive subject of GBV and listening to survivor's stories. Necessary risk and safety planning must be put in place and regularly reviewed, while support for staff should be provided in terms of dealing with the stress and trauma they may experience.

5.2 Implementing GBV policies and protocols

As policies and protocols are developed, these should be documented in the GBV integration plan to ensure this remains up-to-date. Steps should be taken to ensure these are understood and implemented throughout the project.

- All **program staff** should be made aware of relevant policies and protocols.
- Policies and protocols should be made **accessible and available** to all—this will include translation into local languages and ensuring content is available in soft and hard copy forms.
- **Partners, stakeholders and communities** must be sensitized on the relevant policies and protocols, expected standards of behavior, their right to safety and protection, and mechanisms to raise concerns to ensure that these are all fully understood and enforceable.
- Program supervisors and managers should have **accountability mechanisms** put in place for consistent implementation.

IMPORTANT NOTE: **Staff should be aware it may not always be safe for a survivor to disclose or report GBV, or to seek services**. The survivor could experience further trauma and human rights violations if their confidentiality is violated, if the perpetrator escalates the violence as a result, or if the perpetrator targets staff or GBV service providers who assist the survivor. Don't forget that asking survivors of GBV about their experiences may cause additional harm or trauma.

STEP 6: Train staff on the GBV approaches for the project

At project implementation stage it is important to ensure all staff receive the relevant training for them to integrate GBV considerations into their work effectively.

There are different types of GBV training and a project's training needs should be guided by the findings of the gender analysis. For example, if the analysis shows that the community holds attitudes that accept the use of GBV, a GBV prevention training would be needed. If the analysis finds that survivors cannot access timely post-GBV care, a GBV response training would be needed.

Program staff across impact areas will need training to prepare them to monitor GBV risks and handle GBV disclosures. Staff expertise is likely to primarily be focused on the impact area where they are working, and they might be unfamiliar with issues surrounding GBV.

CARE projects across impact areas should reassess staff capacity during implementation and refresh or provide additional GBV-related training as necessary.

➡ Further details of **staff training for GBV integration & programming** are included in the accompanying resources for this guidance, available from care.org/gbv-guidance.

IMPORTANT NOTE: All staff, irrespective of how long they have been with CARE, should participate in GBV training so they are able to clearly articulate and implement CARE's ethical principles and do no harm approach.

Projects should create spaces for staff to regularly and critically reflect on project GBV learnings. Reflection spaces should be structured and resourced within programming, such as group exercises to encourage personal introspection on GBV and gender-related knowledge, attitudes and practices (see CARE's GBV First-Line Support Curriculum for examples). Linking these to other reflection or feedback mechanisms (such as Feedback and Accountability Mechanisms, stakeholder dialogue or policy discussions) where staff are exposed to diverse perspectives and opinions is important. Contact Chrysalis and CARE USA's Gender Justice team for additional support and advice.

6.1 Training for all program staff

The level of training will depend on the activities undertaken, but in general, projects should plan for **PSHEA training** and **GBV integration training** for all staff, plus training on gender and power where relevant.

- **PSHEA training** is necessary to ensure staff understand the organizational measures put in place to protect program participants, communities and staff from harm perpetrated by development or aid workers, and their responsibilities in relation to this.
- **GBV integration training** is broader than PSHEA training, focusing on how to prevent, reduce and respond to GBV that could be beyond the project, no matter who the perpetrator. This training supports teams to integrate GBV in the whole project cycle and includes how to use this guidance. It is a combination of training sessions and accompaniment.
- **Training on gender and power** supports staff in internally reflecting on their own biases, including on GBV. Within CARE, this usually takes the form of Reflections on Equity, Diversity & Inclusion (REDI) or Social Analysis & Action (SAA) and is encouraged for all program staff.

PROGRAM EXAMPLE: In collaboration with a Rwandan organization, Youth Association for Human Rights Promotion and Development, CARE implemented the Youth Employability in The Informal Sector (YEIS) Project in Rwanda from 2015 to 2019. To mainstream gender in YEIS program implementation, project implementing staff received several trainings. The training curriculum for VSLAs, for instance, covered issues of gender equality and women's rights, including efforts to reduce gender-based violence. Feedback from evaluations revealed that participants improved their understanding of gender-related concepts, including GBV. A project supervisor shared that "the training enabled me to avoid some bad practices that could be qualified as GBV. The knowledge acquired from the trainings helped me and the project staff to effectively facilitate the project beneficiaries about gender and power dynamics." The full evaluation is available here.

6.2 Training for staff providing first line support

Before beginning any GBV programming, it is essential to prepare for how staff will respond if a participant discloses they have experienced GBV. All staff should be aware of the **DOs and DON'Ts of responding to a disclosure**, but **first-line support goes beyond this** to add brief, empathetic counseling, safety planning and referrals to appropriate services.

When survivors disclose they have experienced violence, the response can determine whether or not they seek help, or return to an unsafe environment. Projects must be aware of what health, police, legal aid, shelter, social services, and other post-GBV care is available locally, and how project participants can access it. This is critical, particularly for cases of sexual assault, which require emergency medical attention within 72 hours.

First-line support is often offered by health providers, since they frequently come into contact with GBV survivors. But it can also be offered by project staff, police, social workers, psychologists, child protection officers, teachers, and representatives of community-based organizations. First-line support usually takes between 5-30 minutes, depending on the needs of the survivor. Staff and partners who interact directly with the communities CARE serves should receive **GBV first-line support training.**

- CARE's **GBV first-line support training curriculum** provides practical, participatory guidance and tools on how to respond appropriately and empathetically to a disclosure, conduct a safety plan, and offer referrals to post-GBV care.

6.3 Training to support specific GBV interventions

There are different kinds of GBV training and each project will identify different needs through gender analysis. In some situations, specific types of GBV training may be appropriate, such as focused training on GBV **prevention**, **response**, **quality assurance** of services,[2] and **GBV research ethics**.

- **GBV prevention**: A hybrid online and in-person training is available through CARE's Gender Justice team.
- **GBV response**: Health staff providing post-GBV care should receive **WHO training for health providers.** This provides health-care providers, particularly in low- and middle-income countries, with a foundation for responding to domestic/intimate partner violence and sexual violence against women. The curriculum seeks to build skills and to address providers' attitudes towards survivors of violence.[3]
- **GBV research ethics**: Training is available on GBV research methods and ethics from the London School of Hygiene and Tropical Medicine (an online, short course) and The Johns Hopkins Bloomberg School of Public Health (a graduate-level, eight-week online course). Write to the instructors for permission to audit the courses online or to obtain course materials.

CARE staff should see the GBV Hub on CARE Shares for information about additional GBV trainings.

[2] For further support on quality assurance, refer to Banerjee, Joya, WHO, Jhpiego, CDC, PEPFAR:. Gender-Based Violence Quality Assurance Standards and Facilitation Guide (2019).
[3] World Health Organization: Healthcare for women subjected to intimate partner violence and sexual violence: A clinical handbook (2014).

STEP 7: Ensure activities do no harm throughout implementation

Staff should ensure all project activities follow the GBV policies and protocols established at the start of the project (see **Step 5**). At all stages of implementation, project managers should review activities with a GBV lens to identify and mitigate potential risks. In some cases this may include ensuring staff from other teams —such as communications, knowledge management, advocacy or MEAL—and external consultants are aware of relevant guidelines and best practices.

7.1: Monitoring project activities for any effect on GBV

Programs should only seek to assess evolving risks of GBV and not monitor incidents as they come up.[4] Programs should not be reporting any survivor information that is private and confidential. When monitoring changes in risks, should incidents be disclosed to staff they need to remove personal identifiers from data, and compile this anonymously. The aim is to analyze trends, not to track invidivual cases.

Staff should **monitor changes in risks** by consulting with local GBV, LGBTQI+ or women's rights groups and conducting community consultations (without directly asking about GBV incidents). This should follow any community engagement and ongoing reflection plans detailed in the GBV integration plan.

If new risks are identified these should be mitigated and reduced as much as possible and updated in the GBV integration plan.

7.2: Ensuring project materials do no harm

Many projects create Information, Education & Communication (IEC) materials or other resources to support project activities and campaigns. It is important any communications materials which refer to GBV do no harm by following the ethical principles detailed in **PART I** of this guidance.

Do not develop materials that depict violence, show people being abused, or assign blame (e.g. to men or particular ethnic groups). Instead, ensure the materials maintain the dignity of characters and portray the positive (e.g. non-violent conflict resolution).

➡ Further guidelines for **creating GBV communications materials** are included in the accompanying resources for this guidance, available from care.org/gbv-guidance.

7.3 Managing external communications and advocacy

All advocacy and communications (local, national or international) has the potential to affect other parts of the organization, programming goals, and the safety of staff, partners and participants.

CARE largely manages sensitive/controversial issues through private advocacy or joint messaging with other agencies. When engaging in advocacy (privately or jointly) on such issues it is important that the process of due diligence is followed. Applying a gender-sensitive lens and the do no harm approach to fully understand and manage unintended negative impact and risks will be particularly useful. It is important to ensure established approval procedures are respected. Details of CARE sign-off processes for advocacy is available in the CARE International Advocacy Handbook (p. 41).

As the project progresses there may be requirements to produce communications materials, such as human interest stories or videos highlighting project achievements. It is important for both project staff and communications/knowledge management teams to be familiar with CARE's GBV Communications Policy and Guidelines and monitor communications materials for any potential risks to participants, staff or programming.

[4] Note this does not refer to incidents which fall under the PSHEA Code of Conduct, which should be reported via the appropriate channels; this refers to project staff recording incidents or attempting to conduct case management.

STEP 8: Create feedback and accountability mechanisms

A feedback and accountability mechanism can help address possible cases of GBV, sexual exploitation, and abuse by CARE or partners, acting as an early warning system and allowing us to respond to, and prevent further sexual misconduct or other inappropriate activities. A feedback and accountability mechanism can also help communities to provide input into the quality of care and help identify and barriers or bottlenecks to accessing GBV services. Staff receiving complaints and monitoring feedback mechanisms must be aware of where to report PSHEA concerns, working in close coordination with the PSHEA Focal Point.

Community feedback and grievance mechanisms need to be linked to the project's periodic reviews and monitoring processes, and program assessment should be ongoing. Where risks are identified or feedback is received from participants, teams must adapt, or redesign any element of the program that exacerbates risk. Monitoring of programs should be done with the community, including women and girls, and other marginalized groups. This should be a continual process undertaken throughout the project cycle.

➡ For further information, see CARE's **Guidance for Creating & Managing Effective Community Feedback & Accountability Mechanisms.**

STEP 9: Incorporate GBV indicators

All projects should incorporate appropriate indicators to monitor and understand **how the project is affecting risk** and **how project outcomes are affected by addressing GBV**.

CARE has a common set of guiding indicators which are applicable to all CARE projects and initiatives worldwide. Most indicators have been designed so they can be incorporated into *existing* MEAL tools and processes, to improve information collection and analysis without the need for additional data collection mechanisms.

All CARE staff are expected to:

- Incorporate global indicators into **proposals** (as appropriate and relevant).
- Assess where indicators can be **integrated in existing programs and projects** and adapt accordingly.
- **Report data** to the Project/Program Information and Impact Reporting System (PIIRS) when evaluation process takes place.

Further information for CARE staff on MEAL for CARE's Vision 2030 is available from CARE's Global MEAL Hub on CARE Shares.

CARE's global indicators include the following indicators which are **directly** focused on GBV.

Global indicator #2: % of women and girls in all their diversity who reject intimate partner violence	➡ View guidance for Indicator #2
Global indicator #3: % of women and girls aged 15 years and older subjected to gender-based violence in the last 12 months by form of violence and age	➡ View guidance for Indicator #3
Global indicator #4: # and % women and girls who access GBV response services	➡ View guidance for Indicator #4
Global indicator #13: % of people supported through/by CARE who report on the Gender-Equitable Men (GEM) scale a score of at least 24 (only for programs that are specifically seeking to shift gender attitudes and behaviors)	➡ View guidance for Indicator #13
Global indicator #16: # and description of positive shifts in informal structures (social norms, culture, beliefs, etc.) as defined and influenced by movements and/or activists supported by CARE	➡ View guidance for Indicator #16
Global indicator #20: # people who obtained access to life saving GBV prevention and response services supported by CARE and partners pursuant to relevant standards assistance	➡ View guidance for Indicator #20

CARE's global indicators also include the following indicators **indirectly** focused on GBV, which could, if appropriate be used by a GBV program:

Global indicator #1:% of women and girls who report confidence in their own negotiation and communication skills	➡ View guidance for Indicator #1
Global indicator #14: # and % of women and girls who have actively participated in formal (government-led) and informal (civil society-led, private sector-led) decision-making spaces	➡ View guidance for Indicator #14
Global indicator #17: # of new, amended, or better implemented policies, legislation, multilateral agreements, programs, and/or budgets influenced by the voices of—or actions taken by—women & girls	➡ View guidance for Indicator #17

These indicators should be reported through CARE's monitoring and evaluation system, Program Information and Impact Reporting System (PIIRS), enabling the collection and consolidation of coherent and comparable outcome and impact data. This supports efforts to measure CARE's collective progress in relation to its commitments and to explain how it will contribute to lasting change.

➡ Beyond PIIRS, **additional indicators for GBV integration** adapted from the IASC's GBV Guidelines are included in the **GBV integration resources** which accompany this guidance, available from care.org/gbv-guidance.

PROGRAM EXAMPLE: The Target Enterprises-funded Worker Wellbeing project ran from 2018-2021 in Bangladesh, Indonesia, and Vietnam. The project endline evaluation took into account the possible impacts of program activities on GBV by including measures for gender mainstreaming. Gender-specific issues were included in the research instruments, such as gender roles, GBV, and sexual harassment. Gender mainstreaming and expertise were included as criteria for assessing the quality of proposals. Additionally, a gender expert was included on the project team to ensure that gender was considered throughout the project cycle. Read the evaluation here.

STEP 10: Conduct routine monitoring

Integrating GBV into CARE's Monitoring, Evaluation, Accountability and Learning (MEAL) processes is essential for understanding how project outcomes are affected by addressing GBV. It also allows project staff to monitor and understand how the project is affecting risk, the social norms that contribute to GBV, and participants' access to referral pathways—as well as how well project staff are understanding and applying GBV integration and related policies and systems.[5]

MEAL is a critical approach for planning, budgeting resources, measuring performance, and improving programming. Continuous routine monitoring ensures that programs remain effective and are accountable to stakeholders—especially affected populations.

10.1 Disaggregate data

All programs should collect age and sex disaggregated data; ideally, projects will also collect and disaggregate data by disability and other relevant identity characteristics and vulnerability factors (such as ethnicity, caste, geography) to deliver programs more equitably and efficiently. Even though GBV-integrated programs should not measure GBV without appropriate training and ethical approval, by integrating gender and GBV they can improve outcomes for sector specific programming (WASH, Health, Food Security, etc). This data will support comprehensive analysis of GBV risks (see Step 10.3 below).

10.2 Periodic evaluations

Project midlines, evaluations and other research conducted during the course of the project offer further opportunities to understand the possible impacts of project activities on GBV.

Staff should periodically review data and insights from any research or evaluations, in collaboration with partners, to identify any changes in the risks addressed in the GBV Analysis matrix. If changes or additions need to be made, the GBV integration plan should be updated to reflect these.

10.3 Analyze data & share findings

All indicators should be analyzed and reported using a GBV lens. This involves considering how all information—including information that may not seem 'GBV-related'—could have **implications for GBV prevention, mitigation, and response**.

For example:

- If a program has aimed for 50 percent female participation in assessments but falls short of reaching that target, it may consider changing the time and/or location of the consultations or speaking with the affected community to better understand and address the barriers to female participation.
- If attendance at the one stop center is low, the project may reallocate resources to train providers and police to promote their services and make referrals.

Analysis of indicator data from a GBV perspective can provide valuable learning opportunities and help **identify where modifications may be beneficial**. It is vital to ensure opportunities to adapt projects following data analysis—this has the potential to strengthen interventions even beyond the actions taken related to GBV.

[5] This section has been adapted from the Inter-Agency Standing Committee's Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (2015).

Further resources

General CARE resources to support GBV programming

- **GBV Hub** on CARE Shares *(internal to CARE Staff)*
- CARE's **GBV impact brief**
- CARE's **Gender Based Violence (GBV) & Covid-19 Guidance Note**
- CARE's **Gender-Based Violence in Emergencies Guidance Note**
- Resources on Protection from Sexual Harassment, Exploitation and Abuse, & Child Abuse (PSHEA-CA) from CARE's **Global Safeguarding Hub** on CARE Shares *(internal to CARE Staff)*
- **CARE's Role In Supporting Social Movements: A Feminist Perspective**
- **CIGN Position Paper and Guidance Note on Supporting Women's Social Movements and Collective Action**
- **CARE communications policies on GBV** *(internal to CARE Staff)*

See the accompanying resources for this guidance, available from care.org/gbv-guidance, for further information on key principles & approaches.

Resources to support GBV across the project cycle

- CARE's **Gender Marker**
- CARE's **Social Analysis and Action** (SAA) toolkit
- CARE's **Rapid Gender Analysis** (RGA) toolkit
- CARE's **Gender MEL Toolkit**
- CARE's **GBV First-Line Support Curriculum**
- CARE's **Indashyikirwa IPV prevention curriculum**
- CARE's **Guidance Note on Engaging Men & Boys for Gender Equality**
- Promising Practices for GBV Prevention on **genderinpractice.org**.
- UNFPA's **Essential Services Package for Women and Girls Subject to Violence**
- CARE's **Guidance for Creating and Managing Effective Community Feedback and Accountability Mechanisms**
- CARE's **PIIRS** dashboards on CARE Shares
- CARE's **Global MEAL Hub** on CARE Shares
- CARE's **Vision 2030 Core Global Indicators & Guidance**

See the specific steps within this document and the accompanying resources at care.org/gbv-guidance for further links.

Image captions & credits

Cover: Denise and Emmannuelle, participants in CARE's couples-focused GBV prevention program Indashyikirwa in Rwanda. *Credit: Peter Caton/CARE*

Page 4: The cover of a GBV prevention toolkit focused on addressing workplace sexual harassment as part of the STOP project in Cambodia. *Credit: GMB Films/CARE.*

Page 7: Participants at an inter-group dialogue session as part of the Tipping Point project in Bangladesh. *Credit: Tapash Paul/CARE.*

Page 14: A woman receiving GBV counseling as part of the Sahaja project in Bihar, India. *Credit: CARE India.*

Page 19: A participant in CARE Vanuatu's Young Women's Leadership Program, who works as a counsellor at the Vanuatu Women's Centre. *Credit: Valerie Fernandez/CARE.*

This guidance is a collaborative effort of CARE USA's Gender Justice Team, Chrysalis, and over 40 CARE gender and GBV experts from 30 countries.

This guidance supplements CARE's 2014 guidance, *Guidance for Gender Based Violence (GBV) Monitoring and Mitigation within Non-GBV Focused Sectoral Programming*. Its contents were adapted from a comprehensive literature review of seminal guidance from partners, including but not limited to the Inter-Agency Standing Committee's *GBV Guidelines* and the *Cash Voucher Assistance and GBV Compendium* (led and funded by CARE USA, prepared by CARE USA and the CVA and GBV Advisory Group to the IASC GBV Guidelines Reference Group); the World Health Organization's *GBV Guidelines*, *clinical handbook*, *training curriculum* and other tools; CARE's previous GBV risk mitigation guidance and relevant tools; and national protocols, policies and tools from low and middle-income countries.

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For further information contact Chrysalis and the CARE USA Gender Justice team.

This resource accompanies CARE's GBV Guidance for Development Programs.

GBV principles & approaches:

GBV research ethics

Staff who are not GBV specialists can cause harm by conducting GBV research or even handling personal data without the requisite training, and without key safety, privacy, and confidentiality measures in place to protect personal information. At all stages of the project cycle, programs should ensure any research on GBV remains focused on the principle of do no harm and applies a survivor-centered approach.

This resource outlines ethical principles specific to conducting research on GBV. It includes details of ethical approval requirements and a checklist for planning, implementing and using GBV research.

Ethical principles for GBV research

These principles have been adapted from the WHO core principles for ethical research on VAW.*

- The **safety and security** of research subjects and the research team is paramount and should guide all research decisions.
- When documenting GBV, the **potential benefits** to the respondents or targeted communities must be **greater than the risks** involved to them.
- **Information gathering and documentation** must be done in a manner that presents **the least risk to respondents**, is methodologically sound, and builds on current experiences and good practice.
- Strong justification/rationale must be provided if data that is to be collected is **similar to data already collected in the same geography in the recent past.**
- Before conducting research, the **local availability of care and support services for survivors** must be ascertained; if services are not available in the community or cannot be made available by the research team then research should not be undertaken.
- The **confidentiality** of individuals and the information they reveal must be protected at all times.
- **Informed consent** must be given by anyone participating in research on GBV.
- All members of the **data collection team** must be carefully selected and trained for this research, as well as receive on-going support through the research process.
- If children (anyone under 18) will be research subjects, special safeguards must be put into place.
  See the GBV Hub on CARE Shares for further information on key cosiderations for groups at risk of GBV, including **children and adolescents.**

World Health Organization: Ethical and safety recommendations for intervention research on violence against women (2016).

WHAT information should be collected?

While many projects may be able to rely on **secondary data** to support GBV analysis and other GBV research, the lack of data in particular contexts or the lack of reliability of what data is available may mean **primary data collection** is needed.

Projects should **avoid collecting data on individuals' experiences of GBV**, which should **only be done if programming seeks to directly reduce GBV** (i.e. contribute to a reduction of GBV, as measured through CARE Indicator 3: % of women and girls aged 15 years and older subjected to gender-based violence in the last 12 months by form of violence and age [SDG indicators 5.2.1 and 5.2.2]). **Non-GBV specialists should never ask about personal experiences of GBV.** Asking survivors of GBV about their experiences may cause additional harm or trauma. Step 1.2 in CARE's GBV Guidance for Development Programs includes suggestions for alternative approaches.

Research wishing to ask people about their direct experiences of GBV may need to obtain ethical clearance for the research from the appropriate Institutional Review Boards (IRBs).

Is it necessary for project teams to obtain approval from an ethical review board for certain GBV data collection?

GBV is a sensitive subject and survivors or populations at risk are often regarded as vulnerable groups. Therefore, projects that conduct data collection related to GBV must train data collectors and study teams on GBV research methods and ethics, and may have **to apply for ethical approval through an institutional review board (IRB)**.

Every country has its own rules around what data collection and research is considered sensitive and what requires ethical approval. Many countries, research partners, donors and organizations also have their own requirements (such as partnering with a local university or government ministry, or requiring review by an international review board that covers multiple jurisdictions). Local research partners can often help navigate the local context for IRB as appropriate. In cases where multiple CARE Member Partners work together on a study, one country's IRB may not require ethical review but another might, particularly for a global project or one that is highly sensitive.

See the table below on ethical approval requirements for further information.

WHO can conduct GBV research?

Staff who are not GBV specialists should **never ask about personal experiences of GBV**. Only those trained on GBV research methods and ethics should plan and undertake data collection on individuals' experiences of GBV.

Some forms of research to support gender and GBV analysis may be conducted by program staff who are not specialists. After reading the Ethical Principles section of CARE's GBV Guidance and the ethical principles for GBV research below, program and MEAL staff may include **general questions about GBV** but only if they are appropriate and will be utilized by the specific program. For example, focus group discussions with community members or key informant interviews with stakeholders may ask about general GBV knowledge, attitudes, or practices in that setting, but not about any individual's personal experience of GBV. Staff who are not GBV specialists may engage in participatory data collection methods such as safety audits, but this should be done under the guidance of a GBV specialist.

Data collectors involved with GBV research should receive training on ethics, privacy, confidentiality, informed consent and first-line support to respond to disclosures made by study participants. Researchers should also have access to ongoing support for dealing with the stress and trauma they may experience.

HOW should data be collected and stored?

Collection, storage, use and dissemination of GBV data should be **guided by the same ethical principles as all GBV programming**: safety, respect, non-discrimination, confidentiality, privacy, informed consent, intersectionality and centering local expertise. How best to practically apply these needs to be determined by taking into account available resources, expertise and contexts.

As a general practice, **any sensitive information collected—both soft and hard copy forms—must be stored securely**. For example, soft copies must be stored in password protected or locked locations and hard copies in locked safe boxes and stored within secure locations, with access available only to select authorized personnel. Storage of such information and data needs to also follow safety and ethical guidelines. In the event that such **safety precautions cannot be taken, sensitive data should not be collected**.

Each country team or project must clearly articulate how it will ensure compliance to ethical standards, and allocate staff and budget accordingly.

WHICH terms should be used?

Internationally accepted definitions of the types of GBV being analyzed should be used throughout all phases of GBV analysis, MEAL and researching. Internationally accepted definitions for different types of GBV may differ from those used at the national level, or even across institutions working in the same country context. Definitions and categories of GBV sanctioned in national laws and strategies may vary from internationally recognized forms of GBV or crimes. Therefore, it is important to select and clarify definitions from the very onset along with the rationale for selection to ensure clarity and consistency.

A **glossary of key GBV terms** is available from the GBV Hub on CARE Shares.

WHERE can I find further support within CARE?

CARE's Gender MEL Toolkit includes a section on Ethical Guidelines for Programming and Research. CARE's Safer Programming guidance supports teams to embed safeguarding into programs and ensure they do no harm.

CARE's Global Gender Cohort and Gender Justice Team include GBV specialists who may be able advise on specific GBV research.

CARE's Research and Inquiry Lead, Caitlin Shannon, can advise on research ethics and obtaining approval from an ethical review board.

Ethical approval requirements

Type of data collection	Requirements for ethical approval	Requirements for GBV training and expertise
Routine MEAL Activities *Examples:* • Gender analysis • Evaluation reports • Routine monitoring according to CARE global indicators and targets	Not required, so long as they do not ask individuals directly about their personal experiences of GBV or other sensitive information, and do not collect participants' identifying information.	• All MEAL team members and data collectors should be trained on gender and GBV concepts and relevant CARE indicators • MEAL activities and plans should be guided by GBV specialists
Data collection about **GBV or other sensitive information *in general***, within in a particular setting *Examples:* • Focus groups or key informant interviews that ask about trends and beliefs of a community in general • Anonymized quantitative survey about GBV experiences and attitudes that does not collect identifying information	Typically required to apply for ethical clearance: • If the IRB or institution's Human Research Protection Program decides the study does not collect information about individuals, (or pose a risk to participants) they may grant a waiver ("non-human subjects research determination") and the data collection may proceed. For example, routine data collection for CARE Indicator 2 on rejecting intimate partner violence would not require ethical clearance from an IRB. • If the study does pose a risk or collects individual information, the IRB will likely require the study team to develop a study protocol and apply for ethical review.	• All study team members should be trained on gender and GBV research methods and ethics. • Plans for data collection should be developed and implemented by GBV specialists, with the support of non-specialists.
Data collection that asks about ***individual experiences* of GBV or other sensitive topics**, or **includes sensitive populations as participants** *Examples:* • Focus group discussions or key informant interviews with women to discuss their individual experiences of IPV • A study that asks young girls to talk about GBV in general in a particular setting	• In most cases the IRB will require the study team to develop a study protocol and apply for ethical review. However, even in cases where IRB approval may be not strictly required, safe, ethical and appropriate practice is still required **from CARE**	• Only those trained in GBV research methods and ethics should plan and undertake data collection on individuals' experiences of GBV. • Research activities and plans should be developed and implemented by GBV specialists

GBV research checklist

Ethical Recommendations for planning, implementation, and use of GBV research and evaluations.

Ethical clearance and sound methodology

- ✓ Any formal study that requires the collection of data on GBV must receive ethical clearance through the Institutional Review Board (IRB) from that country and relevant institution.[1]
- ✓ GBV specialists (staff or consultants) must be involved in the design of research with appropriate tools and methods used, and interviewers/field teams trained on how to deploy them safely.

Ensuring safety and confidentiality

- ✓ Ensure respondents understand the purpose of the research, how their information will be used, and that their participation is voluntary.
- ✓ Ensure participants' informed consent is obtained, including on an on-going basis in longitudinal evaluation or research.
- ✓ Undertake formative research, stakeholder analysis and stakeholder consultation to inform the design of culturally appropriate tools.
- ✓ Make all efforts to conduct interviews in private settings where participants cannot be seen or heard.
- ✓ Ensure all data (digital and hard copies) are securely stored (i.e locked cabinets, password protected and encryption of all data).
- ✓ Never record names on questionnaires and use unique ID codes for each participant. Keep all personal identifying information confidential.
- ✓ Always seeks consent prior to audio recording a study participant, and delete after transcription.
- ✓ Take care that data is aggregated sufficiently so that no specific community or individual can be identified (e.g. do not name a specific village; instead specify the setting is a village within a particular district, state or province).
- ✓ Ensure that safe and appropriate methods are used for following up with participants in longitudinal studies (e.g. ask participants how they prefer to be contacted and if it is safe to leave an SMS or voicemail message).

Selection and training of researchers/fieldworkers

- ✓ Appropriate tools are used and interviews must be trained in deploying these safely.
- ✓ Ensure interviewers understand the importance of confidentiality and are trained accordingly.
- ✓ All researchers need to be carefully selected, receive specialized training and on-going support such as burnout-prevention workshops (to deal with secondary trauma or when past experiences of violence may be triggered).

[1] If the research is a program evaluation and does not ask about specific individuals' experiences of GBV, the IRB may decide the research is "non-human subjects research" and waive the requirement of a study protocol and lengthy approvals process. However, if the research asks sensitive questions or includes minors as participants, the project should budget and plan for protocol development and obtaining IRB approval.

Reducing possible distress caused to the participants by the research
✓ The study design must include actions aimed at reducing any possible distress or re-traumatization caused to the participants by the research (i.e. train interviewers to ask about violence in a supportive and non-judgmental manner). ✓ Train data collectors in first-line support to ensure that any participants who disclose GBV receive empathetic and appropriate counseling, safety planning and referrals.
Proper interpretation of findings and use to advance policy interventions
✓ Ensure results of research and M&E are fed back into policy, advocacy and intervention activities (where appropriate, include groups who have participated and stakeholder/advisory groups to validate and disseminate findings).

Further resources

- World Health Organization: Ethical and safety recommendations for intervention research on violence against women (2016).
- World Health Organization: Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies (2007).
- UNFPA: See Beyond Numbers – Improving the gathering of GBV data to inform humanitarian responses (2021).
- UN Women: RESPECT Framework Monitoring and Evaluation (M&E) Guidance (2020).
- World Health Organization & RTI International: Ethical and safety recommendations for intervention research on violence against women (2016).
- World Health Organization, PATH: Researching Violence Against Women: A Practical Guide for Researchers and Activists (2005).
- UN Women, World Health Organization: Violence against women and girls: Data Collection during COVID-19 (2020).
- K4D Helpdesk Report: Documentation of Survivors of Gender-Based Violence (2021).
- Inter-Agency Standing Committee: Tools and good practices for the monitoring and evaluation of GBV risk mitigation interventions in humanitarian settings.

This resource accompanies CARE's GBV Guidance for Development Programs and CARE's GBViE Guidance Note.

GBV principles & approaches

Roles and Responsibilities of GBV and Non-GBV Specialists

This resource outlines the specific roles and responsibilities of both GBV specialists and staff who are not GBV experts.

ALL staff who interact with affected populations have the responsibility to:

- Act intentionally to **mitigate the risks** of GBV
- Respond compassionately and appropriately to **disclosures of GBV**.

GBV risk mitigation actions can be performed by non-GBV specialist staff. **GBV prevention** interventions should be guided by GBV specialists and supported by all program staff. **GBV response** should be provided by GBV specialists.

A GBV specialist is a professional with specialized GBV knowledge and expertise. They have received GBV-specific professional and/or academic training, and/or have considerable experience working on GBV.

GBV specialists

GBV specialists with high quality, relevant training can do all the above. Their role may also include:

- Identifying specific needs of GBV survivors.
- Designing, implementing, monitoring and evaluating GBV prevention or response interventions.
- Ensuring interventions meet required standards through training and following standard operating protocols (SOPs).
- Assessing the quality of GBV referral services.
- Conducting GBV case management
- Conducting GBV training for staff or partners.
- Conducting MEAL activities and GBV data collection

Staff supporting GBV interventions in development programs should refer to CARE's GBV Guidance for Development Programs. Staff in humanitarian settings should refer to the IASC **GBV Guidelines**.

Some GBV interventions require specialist knowledge and skills. GBV specialists must have the following core competencies:

- Understand and applies a survivor-centred approach, including GBV Guiding Principles (Safety, Confidentiality, Respect, Non-discrimination).
- Demonstrate commitment to gender equality.
- Promote and integrate gender analysis and mainstreaming into humanitarian programming.
- Exhibit empathy and positive interpersonal skills, including cultural competence.

See Core Competencies for GBV Specialists for further details.

Staff without specialized training on GBV should NOT engage in GBV-specialized research, programming, post-GBV care, certain kinds of service delivery or MEAL. Engaging in these activities without specialized training and expertise can inadvertently increase the risk of harm to both the survivor and the staff member. For example, an abuser could target the survivor or staff member for additional violence if an intervention is conducted without privacy and confidentiality.

Non-GBV specialists[1]

GBV risk mitigation

All staff who are **not GBV specialists**, regardless of sector, must ensure that their programming is as safe and accessible as possible.

In consultation with women, girls, and populations at high risk of GBV (e.g., sex workers, LGBTQI+ populations, incarcerated people, et al), non-GBV specialists should **identify GBV risks** and **take action to integrate GBV risk mitigation strategies** to reduce the risks of GBV.

Their role includes:

- Ensuring services do not cause harm.
- Identifying GBV prevalence through secondary data analysis, types, risks in the environment, and barriers to accessing services through basic, secondary gender analysis (e.g., a desk or literature review).
- Identifying, mitigating and reducing relevant project and sector-specific GBV risks.
- Seeking out local Women's Rights Groups and activists who can bring a gender lens and contribute their perspectives of potentials for harm of GBV.
- Conducting basic referral service mapping to develop (or update if one exists) a list of referral services.

In particular, non-GBV specialists working on social or gender norms should understand the changes in norms or behaviors their project seeks. They must identify how those changes have the potential to increase GBV risks and plan to mitigate these risks.

Example: A women's economic empowerment project pushes against gender norms prohibiting women from having control over financial resources. As a result, tensions in the home may increase, which increases the risk of GBV. A non-GBV specialist has a responsibility to identify the potential risk and plan to mitigate this, such as through activities which re-envision gender norms in positive ways to support both the project's outcomes and GBV-related outcomes.

Non-GBV specialists implementing development programs should follow the steps in CARE's GBV Guidance for Development Programs to mitigate risks and ensure they understand how to ethically respond to a disclosure of GBV.

Non-GBV specialists implementing projects in acute emergencies should refer to CARE's GBViE Guidance Note and the GBViE Implementation Guide for Risk Mitigation.

[1] Adapted from Global Protection Cluster. IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action. GBV Risk Identification & Mitigation: the role of a non-GBV specialist in responding to a GBV disclosure. 2016

Responding to disclosures of GBV

If someone discloses their experience of GBV, staff should:

- Know how to safely support and listen to them without judgment.
- Provide accurate information on available GBV services and referral options.
- Know how to safely refer a survivor who chooses to seek support.
- Be aware that child survivors may have differing needs to adult survivors, and that referral pathways and reporting obligations can differ depending on age.
- Be aware of the reporting channels and reporting obligations for SHEA concerns, if the survivor discloses that their abuser is CARE staff or related personnel.

Staff in development settings should refer to CARE's summary of **DOs & DON'Ts when responding to a GBV disclosure** for further guidance and participate in GBV first-line response training. Staff in humanitarian settings should refer to the IASC **GBV pocket guide**.

This resource accompanies CARE's GBV Guidance for Development Programs.

GBV principles & approaches

DOs & DON'Ts

How to respond if someone tells you they have experienced gender-based violence

All staff should be able to respond to GBV disclosures in a safe and appropriate way. This means reacting immediately, appropriately, and empathetically when an individual reports that they have been subjected to GBV.

This resource is adapted from the GBV AoR's Standard Operating Procedures (SOP) template. It outlines key points for what staff should and should not do. It should be translated, shared with all staff and displayed where staff can access this. Staff should also receive GBV first-line support training.

DO:

- ☑ **Express appropriate acknowledgment of their disclosure**
  For example, say "I'm sorry that happened to you. You deserve to be safe."
- ☑ **Be aware of any mandatory reporting requirements in your country**
  For example, for child abuse.
- ☑ **Ask if they would like information**
  Make sure this is done discreetly and respectfully.
  If they say yes, give them information about appropriate referral services. If they say no, respect their decision.
- ☑ **Respect the person's privacy and confidentiality**
  Try to find a private place to talk where the person cannot be seen or heard. Reassure them that you will respect their privacy and confidentiality.[1]
- ☑ **Ask if they would like information**
  Make sure this is done discreetly and respectfully.
  If they say yes, give them information about appropriate referral services, using a referral directory or pathway.
- ☑ **Be clear that help is an option in the future**
  Make it clear to affected people that even if they decline help now, they can still access help in the future.
- ☑ **Respect people's right to make their own decisions**
- ☑ **Be aware of and set aside your own biases and prejudices**
- ☑ **Behave appropriately**
  By considering the person's culture, age, and gender.

DON'T:

- X **Exploit** your relationship as a helper
- X **Ask** the person for any money or favor for helping them
- X **Make false promises** or give false information
- X **Exaggerate** your skills
- X **Force help** on people and don't be intrusive or pushy
- X **Pressure** people to tell you their stories or ask probing questions
- X **Share the person's story** with others
- X **Judge** the people for their actions or feelings

This resource accompanies CARE's GBV Guidance for Development Programs.

GBV principles & approaches

Ethical principles for GBV programming

CARE has an ethical imperative to reduce risks of GBV and respond appropriately to disclosures of violence at every stage of the program cycle: design, implementation, and evaluation. In all cases, upholding CARE's programming principle of "do no harm" and maintaining a survivor-centered approach should take precedence.

This resource outlines best practice principles for GBV programming and provides examples across each of CARE's Impact Areas.

The principle of do no harm and following a survivor-centered approach should be at the heart of all GBV programming. All staff must ensure they understand the key principles below and practice these in their work. Projects will need to determine how best to practically apply the principles in relation to specific project activities and contexts.

Respect

All actions taken should be guided by respect for the choices, wishes, rights & dignity of the survivor.

Safety

The safety of participants and staff is the top priority.

Privacy

Individuals have a right to be free from intrusion or interruption, without being seen or heard.

Non-discrimination

All individuals should receive equal and fair treatment.

Informed consent

Individuals should receive & understand information about the activity prior to giving their consent to participate.

Center local expertise

Actions should be informed by the perspectives of local stakeholders and women's rights organizations.

Confidentiality

Information relating to individuals must be kept strictly private unless the individual gives consent for sharing

Intersectionality

All actions should take into account the unique & interconnected needs of diverse individuals.

Do No Harm

GBV is a human rights violation and can be a matter of life and death for many women, girls, and others. All programs should be aware of GBV-related risks associated with their programming, how programming can potentially increase risk, as well as how it can actively lower such risks. "Doing no harm" means considering both the potential risks associated with your programs as well as how the intervention might unintentionally increase the risk of, or exacerbate, conflict and violence.

Even if a program does not have an explicit focus on addressing GBV, people experiencing GBV may disclose their experiences to program staff during program activities and interactions. Project staff may also face threats to their personal safety (for "interfering" in sensitive family and/or community issues if they get involved) and/or emotional trauma through listening to survivors' stories. Additionally, project staff may be at risk of GBV themselves in their homes, in the office, or during site visits and travel. Considering GBV risk mitigation within GBV integration efforts can reduce these risks for program participants and staff.

For example, could the project:

- Reinforce power imbalances (e.g., within a couple, between a boss and employee, between a parent and child) that can lead to GBV perpetration?
- Increase the risk of GBV for project participants, staff, and service providers?
- Re-traumatize GBV survivors by forcing them to re-live painful memories?
- Falsely raise the survivor's hopes for justice or care, if services and systems cannot respond effectively?
- Jeopardize CARE's ability and standing in the community or country to successfully implement future projects?

To avoid harm, programs should never:

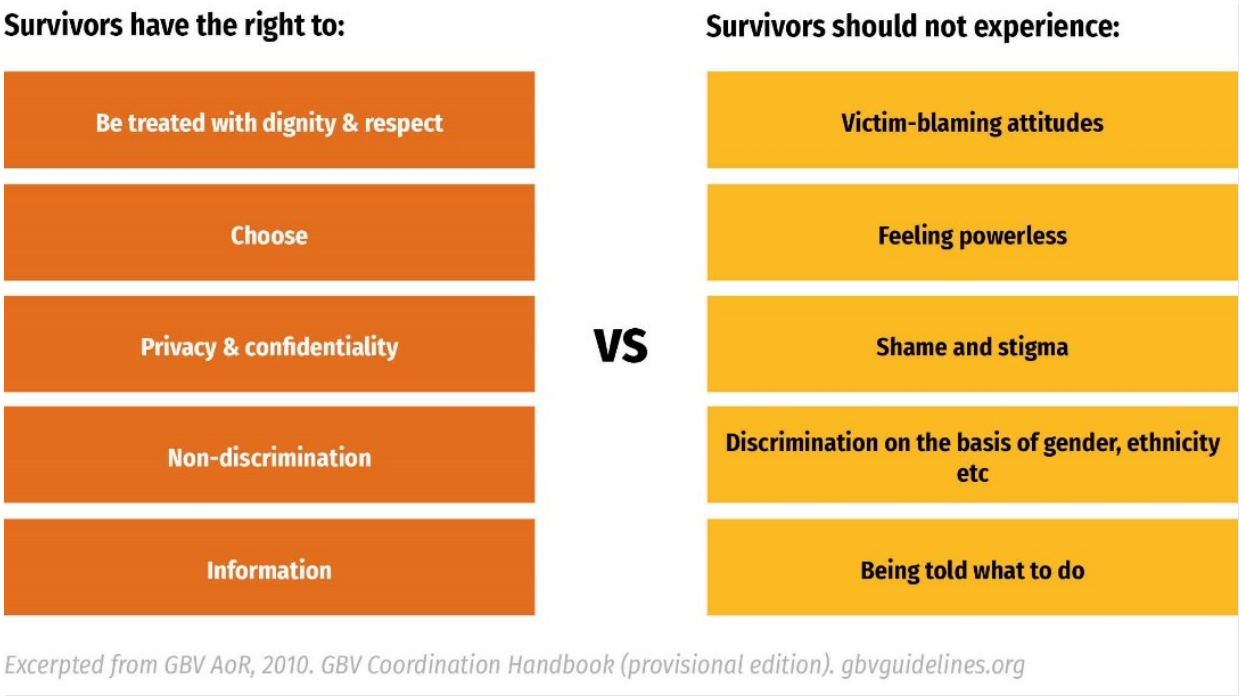
- Seek to implement any GBV programming without staff technical expertise (GBV training), dedicated GBV specialized staff or consultant time and funding.
- Ask individuals about their direct experience of violence.*
- Provide advice or counseling to a GBV survivor (only trained GBV service providers should do that).
- Reinforce gender inequitable stereotypes and beliefs since those reaffirm the perpetration of GBV.
- Ask women to challenge male intimate partners without clear, evidence-based, gender equality approaches, including approaches that engage men and boys in positive ways to promote behavior and norm change.
- Force a GBV survivor to reconcile with the perpetrator, report the incident, or seek services against their will, which violates a survivor-centered approach.

* The only exception is if this questioning is part of a formal study that has received ethical clearance through the Institutional Review Board (IRB), with data collection conducted by GBV specialists who have received proper training in GBV research ethics and methods for all data collectors and study team members.

Survivor-centered approach

A **survivor-centered approach** means that "all those who are engaged in violence against women programming prioritize the rights, needs, and wishes of the survivor."[1] It prioritizes the survivor's self-determination, choices, agency, autonomy, and rights over secondary considerations such as social norms or organizational reputation. It increases the survivor's ability to make informed decisions about own care, recovery, and justice. A survivor-centered approach means that the survivor's rights, needs, and wishes are prioritized when designing and developing GBV-related programming.

The survivor-centered approach can guide professionals—regardless of their role—in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which a GBV survivor's **rights** are respected, safety is ensured, and the survivor is treated with **dignity** and **respect**. The approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person's capacity to make decisions about possible interventions.[2]



Excerpted from GBV AoR, 2010. GBV Coordination Handbook (provisional edition). gbvguidelines.org

[1] UN Women. Survivor-Centered Approach. 2020
[2] Adapted from IASC Gender SWG and GBV AoR, 2010

Examples across CARE's Vision 2030 Impact Areas

Impact Area	Examples of How GBV Affects Impact Area	Examples of Do No Harm Approach in Impact Area
Gender Equality	GBV uses violence to enforce and sustain gender inequality. Gender equality cannot be achieved without addressing GBV.	Interventions that seek to reduce gender inequality and re-envision gender norms can generate backlash. All gender equality interventions should be closely monitored for any increase in GBV.
Right to Food, Water, and Sanitation	Access to food, water and sanitation can all be blocked by GBV. Intimate partner and household violence can include control over household resources, affecting the ability of women and girls to purchase food or menstrual hygiene supplies. Women and girls are the primary water gatherers, and they may be at risk of harassment or violence in the act of gathering water.	Programs that promote the right to food, water, and sanitation should pay attention to potential barriers related to GBV in their initial gender analysis and design process. Efforts to improve access may instead endanger intended beneficiaries. For example, women who have to travel poorly lit paths to latrines may risk sexual assault or endanger their health by avoiding using the toilet at night.
Women's Economic Justice	GBV can limit women's earning potential and their ability to control their own income. For example, child marriage and school-based violence can keep adolescent girls from completing their education. Male partners might threaten or harm female partners who earn money. Workplace sexual harassment can prevent women from advancing or staying in their jobs.	Economic justice programs that do not take into account social norms around women's economic participation may put women at further risk of GBV if these norms limit women's mobility or discourage women's income earning. All programs seeking women's economic justice should avoid harm by understanding and addressing local norms and identifying any GBV-related barriers to economic participation.
Right to Health	GBV in all its forms is a fundamental violation of the right to health, and gravely affects physical, mental, and emotional wellbeing. Some forms of GBV, such as reproductive coercion and disrespect and abuse in childbirth, directly interfere with women's right to access the health care they need. Health providers are often first responders to acts of GBV, and potential entry points into pathways of care.	Programs that increase access to reproductive health care in particular must plan carefully to ensure that women and girls do not suffer backlash from family members. Health providers that are not appropriately trained on GBV can inadvertently harm GBV survivors. For example, reproductive health providers who are not trained to recognize reproductive coercion may perpetrate it themselves, or may put women at risk by informing male partners about their partners' contraceptive use.
Climate Justice	The climate crisis is increasing competition for resources and generating insecurity, exacerbating gender inequality and GBV. Disasters can increase the severity of violence in an abusive relationship because women are separated from support networks that offer protection.	Programs should plan for increases in intimate partner violence, child marriage, and other types of GBV that are often used to reinforce privileges and control over resources following environmental degradation. Additionally, advancing women's leadership on climate issues should be accompanied with an analysis of how women may be targeted in distinct ways from their male counterparts.

Further resources

- Do No Harm framework in CARE's Gender MEL Toolkit
- Collaborative Development Action's (CDA) Do No Harm and Gender: A Guidance Note (2018)
- **CARE's Role In Supporting Social Movements: A Feminist Perspective**
- **CIGN Position Paper and Guidance Note on Supporting Women's Social Movements and Collective Action**
- COFEM's (Coalition of Feminists for Social Change) series of **tip sheets**

This resource is for **all staff** in **development** or **humanitarian** contexts.

GBV principles & approaches

Glossary of GBV terms

Cash and Voucher Assistance (CVA) refers to all programs where cash transfers or vouchers for goods or services are directly provided to individuals, households, or community recipients, not to governments or other state actors. This excludes remittances and microfinance interventions (although microfinance and money transfer institutions may be used for the actual delivery of cash).

Child is defined as any individual under the age of 18, irrespective of local country definitions of when a child reaches adulthood.

Child early and forced marriage (CEFM) is any marriage where at least one of the parties is under 18 years of age. Forced marriage is a marriage in which one and/or both parties have not personally expressed their full and free consent to the union.

Child Abuse and Exploitation involves one of more of the following:

- **Physical Abuse** can occur when a person purposefully injures or threatens to injure a child. This could take the form of slapping, hitting, punching, shaking, kicking, burning, shoving or grabbing. Physical abuse can be a single or repeated act. It doesn't always leave visible marks or injuries.
- **Emotional Abuse** is inappropriate verbal or symbolic acts toward a child or a pattern of failure over time to provide a child with adequate non-physical nurture and emotional availability. Such acts have a high probability of damaging a child's self-esteem or social competence.
- **Neglect** is the failure to provide a child with (when they are able to do so) the conditions that are culturally accepted as being essential for their physical or emotional development and wellbeing
- **Sexual Abuse** is the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions
- **Sexual Exploitation / Sexual Misconduct** is any form of sexual activity with a child. It is evidenced by an activity between a child and an adult or another child who are by age or development in a relationship of responsibility, trust, or power, the activity being intended to gratify or satisfy the needs of the other person. It may include, but is not limited to, contact or non-contact activities, the inducement or coercion of a child to engage in any sexual activity, the use of children in sex work or other sexual practices, or exposing a child to online sexual exploitation material, the use of children in the creation of indecent images, performances, or material, or taking sexually exploitative images of children.

Confidentiality means keeping all information relating to an individual private, including but not limited to personal identifying information and health concerns unless the individual gives consent for disclosure. People have the right to choose to whom they will or will not tell their story.[1] Even if it is meant to help the survivor, no one should share a survivor's experience without their explicit and informed consent. This includes anonymously sharing the story in communications materials.[2]

[1] Inter-Agency Standing Committee on Gender-Based Violence. How to support survivors of gender-based violence when a GBV actor is not available in your area. 2018

[2] The only two potential exceptions to this are in the case of mandatory reporting laws (e.g., for GBV against a child) or if the survivor's experience is completely anonymized and shared with a GBV specialist for the purpose of guiding the individual who has heard about a GBV incident in how to respond. The survivor should still be informed about why, when, and with whom, any information is shared. CARE programs should be aware of mandatory reporting procedures in the context where they work. Even in these cases, it is critical to only share the information that is absolutely required, and only share with the individual who needs to know. In all other cases, it should not be shared without informed consent.

Disrespect and abuse in childbirth entails physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and/or detention in facilities.[3]

Do No Harm means considering potential risks associated with your programs and how your intervention might unintentionally increase conflict and violence. Do No Harm means that no project, service, or assessment activity should cause intended or unintended harm at any point. Harm includes, but is not limited to, GBV.[4] Harmful effects are often unintended and can be avoided through analysis of the gender and power norms that exist in communities and putting in place GBV integration measures from the start of the project.

First-line support is the immediate, brief, empathetic counseling given to a survivor upon a GBV disclosure. The WHO defines "first-line support" using the acronym **"LIVES"**: **L**istening, **I**nquiring, **V**alidating, **E**nsuring safety, and **S**upport through referrals. It is often also referred to as "psychological first aid", but also includes safety planning and providing referrals.

Gender refers to the economic, political, and cultural attributes and opportunities associated with being male or female. It refers to a socially constructed set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations associated with being female and male, as well as power relations between and among women, men, boys, and girls. One's gender identity may or may not correlate with one's sex assigned at birth, may change over time, and may intersect with other factors such as race, class, age, and sexual orientation.

Gender Analysis is a systematic approach, usually using a range of social science research methodologies such as desk reviews or primary data collection, to examine problems, situations, projects, programs, and policies to identify the gender and GBV issues and impacts. Gender analysis of a development program involves identifying the gender issues for the larger context (eg., structural factors); specific sites; and the issues and differential impacts of program objectives, strategies, and methods of implementation. Gender analysis should be done at all stages of the development process; one must always ask how a particular activity, decision, or plan will affect men differently from women in areas such as access and value of labor, property access and ownership, access to information and services, and social status.

Gender-based violence (GBV) is any form of violence against an individual based on that person's biological sex, gender identity or expression, or perceived adherence to socially defined expectations of what it means to be a man or woman, boy or girl.[5] The most common forms of GBV are sexual assault, intimate partner violence against women, and child abuse, but GBV also includes physical and psychological abuse, threats, coercion, deprivation of liberty, and economic deprivation, whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic, and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV takes on many forms and can occur across childhood, adolescence, reproductive years, and old age. GBV includes but is not limited to:

- **Intimate partner violence (IPV):** Behavior by an intimate partner that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors. This definition covers violence by both current and former spouses and other intimate partners. Other terms used to refer to intimate partner violence include domestic violence, wife or spouse abuse, and battering. Dating violence is usually used to refer to intimate relationships among young people, which may be of varying duration and intensity, and do not involve cohabiting. In this tool, IPV is included under the umbrella term of GBV unless otherwise specified.
- **Rape** is defined in this tool as contact between the penis and the vulva or the penis and the anus involving penetration; contact between the mouth and penis, vulva or anus; or penetration of the anus or genitals of

[3] Bowser D, Hill K.: Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis, USAID-TRAction Project (2010).
[4] CARE. SAA Global Implementation Manual. 2020
[5] Adapted from the Interagency Gender Working Group's definition of GBV.

another person by a hand, finger, or other object, however slight. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape.

- **Sexual assault** can include rape but can also include non-penetrative unwanted sexual contact such as molestation, kissing, or fondling.
- **Sexual violence** is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

Gender equality approaches create opportunities for individuals to actively re-envision harmful **gender** norms, promote positions of social and political influence for women and girls in communities, and address power inequities between persons of different genders.

Informed assent is the expressed willingness to participate in an intervention or service after all aspects of the intervention are explained in a manner the participant can fully understand. For children who are too young to give informed consent (definition below), but old enough to understand and agree to participate in services, the child's "informed assent" is sought.

Informed consent requires giving participants the opportunity to make an informed decision about whether or not to participate in any intervention, service, data collection, or communications activities. Informed consent requires three elements: information, comprehension, and voluntary consent. All participants should be given information about the purpose of the engagement and how the information will be used.
Age of consent varies by country. Obtaining informed consent is necessary prior to releasing a GBV survivor's information to other parties, including the police. This is especially important in settings where there is a legal mandate to report an episode of violence to relevant authorities. It is crucial that survivors understand the options open to them and are given sufficient information to enable them to make informed decisions about their care. They also must be aware of and have the power to exercise their right to refuse to engage in an action and/or to not be coerced (e.g., being persuaded based on force or threats). **Children are generally considered unable to provide informed consent** because they do not have the ability and/or experience to anticipate the implications of an action, and they may not understand or be empowered to exercise their right to refuse. There are also instances where consent might not be possible due to cognitive impairments and/or physical, sensory, or developmental disabilities.

Intimate partner: A husband, wife, cohabiting partner, boyfriend, girlfriend, lover, ex-husband, ex-wife, ex-partner, ex-boyfriend, ex-girlfriend, or ex-lover.

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex+ (LGBTQI+) is an umbrella term that refers to individuals' sexual and gender preferences, expressions, and identities that may differ from the norm of heterosexuality.

Marginalized groups or key populations include but are not limited to: men who have sex with men, LGBTQI+ people, sex workers, persons who inject drugs, prisoners, et al. Some of these populations, such as transgender individuals, may be at higher risk of some forms of GBV.

Minor refers to an individual under the legal age of adulthood as per national protocols, typically under age 18. A minor may not be able to consent to receive services in some countries without the informed consent of a parent or guardian.

Privacy is being free from intrusion or interruption, without being able to be seen or heard.

PSHEA – CA is the acronym used at CARE to refer to the Protection from Sexual Harassment, Exploitation and Abuse, and Child Abuse.

Referral directories are lists of post-GBV services compiled through referral mapping.

Referral mapping is the process of identifying organizations and institutions which provide services to GBV survivors and collecting their information into a list or directory.

Referral pathways are flow charts or job-aids which visually depict the steps a GBV survivor should go through to access care.

Referral protocols are documents describing how staff must respond to a GBV disclosure; the roles and responsibilities of each referral partner; what is expected of them in terms of privacy, confidentiality, and respect for the survivor's wishes and dignity; and how data will be collected, managed and analyzed.

Referral services are supportive interventions for GBV survivors which include but are not limited to post-GBV health care, emergency shelter, legal aid, psychosocial or mental health counseling, economic opportunities, police, child protection, etc.

Reproductive coercion can include threats to coerce an individual to become pregnant against her will, destroying or removing contraceptive methods, preventing women from obtaining contraception, and other means of coercion. Research has linked these behaviors to unintended pregnancy, repeated abortion, and intimate partner violence (IPV).[6]

Safeguarding refers to the measures CARE takes to prevent, report, and respond to harm or abuse and to protect the health, well-being, and human rights of anyone who comes into contact with CARE, whether it is CARE Employees and Related Personnel, partners, program participants, and communities.

School-related gender-based violence refers to acts or threats of physical, sexual, or psychological violence or abuse that are based on gendered stereotypes or that target students on the basis of their sex, sexuality, or gender identities. SRGBV reinforces gender roles and perpetuates gender inequalities. It includes rape, unwanted sexual touching, unwanted sexual comments, corporal punishment, bullying, and other forms of non-sexual intimidation or abuse such as verbal harassment or exploitative labor in schools.[7]

Survivor refers to an individual who has experienced GBV. This term is preferred over "victim," which can be disempowering.

A **survivor-centered approach** means that "all those who are engaged in violence against women programming prioritize the rights, needs, and wishes of the survivor."[8] It prioritizes the survivor's self-determination, choices, agency, autonomy, and rights over secondary considerations such as social norms or organizational reputation. It increases the survivor's ability to make informed decisions about own care, recovery, and justice. A survivor-centered approach means that the survivor's rights, needs, and wishes are prioritized when designing and developing GBV-related programming.

The survivor-centered approach can guide professionals—regardless of their role—in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which a GBV survivor's **rights** are respected, safety is ensured, and the survivor is treated with **dignity** and **respect**. The approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person's capacity to make decisions about possible interventions.[9]

[6] Miller E, Silverman JG: Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. Expert review of obstetrics & gynecology. 2010;5(5):511-515.
[7] USAID: School-Related GBV Measurement Tool (2020).
[8] UN Women: Survivor-Centered Approach (2020).
[9] Adapted from IASC Gender SWG and GBV AoR, 2010.

This resource accompanies CARE's GBV Guidance for Development Programs and CARE's GBViE Guidance Note.

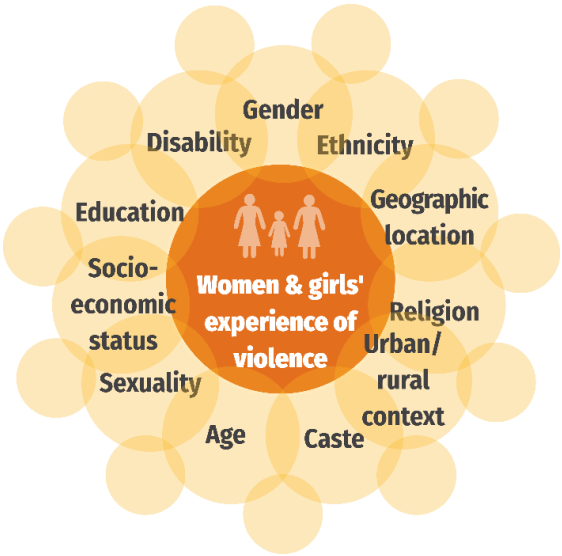
GBV principles & approaches

Intersectionality

CARE uses an intersectional approach to ensure that we serve the most vulnerable in each context in which we work. This particularly important for GBV interventions.

This resource outlines what CARE means by intersectionality and its relevance to GBV programming.

CARE seeks to see and understand diverse groups of women and girls based on their context. **Intersectionality** is an analytical framework for understanding how aspects of a person's social and political identities combine to create different modes of discrimination and privilege. Intersectionality identifies **multiple interconnected factors of advantage and disadvantage that influence power, privilege and oppression**. Examples of these factors include gender, caste, sex, race, ethnicity, socio-economic class, sexuality, religion, disability, weight, and physical appearance.



GBV programming should be designed based on understanding of the unique needs of these groups.

While CARE seeks greater gender equality for women and girls in all their diversity, our impact population in all our work is primarily those **people that most experience gender discrimination**: women and girls and marginalized groups
(including people of diverse sexual orientations and gender identities). GBV programming across any and all of the three pillars of risk mitigation, response and prevention must take into consideration the **intersection between many interrelated risk factors**. We also **work with men and boys as a target population**, to challenge gender discriminatory and patriarchal norms that have significant negative impacts for they themselves, as well as for others in society.

The design of GBV activities—whether through integrated or standalone programming, in development or emergency contexts—should seek to engage the most vulnerable community members in a non-stigmatizing way. The inclusion of elderly, people with disabilities, and youth and adolescents is a key element of the outreach strategy. Prevention activities target participants based on their role in preventing and responding to GBV and their potential to disseminate knowledge and best practices to the broader community. Advocacy and awareness raising initiatives target formal and informal leaders, community members and other stakeholders to sensitize them on risks associated with violence and its consequences. GBV response services are designed to meet the different needs of different groups of women and girls. See the GBV Hub on CARE Shares for further information on key cosiderations for groups at risk of GBV to ensure the needs of the most vulnerable are taken into account.

This resource accompanies CARE's GBV Guidance for Development Programs and CARE's GBViE Guidance Note.

GBV principles & approaches

Key Considerations for Groups at Risk of GBV

Those working to address gender-based violence should ensure that their approach is inclusive and intersectional.[1] This means they must take into account different people's needs. During project design and implementation, staff should keep in mind the diversity and intersectionality of the women, girls and other populations CARE works with and the different ways they might be at risk of, and experience, GBV.

This resource provides information on key considerations for different affected groups. It includes general considerations and those specific to children and adolescents. This resource has been adapted from the Interagency Standing Committee and GBV Protection Cluster's Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, *commonly known as the GBV Guidelines*.

Key considerations

Population	Examples of GBV	GBV Risk Factors
Adolescent girls	• Sexual assault • Sexual exploitation and abuse • Child, early and/or forced marriage • Female genital mutilation/ cutting (FGM/C) • IPV for married/ cohabitating adolescent girls • Physical and emotional abuse • Lack of access to education • Violence by caregivers	• Age, gender, and limited social status • Increased domestic responsibilities that keep girls isolated in the home • Limits on mobility outside the home • Lack of community support and protection • Lack of access to understandable information about health, rights, and services (including reproductive health) • Being discouraged or prevented from attending school • Early pregnancies and motherhood • Engagement in unsafe activities to make money • Loss of family members, especially immediate caretakers • Dependence on exploitative or unhealthy relationships for basic needs
Elderly women	• Sexual assault • Sexual exploitation and abuse • Physical and emotional abuse • Exploitation and abuse by caregivers • Denial of rights to housing and property	• Age, gender, and limited social status • Disabilities, limited mobility, and chronic diseases • Isolation and higher risk of poverty • Neglected health and nutritional needs • Lack of access to understandable information about rights and services • Vulnerability to economic exploitation

[1] Intersectionality means the layers of inequality that a person might experience. For example, a poor woman from an ethnic minority may experience different types of GBV and less access to services than a rich woman from an ethnic majority.

Population	Examples of GBV	GBV Risk Factors
Woman and child heads of households	• Sexual assault • Sexual exploitation and abuse • Physical and emotional abuse • Child and/or forced marriage (including wife inheritance) • Denial of rights to housing and property and inheritance	• Age, gender, and limited social status • Increased domestic responsibilities that keep them isolated in the home • Lack of community support and protection • Dependence on exploitative or unhealthy relationships for basic needs • Engagement in unsafe activities to make money
Girls and women who bear children of rape, and their children born of rape	• Sexual assault • Sexual exploitation and abuse • Intimate partner violence and other forms of domestic violence • Lack of access to education • Social exclusion • Physical and emotional abuse	• Age, gender • Social stigma and isolation • Exclusion from their homes, families, and communities • Poverty, lack of nutrition, and reproductive health problems • Lack of access to medical care • Lack of legal protection • Dependence on exploitative or unhealthy relationships for basic needs • Engagement in unsafe activities to make money
Indigenous women, girls, men and boys, and ethnic and religious minorities	• Social discrimination, exclusion, and oppression • Intimate partner violence • Lack of access to education • Lack of access to services • Theft of land • Physical and emotional abuse	• Social stigma and isolation • Poverty, malnutrition, and reproductive health problems • Lack of legal protection • Lack of opportunities based on their national, religious, or cultural group or their language • Barriers to participating in their communities and earning money
Lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons	• Social exclusion • Sexual assault • Sexual exploitation and abuse • Homophobic violence and abuse • Domestic violence (example: violence against LGBTI children by their parents or violence by a same-sex partner) • Denial of services • Sexual harassment • Rape used as a punishment for sexual orientation • Physical and emotional abuse	• Discrimination • Lack of legal protection • Limited social status • Transgender persons not legally or socially recognized • Same-sex relationships not legally or socially recognized • Exclusion from housing, job opportunities, and access to health care and other services • Exclusion of transgender persons from shelters, bathrooms, and health facilities • Social isolation/rejection from family or community, which can result in homelessness • Engagement in unsafe activities to make money
Separated or unaccompanied girls, boys, and orphans, including	• Sexual assault • Sexual exploitation and abuse • Child and/or forced marriage • Forced labor • Lack of access to education	• Age, gender, and limited social status • Neglected health and nutritional needs • Engagement in unsafe activities to make money • Dependence on exploitative or unhealthy relationships for basic needs

Population	Examples of GBV	GBV Risk Factors
children associated with armed forces/groups	• Domestic violence • Physical and emotional abuse	• Early pregnancy and motherhood • Social stigma, isolation, and rejection by communities because of association with armed forces/groups • Active engagement in combat operations • Primary caretaker is another child
Women and men involved in forced prostitution, and child victims of sexual exploitation	• Sexual assault • Physical and emotional abuse • Sexual exploitation and abuse • Lack of access to education • Other forms of trafficking	• Dependence on exploitative or unhealthy relationships for basic needs • Lack of access to reproductive health information and services • Early pregnancies and motherhood • Isolation and a lack of social support • Social stigma, isolation, and rejection by communities • Harassment and abuse from law enforcement • Lack of legal protection
Women, girls, men, and boys in detention	• Sexual assault as punishment or torture • Physical and emotional abuse • Lack of access to education • Lack of access to physical health and mental health resources	• Lack of sanitation • Overpopulated detention facilities • Men, women, unaccompanied children are not separated • Obstacles to reporting incidents of violence (especially sexual violence) • Fear of speaking out against authorities • Trauma from violence and abuse suffered before detention
Women, girls, men, and boys living with HIV	• Sexual harassment and abuse • Social discrimination and exclusion • Verbal abuse • Lack of access to education • Loss of job or ability to make money • Prevented from seeing their children • Physical and emotional abuse	• Social stigma, isolation, and higher risk of poverty • Loss of land, property, and belongings • Stress and/or depression • Lack of contact with family • Poor physical and emotional health • Harmful use of alcohol and/or drugs
Women, girls, men, and boys with disabilities	• Social discrimination and exclusion • Sexual assault • Sexual exploitation and abuse • Intimate partner violence and other forms of domestic violence • Lack of access to education • Denial of access to housing, property, and livestock • Physical and emotional abuse	• Limited mobility, hearing and vision • Isolation and a lack of social support • Communication barriers • Lack of access to latrines and sanitation services • Barriers to reporting violence • Barriers to participating in their communities and earning money • Lack of access to medical care • Lack of legal protection • Lack of access to reproductive health information and services

Population	Examples of GBV	GBV Risk Factors
Women, girls, men, and boys who are survivors of violence	• Social discrimination and exclusion • Secondary violence (example: abuse by those they report to) • Greater vulnerability to future violence • Physical and emotional abuse	• Disabilities and chronic diseases • Lack of access to medical care • Lack of contact with family • Isolation and higher risk of poverty

Additional considerations for children and adolescents

Key considerations for children and adolescents, including adolescent girls and children or adolescents who identify as LGBTQI+, must be accounted for in GBV integration. As non-specialists:[2]

1. Ensure that the referral pathway specifically notes whether a service provider is equipped with child- or adolescent-friendly services.
2. Do not seek out or investigate cases of child abuse, but also do not ignore reports and allegations.
3. If there is an allegation or report relating to children or adolescent GBV, then go through the appropriate channels to support the survivor, maintain confidentiality, and do no harm.
4. Ensure the safety of the child through providing the child or trusted guardian information on referrals to relevant, child-friendly stakeholders (Ministry or government body responsible for children's welfare, police when appropriate, child protection services, shelter, etc.)
5. Involve the child in decisions in an age-appropriate way
6. Do not force disclosure to parents or caregivers
7. Cash transfers directly to children and adolescents may be limited or not advised in the context. Additional risk mitigation must be considered if CVA is to be given directly to children or adolescents.[3]

Keep in mind that the parent or legal guardian may be the perpetrator of GBV against the child. Such situations are complex. CARE staff should put the principle of the child's best interest above all else and seek the counsel of Child Protection and GBV specialists when addressing disclosures involving children.

Mandatory reporting

In some instances and countries, there are laws that mandate the reporting of specific types of GBV (i.e. for GBV against children and adolescents) or specific acts (such as trauma via a gun or knife). Every effort should be made to comply with laws in a way that upholds a survivor-centered approach. This means that you only disclose to the individual required by law and that you give the survivor the option to self-disclose and/or seek alternatives, such as reporting it after they are removed from the immediate risk of harm by the perpetrator. Another key consideration for applying a survivor-centered approach to mandatory reporting is to ensure that all staff understand what is required by the law and to socialize that in the communities where we work.

"Forced to Report", a study from the British Red Cross and ICRC, showed that mandated reporting for healthcare workers was sometimes a deterrent from survivors seeking care and that sometimes healthcare workers thought that the law required them to report, but it did not.[4]

[2] Adapted from the GBV Pocket Guide.
[3] Consult the Cash Working Group or Global Protection Cluster for guidance: GPC Task Team on Cash for Protection.
[4] British Red Cross. Forced to report- the humanitarian impact of mandatory reporting on access to health care. 2020

CARE's global Safeguarding Policy on Protection from Sexual Exploitation and Abuse, and Child Abuse (PSEAH-CA) covers GBV perpetrated by those working in, or with, development or humanitarian organizations. In accordance with this policy, all CARE staff, partners, and related personnel are mandated to report PSEAH-CA concerns through the appropriate reporting mechanisms. Further information can be found on the Global Safeguarding Hub on CARE Shares.

Knowing limits

At all times, it is important to be clear about your role and what you can offer survivors. Becoming overly involved or taking on the role of counselor or case manager without the proper training can be harmful to survivors. Therefore, when survivors of GBV ask CARE staff for support, those staff should be trained and prepared to provide basic support, make referrals and maintain confidentiality. However, staff who are not GBV specialists should not take on roles outside of this nor be directed to by their supervisors.

Harmful laws

Legal provisions, such as those that criminalize people who identify as LGBTQI+ or stipulate the perpetrator of rape can be absolved by marrying the survivor, can complicate ethical and survivor-centered programming. In cases that may relate to these laws, maintaining confidentiality and making referrals with knowledge of the types of services available is highly important. In no case should staff encourage survivors to do anything they do not want to do. If a survivor discloses their sexual orientation, this must be kept confidential, and each survivor should be treated with respect and care- even if the social norms or religious beliefs held by staff are not the same as the survivor.

Further resources

- CARE's Gender MEL Toolkit
- CARE's Impact area scenarios for GBV integration

This resource for **all staff** implementing **development** programs. It accompanies CARE's **GBV Guidance for Development Programs**.

GBV integration resource:

Impact Area scenario: **Women's Economic Justice**

Scenario

A Cameroonian organization called Horizons Femmes is partnering with CARE to improve women's economic opportunities through multi-purpose cash assistance. Both organizations have conducted a Rapid Gender Analysis (RGA) through telephone interviews with local women about their needs and circumstances during COVID-19. Research staff have heard many stories of extreme economic hardship faced by internally displaced women and sex workers in urban areas because of lockdowns and social distancing measures. They have continued discussions with project participants after the RGA to identify any potential risks they thought might arise from receiving cash transfers, and what could be done to reduce those risks. CARE and Horizon Femmes adapted IRC's Safer Cash toolkit for this risk assessment, and consulted sub-groups of participants (e.g. young girls, Internally Displaced People (IDPs), married women, single women, sex workers (host population), and sex workers (IDPs)). They identified three main risks: 1) extortion of funds and phone theft by young boys and managers of hotels; 2) pressure by owners and landlords of rental houses and increases in rent; and 3) social tensions between host and IDP populations. The team realized that providing cash transfers to women might unintentionally increase their risk of violence from their intimate partners, community members, and in the case of sex workers, their pimps, madams, and clients.

Suggestions for integrating GBV into this program:

Design

- Use the CVA and GBV Compendium's GBV and CVA risk matrix to complete this gender and GBV analysis.

Implementation

- Set up a dedicated hotline for feedback and complaints and for survivors of GBV to access referrals to other local GBV services
- Provide community members with information about GBV referral services and how to access them.

Evaluation

- Conduct a project review to see if the program was successful in reducing the risk of GBV associated with CVAs
- Compile the adapted tools in a Standard Operating Procedures and Post Distribution Monitoring to standardize the practice in future projects.

This resource for **all staff** implementing **development** programs. It accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Impact Area scenario: **Women's Voice & Leadership**

Scenario

CARE is implementing a project in Sri Lanka to empower more women garment workers to influence policies and decisions that affect their lives and have equitable access to opportunities and services. The project is supporting women's social clubs and associations to build confidence and awareness of their rights and relevant laws and enable women to mobilize collectively, build alliances with other community-based organizations, and put forward their concerns to the Labor Ministry through quarterly dialogues with local duty bearers (including police officers, legal aid providers, and lawyers). During consultations with the women, it is reported that the women have to work long hours and, although it is not legal, pregnancy and maternity leave are acceptable grounds for termination. To keep their jobs, sexual exploitation, abuse, and harassment in the workplace have been normalized. Women leaders who raise complaints or speak out on behalf of others are penalized by their employers, such as being overlooked for promotions and threatened with termination. When complaints are raised, local authorities (police, and legal service providers at national and local levels) demonstrate a lack of willingness to pursue and prosecute cases that are reported.

Suggestions for integrating GBV into this program:

Design

- Develop a referral pathway for GBV services that is shared through the women's social clubs and associations.

Implementation

- Train garment factory managers and local authorities on the law and policies including those that address maternity leave and GBV.
- Create avenues to share information on GBV and the law with all garment workers as not all are part of the clubs and association.

Evaluation

- Assess whether local authorities demonstrate improved positive attitudes, and behavior towards survivors when they report.

This resource for **all staff** implementing **development** programs. It accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Impact Area scenario: **Climate Justice**

Scenario

CARE is implementing a conservation project where there is increased human-animal conflict due to the nearby village cutting down trees in the forest for firewood. During consultations with the stakeholders, forest rangers report that a majority of offenders are women and they cannot fully curb the practice because they know the women need firewood to use as fuel to cook for their family. The national disaster management authority reports that there has rainfall has also been unpredictable due to deforestation. Consultations with women reveal that they have to walk over five kilometers every day to collect firewood. To save on daylight to do chores, they and their oldest female children wake up before dawn to collect firewood and return in time to begin preparing for the day. The women also tell CARE that the route to fetch firewood is known and there have been increased reports of gender-based violence perpetrated by both community members and park rangers. They also report that they are unable to fully participate in safe spaces as they also need to fetch firewood to prepare refreshments for participants.

Suggestions for integrating GBV into this program:

Design

- Consult the women and girls about what they desire to use as fuel-efficient means e.g. community solar kitchens, animal waste, etc.

Implementation

- Create a safe space with a fuel-efficient community kitchen, e.g. a solar community kitchen where women do not have the extra burden to fetch firewood.
- Sensitize the forest service on the reports on gender-based violence in the area and work with them to set up a dedicated hotline for feedback and complaints.

Evaluation

- Conduct a follow-up safety audit to evaluate the women's and girls' perception of safety.

This resource for **all staff** implementing **development** programs. It accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Impact Area scenario: **Education**

Scenario

CARE is implementing an education program in an Egyptian community that trains community facilitators to use its Community Score Card process, which brings together parents, teachers, students and other stakeholders to identify and co-create solutions to school-related issues. Several teachers in this community have shared with CARE staff that some boys are taunted for "acting gay" and that there have been reports of violence against them. They have noted that same-sex relationships are criminalized in Egypt's national Debauchery Law, so boys may feel uncomfortable reporting incidents of violence themselves.

Suggestions for integrating GBV into this program:

Design

- Work with school administrators and teachers to establish confidential mechanisms and referral pathways for students and teachers to report violence in school.

Implementation

- Train teachers to identify and mitigate GBV risks to students, as well as how to support a student who might be experiencing GBV.

This resource for **all staff** implementing **development** programs. It accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Impact Area scenario: **Right to Food, Water & Nutrition**

Scenario A

CARE is implementing a local community program for Rwandan women on seed distribution, farming techniques, and financial literacy education. For most of the households in this community, men historically worked the land while women sold produce from family farms at the town market, enabling them to feed their children and earn additional income. In some households, environmental and socioeconomic shocks led men to stop farming. As a result, some households faced increasing financial burdens and food insecurity. Women were expected to continue providing household labor and childcare but faced increasing threats of violence from their husbands, especially if they brought home more money than their husbands. Most participants were excited to gain skills to re-start the family farm through this CARE program and believed that it would help produce food to improve the nutritional needs and healthy diet of their families.

Suggestions for integrating GBV into this program:

Design

- Integrate a gender analysis into project design to assess attitudes around GBV and women's wage earning
- Engage local leaders, including prominent male leaders, or create spaces for consultations with men when setting up the program in order to explain the project and calm any fears or concerns men may have about women's participation.
- Collaborate with GBV specialists to integrate light-touch intervention components, such as couples' communication sessions and financial literacy classes, to proactively address anticipated changes in gender roles at the household level.

Implementation

- Create opportunities for participants to provide feedback on program implementation and confidential reporting mechanisms for program participants.

Scenario B

El Niño, a climate-change related warming of the Pacific Ocean in 2014-2016, caused a sharp increase in cyclones, flooding, droughts, and crop failures In Vanuatu, making it difficult for many Vanuatuan women to access safe drinking water, latrines, and places to wash safely. CARE interviewed women in a community as part of a WASH program evaluation; many women shared that ever since El Niño, they felt even more tired, overburdened, and unsafe. Women reported that men were able to wash and bathe in public, even during drought, without having to find cover, but women were unable to do this; it was perceived as unsafe and inappropriate for women to bathe in public. They had to walk 1 hour and 30 minutes to a creek to quickly wash themselves and then carry the water the two hours back home. The path to the creek seemed dangerous and some women were harassed or sexually assaulted by men along the path. *This scenario is based on A Case Study: Gender in WASH in Slow Onset Emergencies in Vanuatu.*

Suggestions for integrating GBV into this program:

Design

- Solicit feedback from local women and women's groups about the placement, availability, and accessibility of WASH services.
- Assess routes used by women to access new and proposed WASH services for safety risks.
- Consider integrating program elements that mitigate safety risks, like adding locks to latrines, having separate latrines for men and women, planning social & behavior change activities, and adding WASH services that are closer to participants' homes.

Implementation

- Assess information on changes in GBV risks to participants, barriers to accessing WASH services, and community feedback.
- Incorporate ongoing feedback from local women's groups, activists, and community organizations to course correct.

Scenario C

CARE has taken over a monthly food distribution program in a Honduran community. Program staff had conducted a gender analysis in the community to ask about barriers and challenges and learned that the food distribution sites were associated with sexual exploitation and abuse in the past, with local community members thinking that they needed to exchange sex for food. In particular, the gender analysis learned from transgender and women interviewees that they felt too scared to pick up food from older program sites, as many women were coerced into exchanging sexual favors for food by male staff and volunteers. In the past, transgender community members had been accused of being sex workers because of their gender identity.

Suggestions for integrating GBV into this program:

Implementation

- Inform the community about updates to the food distribution system and how they could provide oral or written feedback or complaints should they need to.
- Provide community members with information on how they can report any concerns about sexual exploitation and abuse or staff inappropriate behavior.

Evaluation

- Follow-up with women and transgender community members to assess their perception of safety while visiting food distribution sites.

For additional information see the CHS PSEAH Implementation Quick Reference Handbook and Empowered Aid Toolkit for Planning and Monitoring Safer Aid Distributions Toolkit.

This resource for **all staff** implementing **development** programs. It accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Impact Area scenario: **Right to Health**

Scenario

A CARE Women and Girls' Safe Space program implements after-school sessions where women and girls in a rural Indian community learn basic sewing skills, have a place to talk about their lives, and receive women's health education. The counselor at the Women and Girls' Safe Space has explained various contraceptive methods and how they worked and mentioned that the on-site midwife could provide family planning counseling and contraceptive services. Some girls are forced by their families to drop out of school and marry older men, and many women and girls' husbands are physically violent towards them and police their movements. Several women and girls who attend CARE's sessions have often expressed that they do not want to bring up children in abusive homes.

Suggestions for integrating GBV into this program:

Design

- Plan for GBV referral mapping in collaboration with GBV specialists so that participants have access to first-line support including survivor-centered counseling and safety planning.

Implementation

- Provide training to the midwife on offering effective GBV first-line support.
- Work with GBV specialists, the midwife, and other health professionals to prepare a response plan for patients who may be experiencing GBV.
- Build the midwife's capacity to provide customized, private, and confidential counseling sessions on contraceptive options, including methods such as injectables and IUDs.

This resource for **all staff** implementing **development** programs. It accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Sample indicators for GBV integration

All projects should incorporate appropriate indicators to monitor and understand how the project is affecting risk and how project outcomes are affected by addressing GBV.

This resource includes potential indicators from CARE's global indicators and additional potential indicators adapted from the Interagency Standing Committee Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, *commonly known as the* ***GBV Guidelines***.

CARE's global indicators

In an effort to measure CARE's collective progress in relation to its commitments and to explain how it will contribute to lasting change, a common set of guiding indicators have been developed. These are applicable to all CARE projects and initiatives worldwide. These should be reported through CARE's monitoring and evaluation system, Program Information and Impact Reporting System (PIIRS), enabling the collection and consolidation of coherent and comparable outcome and impact data.

CARE's global indicators include the following indicators which are *directly* focused on GBV:

Indicator #2	**% of women and girls in all their diversity who reject intimate partner violence** View guidance for Indicator #2
Indicator #3	**% of women and girls aged 15 years and older subjected to gender-based violence in the last 12 months by form of violence and age** View guidance for Indicator #3
Indicator #4	**and % women and girls who access GBV response services** View guidance for Indicator #4
Indicator #13	**% of people supported through/by CARE who report on the Gender-Equitable Men (GEM) scale a score of at least 24** (only for programs that are specifically seeking to shift gender attitudes and behaviors) View guidance for Indicator #13
Indicator #16	**and description of positive shifts in informal structures (social norms, culture, beliefs, etc.) as defined and influenced by movements and/or activists supported by CARE** View guidance for Indicator #16
Indicator #20	**# people who obtained access to life saving GBV prevention and response services supported by CARE and partners pursuant to relevant standards assistance** View guidance for Indicator #20

CARE's global indicators include the following indicators *indirectly* focused on GBV, which could, if appropriate be used by a GBV program:

Indicator #1	**% of women and girls who report confidence in their own negotiation and communication skills** View guidance for Indicator #1
Indicator #14	**# and % of women and girls who have actively participated in formal (government-led) and informal (civil society-led, private sector-led) decision-making spaces** View guidance for Indicator #14
Indicator #17	**# of new, amended, or better implemented policies, legislation, multilateral agreements, programs, and/or budgets influenced by the voices of—or actions taken by— women and girls** View guidance for Indicator #14

In line with the Sustainable Development Goals, CARE adopts the overarching principle that "all indicators should be disaggregated, where relevant, by income, sex, age, race, ethnicity, migratory status, disability, and geographic location, or other characteristics." However, it is worth noting that that PIIRS only collects disaggregates data by sex and not by age. Projects should strive to collect age-disaggregated data where possible.

Additional indicators for GBV integration

Beyond PIIRS, the following matrix—adapted from the GBV Guidelines—includes additional indicators for GBV integration. Depending on the project's budget, MEAL and GBV capacity, and resources, they may be suitable for non-GBV specialists and GBV-specialists alike. They can be adapted for specific sectors, for example the first indicator below could replace "project activities" with "learning environments" for education projects.

GBV Indicators across all Sectors

Indicator	Indicator Definition	Possible Data Sources	Target	Stage of Program
Consultations with the affected population on GBV risk factors in project activities *Disaggregate consultations by sex and age*	**Quantitative:** # of project activities conducting consultations with the affected population to discuss GBV risk factors in accessing the service **Qualitative:** What types of GBV-related risk factors affect persons experience in accessing project activities, spaces, and/or services?	Organizational records, focus group discussion (FGD), key informant interview (KII)	100%	Baseline and Endline (output)
Training of project staff on GBV risk mitigation and management	# of project staff who participated in a training on the IASC GBV Guidelines or other GBV integration-specific training # of project staff who receive CARE GED trainings especially modules 3-5.	Training attendance, meeting minutes, survey (at agency or sector level)	100% 60%	Baseline and Outcome

Indicator	Indicator Definition	Possible Data Sources	Target	Stage of Program
	% of staff who score 60% or above on the GBV Knowledge, Attitudes and Practices test	Test score		
Staff knowledge of referral pathway for GBV survivors 	# of staff who, in response to a prompted question, correctly say the referral pathway for GBV survivors	Survey	100%	Baseline and Endline (Outcome)
Staff knowledge of referral pathway for GBV survivors	# and % of staff trained on responding to a GBV disclosure and providing appropriate referrals	Survey	100%	Baseline and Endline (Outcome)
Risk factors of GBV in programs (e.g., commodity- or cash-based interventions; distribution sites and service delivery points, etc.)	**Quantitative:** # of affected persons who report concerns about experiencing GBV when asked about participating in programs **Qualitative:** What types of safety concerns does the affected population describe in these programs?	Survey, FGD, KII, participatory community mapping	0%	Baseline and Endline (Outcome)
Staff knowledge of standards for confidential sharing of GBV reports	# of staff who, in response to a prompted question, correctly say that information shared on GBV reports should not reveal the identity of survivors	Survey (at agency or program level)	100%	
Inclusion of GBV integration strategies in policies, guidelines or standards	# of policies, guidelines or standards that include GBV risk mitigation and integration strategies	Desk review (at agency, sector, national or global level)	Deter mine in the field	Baseline and Output
Inclusion of GBV referral information in community outreach activities	# of community outreach activities programs that include information on where to report risk and access care for GBV survivors	Desk review, KII, survey (at agency or sector level)	Deter mine in the field	Baseline and Output
Coordination of GBV risk-reduction activities with other sectors	# of sectors consulted with to address GBV risk-reduction activities	KII, meeting minutes (at agency or sector level)	Deter mine in the field	Baseline and Endline (Outcome)

Sector-Specific Indicators

EDUCATION

Indicator	Indicator Definition	Possible Data Sources	Target	Stage of Program
Risk factors of GBV for females to attend learning environments	Quantitative: # of females who report concerns about experiencing GBV when asked about attending learning environments Qualitative: What types of safety concerns do females describe in attending learning environments?	Survey, FGD	0%	Baseline and Outcome
Active-duty education staff who have signed a code of conduct	# of active-duty education staff who have signed a code of conduct	Organizational records	100%	Baseline and Outcome

HEALTH

Indicator	Indicator Definition	Possible Data Sources	Target	Stage of Program
Existence of a standard referral pathway for GBV survivors	# of health sites with a standard referral pathway for GBV survivors	KII Document review	100%	Baseline and Output
Existence of a GBV standard operating procedure (SOP)* 	# of health sites with a standard operating procedure for GBV survivors	KII Document review	100%	Baseline and Output

*For guidance on developing an SOP, see WHO. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers. 2017.

WASH

Indicator	Indicator Definition	Possible Data Sources	Target	Stage of Program
Female participation prior to WASH facility siting and design	Quantitative: # of affected persons consulted prior to WASH facility siting and design who are female	Organizational records, FGD, KII	Determine in the field	Output

Conflict sensitivity indicators

Conflict sensitivity indicators enable a project to monitor and measure the interaction between it and the location/context in which it is implemented.

Context indicators provide information and measure change in the broader context at the level (e.g. national and subnational) relevant to the project. These dynamics may not directly impact the project or vice versa but they have the potential to indirectly influence the immediate environment in which the project operates.

Interaction indicators provide information and measure change in the two-way interaction between the project and its immediate target area. These interactions may either positively or negatively affect individuals, communities, organizations, institutions or the environment (and vice versa) a project is implemented in. Not only is such interaction a two-way process, it is also dynamic and fluid as the context or situation changes. Depending on the type of interaction (positive or negative) appropriate action needs to be taken, such as adapting program activities or revising risk mitigation strategies.

The above indicators will be determined following a conflict sensitive/do no harm analysis. Further information on conflict sensitivity analysis can be found in the How To Guide to Conflict Sensitivity from the Conflict Sensitivity Consortium and this Thematic Study Report on Conflict Sensitivity from UNDP Myanmar and International Alert.

Further resources to support GBV MEAL

- CARE's PIIRS dashboards on CARE Shares
- CARE's Global MEAL Hub on CARE Shares
- CARE's Gender MEL Toolkit
- CARE's GBV resource on research ethics
- USAID: Toolkit for Monitoring and Evaluating Gender-based Violence Interventions along the Humanitarian – Development Continuum (2014).
- World Health Organization: Ethical and safety recommendations for intervention research on violence against women (2016).
- MEASURE Evaluation: Compendium of Violence Against Women Indicators (2008).
- UNFPA: Beyond Numbers - Improving the gathering of GBV data to inform humanitarian responses (2021).
- Sustainable Development Goals – Targets and Indicators
- Conflict Sensitivity Consortium: How To Guide to Conflict Sensitivity (2017).

This resource for **all staff** implementing **development** programs. It accompanies CARE's **GBV Guidance for Development Programs**.

GBV integration resource:

Staff training to support GBV integration & programming

It is vital all program staff receive the relevant level of training to enable them to respond appropriately and mitigate the risks of GBV within programs.

This resource outlines relevant CARE policies and training. For up-to-date details of training available, visit the training page of the GBV Hub on CARE Shares.

Training on gender and power

CARE and partner staff at all levels should undergo training which strengthens their ability to critically reflect on gender and power, understand the dimensions of GBV and its consequences, and facilitate community-level action. This might include CARE's Reflections on Equity, Diversity and Inclusion (REDI) curriculum and/or Social Analysis and Action (SAA).

- **REDI training** is available through CARE's Global Gender Cohort. Contact gendercohort@care.org for more information.
- **SAA sessions** can be facilitated by Global Gender Cohort members, who may also be able to assist with contextualizing manuals for specific programs. Contact gendercohort@care.org for more information.

Training on Prevention of Sexual Harassment, Exploitation and Abuse (PSHEA)

All staff are required to complete online training on PSHEA to be able to recognize potential signs of abuse, respond to survivors, and safely and appropriately report all concerns.

- **PSHEA training** is available through CARE Academy.

GBV First-Line Support Training

Staff and partners directly involved in first-line support should receive **GBV First-Line Support Training** and, where relevant, **WHO 2019 training for health providers.**

- **GBV First-Line Support Training** is available through CARE's Gender Justice team.

GBV Integration Training

GBV Integration Training supports teams to integrate GBV in the whole program cycle and includes how to use the GBV integration toolkit. The training is a combination of training sessions and accompaniment.

- **GBV Integration training** is available through CARE's Gender Justice team.
- Examples of project-specific GBV Risk Mitigation training include these from the IMAGINE project and the Tipping Point project.

GBV Prevention Training

GBV Prevention Training supports participants to deepen their understanding of GBV prevention programming approaches and strengthen their capacity to design and implement quality GBV prevention programs

- **GBV prevention training** is available through CARE's Gender Justice team.

This resource for **all staff** implementing **development** programs. It accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Creating GBV Communications Materials

Many projects create Information, Education & Communication (IEC) materials to support project activities and campaigns. It is important any communications materials which refer to GBV do no harm by following the ethical principles detailed in CARE's GBV guidance for development programs Section I.

This resource outlines key points to guide development of posters, leaflets, videos, social media graphics or any other material used to support project activities or campaigns. It has been adapted from Raising Voices' SASA! Activist Toolkit.[1]

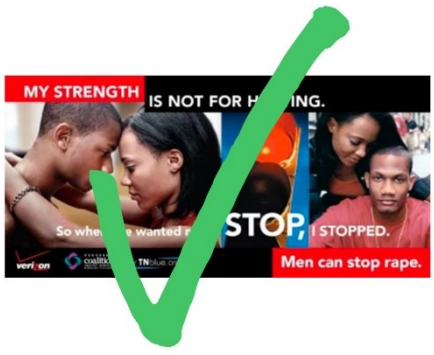
Maintain the Dignity of the Characters

When creating communication materials about GBV, it is tempting to use images that show women being abused. This approach needs to be used carefully, if done at all. Avoid showing women in undignified positions (i.e., naked, lying on the ground, in the middle of experiencing rape, etc.). While explicit images of acts of violence showing women in powerless and exposed situations may accurately reflect reality, they are rarely effective in helping to change people's attitudes.

Similarly, avoid showing sensationalized depictions of men being highly aggressive or violent; these are undignified portrayals of men. Women and men viewing explicit images such as these rarely want to identify with the characters or the issue that is being represented. Many people may feel ashamed to look at the image and as a result will either ignore it or joke about it, to diminish feelings of shame and embarrassment. The use of explicit images can further marginalize the issue, keeping it taboo instead of encouraging people to discuss it. Try instead to maintain the dignity of the characters by showing women and men as reasonable and thoughtful characters who are able to make positive decisions.

Portray the Positive

When discussing violence, instead of telling people that violence is bad, show how nonviolent resolution of conflict and nonviolent relationships are positive. For example, instead of showing a picture of a woman being beaten that reads "Stop Gender-Based Violence," it may be more effective to show a picture of a woman and man sitting together discussing a problem, with the male character saying, "I respect my wife; we talk about our problems together. Do you?" Avoid visual representations that portray survivors as victims. Instead, aim to show survivors as empowered people who decided to speak up. Materials that portray the positive and respectful role model and alternative ways of thinking and behaving are more engaging and can help facilitate a process of change.



[1] Raising Voices: SASA! Activist Toolkit for Preventing Violence Against Women and HIV/AIDS (Uganda, 2008).

Help Viewers Engage

When viewers see themselves in the materials and characters, they are more likely to think about the issue and reflect on how it affects them. Materials that show "regular" women and men will help more people identify with the characters. Avoid stereotypes. Take care in how you show the man who is being violent. Making this man into a "monster" (i.e., making him very scary, ugly, or mean) will prevent men from identifying with the character. Showing a man who is not out of control or looking too crazy will help others identify with him and his behavior. Similarly, when showing women, try to make the characters look like women in your community. Show women of different ages and sizes, from different economic levels, or who have a disability. The characters should represent the range of people in your community.

Avoid Blaming and Accusations

Communication materials should avoid blaming men or particular populations for violence. Accusing men of violence and publicly shaming men in materials often only increases resistance and backlash. It is important to hold men accountable yet not to insult, demean, or demonize them. This will only make them defensive and unengaged. This does not mean that the issue of male responsibility for perpetrating the majority of GBV should not be explored. For example, avoid "xx women were victims of homicide." Instead, highlight "xx women were killed by a partner." Depictions of violence that make the perpetrator less visible reinforce problematic perceptions of women as "victims" of crimes that happen to them, as opposed holding perpetrators accountable for their actions.

Further resources on portraying GBV in project and campaign materials

- **CARE**'s GBV Communications Policy and Guidelines
- **Raising Voices**' SASA! Activist Kit
- **UN Women**, **UNFPA** and **UNICEF**'s Guidelines on Responsible representation and reporting of violence against women and children
- **Gender-Based Violence AoR Global Protection Cluster**'s Preliminary guidance on Developing Key Messages for Communities on GBV & COVID-19
- **Sahiyo**'s resource guide to best practice for sensitive and effective reporting on FGC/M

This resource for **all staff.** It accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Organizational policies to support GBV integration & programming

It is vital all program staff are familiar with relevant organizational policies relating to GBV.

This resource outlines relevant CARE policies for staff when integrating GBV into programming.

The following linked policy documents must be understood and implemented by all CARE staff and Partners:

- CARE International **Safeguarding Policy**: Protection from Sexual Harassment, Exploitation, Abuse, and Child Abuse (2020)
  Note: a guidance note on Safer Programming that supports programmers in practically integrating and embedding safeguarding into CARE programs is available on the Safeguarding Hub in CARE Shares.
- CARE International **Vision 2030 Strategy**
- CARE International **Gender Equality Policy** (2018)
- CARE International **Programming Principles** (section 1.1.3 of CI Code, 2018)
- CARE International **Communications Involving Survivors of Gender-Based Violence**: Policy and Guidelines

CARE has a zero-tolerance approach toward sexual harassment, exploitation and abuse, and child abuse. We will carefully examine allegations and investigate, and take appropriate disciplinary action where this is needed, taking into consideration the rights and interests of the survivor, consistent with CARE's survivor-centered approach. We make very clear that sexual harassment, exploitation and abuse, and child abuse in any form, perpetrated by our staff, partners, or other related personnel, towards anyone, will not be tolerated.

Program assessment should be ongoing. Where risks are identified or feedback is received from participants, organizations must adapt, or redesign any element of the program which is exacerbating risk. Monitoring of programs should be done with the community, including women and girls, and other marginalized groups. This should be a continual process throughout the program cycle.

This resource for **all staff** working in **development** contexts. It accompanies CARE's GBV Guidance for Development Programs.

GBV RESOURCE:

Referral Mapping Tool

Referral mapping collects information about organizations providing services to GBV survivors.

This template is a resource to support staff with identifying services which provide survivor-centered care to those who have experienced GBV. It should be used to support GBV integration within development program in line with the 10 Steps for GBV integration outlined in CARE's GBV Guidance for Development Programs.

Note mapping the location, hours and types of services is not the same as assessing the quality of services, which requires specialized, additional training. Non-GBV specialists should not assess the quality of services, but should consult a GBV specialist and make reasonable judgments about whether or not it is safe, appropriate or helpful to refer a survivor there.

GBV Referral Mapping Tool	
Name of facility or service	
Address	
Contact Person's Name	
Contact Person's Title	
Phone	
Email	
Days and Hours of Operation	
Type of Organization	• Governmental • International NGO • National NGO • Community Based Organization • Faith Based Organization • Private sector • Other (describe):
Services offered (check all that apply)	• Health • Law enforcement • Legal aid • Shelter/safe house • Mental Health/ Psychosocial counseling • Economic opportunities/ empowerment • Community mobilization, prevention, and advocacy • Other (describe):
Target Populations	• Women • Men • Adolescents/Youth • Children • People living with HIV

	• Key populations (men who have sex with men, LGBTQI+ people, people who inject drugs, et al. Describe): • • Internally displaced populations or refugees • Others (describe):
Funding Sources	
How do your clients find your services?	
Are there any people whom you do not accept as clients here? Why not?	
How do you enroll survivors in your services? Do you have any intake forms or procedures?	
How do you handle GBV cases?	
Are your services free of charge? (check one)	• **YES** • **NO** (write the typical costs, e.g. medication, food, fees, etc.):
Does your organization use any guidelines, policies or protocols on GBV for case management? (circle one)	• **YES** (ask to see the documents and write their names here): • **NO** •
What is the average number of GBV cases you have seen here in the past year?	
Do you have any suggestions about how to improve GBV services and coordination in this area?	
Any comments or questions?	

Further resources to support referral planning

- Step 3 in CARE's GBV Guidance for Development Programs
- IRC GBV Assessment Tools (e.g., GBV Service Mapping; Community Mapping Guidance)

This resource is for all program staff. It This accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Safety Audits

A safety audit is a tool to assess safety and security concerns, with a focus on women and girls. While safety audits are typically carried out in emergency settings, they can also be conducted in development settings.

This resource outlines the safety audit process and how this may support GBV integration.

A proper safety audit covers "any geographic location with specific boundaries" which includes informal urban settlements, rural villages."[1] The safety audit tool **uses visual observation to assess GBV risks** based on the physical layout and structures in the geographic location as well as resource availability and provision of essential services and assistance. Because one organization cannot provide all essential services to a community, **safety audits are best done in collaboration** with other organizations for better buy-in when addressing risks that are identified. It is also highly recommended to conduct **participatory safety audits** that directly include community members, particularly women, girls, and marginalized groups, as long as it does not cause any security risks or social sanctions for the community actor.

WHY

A safety audit facilitates the identification of visible risks and the assessment of vulnerabilities to persons of all genders. The findings and analysis of safety audits then inform the design of interventions that include risk mitigation strategies and/or advocacy goals. Programs that have been designed with a contextual understanding of GBV risks and proactively work to mitigate them have a greater rate of success. Community members can access services safely, which will likely increase uptake of services and subsequent satisfaction.

A safety audit can form part of into broader gender and GBV analysis. This may be a Rapid Gender Analysis (RGA) during humanitarian crises or it may feed into GBV integration plans in development settings (see **Step 1** in the full GBV guidance for Development Programs for further details). The risk mitigation actions identified through safety audits and other GBV analysis can inform proposals and program design.

WHO

GBV risk mitigation is the responsibility of all staff. Therefore, all staff across all sectors can carry out a safety audit *as long as they have been trained by a GBV specialist***.** This should be a priority for staff, particularly those working in Education, Food Security, Shelter, and WASH services. Additionally, community actors should also be trained in safety audits if the activity does not pose a risk to the community. The GBV specialist should also be consulted during the risk mitigation activity planning.

Staff conducting a safety audit should be aware of referral pathways in case of spontaneous self-disclosures from survivors. See **Step 3** in CARE's GBV guidance for Development Programs for details of how to integrate this into development programming or CARE's GBViE implementation guide: Risk Mitigation for details of how this is approached in emergency settings.

HOW

Safety audits use observation and when the geographic area is secure, it can be completed by walking around and writing down notes. In locations where there is insecurity (e.g. increased police presence or where the collection of information causes may cause alarm), data collectors should be even more oriented with the data collection to

[1] UNICEF. Safety Audits: A How-To Guide. 2018.

support them in taking mental notes of questions and observations. In this scenario, the safety audit form will be completed after leaving the site/community.

The focus of the safety audit tool is to reduce risks for women and girls in the site/community. Therefore, safety audits should collect information on:

- Overall layout (walkways, lighting, shared housing)
- Unsafe locations around the community (e.g., drinking dens, known gang territory)
- GBV risks linked to:
  - WASH (location, waiting times, sex disaggregated showers/ latrines, locks);
  - Access and use of essential spaces and services (health, markets, schools, community centers, etc.) and receipt of CVAs;
  - Access to resources: farms and waterpoints;
  - Movement of women and girls: e.g., to fetching firewood, laundry, employment, etc.;
  - Presence of security actors (police, local vigilantes recognized by community members);
  - Any other relevant parameter that is helpful for the community (e.g., bus routes, political rallies, etc.);
  - Sexual harassment, exploitation, abuse, and child abuse if the program location, and set up of the site, present increased risk for exploitation, harm, and abuse, either directly or indirectly, caused by engagement in the program;
  - Potential risk mitigation strategies for the identified risks.

Learn more in this practical example of how to use a safety audit for development settings and this mapping of safety audit tools and reports in humanitarian settings.

Example of a safety audit in Indonesia: In 2018, UNWOMEN carried out a safety audit in a development setting in Indonesia as part of their Safer Cities project. The safety audit was participatory that included FGDs, KIIs and a safety walk. The safety audit also utilized SafetiPin, a map based mobile phone and online application that use a safety audit to provide information to women about urban safety in public spaces. The information provided is based on data collected by women users of the application and trained auditors. The geographic location was Jakarta post sunset and parameters of the audit were along: lighting, openness, visibility, crowd security, walkpath, availability of public transport, gender diversity.

WHEN

A safety audit should be conducted as part of ongoing assessments that are completed in the field. A safety audit can be done during the design phase of a project and will require follow-up during the implementation stage. The monitoring and evaluation process should include plans to determine the results of the audit; see UNICEF's 2018 Safety Audits: A How-To Guide for examples.

Follow-up safety audits should be done as part of continuous monitoring, evaluation, and accountability activities to assess whether the mitigation interventions are working and if there are new risks that have arisen or that are now safe to observe.

Safety audits must be carried out in line with CARE's data collection and safety and security protocols on the ground. This includes approval from the relevant officials on the ground, staff being easily identifiable on location, and contingency plans. See CARE's GBV resource on research ethics for further guidance.

After the safety audit is done, staff must be debriefed to share their observations and fill the safety audit tools. After the safety audit findings have been analyzed and GBV risks have been identified, a follow-up meeting must be held to discuss an action plan for disseminating the findings.

WHAT NEXT

Safety audits are best done in collaboration with other organizations and/or community members thus their findings are best discussed with other organizations. Therefore, findings should be disseminated to organizations working in the community, leaders of the community, and community members. This ensures collective effort and accountability towards addressing GBV risks in the community.

Collaborative safety audit action planning is the most effective means of addressing GBV risks. Organizations and community stakeholders in the area are responsible for placing GBV risk mitigation strategies, as a result, safety audit action plans should include, the risk mitigation strategy, organization responsible, a timeline to address the issue and the resources needed. Some action points may be within the purview of government actors and can be used for advocacy.

Further resources to support safety audits

- UN Habitat: Women's Safety Audit: What Works and Where? (2009).
- UNICEF GBViE Help Desk: Safety Audits: A How-To Guide (2018).
- Oxfam: SafetiPin: an innovative mobile app to collect data on women's safety in Indian cities (2015).

This resource is for **all staff** implementing **development** programs. It accompanies CARE's GBV Guidance for Development Programs.

GBV integration resource:

Sample GBV integration plan

A GBV integration plan describes key activities and programmatic principles that will be deployed during the project life cycle to integrate intentional attention to GBV throughout.

This resource provides a template to support program staff with developing their own GBV integration plan. It should be used to support GBV integration within development program in line with the 10 Steps for GBV integration outlined in CARE's GBV Guidance for Development Programs. There is no set format for a GBV integration plan and this may vary depending on the project scope and context; this resource is an example which teams should adapt to their needs. An example of a GBV Risk Mitigation and Management Approach document from a CARE project can be found on CARE Shares.

Analysis of GBV Risks

Copy in a GBV risk matrix or other documented reflections on potential GBV risks and actions to address these.

*See **Sample GBV risk matrix** in CARE's GBV integration resources, available from the GBV Hub on CARE Shares, for a template for this.*

Staff training process

Copy in any staff training needs identified, including details of who requires which training and when/how this will take place.

*See **Staff training to support GBV integration** in CARE's GBV integration resources, available from the GBV Hub on CARE Shares, for further details of key trainings.*

GBV referral mechanism

Note whether a referral mechanism already exists. If so, attach details within this GBV integration plan. If not, note the plans for how this will be developed.

As referral plans are developed, attach details and supporting documents within this plan. Supporting documents may include links to referral directories, details of referral pathways, incident report forms, GBV referral tracking form, or other related documentation.

See Step 3 in CARE's GBV Guidance for Development Programs, available from the GBV Hub on CARE Shares, for further details on referral planning.

Feedback and Accountability Mechanisms

Note whether a feedback and accountability mechanism already exists. If so, attach details within this GBV integration plan. If not, note the plans for how this will be developed and how this will link with project MEAL systems. As mechanisms are developed, attach details and supporting documents within this plan. Supporting documents may feedback forms or templates for aggregating data.

See CARE's Guidance for Creating and Managing Effective Community Feedback and Accountability Mechanisms for further information.

Roles and responsibilities

List the roles and responsibilities of specific staff members within the team and the organization, for both CARE and partners, bearing in mind that some may fall outside of the project team such as HR, MEAL, knowledge management or communications staff.

Confidential information management

Note any key points on data security and how confidential information will be managed. This may include reporting lines, who will have access to sensitive data, how this will be stored and any saving protocols.

See Ethical considerations for GBV research in CARE's Gender MEL Toolkit and the publication Beyond Numbers - Improving the gathering of GBV data to inform humanitarian responses from UNFPA for further information.

Links to relevant policies

Include links to relevant Country Office and CARE International policies which should be shared with and understood by all CARE and partner staff.

*See **Organizational policies to support GBV integration** in CARE's GBV integration resources, available from the GBV Hub on CARE Shares, for further details of key trainings.*

Plan for community engagement in GBV integration

Note details of how this GBV integration plan will be shared and reviewed within the community, such as quarterly reflection meetings or ongoing community engagement activities.

See this Community Participatory Analysis Toolkit for an example of how CARE's Tipping Point project integrated community engagement across analysis and implementation.

Further resources & examples to support development of a GBV integration plan

- *CARE's GBV Guidance for Development Programs*
- Tipping Point Risk Mitigation Strategy
- Mainstreaming GBV Considerations in CVA

This resource is for **all staff** working in **development** contexts. It accompanies CARE's GBV Guidance for Development Programs.

GBV RESOURCE:

Sample GBV risk matrix

A GBV analysis matrix summarizes findings from gender and GBV analysis and actions to address findings (such as mitigating risks, addressing gender norms around GBV, etc).

This resource provides a template to support program staff with developing their own GBV analysis matrix. The sample matrix below is adapted from the Cash & Voucher Assistance and Gender- Based Violence Compendium by CARE USA and the GBV Guidelines Reference Group.

A GBV risk matrix shows how findings from a GBV-inclusive gender analysis can help in planning how a project will address GBV. The example below shows how program planners for a hypothetical Cash & Voucher Assistance (CVA) project might find various conditions and norms that are contributing or could contribute to GBV. These are listed in the second column. In the third column, planners can analyze the type of GBV that are resulting or could result from the findings. The fourth column shows how the community or individuals in the community might be able to address GBV. In the fifth, the planners would list what actions the CARE should take within its program to address the findings. The final column listing potential benefits helps planners think through the effects of addressing GBV in their impact area.

GBV/CVA Risk Category	Gender/GBV Analysis Findings	Potential GBV Types	Individual and Community Measures to Address Findings	CARE Measures to Address Findings	Potential Benefits in This Area
Participation and Inclusion (Particularly Regarding Information Dissemination and Awareness)	Individuals do not wish to register with the agency for fear that gender identity or sexual orientation could be determined and lead to discrimination as a direct result of participating in a CVA intervention	Physical assault, psychological abuse	Informal support networks and GBV response services	Explore options to ensure confidentiality; alternative / discreet delivery mechanisms; broad targeting criteria to avoid stigma	Improved access to resources and opportunities for persons with diverse sexual orientations and gender identities

GBV/CVA Risk Category	Gender/GBV Analysis Findings	Potential GBV Types	Individual and Community Measures to Address Findings	CARE Measures to Address Findings	Potential Benefits in This Area
Safe and Dignified Access (Particularly Regarding Delivery Mechanisms of CVA)	Older women with disabilities are seen as "easy targets" for theft after cash or vouchers are delivered	Sexual assault, physical assault, psychological/ emotional abuse	Rely on trusted caregivers to collect assistance; support women's groups; consult with target populations about preferred and safe delivery methods	Identify safe delivery mechanism; work with CBOs to ensure safety after delivery; monitoring, feedback and response mechanisms in place	Electronic CVA can be very discreet, disbursed in multiple tranches, and allow this group to access resources and services, but consider barriers to access and use of technology for this group
Confidentiality of Personal Data of Survivors and Persons at Risk	Personal data is shared without proper protocols for confidentiality, resulting in discrimination against female beneficiaries of an ethnic minority.	Emotional and physical violence	Community consultations and outreach by local women's groups and other CBOs, discussion of targeting criteria	Consult with communities about vulnerability targeting criteria; include data protection protocols in partner agreements.	Broader discussion of GBV risks and trends with CBOs
Social Norms and Partner, Household & Community Relations	Increased household income may lead to early marriage for adolescent girls as families can afford "bride price". Additionally, some families may be in need of a new bride's dowry for sustenance.	Forced marriage of children (early marriage)	Community consultations and outreach by CBOs, gender and women's rights discussion groups including women and men of different ages	Place conditions on CVA for e.g., school registration of girls and boys; ensure strong community consultations to inform design; ensure that CVA is part of a broader program supporting basic needs and resilience, women's rights education	CVA and complementary services can lead to feelings of empowerment for women and girls; households better able to meet needs and decreased household tensions
Other (Context-Specific)					

See the following page for a blank table to support teams with creating their own GBV analysis matrix.

GBV risk matrix template

GBV Risk Category	Gender/GBV Analysis Findings	Potential GBV Types	Individual and Community Measures to Address Findings	CARE Measures to Address Findings	Potential Benefits in This Area

Further resources to support GBV risk analysis

- GBV guidance for Development Programs
- CARE's Rapid Gender Analysis (RGA) toolkit
- Gender Analysis in CARE's Gender MEL Toolkit
- Ethical considerations for Research and Programming in CARE's Gender MEL Toolkit
- Elhra GBV Gap Analysis