GENDER-BASED VIOLENCE GUIDANCE

FOR DEVELOPMENT PROGRAMS

care®

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.*

This guidance was a collaborative effort led by Chrysalis and CARE USA's Gender Justice team. It was funded with the generous support of the Together for Her Pooled Fund, the Mary Kay Ash Foundation and Mary Kay Inc., and by the CARE International Secretariat.

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
- GBV research ethics
- DOs & DON'Ts when responding to a GBV disclosure
- Glossary of GBV terms

GBV INTEGRATION RESOURCES

- Sample GBV integration plan
- Sample GBV analysis matrix
- Organizational policies to support GBV integration
- Staff training to support GBV integration
- How to conduct a safety audit
- Referral mapping tool
- Creating GBV communications materials
- Sample indicators for GBV integration

IMPACT AREA SCENARIOS FOR GBV INTEGRATION

- 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 shift 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 people of all genders**; 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

People of all genders 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 people of all genders.

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 transformation**, toxic masculinities, homophobia and transphobia
- **Economic exploitation and exclusion** of women and girls

Who does CARE reach?

CARE works with people of all genders 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, transform 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 transformation**—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:

- **Transforming social and gender norms**
- **Empowering people** of all genders
- **Engaging couples, men, boys and other key stakeholders** to promote non-violent conflict 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

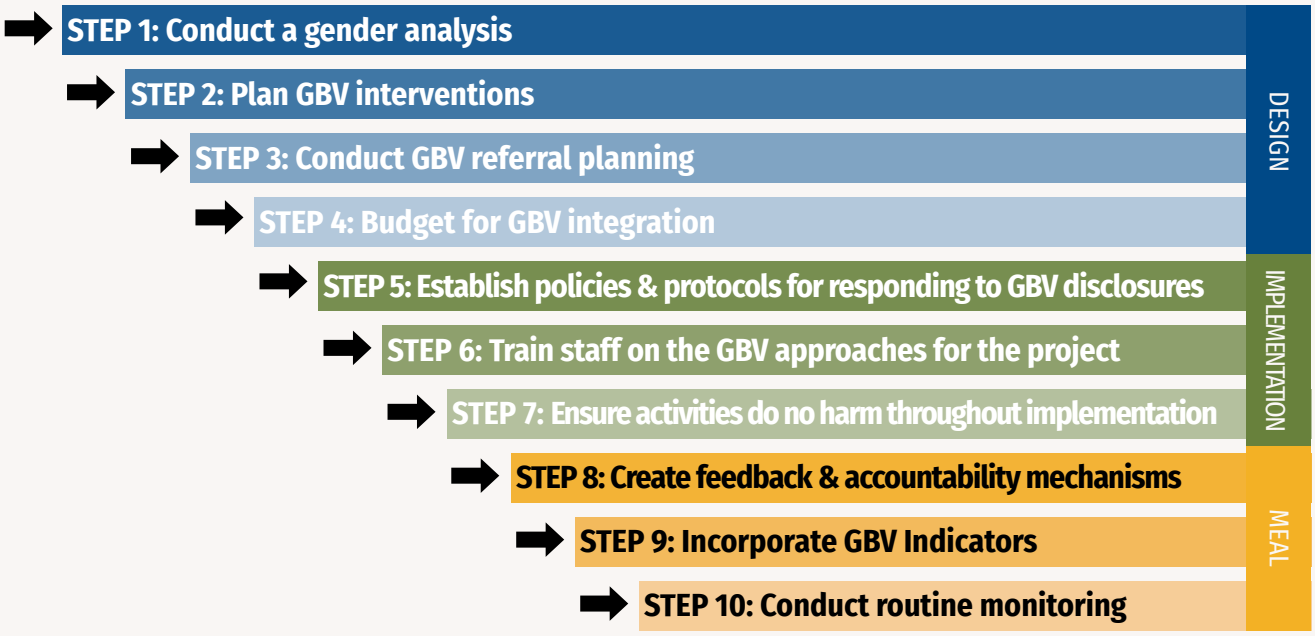
STEP-BY-STEP PROGRAM GUIDANCE

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 people of all genders: Empowering people of all genders, especially women and girls, 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.

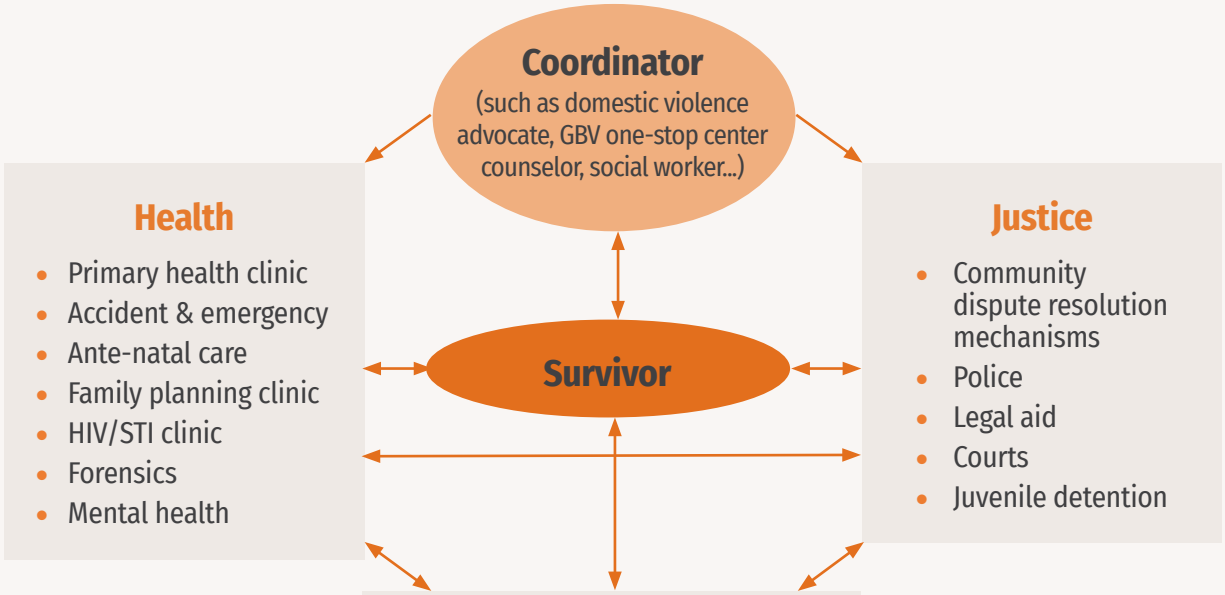
Mapping the location, hours and types of services is not the same as assessing the quality of services, which requires specialized, additional training. Only GBV specialists with **specific training in quality assessment and assurance** can assess the quality of post-GBV services.[1] **Non-GBV specialists 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 people of all genders 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.

Acknowledgements

This guidance was funded with the generous support of the **Together for Her Pooled Fund**, the **Mary Kay Ash Foundation** and **Mary Kay Inc.**, and by the **CARE International Secretariat**. The lead authors include **Joya Banerjee**, **Peninah (Nemo) Kimiri**, **Priyanka Samarakoon**, **Jenny Conrad**, **Thiagi Piyadasa**, and the **Iris Group**.

The authors would like to thank the following individuals for their contributions: Sarah Eckhoff, Leigh Stefanik, Chrissy Haneef, Erin Patrick, Jay Goulden, Everjoy Mahuku, Amy Ibold, Amy O'Toole, Holly Welcome Radice, Isadora Quay, Mary Beth Hastings, My-Linh Nguyen, Opper Maravanyika, Amira Taha, Hilary Mathews, Chloe Day, Debbie Landis, Aishwarya Nagar, Tirzah Brown, Suniti Neogy, Fabio Verani, Georgina Lund, Bantie Brownell-Morris, Maya FarrHenderson, Ashika Gunasena, Vindhya Fernando, Victoria Korsnes Nordli, Alexandra Moncada, Nihad Gohar, Rakhi Ghoshal, Nilar Tun, and Le Thi Hong Giang.

The authors would also like to thank the **CARE GBV / GBViE Community of Practice** for their thoughtful input.

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